COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services

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May 1, 2017

MEMORANDUM

TO: The Honorable Terence R. McAuliffe
Governor of Virginia

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

Daniel Timberlake
Director, Department of Planning and Budget

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 (3rd Quarter – State Fiscal Year 2017)

The 2016 Appropriation Act, Item 306 AAAA and ZZ(2) requires a quarterly report 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.

VIRGINIA'S MEDICAID PROGRAM
DMAS
INNOVATION · QUALITY · VALUE

Quarterly Report on Progress of the Financial Alignment Demonstration for Medicare-Medicaid Enrollees (3rd Quarter – State Fiscal Year 2017)

Report Mandate

The 2016 Appropriation Act, Item 306 AAAA (1) requires:

> *"The Department of Medical Assistance Services (DMAS) shall provide quarterly reports beginning on July 1, 2015, to the Governor, Director, Department of Planning and Budget and 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

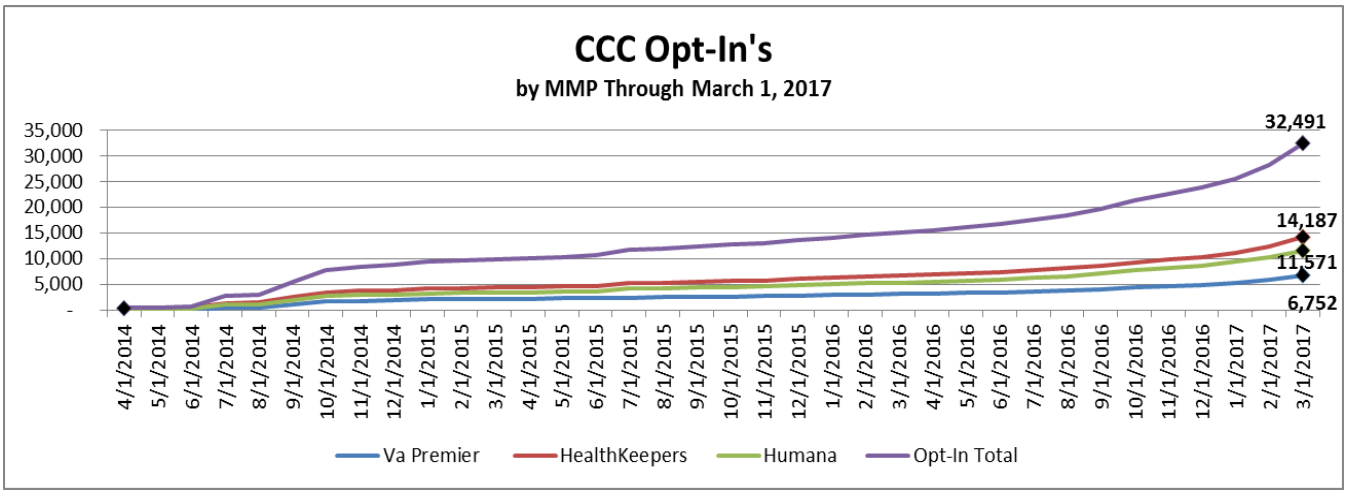
The Commonwealth Coordinated Care (CCC) program provides all Medicare Part A, B, and D benefits, as well as the majority of Medicaid benefits, including medical services, behavioral health services, and both institutional and community-based long-term services and supports to CCC enrollees through contracted 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 five regions of the state: Central Virginia, Tidewater, Roanoke, Western/Charlottesville, and Northern Virginia. DMAS submits an annual report to the General Assembly, as well as quarterly reports on the implementation progress of CCC. The reports can be viewed on Virginia's Legislative Information System webpage.

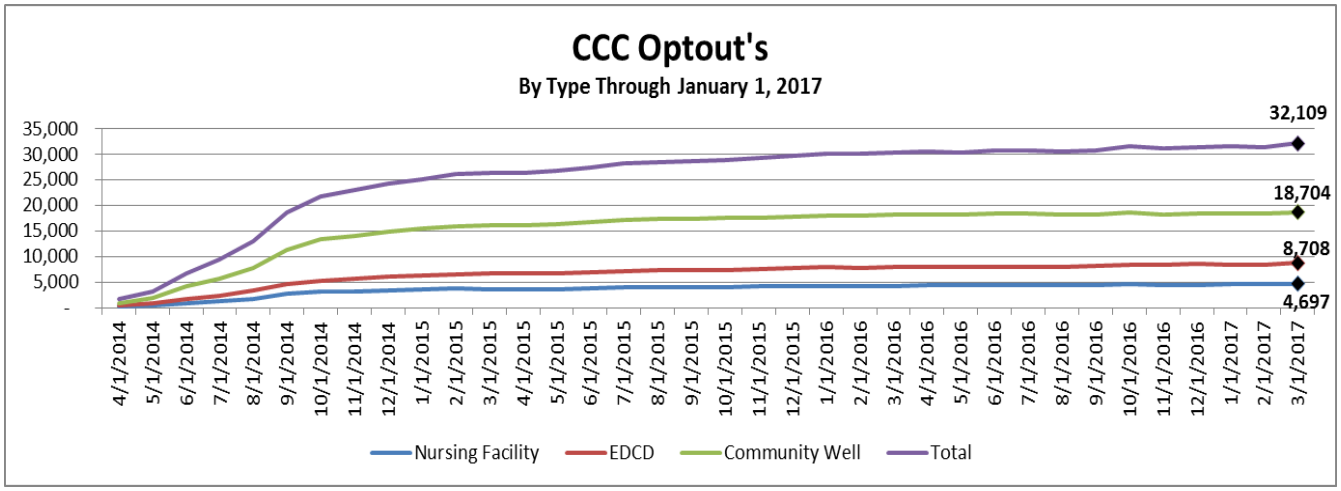
Enrollment

The number of individuals electing to opt in to CCC continued to trend upward in the second quarter of FY 2017. As of March 1, 2017, there are 32,491 total CCC enrollees. Of that total, 14,180 (44 percent) are enrolled with Anthem; 11,559 (36 percent) are enrolled with Humana; and 6,752 (21 percent) 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 algorithm to assign enrollees to a specific health plan based on previous Medicare managed care enrollment and historic utilization.

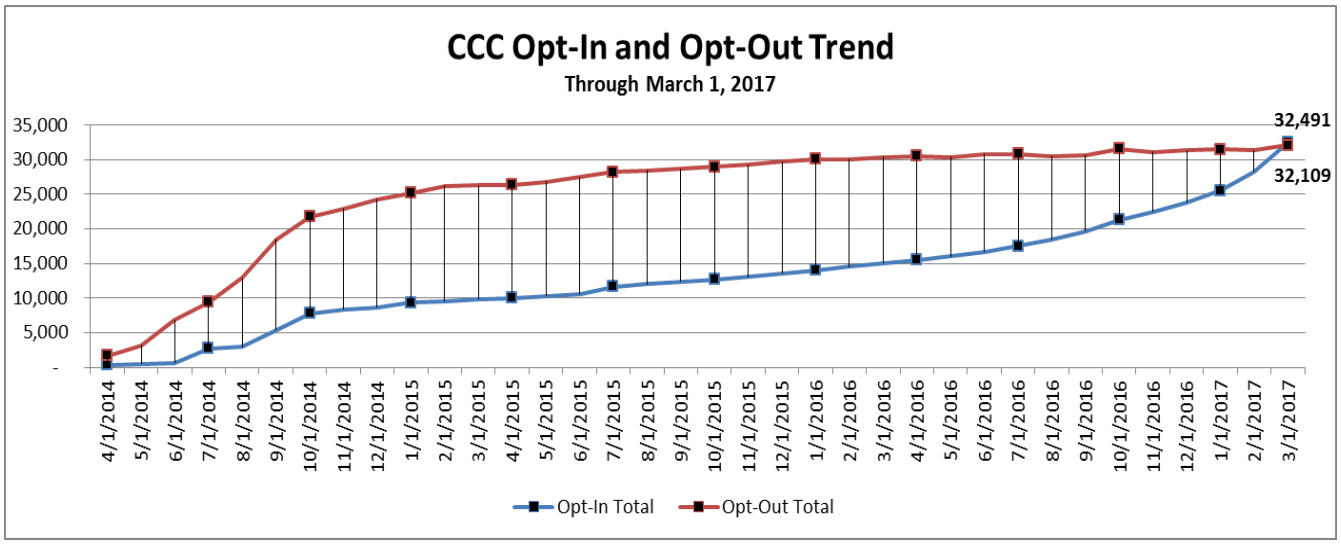


The number of individuals eligible for CCC who opt out and dis-enroll from CCC also continued to rise in the last quarter to 32,109. This is a lower rate of increase than previous quarters and is lower than the rise in individuals electing to opt in. The majority (58 percent) of opt-outs come from the "well population" (not living in a nursing facility and not on the Elderly or Disabled with Consumer Direction (EDCD) waiver). DMAS and the CCC health plans 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.



The slowing of opt-out rates, combined with continuing increase in enrollments, has resulted in slightly more opt-ins than opt-outs. Of those that have acted, approximately 50 percent have opted out of CCC

and approximately 50 percent have opted in, as compared to 51 percent opting out and 49 percent 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. As CCC begins to sunset DMAS anticipates an increase in opt-outs.



Operational Enhancements

DMAS continues to increase the efficiency and accuracy of enrollment data. 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 the Medicaid Management Information System (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. Therefore, MMPs are required to demonstrate annually that they have an adequate provider network as approved by CMS and DMAS to ensure enrollees have 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. As required in the three-way contract, 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. Dual Demonstration network adequacy standards used by CMS and DMAS have been 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 employs

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 quarters of FY 2017.

Resolution of Provider Concerns

CCC and MMP staff offer 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 the Ombudsman's outreach efforts.

In the previous year, DMAS and the MMPs ended the joint provider conference calls due to significantly decreased demand. The provider community agreed that the calls were no longer needed on a regular basis and could be reinstated if necessary. There were no requests to hold joint DMAS/MMP/provider calls in the past quarter. DMAS and the MMPs consider this to be an indicator of ongoing operational success. DMAS also believes this model to be a best practice from the CCC program and will be requiring a similar coordinated call monitoring structure for all contracted Commonwealth Coordinated Care Plus (CCC Plus) plans. Call center staff will be trained to respond to questions and concerns specific to the Virginia CCC Plus program regarding verification of member enrollment, covered services, provider contracting and credentialing, service authorization, and claims payment.

Further, to improve the effectiveness of care coordination activities, CCC staff will resume hosting monthly conference calls with MMP care coordinators. These calls were suspended during the last quarter due to scheduling conflicts. During these calls, CCC staff addresses non-urgent issues or concerns raised by providers or other stakeholders, provide ongoing program education, and answer 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 worked 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. If needed, these meetings can be re-established in the future. There have been no further significant issues identified by VHCA. 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 our External Quality Review Organization contractor, Health Systems Advisory Group (HSAG), on the Annual Technical Report to CMS. This report will summarize key CY2016 CCC quality of care related activities. The report is due to CMS in April 2017. DMAS will make the report available online at the same time it is submitted.

Additionally, CCC staff continues to monitor the annual MMP quality improvement projects to ensure effectiveness and to proactively identify issues that may require special attention. Staff is utilizing data from regular monthly, quarterly and annual reporting requirements along with the Healthcare Effectiveness Data and Information Set (HEDIS) results for CY2015 to inform evaluation and oversight

activities. The CY2015 HEDIS results are the first effectiveness data and information set measures to be made available on the CCC program. DMAS will be posting the results online early in 2017.

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. 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 Managed Long Term Services and Supports (MLTSS) program (called CCC Plus). CCC has provided the department with significant experience which DMAS will utilize to ensure that CCC Plus is also a success. CCC Plus 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 CCC Plus. CMS and DMAS continue discussions on coordinating the successful transition of CCC members into CCC Plus. Recently both parties have come to an agreement that CCC members will be enrolled with the same health plan for their CCC Plus services so long as their CCC plan is also participating in CCC Plus. This includes CMS enrolling members into the health plan's Medicare Advantage product. Members will have the opportunity to change health plans during the initial transition period and then again during the CCC Plus open enrollment period.