COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services

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July 30, 2015

**MEMORANDUM**

**TO**: The Honorable Walter A. Stosch
Co-Chairman, Senate Finance Committee

The Honorable Charles J. Colgan
Co-Chairman, Senate Finance Committee

The Honorable S. Chris Jones
Chairman, House Appropriations Committee

**FROM**: Cynthia B. Jones

**SUBJECT**: Quarterly Report on Implementation Progress of the Financial Alignment Demonstration Waiver (Duals)

The 2015 Appropriation Act, Item 301 RRRR (1) requires:

> *"The Department of Medical Assistance Services (DMAS) shall provide quarterly reports beginning on July 1, 2015, to the Chairmen of the House Appropriations and Senate Finance Committees on the implementation of the Commonwealth Coordinated Care program, including information on program enrollment, the ability of Medicare and Medicaid Managed Care Plans to ensure a robust provider network, resolution of provider concerns regarding the cost and technical difficulties in participating in the program, quality of care, and progress in resolving issues related to federal Medicare requirements which impede the efficient and effective delivery of care."*

Should you have any questions or need additional information, please feel free to contact me at (804) 786-8099.

CBJ/

Enclosure

pc: The Honorable William A. Hazel, Jr., MD, Secretary of Health and Human Resources

**Department of Medical Assistance Services**
**Quarterly Report to the General Assembly**

***Report on Implementation Progress of the Financial Alignment Demonstration Waiver (Duals)***

**July 2015**

## Report Mandate

The 2015 Appropriation Act, Item 301 RRRR (1) requires:

> *"The Department of Medical Assistance Services (DMAS) shall provide quarterly reports beginning on July 1, 2015, to the Chairmen of the House Appropriations and Senate Finance Committees on the implementation of the Commonwealth Coordinated Care program, including information on program enrollment, the ability of Medicare and Medicaid Managed Care Plans to ensure a robust provider network, resolution of provider concerns regarding the cost and technical difficulties in participating in the program, quality of care, and progress in resolving issues related to federal Medicare requirements which impede the efficient and effective delivery of care."*

The CCC Annual Report, RD 429, was submitted to the members of the General Assembly in November 2014. This report is in accordance with the General Assembly Mandate (cited above) and is the first of the quarterly reports (in addition to the annual report) to document the progress of the CCC Program.

## Background

Under the Commonwealth Coordinated Care (CCC) Program, the Centers for Medicare and Medicaid Services (CMS), DMAS and three Medicare Medicaid Plans (MMPs), Anthem HealthKeepers, Humana and Virginia Premier, have contracted to provide all Medicare Part A, B, and D (hospital, outpatient medical and pharmacy respectively) benefits and the majority of Medicaid benefits to CCC enrollees, including medical services, behavioral health services and both institutional and community-based long term care services and supports (including consumer direction). CCC is a voluntary program and allows individuals to opt in or out at any time. The program began in March 2014 with a phased-in approach across 5 regions of the state, Central Virginia, Tidewater, Roanoke, Western/ Charlottesville and Northern Virginia. CCC will operate for three years in addition to the initial enrollment year. As of May 31, 2015, there are over 30,000 enrollees in the CCC program.

## Enrollment

In response to the feedback from stakeholders, CCC staff developed a new format for sharing enrollment information -- the CCC Enrollment Dashboard. The Enrollment Dashboard provides more detailed enrollment information as requested by stakeholders, including a breakdown of: the total enrollment population; enrollment by region; enrollment by plan; and type (community well (those living in the community and not on a waiver), Elderly or Disabled with Consumer

Direction Waiver (EDCD) Waiver recipient, or nursing facility resident). In addition, the dashboard includes information about the enrollment broker (MAXIMUS), the number of letters mailed to prospectively eligible beneficiaries, and the top five (5) opt-out reasons as captured by MAXIMUS.

The first dashboard was published in February of 2015 and has been updated monthly since then. All of the monthly dashboards can be found at the following link: http://www.dmas.virginia.gov/Content_pgs/altc-stkhld.aspx. Future reports will include trend enrollment and disenrollment data.

## Network Adequacy

Federal managed care regulations require health plans to demonstrate provider network sufficiency. As such, the MMPs are required to demonstrate annually and as requested, that they have an adequate provider network as approved by CMS and DMAS to ensure access to medical, behavioral health, pharmacy, and long-term services and supports. This includes ensuring providers are appropriate for and proficient in addressing the needs of the enrolled population. The MMP must maintain a provider network sufficient to provide all enrollees with access to the full range of covered services, including behavioral health services, other specialty services, and all other services required by federal and state regulations. The MMP must notify CMS and DMAS of any significant provider network changes immediately.

Network adequacy is determined on a locality by locality basis. As part of the Medicare network review, plans were required to meet the current Medicare Advantage standards, which require the MMP's network to be sufficient to serve the total Medicare eligible population within a locality. Future Dual Demonstration network adequacy standards used by CMS and DMAS will be revised to determine adequacy using the total CCC eligible population within a locality. For Medicaid-specific services, the plans were required to demonstrate that at least two providers for each service are available to enrollees. Each MMP's network submission is reviewed by a joint CMS and DMAS Contract Monitoring Team (CMT). Additionally, CMS employs a contractor to audit each MMP's network to ensure all requirements are met.

A table showing each MMPs covered service area by locality has been attached to this report (Attachment 1). An updated version of this table will be submitted for each quarterly report.

## Quality

Health care quality is defined as the degree to which health services for CCC enrollees increase the likelihood of desired health outcomes and are consistent with the current professional guidelines and best practices. To monitor and ensure the high quality of health care and services provided to CCC enrollees, CCC implemented a series of quality monitoring activities. MMPs are required to submit annual quality management and evaluation results. Performance measures are collected and reported by MMPs via CMS' Core Reporting Requirements, Virginia State Specific Reporting Requirements, and additional CCC Contractual Required Reporting Requirements. MMPs are required to participate in the Medicare Consumer Assessment of

Healthcare Providers and Systems (CAHPS) Survey and administer a Member Satisfaction Survey.

In addition, MMPs are required and monitored by DMAS to conduct quality improvement projects focusing on member care management and cardiovascular disease. MMPs are provided incentives by DMAS to meet performance benchmarks to earn back the capitation payment withhold via the CCC Quality Withhold Program. The CCC Quality Withhold Program withholds a percentage (one percent in year one, two percent in year two and three percent in year three) of the MMPs monthly capitation payment. The MMPs can earn back all, or a portion, of the withheld amount by meeting the quality withhold measure benchmarks set by CMS and DMAS. Quality improvement activities are monitored via ongoing meetings with the MMPs. DMAS has contracted with Health Services Advisory Group as our external quality review organization to conduct third party auditing on the MMPs' operation system, performance measures reporting, performance improvement projects and encounter data reporting. Member and external stakeholders have been engaged in quality activities via the CCC Quality Learning Collaborative and MMP Member Advisory Committee.

The first of the CCC Quality Monitoring Dashboards, which focuses on Care Management, is linked here. Each dashboard requires CMS review and approval prior to publication. New and updated dashboards will be included in future quarterly reports as they are approved. The dashboards along with other information on the CCC Quality Monitoring efforts can be found here: http://www.dmas.virginia.gov/Content_pgs/ccc-qm.aspx.

## Outreach

DMAS began training care coordinators from each of the health plans as a way to improve their performance and education. Various topics have been covered including plans of care, health risk assessments, interdisciplinary care teams, EDCD Waiver requirements, person centered care planning, advance directives and goal setting. Pre- and post-tests were conducted to evaluate understanding as well as a survey for the training session. To date, one round of training has been completed with each of the plans with a second round planned in June. In addition to the trainings, DMAS began hosting biweekly conference calls with the Care Coordinators as an opportunity for questions and answer from staff as well as a venue for sharing best practices.

## Targeted Stakeholder Meeting

DMAS, the three Medicare/Medicaid Plans (with recent involvement from the Virginia Association of Health Plans - VAHP) and the Virginia Health Care Association (VHCA), have been working together to correct issues arising since the launch of the CCC program in April 2014. This collaboration on issues has taken many forms, including multiple face-to-face meetings between the three "groups"; separate meetings with individual parties; numerous informal staff-to-staff interactions; and, most recently, VHCA and VAHP have solicited participation for two smaller issue-specific workgroups: the Claims Processing Workgroup and the Care Coordination Workgroup. These two smaller groups met for the first time on June 10th and 11th, 2015. The groups will continue to meet until the parties are satisfied that the specific

CCC implementation issues are resolved to the satisfaction of all parties, with a goal of resolution no later than October 1, 2015.

The goal of the Claims Processing Workgroup is to respond to the multiple processing issues that emerged from the three MMPs under CCC, primarily with the initial inability to process patient pay adjustments for Medicaid claims and subsequently the systematic processing issues that emerged under the switch to individual Resource Utilization Groups (RUGs) based billing under Medicaid. Specifically, the MMPs had difficulty applying the patient pay adjustment against Medicaid billing, thus facilities were overpaid by utilizing the unadjusted Medicaid rate. This led to the accumulation of significant reimbursement overages, which providers have been carrying on their books since the beginning of CCC. MMPs are only now beginning to address these overages. This has resulted in an additional administrative burden on the nursing facilities. The continued collaboration has been and remains integral in attempting to make this recoupment smooth for all parties.

With RUGs-based billing, it became apparent in early 2015 that MMP system glitches were causing significant numbers of Medicaid claims to be paid inaccurately or unpaid altogether. Each MMP had specific systems or process issues that contributed to a significant accumulation of accounts receivable at nursing facilities for the Medicaid portion of the reimbursements; at one point it was estimated that over $12 million in Medicaid claims remained outstanding. The MMPs have worked very hard to correct many of the issues, which has allowed for identification of provider processing issues with each MMP's requirements. These have been or are being corrected. The goal of the workgroup is to continue the progress toward a more efficient and consistent billing process under CCC so that all the MMPs can begin to meet the 14 day payment requirement contained in their contract with DMAS and CMS. Once these Medicaid payment issues are addressed (along with some other plan specific issues that have been identified with each MMP), the workgroup will deal with Medicare processing concerns which have also been significant.

While some nursing facility providers have acknowledged that the MMP care coordinators have been helpful to their members, some nursing facility providers have voiced general concerns that the care coordination aspects of CCC have not yet lived up to their potential. Some have indicated that care coordinators have not played much of a role in care planning or service facilitation for CCC residents at nursing facilities. To the contrary, some nursing facility providers believe that the care coordinator has been more involved in the hospital discharge process and not facilitating the necessary care in those facilities. This has caused some backlash toward the CCC program because the MMPs appear nonexistent on the front end of care, but then subsequently deny coverage of services already provided. To provide a forum where these and other issues can be addressed, the VHCA and VAHP have established the Care Coordination Workgroup. The primary goal of this workgroup is to define the role of the care coordinator so that both the MMPs and the providers understand what is necessary for the population served, and that expectations are consistent across the parties. This may also allow for different approaches to care coordination depending on the population served and their specific needs based on whether they are being served in the facility or in the community and their individual needs.

Together, these two workgroups should produce helpful educational materials, identify best practices and processes, identify policy barriers and find efficiencies and collaborative solutions

that will help providers on the ground, operating in and around the CCC program. Through these collaborative efforts, the groups hope to improve communication and overall cohesiveness between providers, health plans, the agency - and most importantly, the CCC beneficiaries. Additionally, the larger collaborative effort continues to work on other CCC implementation issues such as service authorization denials/delays, enrollee identification, network participation, coordination of benefits and Medicare/Medicaid program conflicts, and the significant administrative burden on providers relative to the existing fee-for-service programs. The groups will continue efforts to discuss and resolve these significant CCC concerns as well.

DMAS is also reaching out to Leading Age Virginia to request its participation in these meetings; however, outcomes of these meetings will be communicated to all nursing facilities regardless of their affiliation with an association.

DMAS, VHCA, and VAHP feel strongly about working toward success in the CCC program and recognize the importance of getting it right, particularly as the Commonwealth prepares to embark on its journey to move 107,000 lives from a fee-for-service, into a managed care model. Many of the issues experienced to date under CCC have been mitigated by lower than expected enrollment; to the extent beneficiaries will no longer be allowed to opt out of the Medicaid side of CCC, all parties are that much more concerned that these issues be resolved so that the CCC program might become an efficient and effective care delivery model for the frail populations served.

The group's charters, meeting summaries and tangible deliverables (documents, educational material etc.) will be made available on DMAS's CCC page. Documents will also be made available to VHCA and Leading Age Virginia for publication on their websites.