COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services

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November 1, 2015

MEMORANDUM

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

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

The Honorable S. Chris Jones
Chairman, House Appropriations Committee

FROM: Cynthia B. Jones CBJ/zn
Director, Virginia Department of Medical Assistance Services

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

The 2015 Appropriation Act, Item 301 RRRR 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)

October 2015

Report Mandate

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

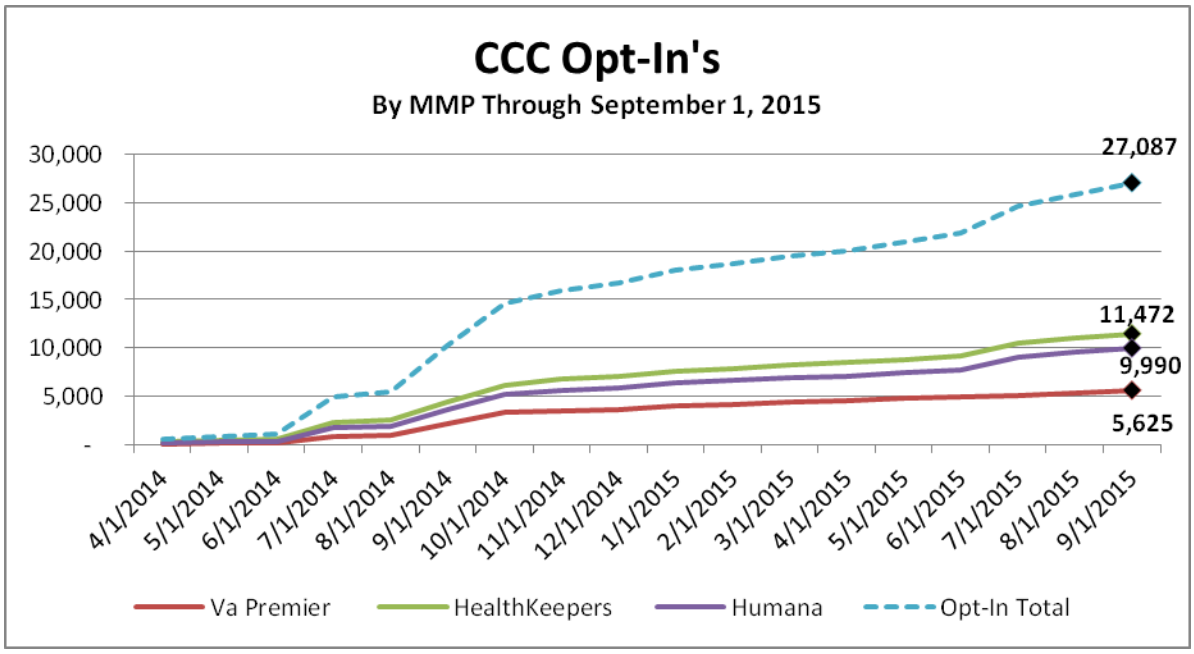
> *"The Department of Medical Assistance Services (DMAS) shall provide quarterly reports beginning on July 1, 2015, to the Chairmen of the House Appropriations and Senate Finance Committees on the implementation of the Commonwealth Coordinated Care program, including information on program enrollment, 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."*

Background

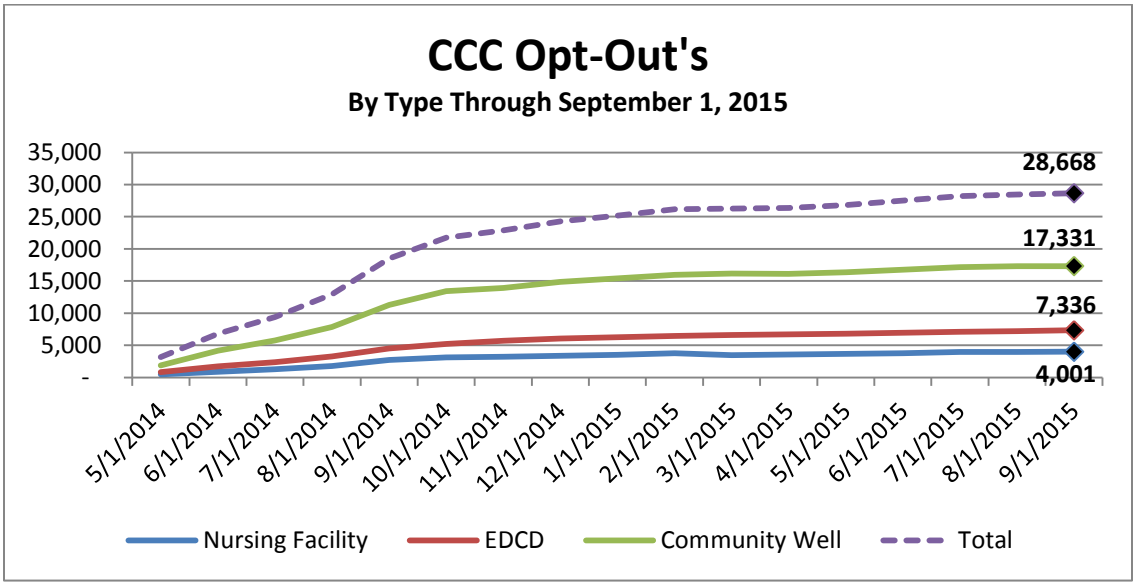
Under the Commonwealth Coordinated Care (CCC) Program the Centers for Medicare and Medicaid Services (CMS), DMAS and three Medicare Medicaid Plans (MMPs), Anthem HealthKeepers, Humana and Virginia Premier, have contracted to provide all Medicare Part A, B, and D benefits and the majority of Medicaid 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.

Enrollment

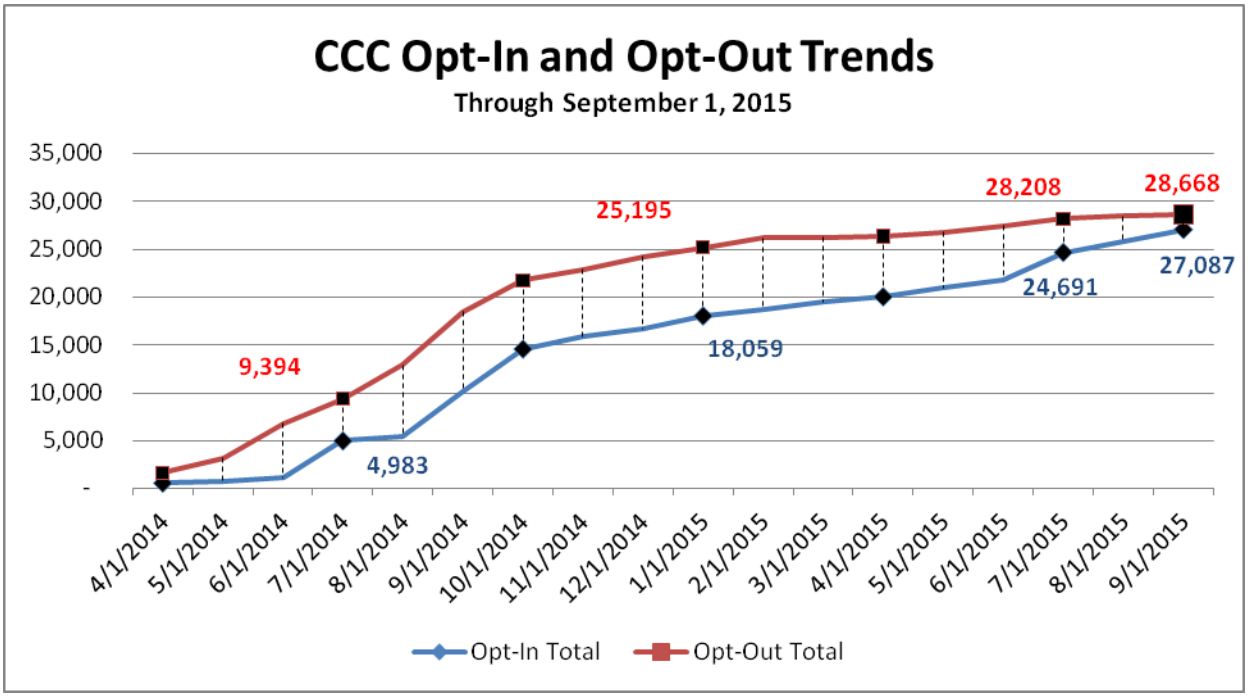
As displayed in the chart below CCC "Opt-In's" continue to trend upward. Currently there are 27,087 total CCC enrollees. Of that total 11,472 (42%) are enrolled with Anthem, 9,990 (37%) are enrolled with Humana and 5,625 (21%) are with Virginia Premier. The distribution of enrollees between the MMPs is largely, though not exclusively, due to the size of the MMPs networks. Since Anthem and Humana have met network adequacy in more localities they receive more enrollees through the automatic enrollment process.



The number of enrollees opting out and disenrolling from CCC continued to rise to 28,668 in September. Sixty percent of all opt-outs come from the community well population. DMAS and CCC staff continue to work toward reducing the number of opt-outs and disenrollments through outreach and education as well as reduced waiting periods for the first contact between the MMP Care Coordination and the enrollee.



The slowing of opt-out rates combined with continuing increase in enrollments has resulted in a decreased gap between the number of opt-outs and opt-ins. Of those that have acted fifty-one percent have opted out of CCC and forty-nine percent have opted in (these figure do not take into account those eligible for CCC that live in a single MMP locality and therefore do not have to opt-in or out of the program).



MMIS Enhancements

To increase the efficiency and accuracy of enrollment data between CMS and DMAS, the department has recently made enhancements to the Medicaid Management Information System (MMIS) to streamline the communication on enrollment transactions to decrease the number of enrollment discrepancies. These enhancements include more accurate enrollment transactions that are sent to CMS via MMIS, as well as the automation of some enrollment transaction requests from CMS to DMAS.

DMAS has also successfully prepared for the annual Medicare Low Income Subsidy reassignment process, which will allow DMAS to passively enroll CCC eligible members effective January 1, 2016 that would otherwise be excluded from CCC passive enrollment for calendar year 2016.

DMAS has made great strides during the quarter to accept CCC encounters directly from the MMPs. DMAS continues to hit all development milestones including finalizing the requirements and overall system design document, and is on track to begin accepting and processing CCC encounters beginning April 2016.

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 MMPs 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 (2) 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 employed a contractor to audit each MMP's network to ensure all requirements are met.

There have been no significant changes (addition or loss of a locality due to network adequacy standards) by any of the MMPs through the first quarter of FY 2015.

Resolution of Provider Concerns

CCC and MMP staff developed several avenues for providers to provide feedback, have their concerns addressed and ask questions. These opportunities include the dedicated CCC email address, the Quarterly CCC Advisory Committee meetings, targeted stakeholder meetings, individual MMP conference calls with providers and outreach efforts of the Ombudsman. Additionally, DMAS and the MMPs host joint conference calls with providers by type and as demand has dictated; currently these conference calls occur once a month for nursing facilities, hospitals and medical practices, while adult day, behavioral health and personal care, home health & service facilitator calls occur bi-weekly.

Through this quarter there have been no new issues brought to the attention of DMAS or the MMPs that indicate any widespread problems with provider reimbursement or costs to participate. DMAS and MMP staff continues to work with the Virginia Association of Health Plans and the Virginia Health Care Association to resolve issues discussed in a previous report. As a result of these meetings the health plans have produced helpful materials for providers and have also standardized several billing processes. DMAS will also continue to address the concerns and questions raised by individual providers as needed.

Quality

The previous quarterly report included a high level overview of CCC quality monitoring activities. For this quarter we will focus on the work done with the External Quality Review Organization (EQRO) in our organizational systems review and the CCC MMP Merged Survey, both of which experienced significant progress over this quarter.

DMAS has been working closely with our contracted EQRO, Health Services Advisory Group (HSAG), to conduct a full scale operation system review (OSR) audit of MMPs. The goal of the OSR is to ensure MMPs are in compliance with Medicaid and Medicare Managed Care

regulations, policies and procedures. CCC and HSAG staff completed all pre-audit requirements, such as the development and review of the OSR methodology and tools, and prearranged the audit timeframe with the MMPs. The onsite audit began in September 2015 and will conclude in early October 2015. The results will be finalized and released to DMAS senior management by the end of this year.

In 2015, a project team including DMAS and MMP representatives was created to plan and design a member satisfaction and quality of life survey. The goal of the survey is to assess member satisfaction on CCC MMP care management and member quality of life, using a short survey tool. The project team began working on the survey design in early summer and received approval to proceed by DMAS senior management by the end of September. Each MMP will survey 1,200 of their CCC enrollees by contracting with external survey vendors. The survey method will follow the Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. This type of survey asks consumers to evaluate their experiences with health care and focuses on aspects of quality that consumers are best qualified to assess, such as the communication skills of providers and ease of access to health care services. The survey will be administered in the fall with final result and analysis being submitted to DMAS by the end of January 2016.

Summary

Virginia's Medicare-Medicaid beneficiaries face a set of unique challenges and barriers to well-being, to include multiple chronic health conditions, co-occurring behavioral health needs, physical disabilities and socioeconomic disparities. The primary goal of the CCC program is to improve the quality of life for these vulnerable individuals and their families. We acknowledge there is still work to be done to reach this goal; however, we believe that continuing to improve our Information Management systems, ensure proper network adequacy, monitor the quality of the care and especially through continued work with our stakeholders we will see significant improvement in the health care and lives of the CCC enrollees.