COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services

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November 1, 2017

MEMORANDUM

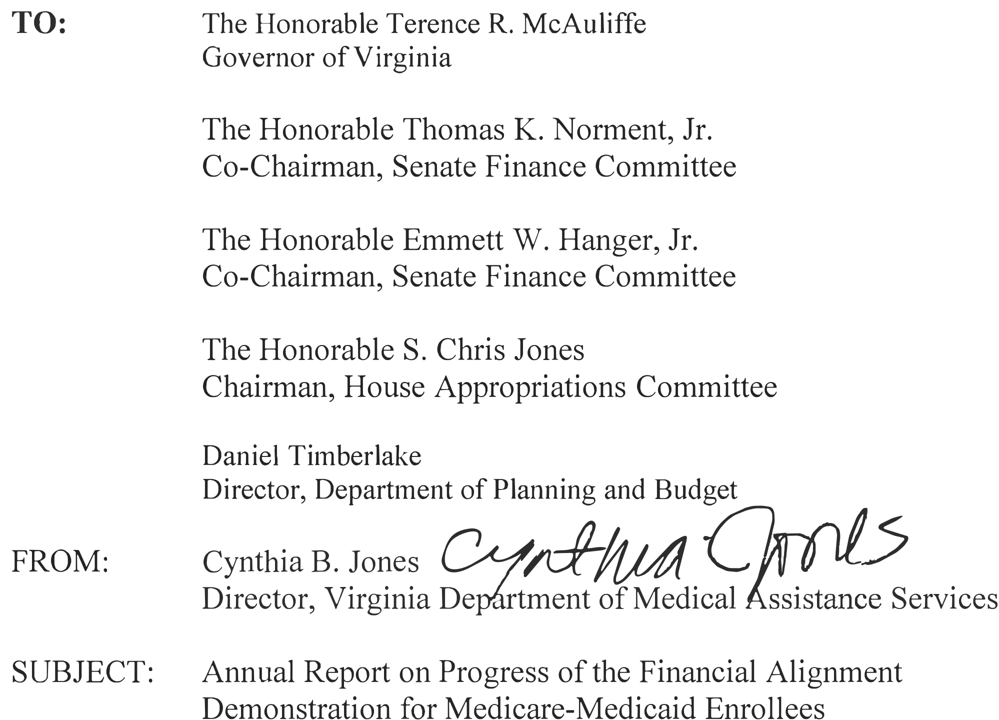
TO: The Honorable Terence R. McAuliffe
Governor of Virginia

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: Annual Report on Progress of the Financial Alignment Demonstration for Medicare-Medicaid Enrollees

The 2017 Appropriation Act, Item 306 AAAA(1) and ZZ(2) requires the Department of Medical Assistance Services to include in the quarterly report an annual update that details 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

Annual: Commonwealth Coordinated Care Report-State Fiscal Year 2017

A Report to the Virginia General Assembly

November 1, 2017

Report Mandate:

The 2017 Appropriation Act, Item 306 ZZ(2) and AAAA(1) requires:

ZZ(2) The department shall include in the fall quarterly report required in paragraph AAAA of this Item an annual update that details the implementation progress of the financial alignment demonstration. This update shall include, but is not limited to, costs of implementation, projected cost savings, number of individuals enrolled, and any other implementation issues that arise.

AAAA(1) 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

Individuals enrolled in both Medicare and Medicaid, known as dual eligible individuals, often have substantial acute medical and behavioral needs, in addition to chronic long-term service and support (LTSS) needs. Although dual eligible individuals comprise 15 percent of the Medicaid population, they account for 39 percent of Medicaid expenditures. In Virginia dual eligible individuals were initially excluded from participating in Medicaid managed care programs. Their care was dictated by conflicting state and federal rules and separate funding streams, resulting in fragmented and poorly coordinated care. Therefore, addressing quality and costs for these individuals has been a priority in the Commonwealth for many years.

In October of 2011, the Department of Medicaid Assistance Services (DMAS) submitted a letter of intent to the Centers for Medicare & Medicaid Services (CMS) indicating that Virginia's objective to integrate Medicare and Medicaid benefits under one system of coordinated care based upon a full-risk, capitated model. In 2014 the General Assembly authorized that program for dually eligible individuals known as Commonwealth Coordinated Care (CCC).

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.

The program was the first of its kind to align the administrative and financial components of the federal Medicare program and the state administered Medicaid program.

The 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 LTSS to CCC members through contracted Medicare Medicaid Plans (MMPs). DMAS contracted with three MMPs to provider program services: Anthem HealthKeepers, Humana, and Virginia Premier. Since its implementation DMAS has made significant strides in operationalizing a coordinated, integrated model of care for dual eligible individuals.

CCC is scheduled to sunset on December 31, 2017. DMAS is using lessons learned from this program to plan for CCC's transition to its new and revised version, CCC Plus, which will expand upon the principles of coordinated care, operate statewide, and serve members with complex care needs across the full continuum of care. All members eligible for CCC will transition to CCC Plus by January 1, 2018. CMS and DMAS continue discussions on coordinating the successful transition of CCC members into CCC Plus. 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 some of the current members into the health plan's Medicare Advantage (MA) – Dual Eligible Special Needs Plan (D-SNP). Members will have the opportunity to change health plans during the initial transition period and then again during each CCC Plus open enrollment period.

Enrollment

As of August 1, 2017, there were 24,997 total CCC members. Of that total, 11,373 (45 percent) were enrolled with Anthem; 8,497 (34 percent) were enrolled with Humana; and 5,167 (21percent) were with Virginia Premier (see Appendix A, Graph 1: CCC Opt-In Trend). The distribution of members 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 members through the intelligent assignment process, which uses an automated algorithm to assign members to a specific health plan based on their previous Medicare managed care enrollment and historic utilization.

As DMAS prepares to sunset the CCC program, the number of enrollees electing to opt-in to the program has decreased. Over the last three months, enrollment decreased by roughly 3,000 members. DMAS anticipated this change and as of May 2017 the Agency halted passive enrollment into CCC as enrolling someone into a health plan for only a few months would be disruptive and possibly detrimental to their health care needs.

The number of enrollees eligible for CCC who opt-out from the program has also decreased. As of August 1, 2017, 31,149 enrollees opted out from CCC (see Appendix A, Graph 2: CCC Opt-outs). This decrease can also be tied to the sunset of the program - as there are fewer people being passively assigned there are fewer people to opt-out. The majority (58 percent) of opt-outs come from the "community well" population - enrollees who are neither living in a nursing facility nor enrolled in DMAS' Elderly or Disabled with Consumer Direction (EDCD) Waiver).

Quality Monitoring and Care Coordination Performance

DMAS' approach to quality monitoring in the CCC program has remained much the same from the previous fiscal years. Routine Quality Monitoring activities included, but were not limited to:

- DMAS and MMP quality committee and team meetings to monitor quality strategy design and implementation;
- MMPs' quarterly member advisory committee meetings;
- Monitoring MMP performance improvement projects, which focus on (1) improving member care management and (2) preventing cardiovascular disease; and
- DMAS' External Quality Review Organization (EQRO), Health Services Advisory Group, conducted their annual review and validation of the MMP's performance measures and performance improvement projects.

This year, in addition to the activities mentioned above, DMAS' CCC and Medallion 3.0[1] staff collaborated to

[1] DMAS' statewide mandatory Medicaid program that serves over 700,000 members, including children, care taker parents, and pregnant women.

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align DMAS' quality monitoring activities. For example, DMAS convened joint calendar year (CY) managed care health plan best practice sharing sessions, where DMAS' contracted managed care health plans from both the CCC and Medallion 3.0 programs shared best practices and lessons learned.

The Health Outcomes Survey (HOS) is the first patient-reported outcomes measure used in Medicare managed care. The goal of the HOS is to gather valid, reliable, clinically meaningful data to use in quality improvement activities; pay for performance; monitoring health plan performance; public reporting; and to improve health. Since CCC provides Medicare services, the HOS is used to evaluate the health status of CCC members. The results of the CY 2016 HOS illustrated that CCC members are sicker, both physically and mentally, than the national average for MA enrollees (see Appendix B; Table 1).

These results highlight the intense need for effective care coordination. Care coordination is the backbone of the CCC program, and while it can be challenging, it is essential to improving member health outcomes. Based on the CY 2016 Consumer Assessment of Healthcare Providers and Systems (CAHPS®) results, which measure patients' experiences with their health care, the CCC MMPs' care coordination composite measure was significantly higher than the national MMP average. Additionally, compared to much more experienced MA plans, the CCC MMPs' composite score was either equal to or higher than that of other MA plans. These results can be attributed to hard work on the part of CMS, DMAS, the MMPs, and the provider community at large.

The HOS and CAHPS® results illustrate that CCC members are generally very satisfied with the care coordination services they receive. Care coordination empowers members to better navigate the complicated health care system and to have greater control of their health (see Appendix C, CCC Success Story for a demonstration of how the CCC program is working to achieve the program's goals).

Transition to Commonwealth Coordinated Care Plus

DMAS has been working with CMS, the CCC Advisory Committee and key stakeholders to prepare for the CCC program to sunset on December 31, 2017 and to plan the transition to CCC Plus. For example, with input from the Advisory Committee, DMAS expanded the role of the CCC Advisory Committee to include oversight for both CCC and CCC Plus. The Committee will continue as the CCC Plus Advisory Committee when the CCC program sunsets. Meetings with key stakeholders (e.g., nursing facilities, home health, early childhood development, behavioral health, etc.) have focused on applying lessons learned from CCC to CCC Plus to maximize the efficiency and effectiveness of CCC Plus to best meet members' needs.

Enrollees who opted out of CCC will transition to CCC Plus according to the CCC Plus regional rollout plan (See Appendix D for Regional Rollout Schedule). All CCC members will transition to CCC Plus on January 1, 2018. To ensure a smooth transition:

- CMS and DMAS have agreed that all Anthem and Virginia Premier CCC members will transition to the same health plan for CCC Plus.
- CMS has agreed to transition members into Anthem and Virginia Premiers' Medicare D-SNP, whenever possible.

Since Humana will not operate as a CCC Plus health plan, CCC members enrolled with Humana will be assigned to one of the six CCC Plus health plans using the intelligent assignment process, which uses an automated algorithm to assign members to a specific health plan based on previous Medicare managed care enrollment and historic utilization. Members will have the opportunity to change health plans during the initial transition period and then again during the CCC Plus open enrollment period.

Appropriations and Cost Savings

Appropriations

Beginning with the 2013 Appropriations Act, the General Assembly has provided funding to implement and operate the CCC program. The amounts displayed in Table 1 below do not include capitation payments paid to the MMPs. The appropriated amounts included costs to:

- Employ DMAS personnel to implement and monitor the program;
- Support contract modifications for DMAS' Medicaid EQRO, as required by federal regulations for Medicaid managed care systems;
- Cover implementation and operating costs for DMAS' enrollment broker, Maximus;
- Cover actuary expenses to develop rates for the MMPs; and,

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- Implement changes to the state's Medicaid Management Information System (MMIS).

Table 1: CCC Appropriations

FY	General Funds	Non General Funds	Total
2014	$650,784	$1,850,891	$2,501,675
2015	$1,208,568	$2,408,675	$3,617,243
2016	$1,819,523	$3,091,630	$4,839,153
2017	$1,819,523	$3,019,630	$4,839,153

During the 2014 General Assembly Session, DMAS requested and received approval for additional on-going funding for CCC. Specifically, $1,115,564 ($557,564 from non-general funds) and $1,221,910 ($610,955 from non-general funds) was requested and approved for FYs 2015 and 2016, respectively. The funding was needed for contract modifications to cover costs associated with increased work for the enrollment broker and DMAS' actuary to revise the MMP Per-Member-Per-Month Capitation rates, additional enhancements to the Medicaid Management Information System (MMIS) and hiring additional staff to monitor the program. All CCC staff will transition to work on CCC Plus.

There are no appropriation changes from FY 2016 to FY 2017 related to CCC activities.

Cost Savings

Per the CCC program requirements, Medicaid payments to the MMPs are based on estimates of what would have been spent in the absence of the CCC program, less a savings adjustment of one (1), two (2), and four (4) percent in years one (1), two (2) and three (3), respectively. For example, if CCC had not been implemented it would have cost the State at least $2.5 million more to serve the same population through Medicaid Fee-For-Service.

As illustrated in Table 2 below, the total net savings for CCC was $2.5 million in FY 2015, $4.5 million in FY 2016, and $10.2 million in FY 2017. These figures reflect the reduction in the capitated payment amounts as described above and the savings in reduced service needs of CCC members due to a more robust care coordination model.

In Table 2, the column labeled "Cost Without CCC" reflects the total Medicaid costs for dual eligible individuals if the CCC program was not an option, and the column labeled "Cost With CCC" reflects the total Medicaid costs for dual eligible individuals given the CCC program is available.

Table 2: CCC Cost Savings

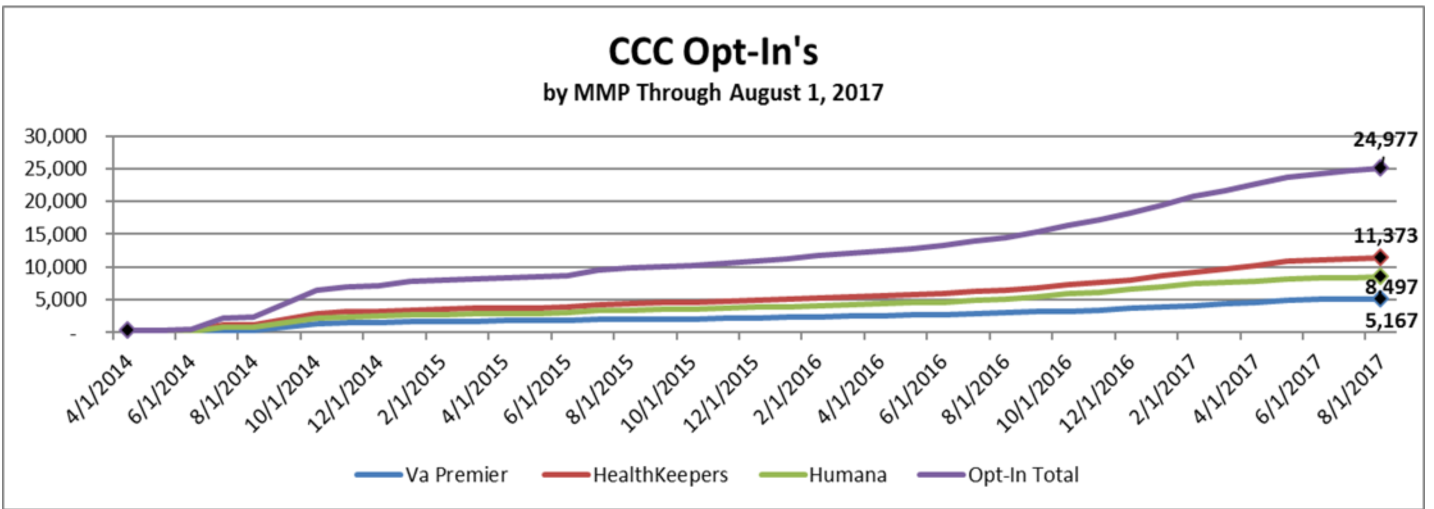
FY	Cost Without CCC	Cost With CCC	Net Savings
2015	$249,777,127	$247,279,356	($2,497,771)
2016	$314,135,291	$309,661,584	($4,473,707)
2017	$340,313,814	$330,071,976	($10,241,838)

Summary

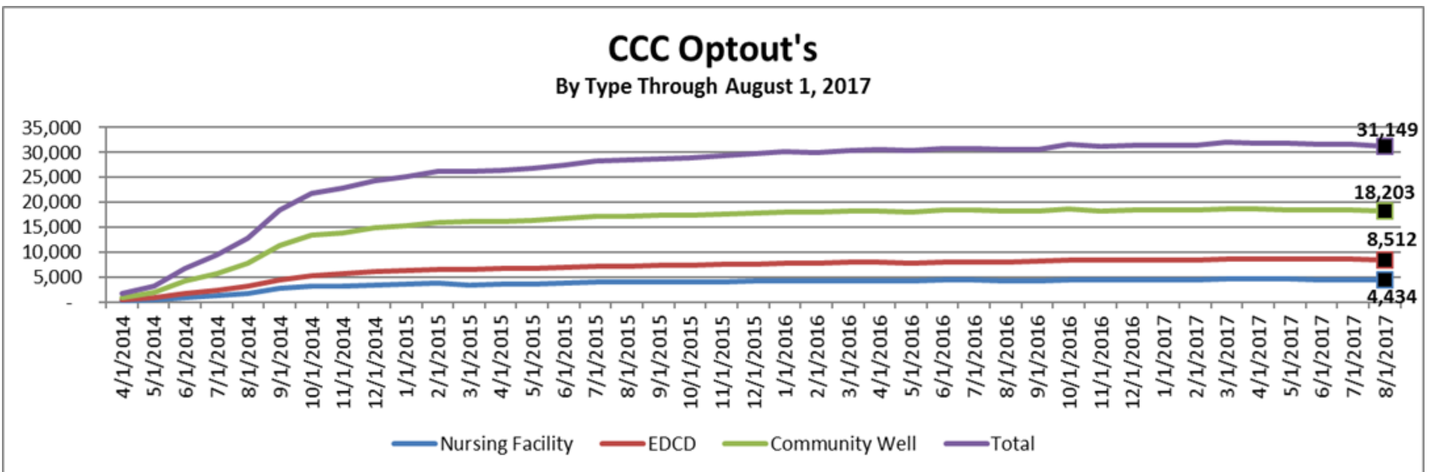
In conclusion, dual eligible individuals face complex and costly challenges, including substantial acute and primary, behavioral, chronic, and LTSS needs. DMAS, CMS and the three MMPs strive to address these challenges and improve the quality of life for the members enrolled in the CCC program and their families by reducing fragmentation, providing high-quality and coordinated care, and encouraging individual participation in treatment decisions. The CCC program has demonstrated impressive results since it was implemented in 2014. CCC's scheduled sunset on December 31, 2017 aligns with the phase in of CCC Plus. CCC provided DMAS significant experience. DMAS looks forward to continuing its work with the CCC Plus Advisory Committee and key stakeholder groups to ensure CCC Plus is at least as successful if not more.

Appendix A.

Graph 1: CCC Opt-In Trend



Graph 2: CCC Opt-out Trend



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Appendix B.

Table 1: CY 2016 HOS Mean Adjusted Physical and Mental Composite Summary Scores

Health Plan	Adjusted Physical Composite Summary Score	Adjusted Mental Composite Summary Score
Anthem	34.8	48.8
Humana	35.0	49.3
VA Premier	35.3	49.0
HOS Virginia Average	39.7	52.7
HOS National Average	39.3	53.1

The HOS Composite Score is based off member survey results and indicates the "sickness" of the members. The lower the composite score the sicker the member (Scale is specific to each health plan and is adjusted based on member health risk status and overall case load mix). Table 1 illustrates that, on average, of the three MMP's, Anthem members rate themselves as being sicker (physically and mentally) than the other MMPs' members. Furthermore, the MMPs' members rate themselves as being sicker (physically and mentally) than other MA plans operating in Virginia and nationally.

Table 2: CY 2016 CAHPS® Care Coordination Composite Measure Score

Health Plan	Care Coordination Composite Score
Anthem	3.6
Humana	3.59
VA Premier	3.6
National MMP	3.54
National MA	3.59

The CAHPS® Care Coordination Composite Measure Score indicates the overall effectiveness and member satisfaction with the MMPs' Care Coordination services. The scale is 1 – 4 with the higher the score the better. Based on the results, on average, the CCC MMPs rate higher than MMPs in other states and on average with the more experienced MA plans.

Appendix C.

CCC Success Story

Health History: Member has a history of hypertension, type two diabetes, history of smoking, hypothyroidism, hearing deficit, back pain, dyslipidemia, chronic obstructive pulmonary disease (COPD) and decreased range of motion in one shoulder.

Course of Care: Health Plan care coordinator contacted member for reassessment. Member was unsure of current health status and stated that he was not taking any medications nor had a primary care physician (PCP). Member stated he has not been to the doctor in at least six months and has not met any of the Healthcare Effectiveness Data and Information Set (HEDIS) measure goals at the time of assessment.

In response, the care coordinator developed and initiated the following steps for this member:

- Made appointment with health plan's Medical Home (A team of care providers is wholly accountable for a patient's physical and mental health care needs, including prevention and wellness, acute care, and chronic care.) Member has been seen in Medical Home eight times since then, as well as two follow-up visits for health education.
- Monthly mail order pill packs initiated along with education on the packs' use to assist with medication compliance.
- Home Health referral obtained for skilled nursing and physical therapy. Home Health addressed ongoing education needs related to diabetes and shoulder and back pain.
- Member referred to an Ear, Nose and Throat (ENT) for hearing problems. A social worker with the MCO is assisting with obtaining hearing aids.
- Member has been seen by an optometrist. Social worker was able to obtain a voucher for glasses through "New Eyes" and the member has received new glasses at no cost to him.
- Social worker assisted member with public housing applications.
- Social worker has assisted member with the application for low cost dentures through New Horizons.
- Social worker assisted member with completing an application for transportation services so that the member could get out into the community on a regular basis.
- Set up transportation services through member's health plan for medical appointments. The member stated that lack of transportation was the main reason he did not keep his scheduled appointments.
- Member received recommended vaccinations (e.g., Influenza/Pneumonia).
- Member scheduled for a colonoscopy.
- Appointment scheduled with a podiatrist for diabetic foot care.
- Mail order set up for diabetic testing supplies.

Through communication and team work with the care coordinator, social worker, and Medical Home, this member has established a trusting relationship with his health care providers which will help him achieve better overall health.

Update:

- Member continues to follow-up with the health plans' Medical Home as recommended.

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- Member continues to be compliant on his medication due to mail order delivery in bubble packs.
- Member completed home health and the physical therapist care. Member improved mobility, which resulted in less frequent falls in his home and community and increased his understanding of his diabetes.
- Member received glasses through the “New Eyes” program.
- Member did not receive public housing, but his social worker helped him obtain a more affordable apartment where his brother and mother can also stay. However, the member and his brother will move into an Assisted Living Facility (ALF) after their mother passes away. Their mother is on hospice at this time and the care coordinator and social worker were able to get level of care screenings and approval for residing in an ALF.
- Member currently uses “Radar” (public disability assistance for travel) to assist with transportation throughout the community.
- Member continues to use transportation services and goes to scheduled appointments as recommended.
- Member has received colonoscopy.
- Member follows-up with podiatry on a regular basis as recommended.
- Member has received diabetic testing supplies and now monitors blood glucose as directed at home.

Appendix D.

CCC Plus Regional Rollout Schedule

Date	Regions	Regional Launch	All Populations
Aug 1, 2017	Tidewater	20,846	46,811
September 1, 2017	Central	23,368	52,698
October 1, 2017	Charlottesville/Western	17,266	30,114
November 1, 2017	Roanoke/Alleghany	11,169	26,014
November 1, 2017	Southwest	12,769	21,767
December 1, 2017	Northern/Winchester	26,450	39,447
January 2018	CCC Demonstration (Transition plan determined with CMS)	28,205	
January 2018	Persons who are Aged, Blind, Disabled (ABD) (Transitioning from Medallion 3.0)	76,778	
Total	**All Regions**	**216,851**	**216,851**

Source: VAMMIS Data; totals are based on CCC Plus target population data as of May 31, 2017

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