COMMONWEALTH *of* VIRGINIA

Department of Medical Assistance Services

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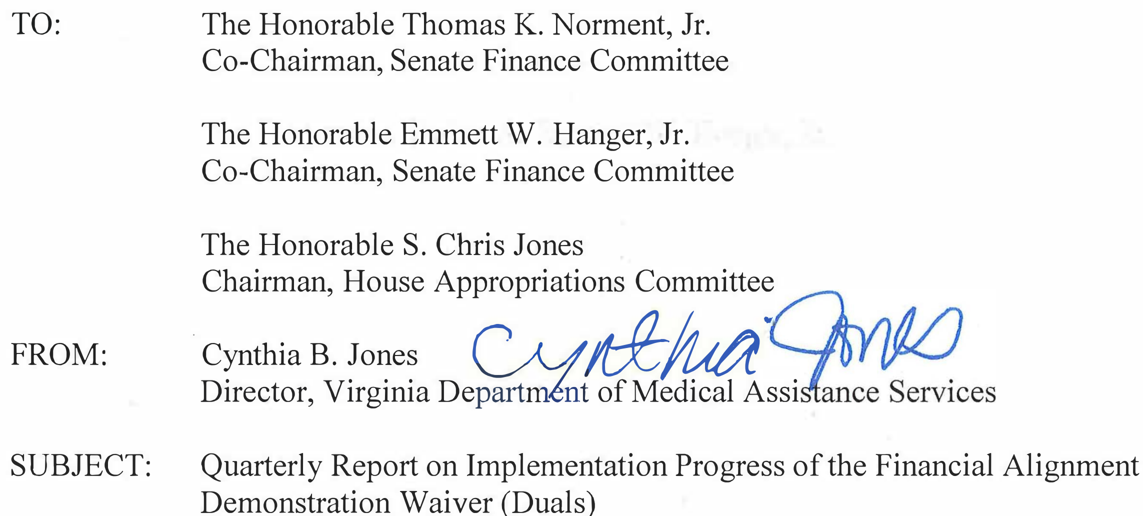
April 29, 2016

MEMORANDUM

TO: The Honorable Thomas K. Norment, Jr.
Co-Chairman, Senate Finance Committee

The Honorable Emmett W. Hanger, Jr.
Co-Chairman, Senate Finance Committee

The Honorable S. Chris Jones
Chairman, House Appropriations Committee



FROM: Cynthia B. Jones
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

ADMINISTERING MEDICAID AND THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM IN VIRGINIA

DMAS' mission is to provide a system of high quality and cost effective health care services to qualifying Virginians and their families.

The Medicaid program, signed into law by President Lyndon B. Johnson on July 30, 1965, celebrated its 50th year in 2015.

Medicaid is a joint federal and state program authorized under Title XIX of the Social Security Act that provides health and long-term care coverage for specific groups of Virginians with low incomes. In Virginia, Medicaid is administered by the Department of Medical Assistance Services (DMAS) and is jointly funded by Virginia and the federal government. Virginia's federal matching rate, known as the Federal Medical Assistance Percentage (FMAP) is generally 50%, so Virginia receives $1 of federal matching funds for every $1 Virginia spends on Medicaid.

Medicaid is primarily available to children in families with low-income, pregnant women, elderly, individuals with disabilities, and parents below strict income limits.

DMAS also administers Virginia's Children's Health Insurance Program (CHIP) known as FAMIS. FAMIS covers children and pregnant women in families earning too much to qualify for Medicaid but too little to afford private insurance.

All states must follow federal Medicaid/CHIP guidelines regarding who is covered, but set their own income and asset eligibility criteria. Virginia's eligibility criteria are among the strictest in the nation.

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

Report Mandate

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

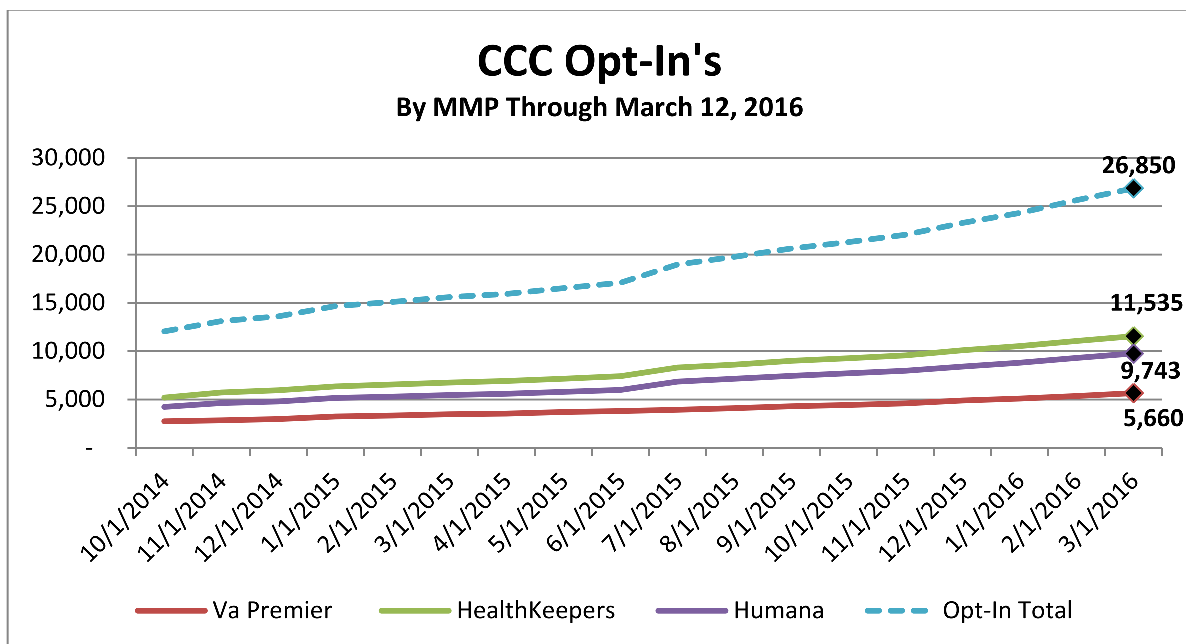
> *"The Department of Medical Assistance Services (DMAS) shall provide quarterly reports beginning on July 1, 2015, to the Chairmen of the House Appropriations and Senate Finance Committees on the implementation of the Commonwealth Coordinated Care program, including information on program enrollment,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

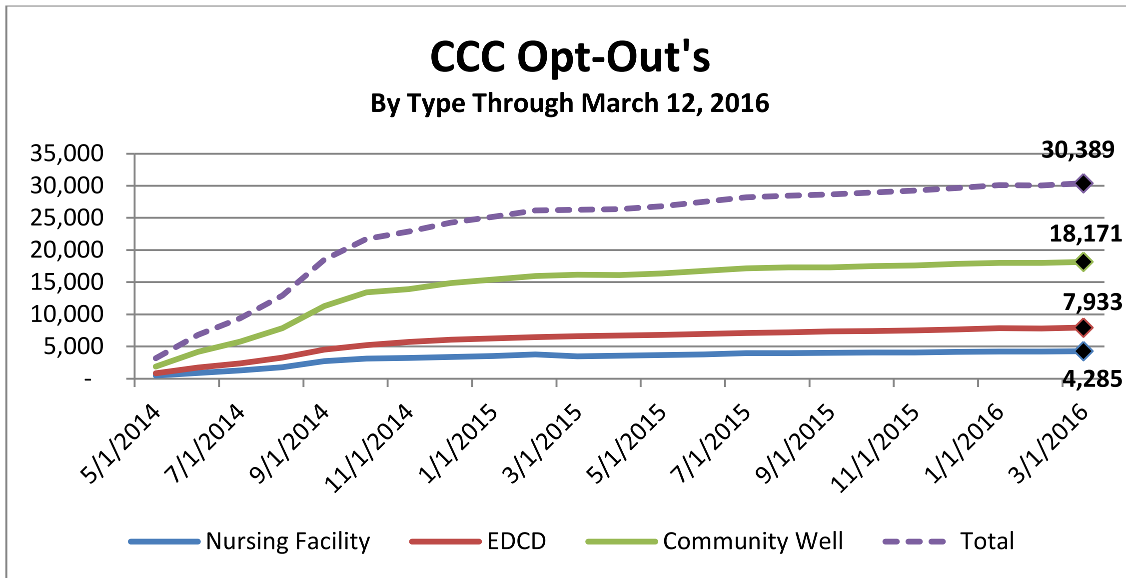
Under the Commonwealth Coordinated Care (CCC) Program, the Centers for Medicare and Medicaid Services (CMS), DMAS and three Medicare Medicaid Plans (MMPs), Anthem HealthKeepers, Humana and Virginia Premier, have contracted to provide all Medicare Part A, B, and D benefits and the majority of Medicaid 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. DMAS submits an annual report as well as quarterly reports on the implementation progress of CCC. The reports can be viewed on Virginia's Legislative Information System webpage.

Enrollment

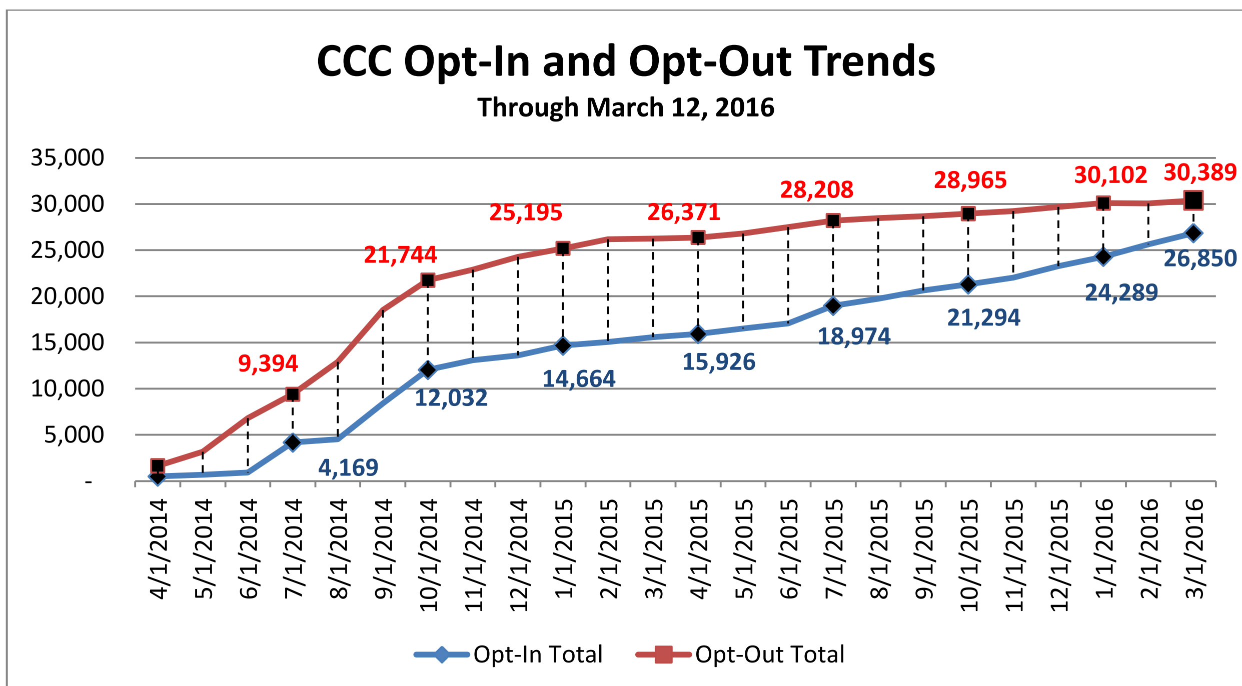
As displayed in the chart below, CCC "Opt-In's" continue to trend upward. Currently, there are 26,850 total CCC enrollees. Of that total, 11,535 (43%) are enrolled with Anthem, 9,743 (36%) are enrolled with Humana and 5,660 (21%) are with Virginia Premier. The distribution of enrollees between the MMPs 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 automated intelligent assignment process. The intelligent assignment process uses an algorithm to assign enrollees to a specific health plan based on key elements including previous Medicare managed care enrollment, historic utilization and previous MMP enrollment, if applicable.



The number of CCC eligible individuals opting out and disenrolling from CCC continued to rise to 30,389 in March. 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, 53 percent have opted out of CCC and 47 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 placed into production enhancements to the Medicaid Management Information System (MMIS) to streamline the communication on enrollment transactions to decrease the number of enrollment discrepancies. These enhancements, which went into place in September 2015, include more accurate enrollment transactions that are sent to CMS via MMIS, as well as the automation of passive enrollment rejection transaction requests and unsolicited disenrollment transaction requests from CMS to DMAS.

Encounter data is collected by the MMPs and documents all of the health care and related services provided to a member. DMAS has made great strides in the design of the MMIS 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. In addition, beginning in April 2016, MMPs will be submitting their entire listing of network providers to be systematically loaded and updated as needed in MMIS.

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 three two quarters of FY 2015.

Resolution of Provider Concerns

CCC and MMP staff developed several avenues for providers to offer 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 have hosted joint conference calls with providers by provider type (nursing facilities, hospitals and medical practices, behavioral health, adult day and personal care, home health and service facilitator). Over the life of the program, the frequency of the calls has decreased as demand has dropped. Recently demand has nearly dropped off completely; therefore, after consulting with providers, it was determined these calls are no longer necessary. The last of the joint conference calls was provided in December.

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 had been working with the Virginia Association of Health Plans and the Virginia Health Care Association to resolve issues discussed in a previous report. MMPs successfully implemented the mutually agreed upon modifications and due to decreased demand these meetings were dropped for this quarter. If needed, these meetings can be reestablished in the future. DMAS will also continue to work to address the concerns and questions raised by individual providers as they come to our attention.

Quality

DMAS has been working closely with our contracted External Quality Review Organization (EQRO) Health Services Advisory Group (HSAG) to conduct a full scale operation system review audit of MMPs. The goal of the audit is to ensure the MMPs are in compliance with Medicare and Medicaid managed care regulations, policies and procedures. This project started early in CY 2015 and concluded November 2015 with the final reports being submitted to DMAS and CMS at the end of 2015. In response to the identified deficiencies, MMPs are required to submit corrective action plans. By March 2016, all three MMP corrective action plans have been approved by the joint CMS and DMAS contract management team. The implementation of these plans will be monitored by the teams as well.

Additionally, CCC staff continued monitoring the annual MMP quality improvement projects. These projects began in early CY 2015 and focus on improving member care management and preventing hearts attacks and strokes. The project reports have been finalized and approved by both CMS and DMAS. The lessons learned from these projects have enabled the MMPs to implement rapid improvement strategies under for these two focus areas.

Finally, the HSAG 2015 annual technical report which summarizes all key quality activities, and the 2016 HSAG work plan were submitted to and approved by CMS and DMAS. Although all documents have been finalized and approved, additional CMS approval is required before they can be published. Once the reports have been approved for publishing, DMAS will post them on the DMAS website.

Summary

Virginia's Medicare-Medicaid beneficiaries face a unique set of challenges and barriers to well-being, including multiple chronic health conditions, co-occurring behavioral health needs, physical disabilities, and socioeconomic disparities. The Department strives to address these challenges and improve the quality of life for the vulnerable individuals enrolled in the CCC program and their families. DMAS continues to strengthen the program by improving IM systems, ensuring robust provider networks, monitoring the quality of care and continuing stakeholder engagement.

With CCC scheduled to sunset on December 31, 2017, DMAS is taking the lessons learned and planning for CCC's transition to the Managed Long-term Services and Supports (MLTSS) program. MLTSS will expand upon the principles of coordinated care, operate statewide, and serve individuals with complex care needs across the full continuum of care. All CCC eligible beneficiaries (opt-ins and opt-outs) will transition to MLTSS as the program launches from July 1, 2017 through January 1, 2018. As DMAS develops MLTSS, special care and attention will be given to the successful transition of CCC members into the new managed care contracts. DMAS is gaining significant experience with CCC and looks forward to building on this to ensure that MLTSS is also a success.