COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services

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MEMORANDUM

TO: Karen S. Rheuban, M.D.
Chair, Board of Medical Assistance Services

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: Annual Report on the Medicaid Physician and Managed Care Liaison Committee

The 2017 Appropriation Act, Item 306 GGG, requires the Department of Medical Assistance Services shall establish a Medicaid Physician and Managed Care Liaison Committee and the Committee shall establish an Emergency Department Care Coordination work group. The department, in cooperation with the committee, shall report on the committee's activities annually to the Board of Medical Assistance Services and to the Chairmen of the House Appropriations and Senate Finance Committees and the Department of Planning and Budget no later than October 1 each year.

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

Annual Report to the General Assembly on the Medicaid Physician and Managed Care Liaison Committee

A Report to the Virginia General Assembly — *October 1, 2017*

Report Mandate:

The 2017 Appropriation Act, Item 306 GGG, states:

"Effective July 1, 2013, the Department of Medical Assistance Services shall establish a Medicaid Physician and Managed Care Liaison Committee (MPMCLC) including, but not limited to, representatives from the following organizations: the Virginia Academy of Family Physicians; the American Academy of Pediatricians – Virginia Chapter; the Virginia College of Emergency Physicians; the American College of Obstetrics and Gynecology – Virginia Section; Virginia Chapter, American College of Radiology; the Psychiatric Society of Virginia; the Virginia Medical Group Management Association; and the Medical Society of Virginia. The committee shall also include representatives from each of the department's contracted managed care organizations and a representative from the Virginia Association of Health Plans. The committee will work with the department to investigate the implementation of quality, cost-effective health care initiatives, to identify means to increase provider participation in the Medicaid program, to remove administrative obstacles to quality, cost-effective patient care, and to address other matters as raised by the department or members of the committee. The Committee shall establish an Emergency Department Care Coordination work group comprised of representatives from the Committee, including the Virginia College of Emergency Physicians, the Medical Society of Virginia, the Virginia Hospital and Healthcare Association, the Virginia Academy of Family Physicians and the Virginia Association of Health Plans to review the following issues: (i) how to improve coordination of care across provider types of Medicaid "super utilizers"; (ii) the impact of primary care provider incentive funding on improved interoperability between hospital and provider systems; and (iii) methods for formalizing a statewide emergency department collaboration to improve care and treatment of Medicaid recipients and increase cost efficiency in the Medicaid program, including recognized best practices for emergency departments. The committee shall meet semi-annually, or more frequently if requested by the department or members of the committee. The department, in cooperation with the committee, shall report on the committee's activities annually to the Board of Medical Assistance Services and to the Chairmen of the House Appropriations and Senate Finance Committees and the Department of Planning and Budget no later than October 1 each year."

About DMAS and Medicaid

DMAS' mission is to ensure Virginia's Medicaid enrollees receive high quality and cost effective health care.

Medicaid plays a critical role in the lives of over a million Virginians, providing health care for those most in need. Medicaid enrollees include children, pregnant women, parents and care takers, older adults and individuals with disabilities. Virginians must meet income thresholds and other eligibility criteria before qualifying to receive Medicaid benefits.

Medicaid covers primary and specialty health care, inpatient care, and behavioral health and addiction and recovery treatment services. Medicaid also covers long term services and supports, making it possible for thousands of Virginians to remain in their homes or to access residential and nursing home care.

Quick Medicaid facts:

- Covers 1 in 8 Virginians
- Covers 1 in 3 births and 33% of children
- Supports 2 in 3 nursing facility residents

Virginia Medicaid and Children's Health Insurance Program (CHIP) are administered by the Department of Medical Assistance Services (DMAS) and are jointly funded by Virginia and the federal government under the Title XIX and Title XXI of the Social Security Act. Virginia generally receives $1 of federal matching funds for every $1 Virginia spends on Medicaid.

Background

The Medicaid Physician and Managed Care Liaison (MPMCL) Committee membership is comprised of representatives from the DMAS contracted managed care organizations (MCOs), the Virginia Association of Health Plans, and the physician organizations specified in the budget language referenced above. In January 2017, its membership was broadened to include the perspectives of non-physician providers who care for Medicaid members. Additional representatives from other provider associations including the Virginia Council of Nurse Practitioners, the Virginia Nurses Association, the Virginia Affiliate of the American College of Nurse-Midwives, and the Virginia Academy of Clinical Psychologists were invited to join the Committee. The current membership roster is attached.

The Committee meets biannually.

Current Year Activities

Identifying Committee Priorities

The MPMCL Committee held two face-to-face meetings in the past year, one on January 10, 2017 and another on June 9, 2017. Prior to these full committee meetings, members received an agenda of topics for presentation and discussion.

The following topics were on the agendas:

- Updates of Medallion 3.0 and 4.0 Programs
- Common Core Formulary
- ED Care Coordination Program
- Addiction and Recovery Treatment Services (ARTS) Waiver
- Plan and timeline to develop Virginia Medicaid Quality Strategy
- Public Testimony by Stakeholders

The last topic provided the stakeholders the opportunity to provide public testimony on their specific recommendations to improve outcomes for pregnant women, parents, and children within the Medallion 4.0 program.

Updates of Medallion 3.0 and 4.0 Programs

At the first meeting, the DMAS gave a presentation on both the Medallion 4.0 and Medallion 3.0 programs. Medallion 4.0 is scheduled to begin regional implementation in August 2018, and will cover 761,000 Medicaid and FAMIS members. Aspects of Medallion 3.0 such as expansion of networks, adequate rates, foster care, and telehealth will be incorporated into Medallion 4.0. There will be a stronger member and provider engagement by both DMAS and the health plans. On the member side, DMAS will provide an enrollment broker, member meetings, and expedited enrollment. The plans will be member focused, provide case managers, smartphone apps, financial incentives and outreach teams. On the provider side, DMAS will ensure that the health plans meet network adequacy standards and convene stakeholder meetings. The health plans will provide network management, provider training and service as well as ease of access for members to obtain services.

The regional implementation for Medallion 4.0 will begin on August 1, 2018 in the Tidewater region and finish on December 1, 2018 in the Southwest. There will be concurrent operation of both Medallion 3.0 and 4.0 with Medallion 3.0 being phased out by region through December 31, 2018.

Common Core Formulary

DMAS provided an overview of the Common Core Formulary to the Committee and its implementation in the Commonwealth Coordinated Care (CCC) Plus program. CCC Plus is a new statewide Medicaid Managed Long Term Services and Supports program that will serve approximately 214,000 individuals with complex care needs, through an integrated delivery model, across the full continuum of care. CCC Plus will operate statewide across six regions as a mandatory Medicaid managed care program. The program will focus on improving access, quality, and efficiency through a coordinated delivery system that emphasizes integrated care and value-based, alternative payment models. Regional implementation began on August 1, 2017 in Tidewater. Both CCC Plus and Medallion 4.0 will include the Common Core Formulary.

The Common Core Formulary is a list giving details of drugs that may be prescribed to Medicaid members. The Common Core Formulary includes all the preferred drugs on DMAS' Preferred Drug List (PDL). Preferred drugs are those that are available to members without prior authorization. CCC Plus health plans are required at a minimum to cover all preferred drugs on Virginia Medicaid's PDL without prior authorization. The health plans can add drugs to the Common Core Formulary but cannot remove drugs or place additional restrictions (such as prior authorizations, and quantity limits) for

drugs included on the Common Core Formulary. For drugs not included on the DMAS PDL (e.g., oral oncology drugs, HIV drugs, etc.), each health plan has published a formulary with the plan's covered drugs.

The primary goal of the Common Core Formulary is to ensure continuity of care for members. It should minimize disruptions in drug therapy when a member changes health plans and decrease the administrative burden for prescribers. If a drug is covered under the Fee-for-Service program, it will be covered by all the health plans with no additional restrictions or prior authorization requirements. The Medical Society of Virginia spoke at the end of the presentation to share the following results from a survey of their members:

- Physicians who do not accept Medicaid overwhelmingly cited prior authorizations (PAs) as the primary reason for not accepting Medicaid. Forty-seven percent cite prescription PAs as a reason to not accept Medicaid. Respondents also cited service PAs, the time involved in PAs, reimbursement, and inconsistent administrative requirements.
- Physicians who accept Medicated cited prior authorizations (52 percent) as the biggest problem they face in treating Medicaid patients; 40 percent identified inconsistent requirements for medications.

Emergency Department Care Coordination Program

DMAS updated the Committee on the Commonwealth's progress since the conclusion of the MPMCL Committee Emergency Department (ED) Care Coordination workgroup in Summer 2016. The Emergency Department Care Coordination program was established in 2017 at the Virginia Department of Health (VDH) to provide a single, statewide technology solution that connects all hospital emergency departments in the Commonwealth to facilitate real-time communication and collaboration between physicians, other health care providers and clinical and care management personnel for patients receiving services in hospital emergency departments, for the purpose of improving the quality of patient care services (re: § 32.1-372)*. Real-time patient visit information from electronic health records will be integrated with the Prescription Monitoring Program and the Advanced Health Directory. The Prescription Monitoring Program is a program used to promote appropriate use of controlled substances for legitimate medical purposes while deterring the misuses, abuse and diversion of controlled substances. The Advance Health Care Directives Registry is a secure location to store important documents, such as advance health care directives, wills, and physician's orders, that protect an individual's legal rights and ensure that a patient's medical wishes are honored in the event that they become incapacitated and unable to manage their own care. This sharing of information will allow facilities, providers and managed care organizations to identify patient-specific risks, create and share care coordination plans and other care recommendations, and access other clinically beneficial information related to patients receiving services in hospital EDs in the Commonwealth. DMAS and VDH have secured $3.9 million in federal HITECH funding for the ED Care Coordination and PMP integration technology platform, which will be Medicaid implemented by June 30, 2018 and Medicaid health plans only in the first year.

VDH has contracted with Connect Virginia to oversee the ED Care Coordination project, including convening the ED Care Coordination Council, which includes several representatives who also serve on the MPMCL Committee. The Committee reviewed the goals of the ED Care Coordination project and discussed how they can build upon the new technology solution in the future.

The Committee discussed how the ED Care Coordination Program aims to improve individuals' health by providing information, which assists providers in proactively redirecting their care and connecting them to more appropriate primary care settings. Five percent of patients account for nearly 25 percent of all ED visits in the United States. These high utilizers of the ED services typically do not receive the right care, with the right provider, at the right time – or at the right price. High utilizers often present to the ED with low acuity, chronic health concerns which are less appropriately addressed in the ED, which is designed to care for acute, episodic and emergent health conditions.

Establishing comprehensive primary care relationships with these individuals will reduce ED visits and decrease hospital costs, while providing the right care in the best setting for the patient. Ultimately, a member's relationship with their primary care providers will be supported and strengthened, leading to improved adherence to treatment recommendations and continuity of care. Reinforcement of the proper use of the health care delivery system teaches and enables participants to get their needs met by making informed decisions and directly accessing appropriate care. The MPMCL

Committee members expressed interest in working together after implementation of the technology solution. Specifically, the Committee is interested in using the real-time ED admission data to define shared care coordination models for ED high utilizers. This will include more clearly defining the role of the primary care physician, Emergency Department physician and social worker, and MCO case managers in coordinating care and achieving the best outcomes for members.

Update on Addiction and Recovery Treatment Services (ARTS) Waiver

DMAS shared new information from VDH on the opioid epidemic and provided an update on the DMAS Addiction and Recovery Treatment Services (ARTS) waiver. In 2016, an estimated 1,133 Virginians died of suspected opioid overdoses. Medicaid members are prescribed opioids at twice the rate of non-Medicaid members and are at three to six times the risk of opioid overdose. The Medicaid ARTS benefit was funded in the 2016 Appropriations Act to expand access to addiction treatment by transforming the delivery system for Medicaid members with Substance Use Disorders (SUD).

DMAS's ARTS program launched on April 1, 2017, and is based on the industry standard of the American Society of Addiction Medicine (ASAM) levels of care. The ARTS benefit will provide the full continuum of evidence-based addiction treatment to any of the 1.1 million Medicaid and FAMIS members who need treatment. In addition, the new program transfers the community-based addiction treatment services into the MCOs to promote full integration of physical health, traditional mental health, and addiction treatment services.

CMS approved the Commonwealth for a §1115 waiver that will significantly expand residential SUD treatment capacity. As part of the waiver, CMS requires an evaluation of the effectiveness of the services delivered in terms of clinician ARTS training and service provision as well as Medicaid member health outcomes, health care costs, and service utilization. To that end, a team of researchers from the Virginia Commonwealth University School of Medicine is conducting a robust evaluation of the new ARTS benefit and demonstration.

Plan and timeline for Virginia Medicaid Quality Strategy

DMAS presented on the plan and timeline for development of an agency-wide DMAS Quality Strategy across the Fee-for-Service, CCC Plus, and Medallion managed care programs including the internal DMAS Quality Steering Committee, stakeholder engagement efforts, quality improvement efforts, and the components of a quality strategy. The MPMCL Committee members requested that DMAS send a monthly report to providers with a manageable amount of data on a defined set of measures that reports the provider's performance across all the Medicaid members in their practice. The Committee asked for one report of provider performance on quality measures, not the separate data on different measures that they currently receive from each of the plans. Members requested data that is meaningful and actionable and tells them "What can I do differently tomorrow to improve outcomes for my patients that I'm not doing today?" An example measure would be the number of Medicaid members with HbA1c greater than 9 percent indicating poor control of diabetes and higher risk of complications. This information would allow the providers to reach out to these members to schedule visits to discuss how the members can improve control of their diabetes.

DMAS stated that the agency does not currently have this capability but may in the future after DMAS implements the Enterprise Data Warehouse in Summer 2018. Providers were asked to query their professional associations about what data and quality measures they would like to see on a report in the future. DMAS will use this information from the providers to evaluate whether the new Enterprise Data Warehouse has the capacity to produce these reports.

Public Testimony by Stakeholders

Oral or written public comment with specific recommendations for the Medallion 4.0 program that will improve outcomes for pregnant women, parents, and children was shared by the following provider association representatives: Lauren Bates Rowe, Policy Director, Medical Society of Virginia; Bergen Nelson, MD, Assistant Professor Pediatrics, Children's Hospital of Richmond at VCU, Karen Ronson, MD, Deltaville, VA., Kelly Hill-Walsh, PT, Pediatric Physical Therapist, Early Intervention Professional, Certified, Chair, Virginia Interagency Coordinating Counsel and Dr. Amber Price, DNP, CNM, RN, President Elect Virginia Affiliate American College of Nurse Midwives.

Summary

The MPMCL Committee continues to work closely with the provider community obtaining their input and feedback on upcoming major changes within DMAS and implementation of new programs such as CCC Plus and Medallion 4.0 that will affect both providers and members. The Committee is continuing to support the ED Care Coordination Initiative, partnering with DMAS on the future development of quality measures for providers, and addressing emerging new issues such as the Opioid Epidemic, which requires collaboration among the provider community and the Managed Care Organizations.

Medicaid Physician & Managed Care Liaison Committee Members 10/2/2017

Organization	Representative	Contact Email
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