COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services

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February 1, 2018

MEMORANDUM

TO: The Honorable Ralph S. Northam
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: Jennifer S. Lee, M.D.
Director, Virginia Department of Medical Assistance Services

SUBJECT: Final Quarterly Report on Progress of the Financial Alignment Demonstration for Medicare-Medicaid Enrollees for State Fiscal Year 2018

The 2017 Appropriation Act, Item 306 AAAA (1) states the Department of Medical Assistance Services (DMAS) shall provide quarterly reports, due within 30 days of a quarter's end, 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.

Should you have any questions or need additional information, please feel free to contact me at (804) 786-8099.

JSL/

Enclosure

pc: The Honorable Daniel Carey, MD, Secretary of Health and Human Resources

Quarterly Report on Progress of the Financial Alignment Demonstration for Medicare-Medicaid Enrollees (Final Report – State Fiscal Year 2018)

A Report to the Virginia General Assembly *February 1, 2018*

Report Mandate:

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

"The Department of Medical Assistance Services (DMAS) shall provide quarterly reports, due within 30 days of a quarter's end, 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 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 five 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 enrolled in CCC has decreased in the second quarter of FY 2018. Total enrollment was down by roughly 3,000 from the previous quarter. This was expected since CCC was closing during this period and the Department of Medical Assistance Services (DMAS) was no longer able to passively enroll eligible individuals into CCC. This was a decision reached jointly by CMS and DMAS as enrolling someone in to a health plan for only a few months would be disruptive and possibly detrimental to their health care needs.

About DMAS and Medicaid

DMAS's 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.

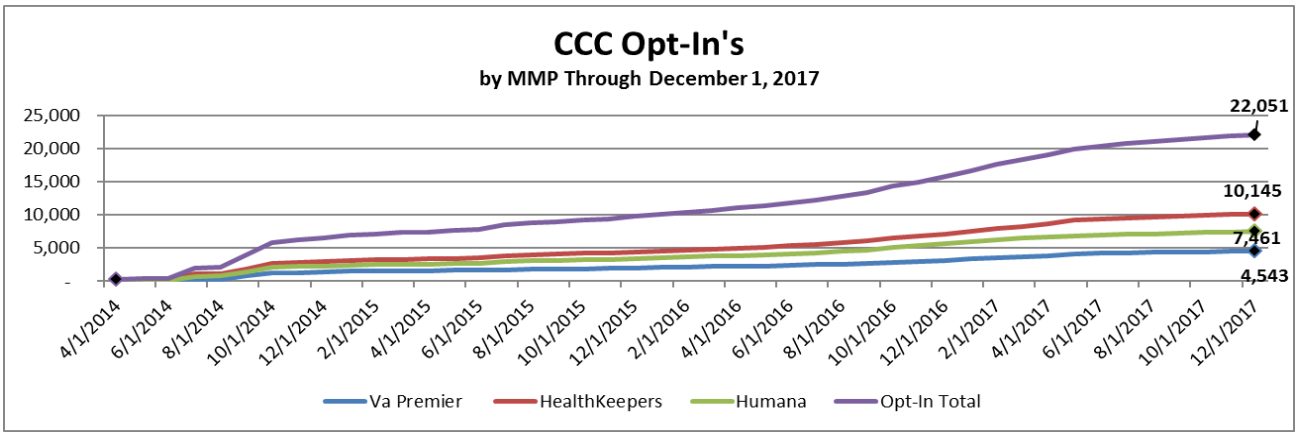
Medicaid covers primary health care services, inpatient and outpatient services that support individuals in need of behavioral health support including addiction and recovery treatment. Medicaid also covers long term supports and services, making it possible for thousands of Virginians to remain in their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

Quick Medicaid facts:

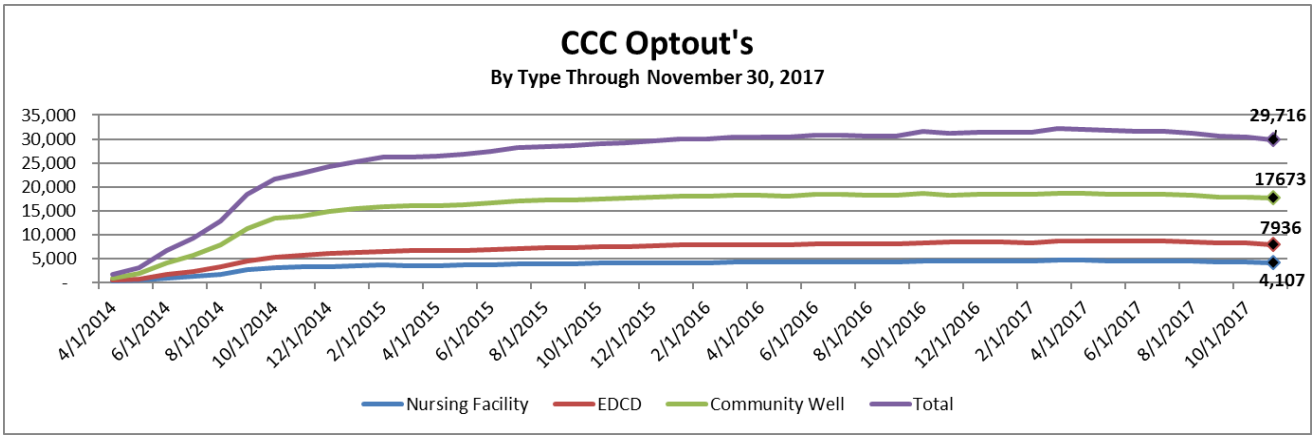
- Covers 1 in 8 Virginians
- Covers 1 in 3 births and 33% of children
- Supports 2 in 3 nursing facility residents

Virginia Medicaid and Children's Health Insurance Program (CHIP) is administered by the Department of Medical Assistance Services (DMAS) and is 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.

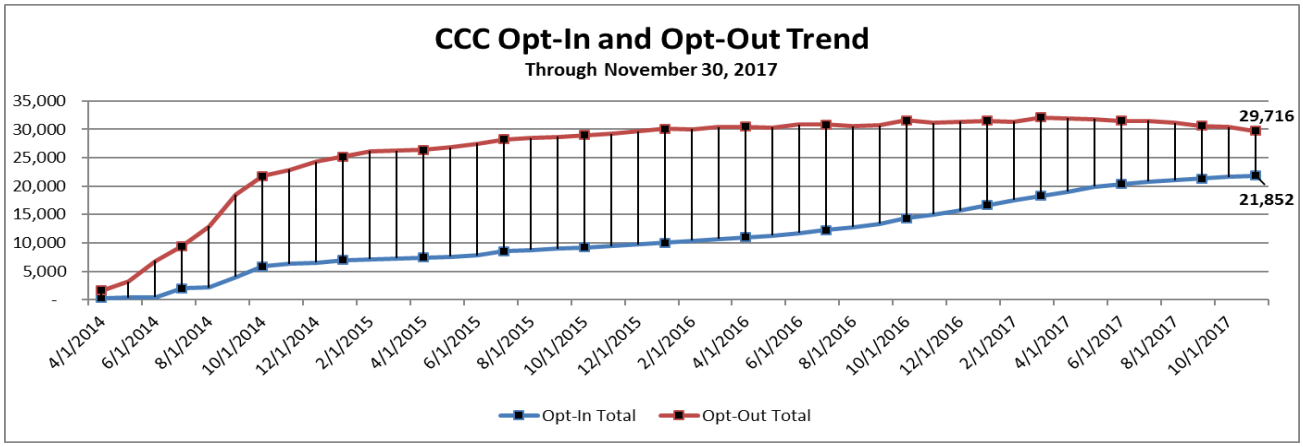
Of the total 22,051 individuals enrolled in CCC, 10,145 (46 percent) are enrolled with Anthem; 7,461 (34 percent) are enrolled with Humana; and 4,543 (21 percent) are with Virginia Premier. The distribution of enrollees between the MMPs is largely, though not exclusively, due to the size of the MMPs 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 automated 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 decreased in the second quarter. As of November 30, 2017 there were 29,716 opt-outs and dis-enrollments compared to 30,588 on September 30, 2017. This decrease can also be tied to the sunset of the program because as there are fewer people to passively assign there are fewer people to opt out. The majority (59 percent) of opt-outs come from the community well (not living in a nursing facility and not on the Elderly or Disabled with Consumer Direction (EDCD) waiver) population.



While there was a slowing of opt-out rates, the decreasing number of people opting in resulted in roughly 8,000 fewer enrollees (approximately 22,000 enrollees) than opt-outs.



Operational Enhancements

With the conclusion of the CCC program, operational enhancements and modifications have focused on ensuring members experience as smooth of a transition to CCC Plus as possible. For instance, DMAS has refined the MCO member assignment process by streamlining communications and enrollment transactions to the CCC Plus health plans in order to decrease the number of enrollment discrepancies and minimize disruption of coverage for members. Additionally, DMAS and CMS developed a Phase Out Plan, which can be found here. This plan was submitted to the public for comment and consideration. No comments or concerns were received. DMAS and CMS will continue to work together and monitor the closure of CCC and the transition of members to CCC Plus until all matters are satisfactorily resolved.

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 enrollee 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 locality 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 employed a contractor to audit each MMP's network to ensure all requirements are met.

There were no significant changes (addition or loss of a locality due to network adequacy standards) by any of the MMPs through December 1, 2017.

Resolution of Provider Concerns

With the ending of the CCC program, DMAS ensured that providers continue to have access to assistance and resolution of outstanding concerns. These strategies include having the MMPs identify key staff to be available for at least 6 months after the end of the demonstration to address general provider concerns and for at least one year following the end of the demonstration to address claims issues and appeals related to the CCC program. Additionally, DMAS staff will continue to

operate and monitor dedicated CCC email address and will continue to be available to answer questions, and assist with issue resolution.

No new issues were brought to the attention of DMAS or the MMPs that indicate any widespread problems with provider reimbursement or costs to participate. DMAS will continue addressing the concerns and questions raised by individual providers as they come to our attention.

Quality

Our External Quality Review Organization contractor, Health Systems Advisory Group (HSAG), completed the MMP CY 2017 Performance Measure Validation process in August 2017. All measures reviewed for the three MMPs were deemed reportable, meaning that measure data were compliant with DMAS specifications and the data, as reported, were valid.

CCC staff is planning to utilize data from monthly, quarterly and annual reports, along with the monthly health plan dashboard, to provide an overview of MMP quality performance trends over the entire course of the demonstration. This information will be provided in the final report on the CCC program.

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. Throughout the CCC program, DMAS worked to address these challenges and improve the quality of life for the CCC enrollees and their families. DMAS is using lessons learned from CCC to prepare for the challenges with the CCC Plus program. CCC has provided DMAS significant experience and DMAS looks forward to building on this 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.

CCC members who are enrolled in a CCC program health plan that has also contracted with the state as a CCC Plus health plan (Anthem HealthKeepers and Virginia Premier) transitioned from the CCC plan to the CCC Plus plan without a break in services. Humana enrollees were assigned to one of the six CCC Plus plans using an algorithm that has been designed to minimize disruption of services as much as possible. All enrollees transferring to CCC Plus will have 90 days to select a different health plan if they are not happy with their initial assignment. Enrollees also have a 90-day continuity of care period during which they can keep their current providers. Additionally, all existing service authorizations will be automatically sent to the enrollee's new health plan and the new health plan is required to honor existing authorizations for the duration of the service authorization or for ninety calendar days from enrollment, whichever comes first. These actions are designed to limit the impact to the enrollees, their families, and the providers.