COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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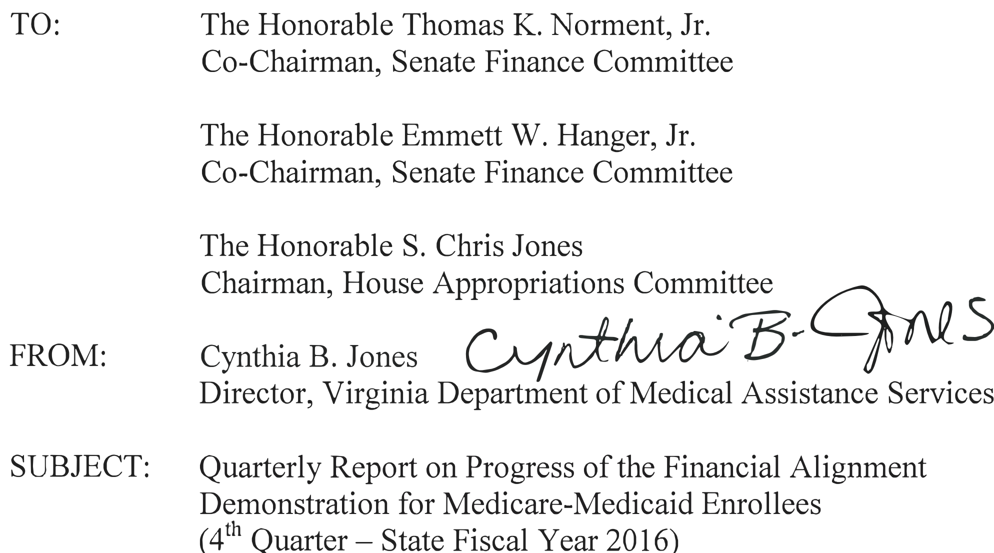
MEMORANDUM



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 Progress of the Financial Alignment Demonstration for Medicare-Medicaid Enrollees
(4th Quarter – State Fiscal Year 2016)

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

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 Progress of the Financial Alignment Demonstration for Medicare-Medicaid Enrollees (4th Quarter – State Fiscal Year 2016)

Report Mandate

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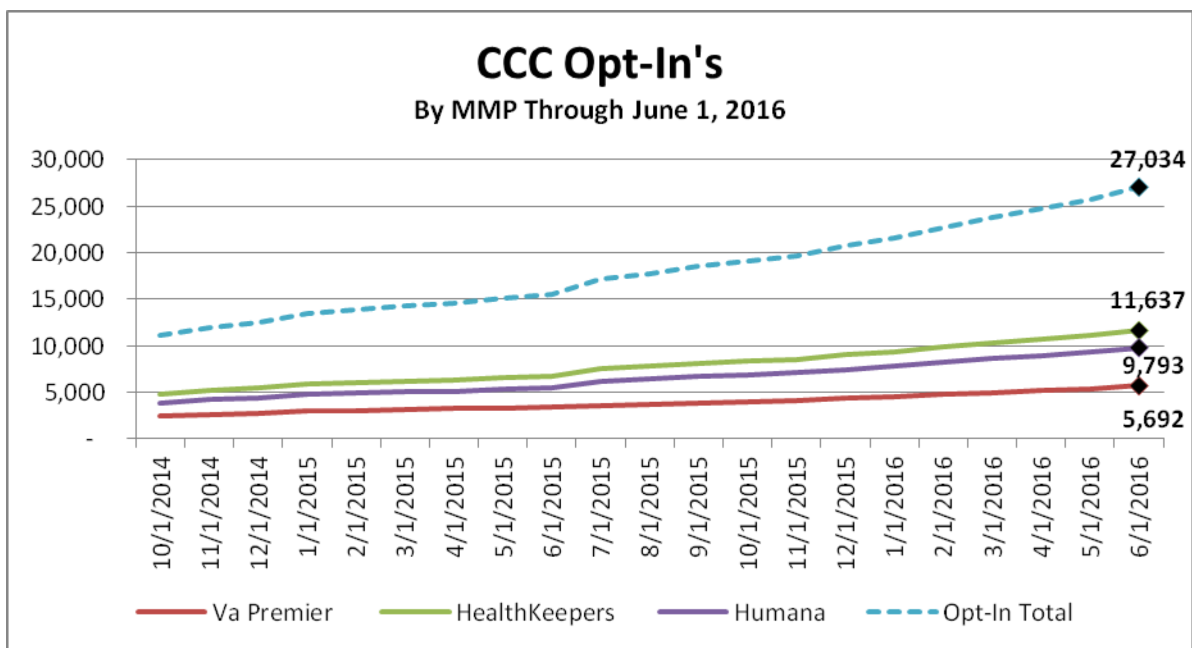
Background

The Commonwealth Coordinated Care (CCC) program provides all Medicare Parts A, B, and D benefits, as well as the majority of Medicaid benefits, including medical services, behavioral health services, and both institutional and community-based long term services and supports to CCC enrollees through contracted Medicare Medicaid Plans (MMPs). DMAS and the Centers for Medicare & Medicaid Services (CMS) contract with three MMPs: HealthKeepers, Humana, and Virginia Premier.

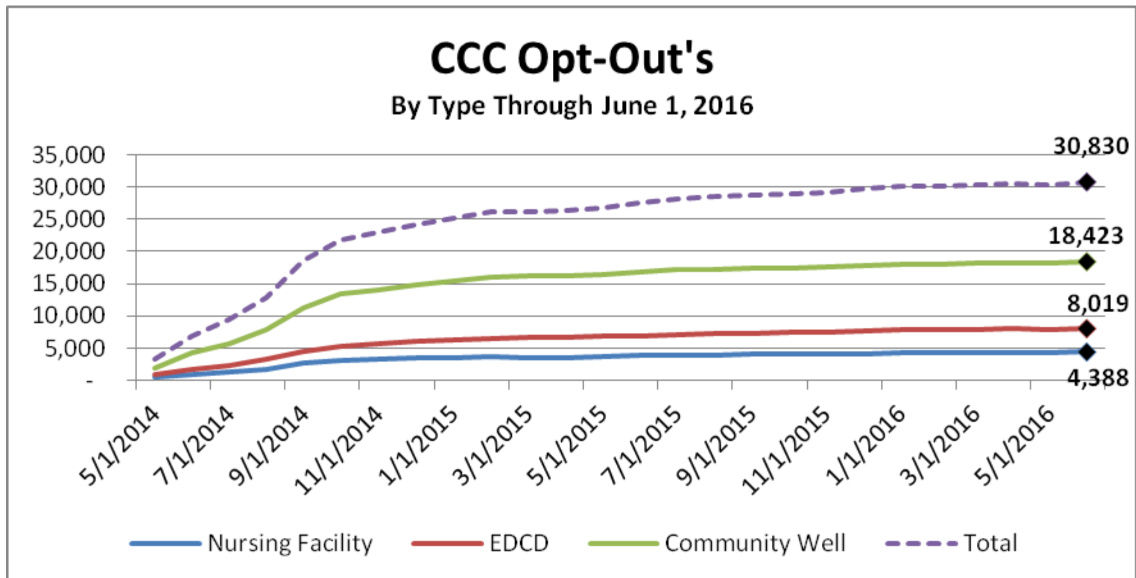
CCC is a voluntary program and allows individuals to opt in or out at any time. The program began in March 2014 and phased in enrollment across 5 regions of the state: Central Virginia, Tidewater, Roanoke, Western/Charlottesville, and Northern Virginia. CCC will operate for three years in addition to 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

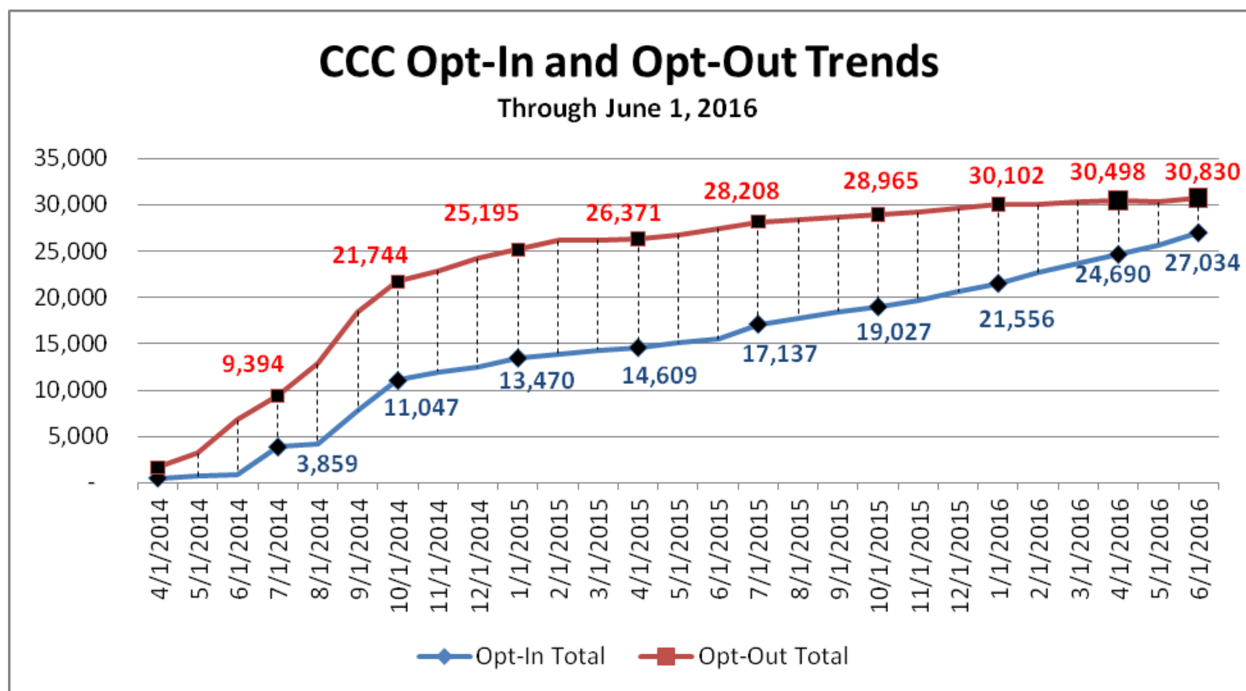
The number of individuals electing to opt in to CCC continued to trend upward in the fourth quarter of FY 2016. There are currently 27,034 total CCC enrollees. Of that total, 11,637 (43%) are enrolled with Anthem; 9,793 (36%) are enrolled with Humana; and 5,692 (21%) are with Virginia Premier. The distribution of enrollees between the MMPs is largely, though not exclusively, due to the size of the MMPs provider networks. Since Anthem and Humana meet network adequacy requirements in more localities, they receive more enrollees through the automated intelligent assignment process, which uses an automated algorithm to assign enrollees to a specific health plan based on previous Medicare managed care enrollment and historic utilization.



The number individuals eligible for CCC who opt out and dis-enroll from CCC also continued to rise to 30,830 in the last quarter, but at a lower rate than the rise in individuals electing to opt in. The majority (65%) of opt-outs come from the community well (not living in a nursing facility and not on the EDCD waiver) population. DMAS and CCC continue to work toward reducing the number of opt-outs and dis-enrollments through outreach and education efforts, as well as through efforts aimed at reducing waiting periods for the enrollee's first contact with the MMP Care Coordination staff. For instance, during this quarter, CCC staff hosted a town hall event in Fauquier County to educate potential enrollees on the benefits of the CCC program. A more detailed explanation appears in the "Network Adequacy" section on page 4.



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% have opted out of CCC and 47% have opted in, as compared to 55% opting out and 45% opting in from the previous quarter. These figures, however, do not account for individuals eligible for CCC that live in a single MMP locality and, therefore, do not have to opt-in or out of the program. DMAS hopes this trend continues as we add two localities to our service area.



Operational Enhancements

DMAS continues to increase the efficiency and accuracy of enrollment data with CMS. For instance, DMAS is further refining program operations and streamlining communication on enrollment transactions in order to decrease the number of enrollment discrepancies and minimize disruption of coverage for members. Other enhancements include increasing the accuracy of enrollment transactions sent to CMS via MMIS and working closely with each MMP to more easily identify enrollment discrepancies and quickly resolve issues.

Network Adequacy

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

Network adequacy is determined at the local level. As part of the Medicare network review, plans are required to meet the current Medicare Advantage standards, which require MMP networks 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. A joint CMS and DMAS Contract Monitoring Team reviews each MMP's network submission. Additionally, CMS employed a contractor to audit each MMP's network to ensure all requirements are met.

In the final quarter of FY 2016 there have been two significant provider network changes. First, Mecklenburg County was added for "opt-in only" beginning June 1. This means that only one health plan has met network adequacy in that locality. As a result individuals eligible for CCC must affirm that they want to opt in to CCC but cannot be passively assigned. Second, Fauquier County was added for "passive assignment" beginning July 1. This means that at least two health plans have met network adequacy in that locality. As a result individuals eligible for CCC will be passively assigned to one of the health plans using the automated intelligent assignment process. Individuals passively assigned have 60 days to opt out of CCC prior to their service begin date if they would like to dis-enroll.

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 the Ombudsman's outreach efforts.

In the previous quarter DMAS and the MMPs ended the joint provider conference calls due to significantly decreased demand. DMAS and the MMPs consider this to be an indicator of operational success. DMAS also believes this model to be a best practice from the CCC program and will be requiring a similar call center troubleshooting model for all awarded Managed Long-Term Services and Supports (MLTSS) plans. Call center staff will be trained to respond to questions and concerns specific to the Virginia MLTSS Program regarding verification of member enrollment; covered services; provider contracting and credentialing; service authorization; and claims payment.

Further, to ensure against regression and to improve the effectiveness of care coordination activities, CCC staff continues to host monthly conference calls with MMP care coordinators. During these calls, CCC staff addresses non-urgent issues or concerns raised by providers or other stakeholders, provides ongoing program education, and answers care coordinator questions. This forum has also served as a platform for the MMPs to share information with each other.

No new issues have been 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 (VAHP) and the Virginia Health Care Association (VHCA) to resolve issues discussed in a previous report. MMPs successfully implemented the mutually agreed upon modifications and, due to decreased demand, these meetings were suspended for this quarter. VAHP requested a status report on this group at the end of April. VHCA solicited feedback from all three provider organizations represented on the CCC claims workgroup and all stated that "*claims processing has generally gotten better*." If needed, these meetings can be re-established in the future. DMAS will also continue addressing the concerns and questions raised by individual providers as they come to our attention.

Quality

DMAS has been working with the External Quality Review Organization contractor Health Systems Advisory Group (HSAG) on the CCC MMP performance measure validation process. This validation process authenticates the MMPs' systems designed to capture and report

quality measures and ultimately verifies the accuracy of what is reported. The validation methodology and tools were developed in early in 2016. This quarter, HSAG completed a remote analysis of systems design for all three MMPs. This review evaluated performance measure reporting logic and was based on completeness, accuracy, and reasonableness.

Additionally, CCC staff continues to monitor the annual MMP quality improvement projects to ensure effectiveness and to proactively identify issues requiring special attention. CMS and DMAS contract management teams also continue to closely monitor the implementation of MMP corrective action plans that were issued in response to the 2015 HSAG MMP Operation System Review Audits. No major issues have been identified to date.

Summary

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

CCC is scheduled to sunset on December 31, 2017. DMAS is using lessons learned from this program to plan for CCC's transition to the MLTSS program. CCC has afforded DMAS significant experience, and DMAS looks forward to building on this to ensure that MLTSS is also a success. 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 individuals eligible for CCC (including those opting in or opting out) will transition to MLTSS upon program launch. CMS and DMAS have begun discussions on coordinating the successful transition of CCC members into MLTSS.