MANAGED CARE 102
VIRGINIA MEDICAID MANAGED CARE DELIVERY SYSTEMS

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

November 14, 2019

DMAS MISSION & VALUES

"To improve the health and well-being of Virginians through access to high-quality health care coverage."

AGENDA

- Background
- Federal and State Authority
- Programs, Populations and Services
- Managed Care Alignment
  - Members
  - Providers
  - Pharmacy
- Managed Care Oversight and Performance
  - Overview
  - Value Based Purchasing
  - Program Integrity
- Initiatives

BACKGROUND: VIRGINIA

- Virginia's managed care system started in the 1990s
- Manage Care Organizations (MCOs) cover over 1.29 million Medicaid lives (1,050,452 Medallion 4.0 and 243,505 CCC Plus members)
- #2 in requiring National Committee for Quality Assurance (NCQA) accreditation for plan participation
- #3 to obtain 1115 waiver for substance use program (Addiction, Recovery and Treatment Services)
- One of 13 states to have operated a duals demonstration program (Commonwealth Coordinated Care); one of 24 states operating a managed long-term services and supports program (CCC Plus)
- #39 to expand Medicaid - January 2019

BACKGROUND: VIRGINIA

- 2017 successfully completed the procurement and implementation of CCC Plus:
  - Focus on vulnerable populations; includes Home and Community-Based Services waivers and nursing facilities
  - Moved dual demonstration participants into statewide program; health plans operate as a dual special needs plan (DSNP)
  - Transitioned Aged, Blind and Disabled (ABD) members to complex care health plans
  - Integration of community mental health rehabilitation services January 2018
- 2017 procured Medallion 4.0; implemented in August 2018
  - Focus on women, children, caretaker adults
  - Integration of behavioral health with regional rollout
  - Base for Medicaid expansion – Launched January 2019

WHO DOES MEDICAID SERVE?

Children — 703,000

Pregnant Women and Parents — 135,000

Older Adults — 78,000

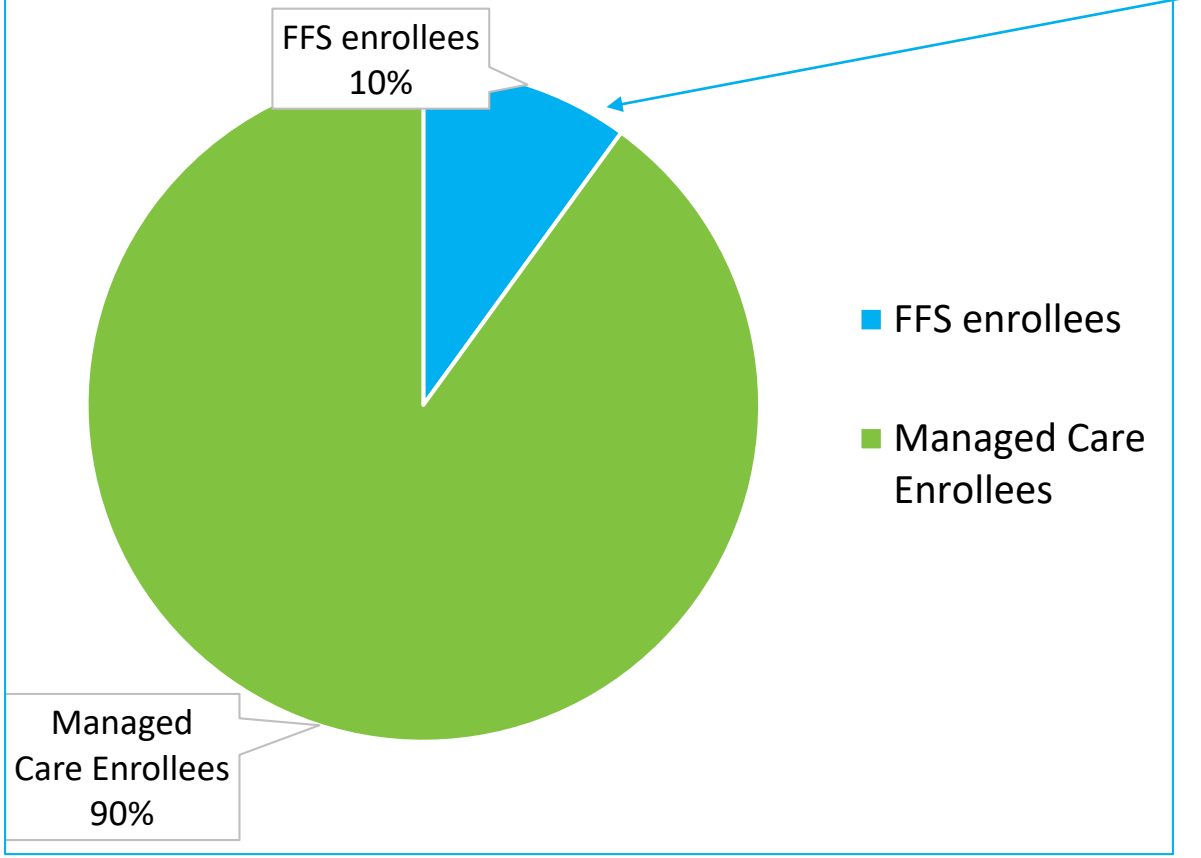
Individuals with Disabilities — 151,000

Expansion Adults — 328,000

Medicaid plays a critical role in the lives of over 1.4 million Virginians

HEALTH CARE DELIVERY

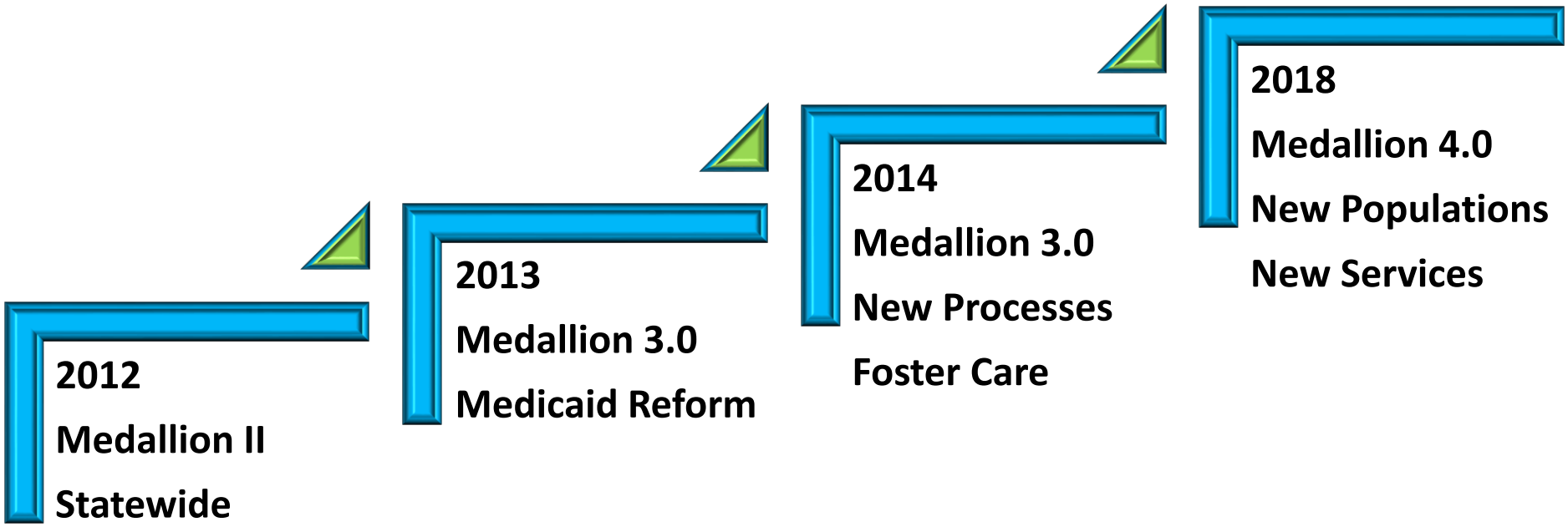
Managed Care Enrollment vs Fee-For-Service



Transitioning from Fee For Service to Managed Care

- In any given month, about 10% of members are in fee-for-service
- Approximately 1/2 of the FFS population are in limited benefits programs (such as Plan First, QMB, etc.)
- The remaining fee-for-service population will spend approximately 30 days in FFS, where they will make their health plan selection and then transition into managed care

MEDALLION – WIDE AND DEEP



MEDALLION 4.0 PROGRAM DESIGN

1. **Regional implementation completed December 2018**
   now serving 1,050,452 Virginians

2. **Plan changes**
   Services, functions and processes added

3. **Focus on member-centric care for populations:**
   pregnant women, infants, children, parents/caregivers, and expansion adults

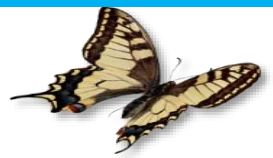
4. **Best of Medallion 3, alignment with CCC Plus, strong networks and statewide access to care**

5. **Platform for new initiatives and innovations**

COMMONWEALTH COORDINATED CARE PLUS

- Virginia's Financial Alignment Demonstration (**CCC**) served 30,000 dually eligible adults
- Began March 2014; ended December 2017
- Voluntary participation program with limited geographic implementation
- No required ratios for Care Coordinators

- **CCC** produced great results and offered valuable experience and lessons learned
- **CCC Plus** was designed to build upon the successes
- **CCC Plus** established ratios for Care Coordinators
- **CCC Plus** established mandatory enrollment providing greater program stability and mitigating coverage gaps



- **CCC Plus** extends the benefits of care coordination, serves over 243,000 individuals statewide through required participation
- **With Medicaid Expansion, CCC Plus** includes former Governor's Access Program (GAP) members with serious mental illness and medically complex individuals

CCC Plus builds on the success of CCC and expands care coordination strategies statewide

CCC PLUS PROGRAM DESIGN

High-quality care in the least restrictive and most integrated treatment setting, through a fully-integrated delivery system, with care coordination, person-centered care and an interdisciplinary team approach

Primary goal is to improve health outcomes

MEDICAID EXPANSION – JANUARY 1, 2019

Coverage provided for most individuals through the Medallion 4.0 and Commonwealth Coordinated Care Plus (CCC Plus) managed care programs

Expansion Populations

- ✓ Adults ages 19 – 64, not Medicare eligible
- ✓ Income from 0% to 138% Federal Poverty Level
- ✓ Populations include:
  1. Caretaker Adults
  2. Childless Adults
  3. Incarcerated Adults
  4. Presumptive Eligible Adults
- ✓ Populations transitioned from:
  - GAP and Plan First
  - SNAP and Parents
  - Marketplace

Expansion Delivery Systems

Medallion 4.0 serves populations other than those who are medically complex

Commonwealth Coordinated Care Plus (CCC Plus) serves populations who are medically complex

Fee for Service serves populations excluded from managed care, including:

- incarcerated adults,
- presumptively eligible adults, and
- newly eligible individuals until they are enrolled in a MCO

MANAGED CARE EXPANSION TIMELINE

2016 – 2018

CCC Plus Statewide Implementation

- Successfully procured the CCC Plus program
- Regional implementation - Aug 2017 – Jan 2018
- Community mental health services phased in Jan 1, 2018

2017-2018

Medallion 4.0 Statewide Implementation

- Successfully procured Medallion 4.0 program
- Regional Implementation – Aug 2018 - Dec 2018
- Community mental health services phased in, beginning Aug 2018 – Dec 2018, (during the regional launch)

Expanded managed care to remaining fee-for-service populations per requirements in the Appropriations Act

January 2019 - Present

Implement Managed Care Expansion; Continue Corrections/Refinement

- During the first full year post- CCC Plus and Medallion 4.0 implementation, plans continue to refine program and correct start-up issues, including with community mental health services
- January 1, 2019 - Successfully phased in the Medicaid expansion population

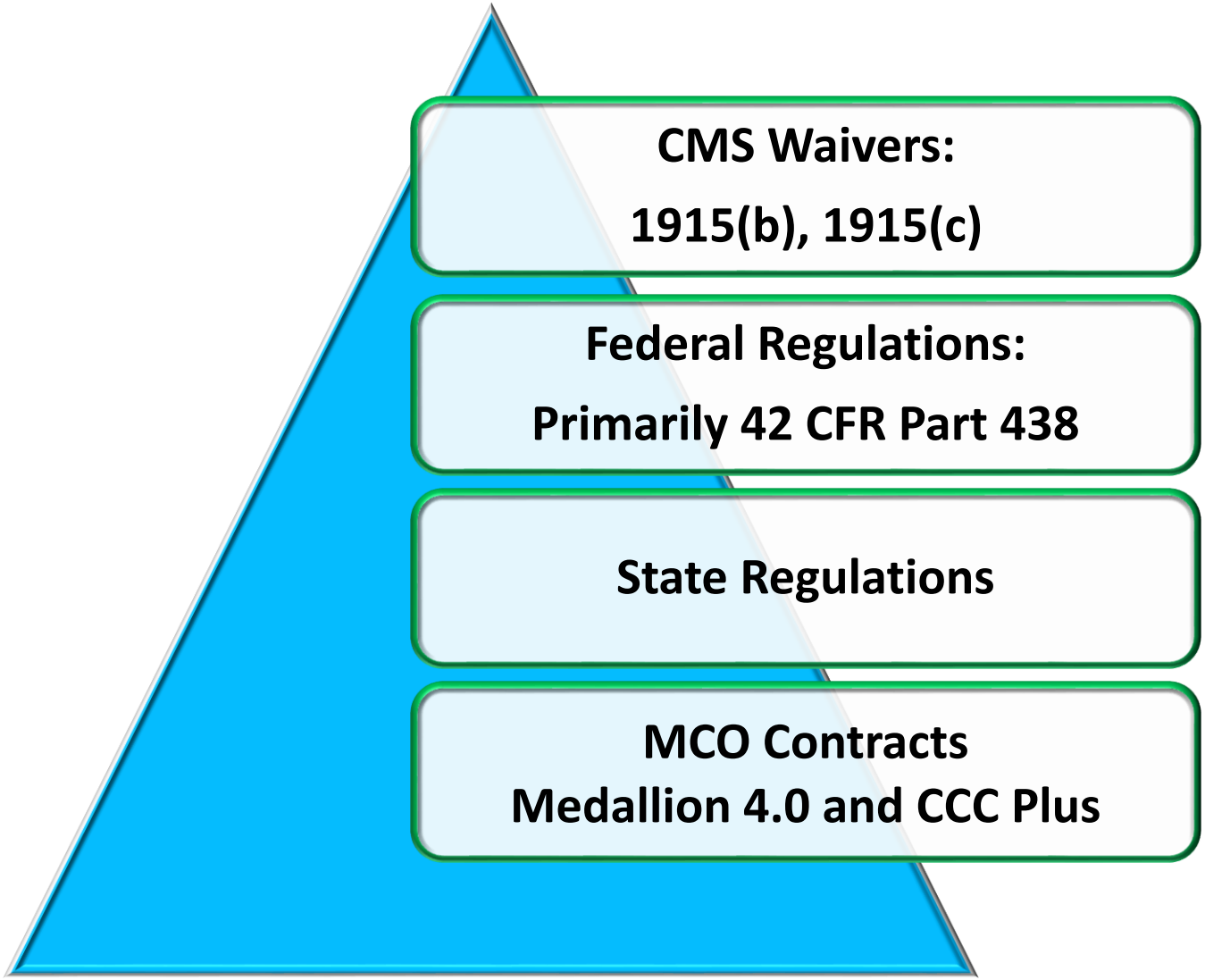
2019 - Ongoing

Increase Monitoring, Oversight; and Transparency

- Focus on quality, accountability, and greater transparency
- Contract monitoring
- Corrective action plans (CAPs)
- Future Initiatives
  - Value based purchasing
  - Alignment of MCO Contracts
  - MES Connectivity
  - COMPASS
  - Behavioral Health Redesign (proposed)

FEDERAL/STATE AUTHORITY

MANAGED CARE PROGRAM AUTHORITIES



FEDERAL AUTHORITY: CMS WAIVERS

Waivers provide states with the flexibility to "waive" certain Medicaid program requirements including state-wideness, freedom of choice, and comparability.

- Most common include:
  - 1915(b): Waiver of freedom of choice, state wideness, comparability – allows for mandatory managed care enrollment
  - 1915(c): Home and Community Based Waivers

https://www.medicaid.gov/medicaid/managed-care/authorities/index.html

1915(b) MANAGED CARE WAIVER

Medallion 4.0 operates under 1915(b) Waiver authority

- Operates statewide with choice of six health plans
- Mandatory managed care enrollment for eligible populations
- Demonstrates cost-effectiveness (actual expenditures cannot exceed projected expenditures for approval period)
- Renewed through CMS every two years
- Complies with the federal managed care regulations including access to care standards, beneficiary protections, quality of care standards, rate setting, and contract approval requirements

1915(b) MANAGED CARE WAIVER

CCC Plus operates under concurrent 1915(b)/(c) waiver authorities

- Operates statewide with choice of six health plans
- Mandatory managed care enrollment for eligible populations, including dual eligibles and individuals receiving facility or community based long term services and supports
- Meets all federal requirements associated with each type of waiver, including cost neutrality in the 1915(c) and cost effectiveness in the 1915(b) waiver
- Renewed through CMS every five years
- Complies with the federal managed care regulations including access to care standards, beneficiary protections, quality of care standards, rate setting, and contract approval requirements

1915 (C) HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVERS

Virginia operates four 1915(c) waivers:

- The Commonwealth Coordinated Care Plus (CCC Plus) Waiver
  - Formerly the Elderly or Disabled Waiver with Consumer Direction and the Technology Assisted Waiver
- Three Developmental Disability (DD) Waivers:
  - Building Independence (BI) Waiver
  - Family and Individual Support (FIS) Waiver
  - Community Living (CL) Waiver

1915 (c) Waiver Highlights

Allows waivers of comparability requirements, in order to offer home and community-based services (HCBS) to limited groups of enrollees as an alternative to institutional care; allows states to cap the number of HCBS participants

Specific federal guidelines apply; for example, must ensure person centered planning, care in the most integrated settings, electronic visit verification system (EVV), etc., and must also be budget neutral

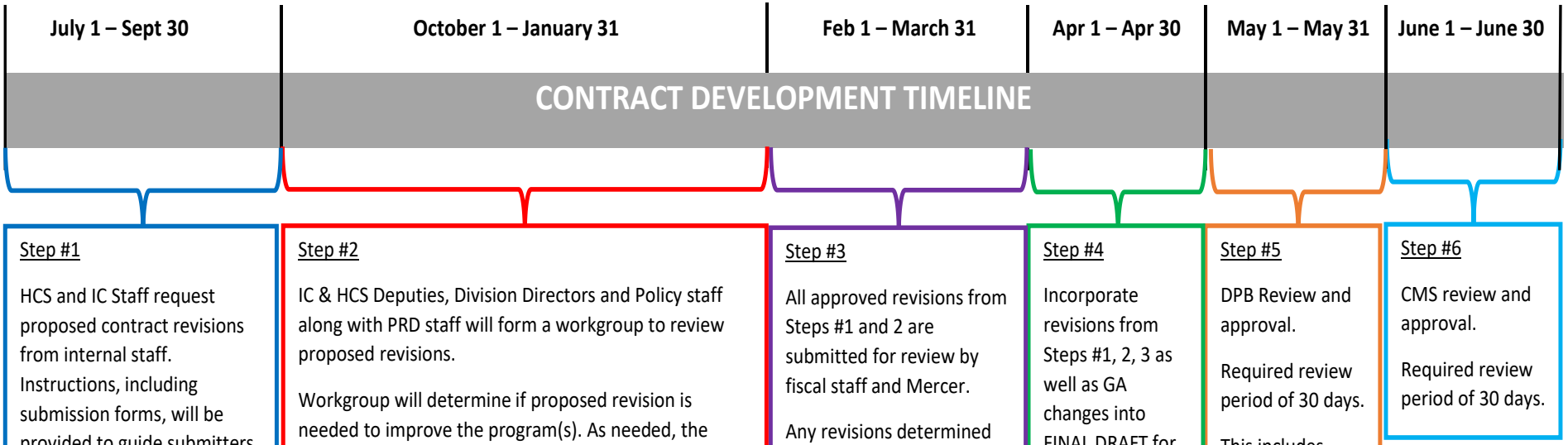
https://www.medicaid.gov/medicaid/hcbs/index.html

FEDERAL AND STATE MANAGED CARE REGULATIONS

Managed Care Contracts are governed by Federal and State Regulations and Oversight:

- ✓ Federal Managed Care Regulations are found in 42 CFR Part 438
- ✓ State Law and Regulation:
  - Provisions of Title 38.2 of the Code of Virginia
  - Virginia Administrative Code Regulations
  - Virginia Procurement Act
- ✓ Medallion 4.0 and CCC Plus MCO Contracts
  - Must meet CMS rules as outlined in Title XIX of the Social Security Act, the 140 page State Guide, and the Code of Federal Regulations, 42 CFR Part 438

CONTRACT DEVELOPMENT TIMELINE



Step #1

HCS and IC Staff request proposed contract revisions from internal staff. Instructions, including submission forms, will be provided to guide submitters.

Typos and other similar revisions are incorporated into DRAFT contracts.

All other proposed revisions are taken to Step #2.

Budget Package Submissions are required at this time as well. Policy Staff will track the submissions and anything approved by the GOV and finally the GA will be incorporated into the draft contract in Step 4.

Step #2

IC & HCS Deputies, Division Directors and Policy staff along with PRD staff will form a workgroup to review proposed revisions.

Workgroup will determine if proposed revision is needed to improve the program(s). As needed, the workgroup will meet with proposers to gather more information. All decisions will be made by January 1 and shared with proposers

Output from the workgroup will be a report of all approved revisions segregated by (1) those believed to have fiscal impact and (2) those believed not to have a fiscal impact.

The report will be sent to and reviewed in the January IFRC meeting.

Following IFRC review, the report will be provided to EMT for review and comment as necessary.

Following IFRC and EMT review, report of all approved revisions is sent to Step #3 for formal fiscal review.

Step #3

All approved revisions from Steps #1 and 2 are submitted for review by fiscal staff and Mercer.

Any revisions determined to have a fiscal impact are referred to the following years' Budget Package Process.

Any revisions determined not to have a fiscal impact are referred to Step #4

Step #4

Incorporate revisions from Steps #1, 2, 3 as well as GA changes into FINAL DRAFT for Steps 5.

This includes revisions that are included in final GA approved budget.

Step #5

DPB Review and approval.

Required review period of 30 days.

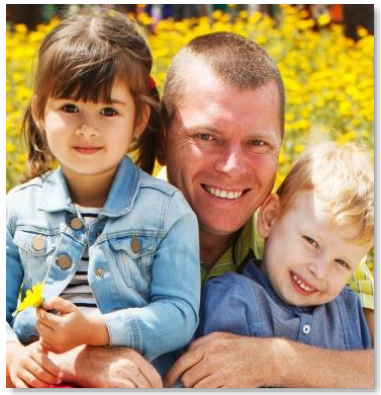
This includes meeting(s) with DPB.

Step #6

CMS review and approval.

Required review period of 30 days.

QUESTIONS?



UNIQUE POPULATIONS AND SERVICES

POPULATIONS AND SERVICES

	Commonwealth Coordinated Care Plus (CCC Plus) 243,505 Members	Medallion 4.0 1,050,452 Members
Covered Groups 	▪ Serving older adults, disabled children, disabled adults, medically complex newly eligible adults; includes individuals with Medicare and Medicaid (full-benefit duals)	▪ Serving infants, children, adolescents, pregnant women, caretaker adults, and newly eligible adults
Covered Benefits 	▪ Full continuum of services (same as Medallion), but also includes long-term services and supports (LTSS) in the community and in nursing facilities and hospice	▪ Births, vaccinations, well child visits, sick visits, acute care, pharmacy, ARTS, behavioral health services, including community mental health rehabilitation services; excludes LTSS

Health Plans cover services within at least equal amount, duration, and scope as Medicaid and provide additional benefits and linkages to resources to address social determinants of health

MEDALLION 4.0 POPULATIONS

MATERNITY

- Early Prenatal Care
- Case Management
- Post-Partum Care
- Support for Full-term Deliveries
- Breast Feeding Care
- Family Planning
- Outreach and Education
- Oral Health

INFANTS (0 – 3)

- Immunizations
- Well Visits
- Early Assessments
- Safe Sleep Education
- Support for Neonatal Abstinence Syndrome
- Preventing Infant Death (Three Branch Workgroup)
- Early Intervention
- Oral Health

CHILDREN & ADOLESCENTS (3 – 18)

- Oral Health
- Vision
- Well Visits
- Early and Periodic Screening, Diagnosis and Treatment
- Support for Special Needs
- Foster Care Services
- Focus on Trauma Informed Care
- Community Mental Health Services
- Adolescent Focused Care

ADULTS

- Wellness
- Chronic Disease Support
- Family Planning/LARC
- Addiction Recovery Treatment Services
- Behavioral Health and Community Mental Health Rehabilitative Services

MEDALLION 4.0 ENROLLMENT DATA

PLAN	Children	FAMIS	Foster Care	Adoption Assistance	EI	FAMIS Moms	Pregnant Women	Expansion	Adults (LIFC)	TOTAL
Aetna	52,254	5,890	399	703	454	183	1,775	51,636	12,350	125,644
Anthem	197,573	28,247	1,461	2,422	1,622	490	3,729	66,840	31,971	334,355
Magellan	23,588	3,008	264	340	247	105	1,014	27,312	5,410	61,288
Optima	122,672	13,565	1,084	1,668	915	222	2,586	52,582	22,733	218,027
United	52,896	7,886	353	543	428	162	1,285	30,913	7,579	102,045
VA Premier	128,241	14,982	1,333	2,316	1,108	200	2,497	54,191	21,885	226,753
TOTAL	577,224	73,578	4,894	7,992	4,774	1,362	12,886	283,474	101,928	1,068,112

FC/AA and EI also are included in other categories, e.g. children

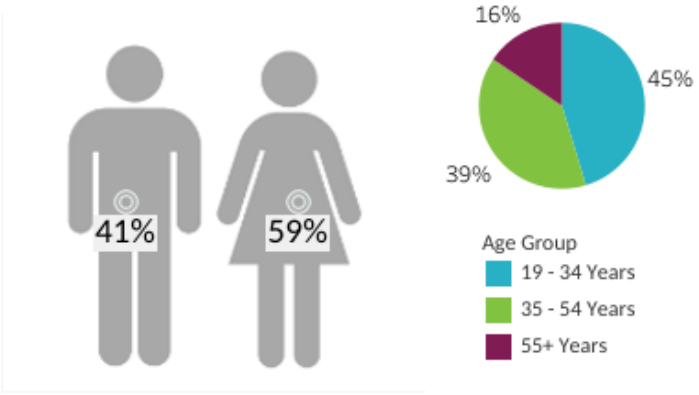
EXPANSION DASHBOARD

Overall Enrollment

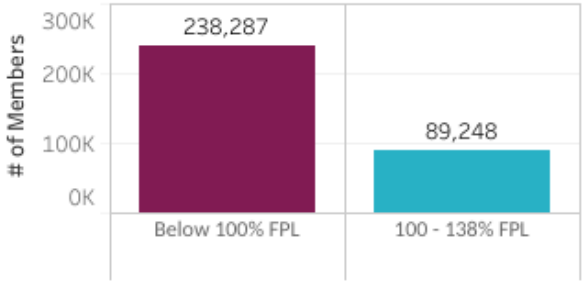
327,535 adults newly enrolled in Medicaid

107,359 newly enrolled adults are parents

Age and Gender of Enrollees

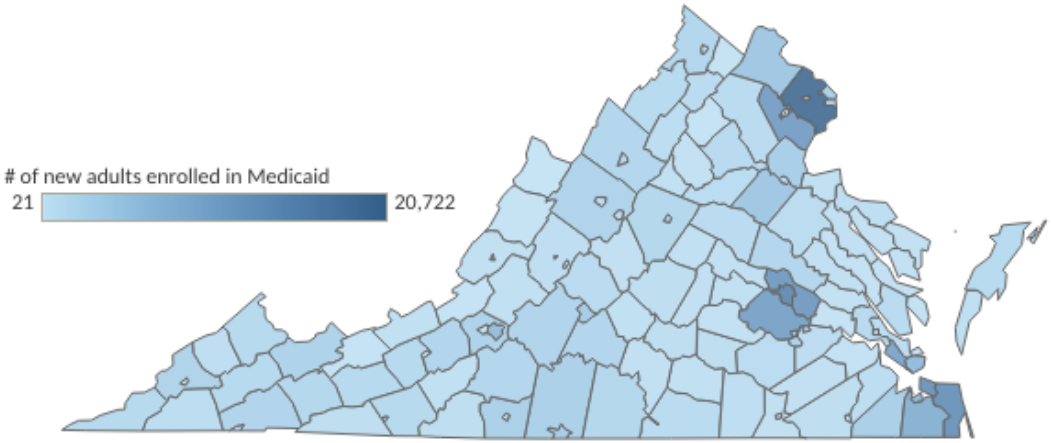


Enrollee Family Income



The federal poverty level is $12,140 annually for a single person or $20,780 annually for a family of 3.

Adults Enrolled in New Health Coverage by Locality



Enrollment as of 11/1/2019

Enrollment by City / County

Central	85,038
Charlottesville / Western	42,379
Northern & Winchester	61,056
Roanoke / Alleghany	35,197
Southwest	26,319
Tidewater	77,546
Grand Total	327,535

MEMBER PROFILE – MEDALLION 4.0

Medallion 4.0 Member Profile	
Member	28 year old male
Eligibility Factor	Medicaid Expansion (Childless adult); meets household income rules*
Service Delivery	Medallion 4.0
Covered Services Utilized	• Glucose Test Strips (medically necessary due to Diabetes diagnosis) • Physician Services (routine monitoring via wellness visits and occasional sick visit) • Prescription Drugs (Insulin) • Influenza Immunization

*https://coverva.org/eligibility/

MEMBER PROFILE – FAMIS CHILD (MEDALLION 4.0)

Medallion 4.0 Member Profile	
Member	8 year old male
Eligibility Factor	FAMIS (family income is below income threshold)*
Service Delivery	Medallion 4.0
Covered Services Utilized	• Dental – Smiles for Children (annual preventive) • Well child exam/check-up and (immunizations) • Speech Therapy (received through the school and billed as a carved-out service by the school)

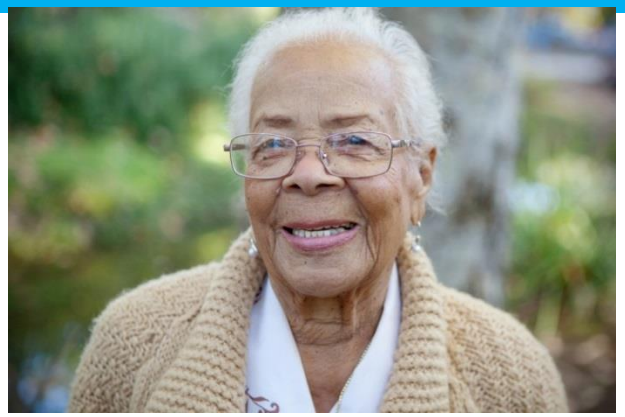
*https://coverva.org/famis/

POPULATIONS EXCLUDED FROM MEDALLION 4.0

- ✓ Limited benefits programs, such as Plan First
- ✓ Health insurance premium payment (HIPP) program participants
- ✓ Hospitalized in state psychiatric facilities
- ✓ Birth injury fund participants
- ✓ Individuals age 65 and older or adults/children who are blind/disabled, including individuals who are dually eligible for Medicare and Medicaid, and individuals receiving long term services and supports, including nursing facility, hospice, and home and community-based waiver services
- ✓ Medicaid expansion populations who are determined to be medically complex based on DMAS established screening criteria

(See Medallion 4.0 Contract section 6.2 for a full list of exclusions)

CCC PLUS POPULATIONS


Approximately 243,505 individuals, including:

- Adults and children living with disabilities
- Adults age 65 and older
- Individuals living in Nursing Facilities (NFs)
- Individuals in the CCC Plus Waiver (formerly the Technology Assisted and Elderly or Disabled with Consumer Direction Waivers)
- Individuals in the three waivers serving the Developmental Disabilities populations for their non-waiver services
- Medically complex individuals eligible through Medicaid Expansion
- Individuals who are dually eligible for Medicare and Medicaid

CCC PLUS ENROLLMENT BY LTSS BENEFIT

MCO	Non-LTSS	EDCD	DD	Early Intervention	Hospice	Nursing Facility	Long Stay Hospital	TECH	Grand Total
AETNA	26,546	4,675	2,025	57	100	2,857	7	19	36,286
ANTHEM	46,278	12,838	4,436	188	117	3,853	11	124	67,845
MAGELLAN	18,049	2,607	1,179	32	86	2,397	6	28	24,384
OPTIMA	29,308	5,557	2,246	126	65	2,297	11	41	39,651
UNITED	20,429	3,450	1,261	29	64	2,594	11	7	27,845
VA PREMIER	35,630	6,266	2,256	82	89	3,000	7	15	47,345
Grand Total	176,240	35,393	13,403	514	521	16,998	53	234	243,356

Source: VAMMIS. November 07, 2019

MEMBER PROFILE - CCC PLUS

CCC Plus Member Profile	
Member	52 year old female
Eligibility Factor	Suffered two Ischemic Strokes at 44 and 46 years old and has significant functional dependencies. Receives Supplemental Security Income (SSI) and meets income and resource limits. Meets LTSS financial and functional eligibility criteria.*
Service Delivery	CCC Plus – CCC Plus Waiver Recipient
Covered Services Utilized	• Physician Services (General Practitioner and Specialty) • Prescriptions • Physical, Occupational, and Speech Therapies • Personal Emergency Response System (PERS) • Adult Day Health Care • Environmental Modifications ($5,000 per state fiscal year) • Personal Care Services (Agency Directed) • Respite Care • Non-emergency transportation (wheelchair)

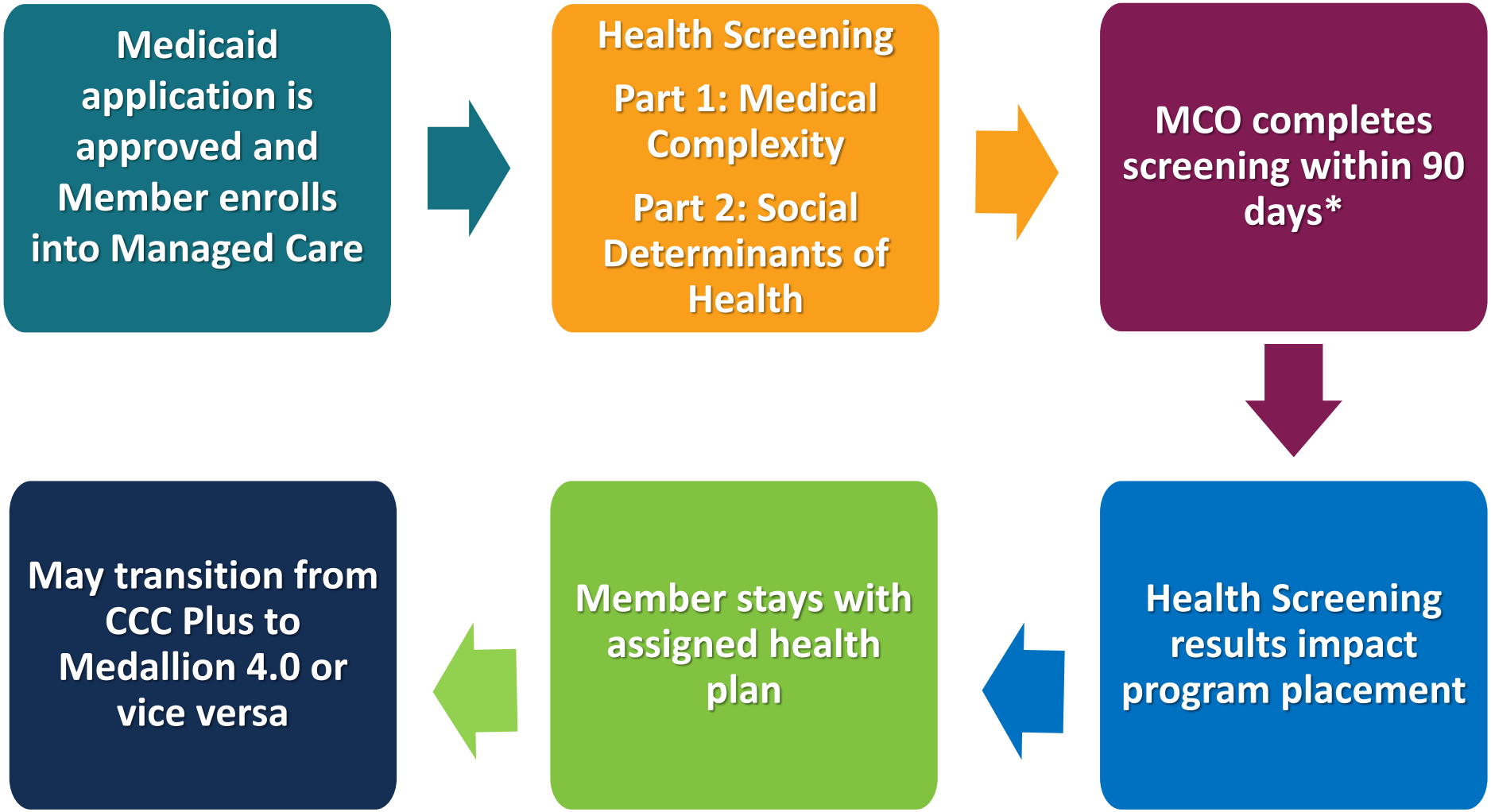
*https://coverva.org/programs/#ABD

POPULATIONS EXCLUDED FROM CCC PLUS

- ✓ Limited Coverage Groups
- ✓ Health Insurance Premium Payment Program
- ✓ Individualized Specialized Settings (e.g. Local Government Owned Nursing Facilities, DBHDS Facilities, individuals under 21 in Psychiatric Residential Treatment Centers, Veterans Nursing Facilities)
- ✓ Individuals in Hospice at time of enrollment

(See CCC Plus Contract section 3.1.2 for a full list of exclusions)

MCO MEMBER HEALTH SCREENING



*Completed by MCO for all newly enrolled CCC Plus members; completed for Medallion 4.0 newly enrolled expansion adults

MEDICALLY COMPLEX SCREENING

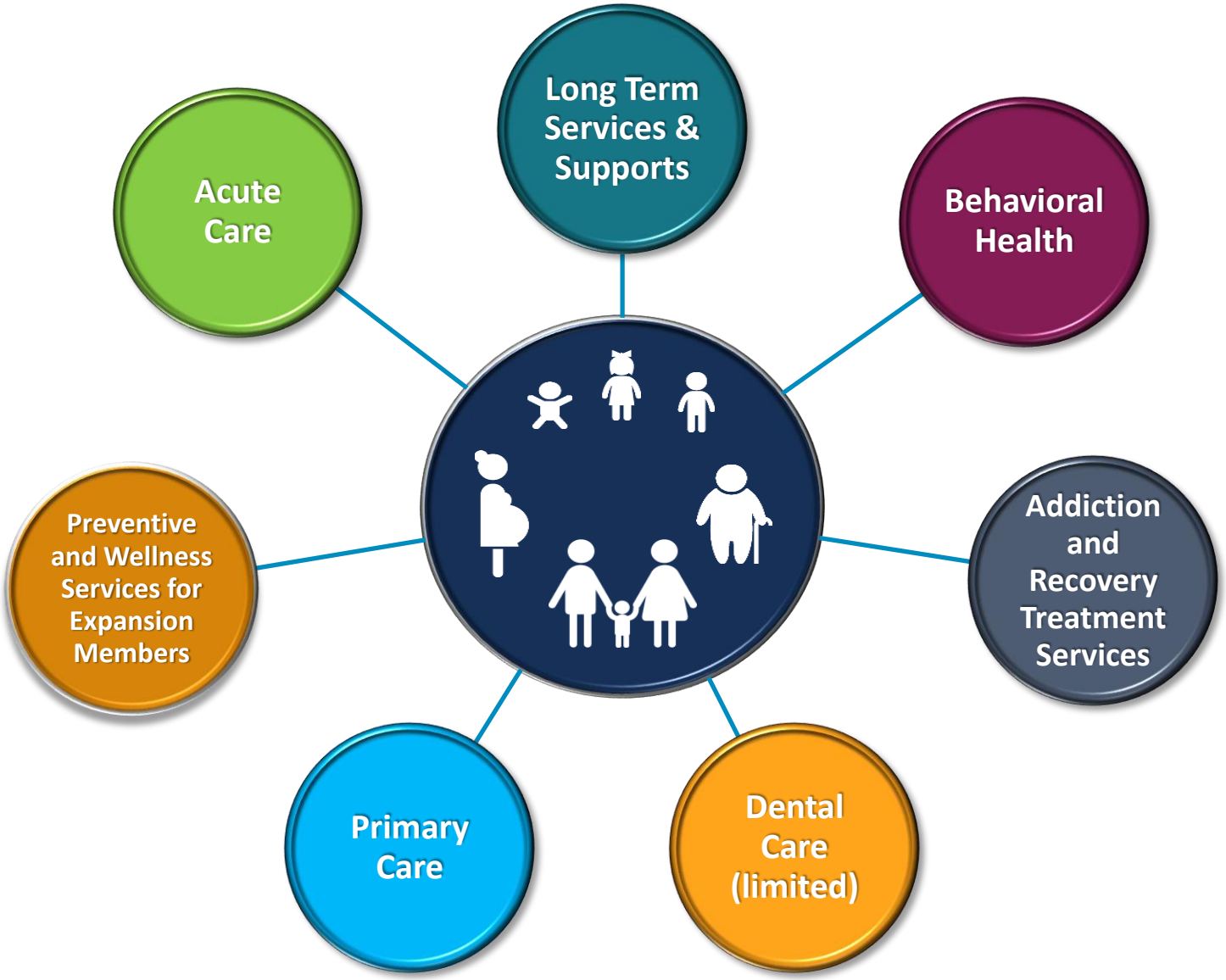
Two Components

- Medical diagnosis based
- CMO at managed care organizations can justify other conditions
- Includes serious mental illness and developmental disabilities
- Must have functional impact

- Social determinants of health
- Housing
- Access to food
- Falls/ER Visits
- Transportation
- Caregiver Status (living situation)
- Job status
- Safety

*Completed by MCO for all newly enrolled CCC Plus members; completed for Medallion 4.0 newly enrolled expansion adults

COVERED SERVICES



CCC PLUS: LONG TERM SERVICES AND SUPPORTS

CCC Plus Waiver Services

- ✓ Adult Day Health Care
- ✓ Personal Assistance Services
- ✓ Private Duty Nursing
- ✓ Respite Care
- ✓ Services Facilitation
- ✓ Assistive Technology
- ✓ Environmental Modifications
- ✓ Personal Emergency Response System and Medication and Monitoring
- ✓ Transition Services

Nursing Facility Care

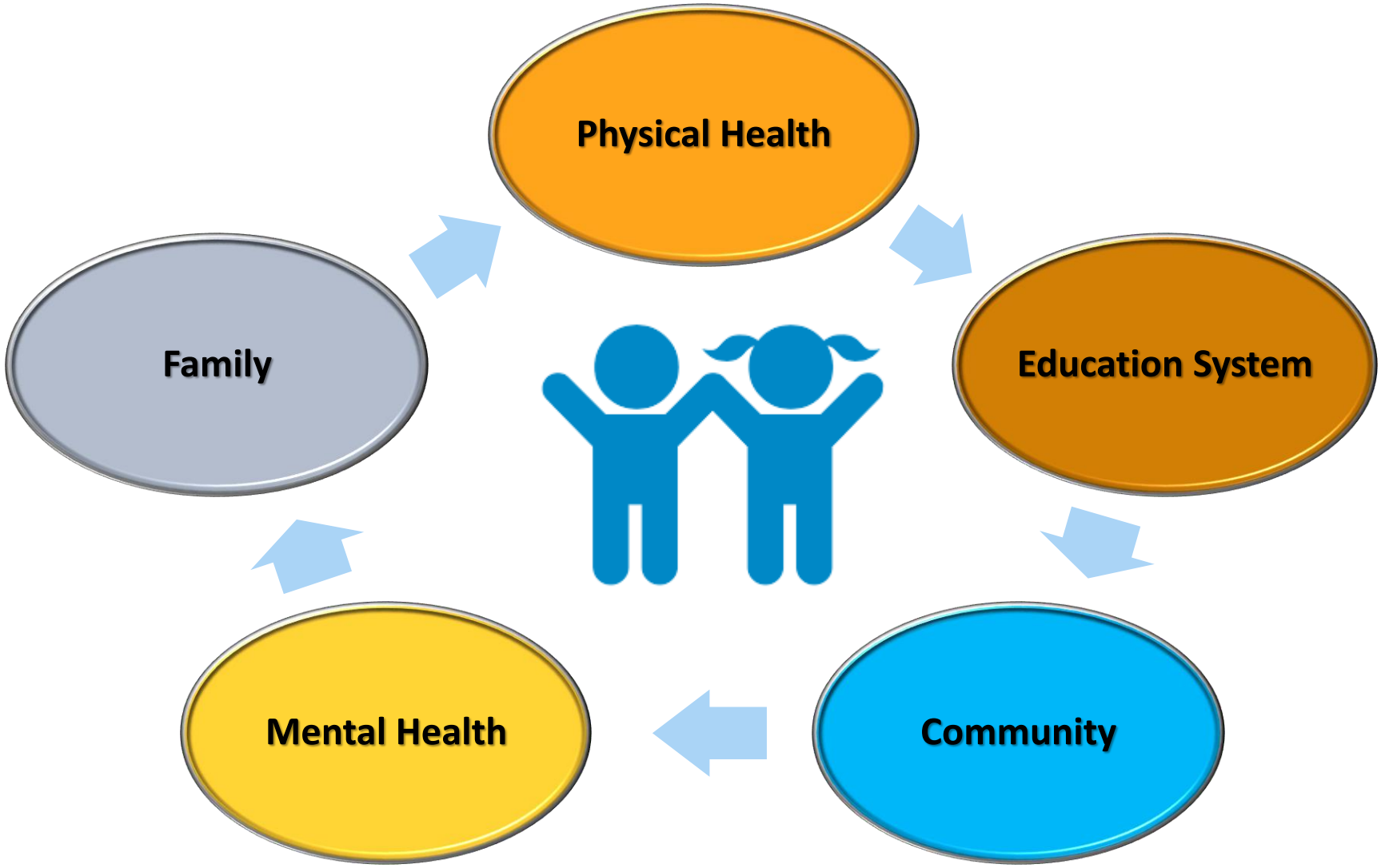
- ✓ Nursing facility
- ✓ Long-stay hospital

CARVED OUT SERVICES

Services for managed care enrolled individuals that are paid for through fee-for-service

- ✓ School Health Services
- ✓ Treatment Foster Care Case Management Services
- ✓ Dental Services
- ✓ Developmental Disabilities Waivers Services (CCC Plus)

MEDALLION 4.0 CARE MANAGEMENT



MEDALLION 4.0 VULNERABLE SUBPOPULATIONS

- ✓ MCOs have complex care management programs that focus on identifying and improving the health status for vulnerable populations:
  - Children and youth with special health care needs
  - Adults with serious mental illness
  - Children with serious emotional disturbances
  - Members with substance use disorders
  - Children in foster care or adoption assistance
  - Children receiving early intervention
  - Women with a high risk pregnancy
  - Members with other complex or multiple chronic conditions

- ✓ Care Management
  - **Supports** members in their efforts to receive care as quickly as possible
  - **Educates** members about the importance of their medical coverage
  - **Coordinates** service providers to support member health care needs
  - **Refers** members to needed medical and behavioral health services

CCC PLUS MODEL OF CARE

A person-centered approach
Provides comprehensive care coordination
Integrates the medical and social models of care
Promotes Member choice and rights
Engages the Member, family/caregivers and providers

Care Coordinators are a point of contact for members and providers

CARE COORDINATOR ROLE

Every member is assigned an MCO Care Coordinator who performs the following functions

Assess

- Conduct/ coordinate Health Risk Assessment
- Identify barriers to optimal health

Plan

- Drive the development of person-centered, individualized care plan
- Include plan to support social determinants of health

Communicate

- Establish collaborative relationships that connect the enrollee, MCO, and providers

Coordinate

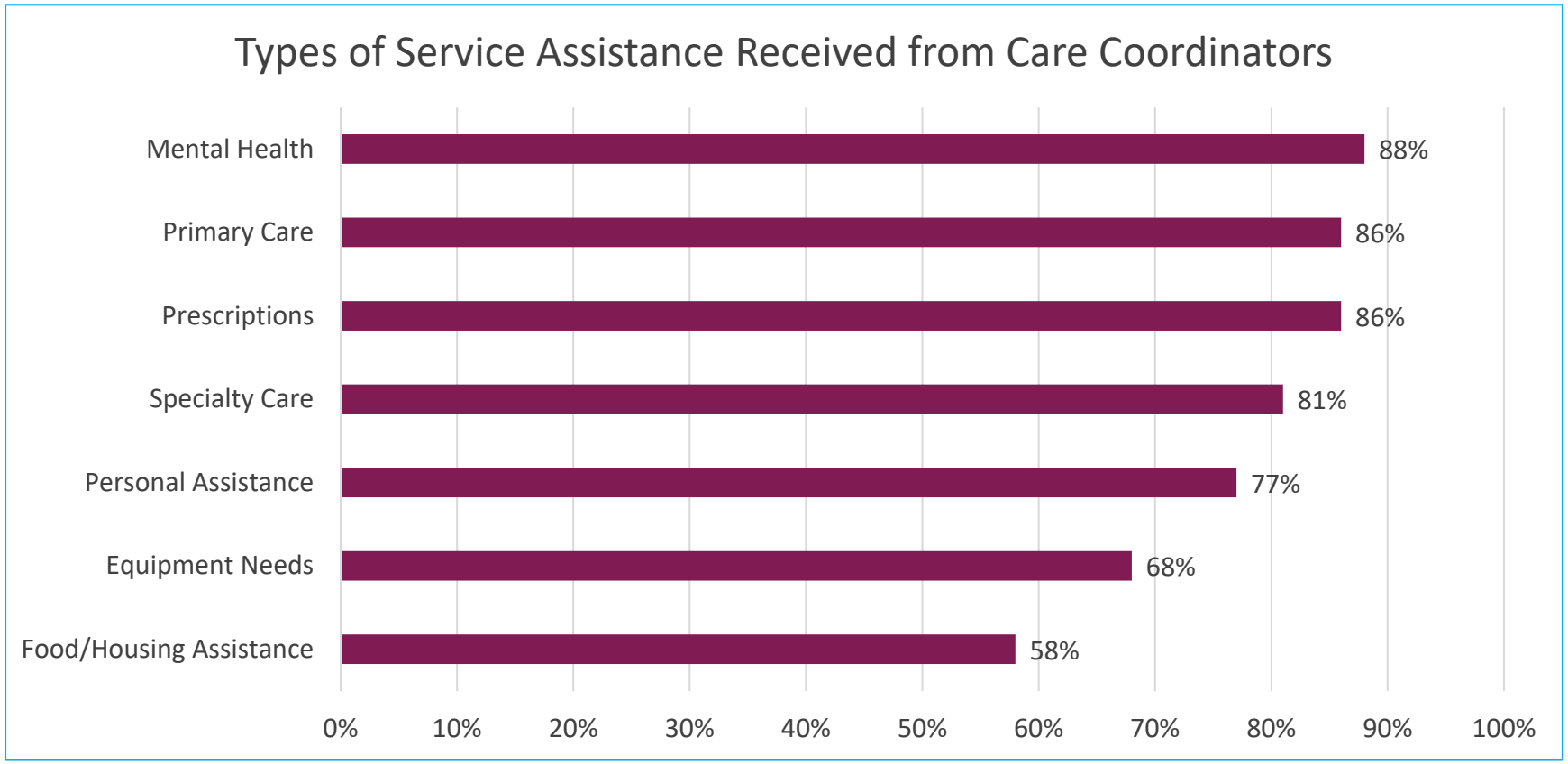
- Help navigate the health care system
- Coordinate team of health care professionals
- Support care transitions

Monitor

- Track progress towards goals
- Monitor status to avoid disruption in care
- Update plan of care

CARE COORDINATION ACTIVITIES

- Most new members reported requesting assistance from their care coordinator
- Of those who requested services, the most common type of support received was in finding mental health services (88%)



OFFICE OF THE STATE LONG-TERM CARE OMBUDSMAN: ROLE OF THE CCC PLUS ADVOCATE

CCC Plus Advocates can help with:

- Enrollment and Disenrollment
- Continuity of Care
- Access to covered benefits, urgent needs, prescription drugs, behavioral health care and long-term services and supports
- Timeliness of Plan Responses to Member Questions and Needs
- Questions about Bills, Care Coordination, and Plan Benefits
- Information and Assistance with Grievances and Appeals

Office of the State Long-Term Care Ombudsman
Department for Aging & Rehabilitative Services
1-800-552-5019 TTY Toll-free 800-464-9950
www.ElderRightsva.org

QUESTIONS?

5 MINUTE BREAK

MANAGED CARE ALIGNMENT

VIRGINIA MEDICAID MCOS

Coverage provided for most individuals through the Medallion 4.0 and Commonwealth Coordinated Care Plus (CCC Plus) managed care programs

aetna®

Aetna Better Health® of Virginia

Anthem. HealthKeepers Plus
Offered by HealthKeepers, Inc.

Magellan COMPLETE CARE®

OptimaHealth Family Care

UnitedHealthcare® Community Plan

VirginiaPremier™
Powered by VCU Health

MEMBER CHOICE

The first and foremost goal and expectation of managed care is to improve the quality of life and health outcomes for enrolled individuals

IT'S ALL ABOUT THE MEMBER

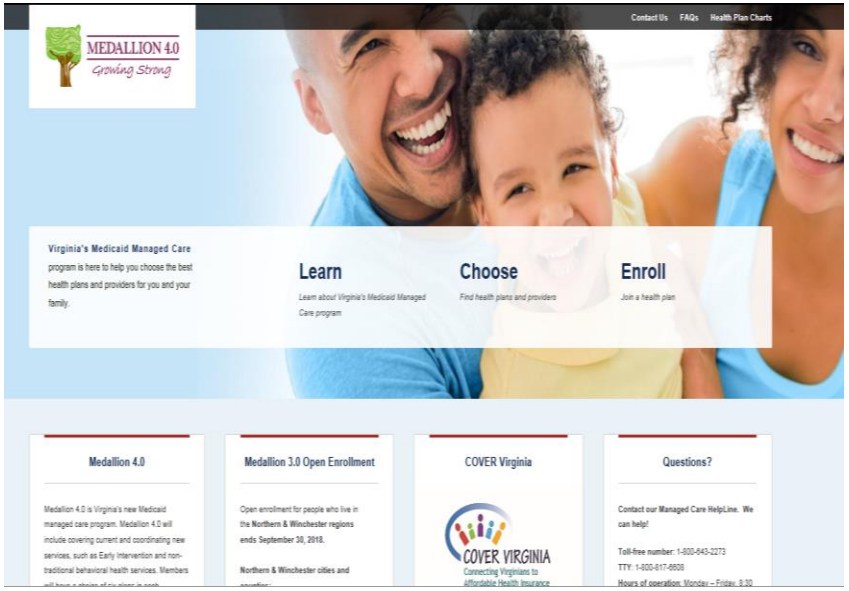
- ***MEMBER CHOICE AND ACCESS***
- ***MEMBER FOCUSED PROGRAMS***
- ***MEMBER ENGAGEMENT AND USE OF SERVICES***

MEMBER ENROLLMENT

Contact Managed Care Helplines to request information, find providers, enroll in a health plan, or change health plans

MEDALLION

- 1-800-643-2273
- virginiamanagedcare.com
- Medallion 4.0 App



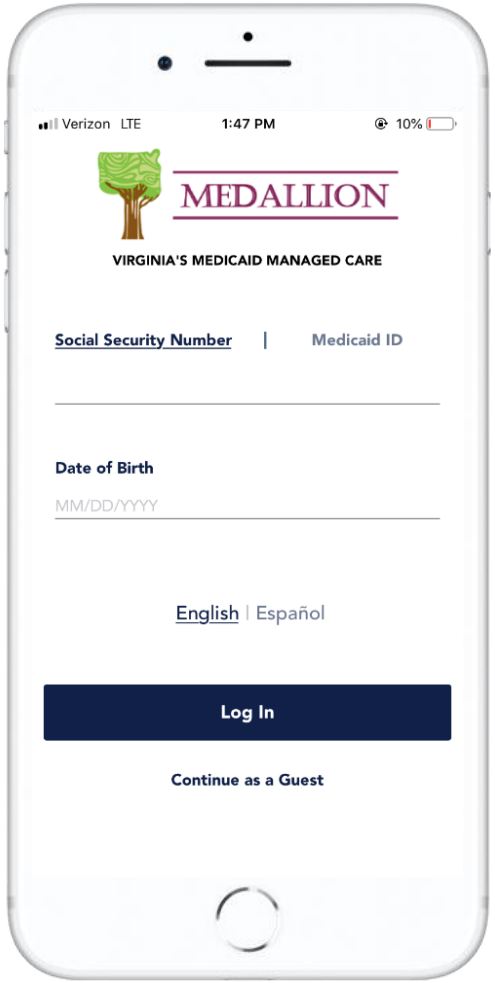
CCC PLUS

- 1-844-374-9159
- cccplusva.com

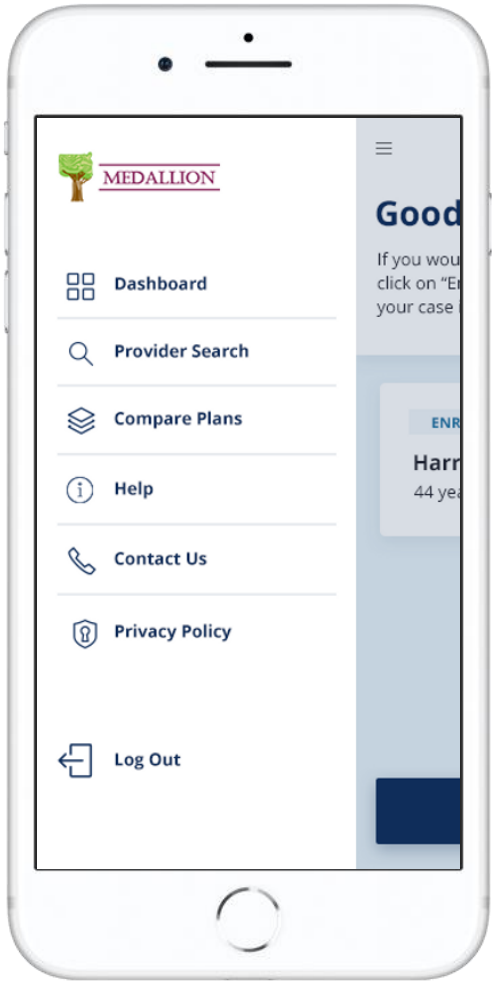
MEDALLION 4.0 MOBILE APP

Splash Screen

Log In

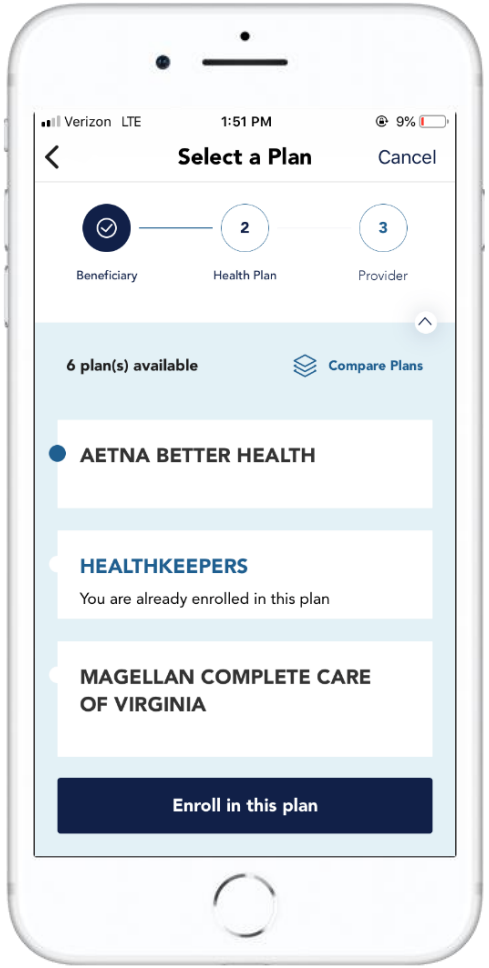


Drawer Menu

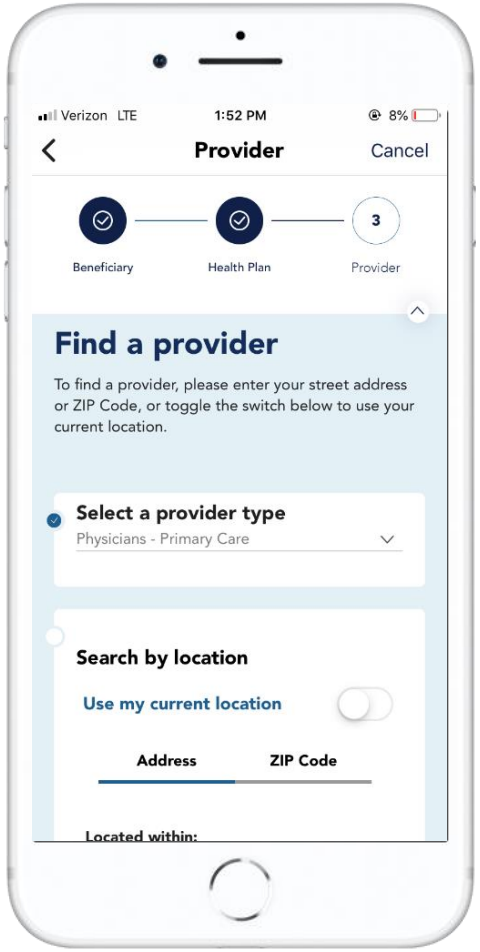


MEDALLION 4.0 MOBILE APP SCREENS

Select A Plan

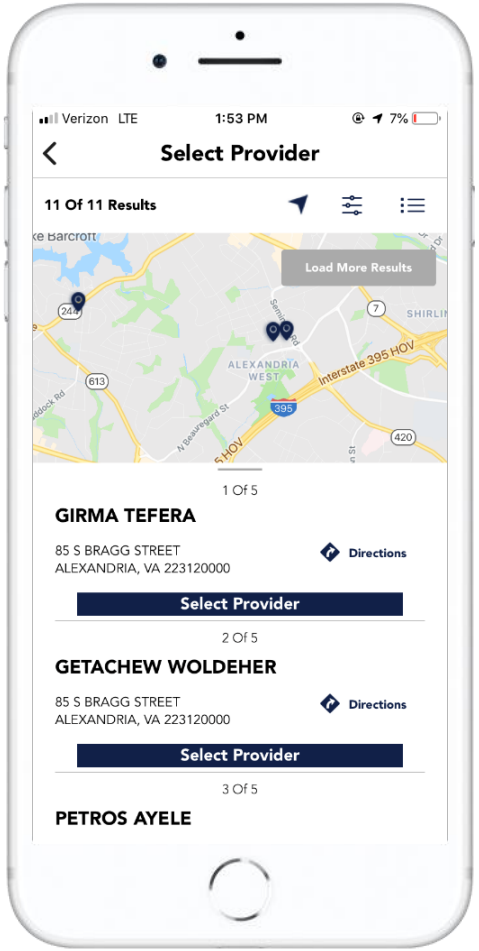


Find A Provider



Select a Provider -

Map View



ENHANCED BENEFITS FOR MEMBERS

- Health plans offer enhanced benefits to members, including, but not limited to:
  - Adult dental
  - Vision for adults
  - Cell phone
  - Centering pregnancy program
  - GED for Foster Care
  - Sports physicals at no cost (under age 21)
  - Swimming lessons for members six (6) years and younger
  - Boys and Girls Club membership (6-18 years old)
  - Free meal delivery after inpatient hospital stays
- Note: Not all health plans will offer all of the same enhanced benefits

ENROLLEE PROTECTIONS

- During the **transition of care** period of up to 30 days. MCOs have to allow members to use their existing providers while new providers are located
- MCOs must go **out of network** to provide a service if they do not have a provider in their network that can provide a service
- Members can submit **grievances** to MCOs

MEMBER APPEALS PROCESS

2 Levels

1

MCO Internal Appeal

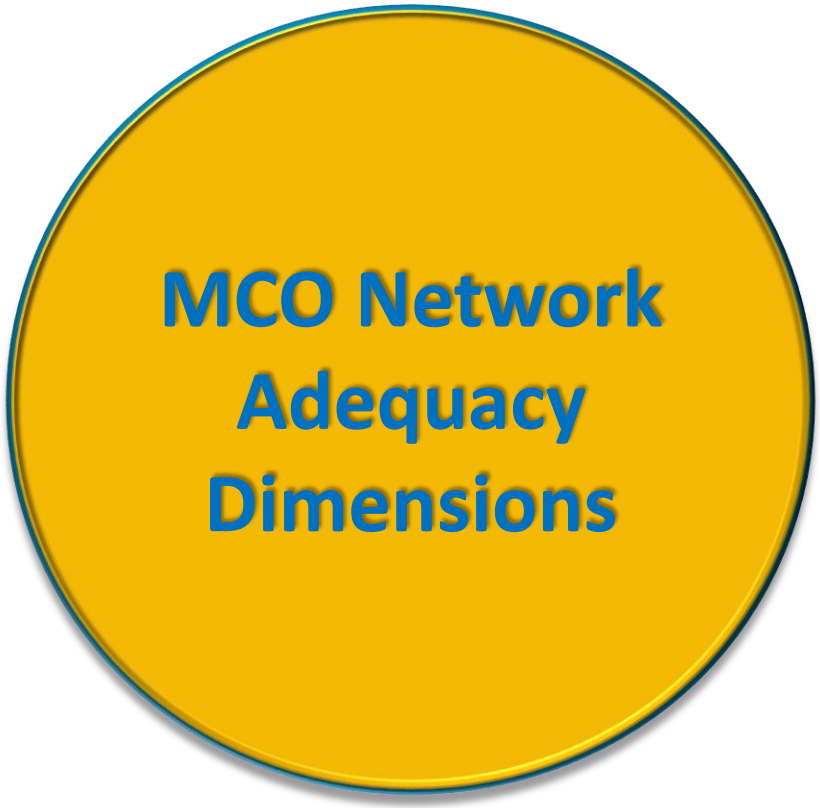
- Appeal any adverse benefit determination or medical decision, including denial or partial approval of service authorizations or claims

2

DMAS State Fair Hearing

- After exhausting the health plan's internal appeal process, members can appeal through the State fair hearing process

ACCESS TO CARE STANDARDS



Staffing
Number and mix of providers
Hours of operation

Accommodations
for physical disabilities
Translation services

Geographic Proximity
Provider to Member
Member to Provider

PROVIDER ENROLLMENT AND CREDENTIALING

- MCOs are responsible for developing and managing their provider networks
- MCO networks must have the capacity to serve their membership within the required access standards
  - ✓ Travel time and distance
  - ✓ Timely access to care
- Plans can offer flexible incentives and provide for greater oversight of providers
- Plans can increase capacity by leveraging their commercial lines of business
- Provider relations staff assist with:
  - ✓ Provider Recruitment
  - ✓ Contracting
  - ✓ Credentialing

PROVIDER PAYMENT

- MCOs must pay all in-and out-of-network providers on a timely basis, consistent with the claims payment procedures described federal regulations and as outlined in the managed care contracts
  - ✓ These payment rules do not override any existing negotiated payment scheduled between the MCO and its providers
- MCOs and providers can negotiate alternative or value based payment arrangements outside of these special payment standards with prior approval from DMAS
- DMAS contractually required payment standards for certain services:
  - ✓ Out of network providers - In the absence of an agreement, the MCO shall at pay the prevailing DMAS rate in existence on the date of service.
  - ✓ Nursing facility, hospice, CCC Plus waiver services, ARTS, CMHRS, and Early Intervention claims must be adjudicated within fourteen (14) calendar days of receipt of the clean claim, and must be paid at a rate of no less than the current Medicaid FFS rate

PHARMACY SERVICES

- Health plans must maintain a drug formulary to meet the unique needs of the members they serve
- The formulary must include all preferred drugs on the DMAS Preferred Drug List (PDL) also known as the Common Core Formulary (CCF)
- The health plan must allow access to all medically necessary non-formulary or non-preferred drugs

COMMON CORE FORMULARY (CCF)

- The CCF includes all "preferred" drugs on the DMAS Preferred Drug List (PDL)
  - DMAS' PDL includes 90+ drug classes
  - Some drugs are not on DMAS' PDL and health plans will decide which drugs to include on their formularies
    - For example, drugs used to treat HIV, hemophilia & cancer are **not** on the DMAS PDL
  - **Health plans cannot require additional prior authorizations (PAs) or add restrictions on CCF drugs**
- Plans can add drugs to the CCF but cannot remove

COMMON CORE FORMULARY (CCF)

- Advantages
  - Members transitioning between health plans and FFS
    - Resulting in less disrupting and improving continuity of care
    - No additional PAs or switching drugs required
  - Less administrative burden
    - Allowing providers to spend more time with their patients
- The CCF does not apply to Medicare Part D plans
- Email concerns to commoncoreformulary@dmas.virginia.gov

OTHER PHARMACY REQUIREMENTS

- MCOs only cover “legend” drugs that have a “rebate.”
- Pharmaceutical manufacturers participating in the Medicaid Drug Rebate Program will pay Medicaid programs “rebates” on drugs used by Medicaid members. These funds are paid directly to the Commonwealth.
- Virginia’s contracted MCOs utilize pharmacy benefit managers (PBM) to administer their pharmacy benefit. Pharmacies enroll with the PBM and NOT the MCO.

QUESTIONS?

MANAGED CARE OVERSIGHT AND PERFORMANCE

OVERSIGHT OF MANAGED CARE

Five main oversight functions; goal is continuous quality improvement:

Contract Development and Monitoring ensures MCO operations are consistent with the contract requirements, includes working with members and providers to resolve any identified service and care management concerns

Systems and Reporting manages data submissions from the MCOs in accordance with the DMAS Managed Care Technical Manual

Compliance Monitoring Process oversees, develops and monitors MCO corrective action plans (CAPS) and sanctions

Quality Performance and Improvement measures MCO performance against standard criteria, such as HEDIS, PIP, PVM and facilitates focused quality projects to improve care for all members, including with the DMAS external quality review (EQR) contractor

Financial Oversight monitored in several ways. Plans are licensed by the Bureau of Insurance (meet solvency criteria). MCO rates are determined by our actuary, are certified as actuarially sound, and approved by CMS

SYSTEMS, REPORTING, AND COMPLIANCE

Continual emphasis on health plan quality, accountability and transparency

MCOs are responsible for robust and transparent reporting on critical elements

MCOs submit deliverables as specified in the contract and in the current the Managed Care Technical Manual

DMAS collects, reviews, and validates contract deliverables based on Technical Manual specifications

Generation of monthly metrics to review MCO performance in several areas

Implemented encounter process system (EPS) which is used for reporting, analysis and (soon) rate setting

Analyze encounter data to determine timeliness, completeness, accuracy and reasonableness

Provide technical assistance to health plans on identified problem areas

Take compliance action, such as issuing Corrective Action Plans and financial penalties when needed a health plan is not conforming to one, or more, contract requirements

QUALITY IMPROVEMENT ACTIVITIES

MCOs complete federal, state and DMAS established quality improvement activities, including:

- NCQA Accreditation; includes reporting of Healthcare Effectiveness Data and Information Set (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) data
- Annual health plan quality rating system (QRS), “score card” tool designed to increase health plan transparency and accountability. Consumers use this information to help make an informed MCO selection
- Participation in performance improvement projects (PIPS) and Performance Measurement Validation Activities (with the DMAS external quality review contractor)
- Participating in either a performance incentive award program (Medallion 4.0) or quality withhold program (CCC Plus)
- Value based payment strategies

PERFORMANCE IMPROVEMENT PROJECTS

Annually, the health plans must perform at least one clinical and one non-clinical PIP

Clinical PIPs include projects focusing on:

- prevention and care of acute and chronic conditions,
- behavioral health,
- long term services and supports,
- high-volume services,
- high risk services, and/or high cost services

Non-clinical PIPs include projects focusing on:

- availability, accessibility,
- cultural competency of services,
- interpersonal aspects of care,
- appeals, grievances, complaints,
- care transitions and continuity,
- coordination of care and care management,
- member satisfaction

2019 CCC Plus Performance Improvement Projects

- Ambulatory Care Emergency Department Visits (Clinical)
- Follow Up After Hospital Discharge (Nonclinical)

2019 Medallion 4.0 Performance Improvement Projects

- Timeliness of Prenatal Care-Subpopulation race, ethnicity, geographic area (Clinical)
- Tobacco Cessation in Pregnant Women (Nonclinical)

ELECTRONIC VISIT VERIFICATION (EVV)

ELECTRONIC VISIT VERIFICATION (EVV)

Required by Section 12006 of the Federal CURES Act for personal care on 01/01/2020 and home health on 01/01/2023

Virginia's EVV Implementation Timeline

Agency and Consumer Directed Personal Care, Companion Care and Respite Services - Oct 1, 2019

Home Health Services - Jan 1, 2023

Virginia's EVV Models:

Agency-Directed (AD) Members

Provider Choice Model: Each provider selects and obtains their own system that meets the Virginia Medicaid system requirements, as described in the EVV Technical Companion Guide (in development)

Consumer-Directed (CD) Members

The Fiscal/Employer Agent (F/EA) will provide an EVV system for use

QUALITY **PROGRAM INTEGRITY** **OVERSIGHT**

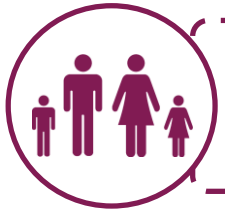
VALUE-BASED PURCHASING TERMINOLOGY

Understanding The Language Of Value

- "Value" is a big buzz word in health policy these days
- Can be difficult to understand the context
- For the purposes of this presentation, we will use the following definitions:
  - Value-Based Payments → Payment structures that tie *provider* financial success to patient receipt of high-quality, efficient care
  - Value-Based Purchasing → A *broader concept* where both monetary and non-monetary incentives are used to drive performance at multiple levels within the health system

The ultimate goal of VBP policy is to promote the effective and efficient provision of care to Medicaid members; rewarding value, not volume of care.

THE NEED FOR VALUE BASED PURCHASING



DMAS plays a critical role in the provision of health care coverage to an increasing number of Virginians.

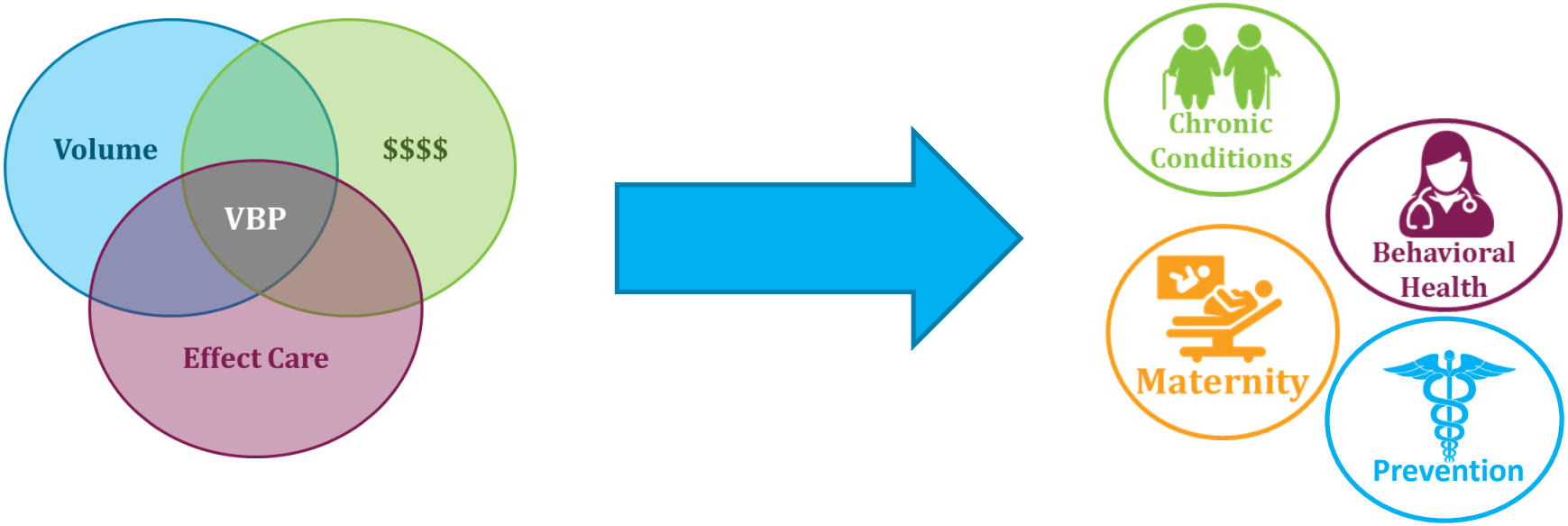
DMAS has a responsibility to members and the Virginia taxpayer to maximize the value it receives for state and federal health care dollars.

VBP is a powerful tool to promote quality and efficiency in the care Medicaid members receive.

CMS is actively encouraging efforts by purchasers, plans, and providers to change payment and improve care delivery.

AREAS OF VBP FOCUS FOR DMAS

VBP efforts need to effectively leverage limited resources to improve care outcomes



DMAS will focus on VBP initiatives and accountability structures that emphasize behavioral health, chronic conditions, maternity care, and prevention.

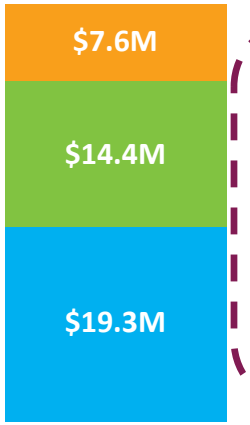
CURRENT AND PROPOSED VBP EFFORTS

Program	Accountability	Incentive
Clinical Efficiencies	• Evaluate levels of preventable utilization (i.e. ED visits, hospital admissions, hospital readmissions) • Develop performance measures to track MCO- & hospital-specific performance	2020: Adjust M4 capitation rate 2021 and Beyond: MCOs have two-sided risk based on measure performance
Performance Withholds	• Performance targets for key process and outcome metrics • Focus on behavioral health, chronic conditions, maternity care, and prevention	CCC+ → 1% capitation withhold beginning in CY 2019 Medallion 4.0 → 1% capitation withhold beginning in SFY 2021
CCC+ Discrete Incentives	Support successful, sustained transitions of complex nursing facility residents into the community	MCOs can earn one-time bonus for each successful transition
Proposed New Initiative		
Episodic Payments	• DMAS Decision Package proposing to develop and implement episodes for maternity, asthma, and congestive heart failure (CHF) • Conditions represent: 1) areas of importance for members, 2) evidence improved care outcomes reduce spending, 3) available resources from other states	Establish provider accountability for spending & quality thresholds over the course of a defined period of care

DMAS CLINICAL EFFICIENCIES (CE) POLICIES

Top 3 Adult Drivers: Diabetes, Urinary Tract Infections, & Pneumonia
Top 3 Pediatric Drivers: Asthma, Perforated Appendix, & Diabetes

Top 10 Drivers: Respiratory Issues (J06.9, J45.9), Ear Infection (H66.9), Fever (R50.9), Soar Throat (J02.9, J02.0), UTI (N39.0), Nausea (R11.2, R11.1), and Headache (R51.)



ED Visits Admissions Readmissions

Base analysis of CY 2016/17 utilization identified over $41M in potentially preventable and/or medically unnecessary spending among *Medallion* members

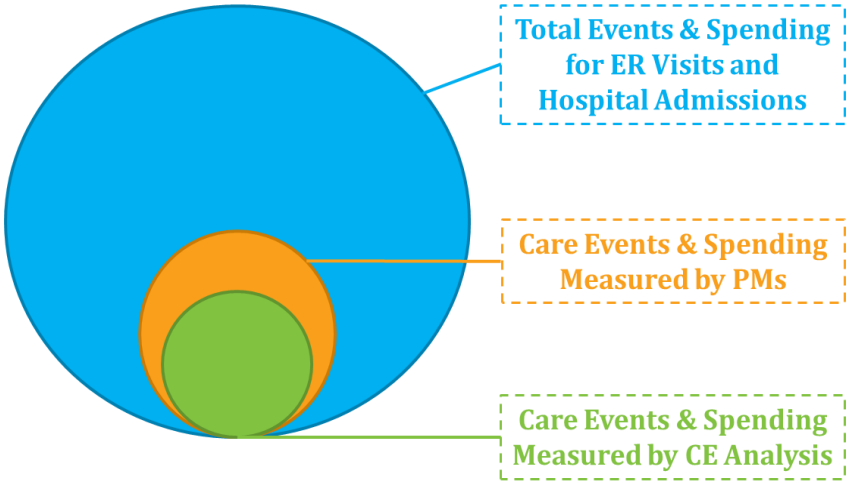
DMAS identified utilization that could be avoided through effective care management and access to/utilization of lower acuity care settings; specifically, potentially preventable and/or medically unnecessary ER visits, hospital admissions, and hospital readmissions.

Base Analysis

Future Policy

DMAS is working to turn its base CE analysis into a series of performance measures that can be tracked year-over-year to assess MCO efficiency improvement. In doing so it will expand the portion of care events relevant to the efficiency analysis and develop capabilities to evaluate hospitals in a similar manner.

Broader Scope from CE Analysis to Performance Measure



MEDALLION AND CCC PLUS PERFORMANCE WITHHOLDS

By SFY 2021, at least 1% of all MCO capitation rates will be at-risk based on performance against quality measures focusing on behavioral health (BH), chronic conditions (CC), maternity care, and prevention

- CCC Plus withhold began in CY 2018
- Medallion withhold will begin in SFY 2021

Performance Withhold Measure Composites			
Domain	**CCC Plus**	**Medallion 4**	**Measure Type**
BH	Follow-up after ER visit for mental illness		HEDIS
CC	COPD and/or asthma admissions rate		PQI
CC	Comprehensive diabetes care		HEDIS
BH	Follow-up after ER visit alcohol or other drug dependence		HEDIS
BH	Initiation and engagement of alcohol and other drug dependence treatment		HEDIS
CC	Heart failure admissions rate		PQI
Maternity		Prenatal and Postpartum Care	HEDIS
Prevention		Childhood immunization status – combo 3	HEDIS
Prevention		Adolescent well-care visits	HEDIS

The Performance Withhold Program places significant financial incentives behind MCO achievement for key member care events and outcomes

EPISODES OF CARE

An episode of care is a set of services provided for a **condition or procedure** over a **period of time**. Episodic payment VBP models assign **expectations and accountability** for **cost and quality** over the course of an episode.

Pregnancy and Delivery	280 days before delivery through 60 days after hospital discharge	Physician(s) billing delivery	C-Section rate, Follow-up care, Screenings
Acute Asthma Exacerbation	Asthma-related ER visit, Obs stay, or Inpatient admission to 30-days post-discharge	Facility treating at trigger	Follow-up care, Filled prescriptions, Repeat exacerbations
Congestive Heart Failure (CHF)	CHF-related ER visit, Obs stay, or Inpatient admissions to 30-days post-discharge	Facility treating at trigger	Follow-up care, Filled prescriptions, Readmission rate

DMAS PROPOSES 3 EPISODIC PAYMENT MODELS

- >100,000 members have an asthma diagnosis (~70% children)
- Members w/ asthma account for >$600M in total spending annually (>$26M directly related to spending w/ a primary Dx of asthma)
- Accounted for >1,100 potentially preventable inpatient admissions in base CE analysis

- >22,000 members have a CHF diagnosis
- Members w/ CHF account for >$650M in total spending annually (>$90M directly related to spending w/ a primary Dx of CHF)
- Accounted for >1,200 potentially preventable inpatient admissions in base CE analysis

- Medicaid covers more than 1 in 3 Virginia births, with medical spending around deliveries along representing over $200M in annual costs
- Virginia low birth weight deliveries and C-Section rates are higher than the national average, resulting in much higher hospital and recovery costs than standard deliveries
- Care outcomes for better deliveries and healthier children can improve short term efficiency and long term population health

DMAS submitted a budget proposal to develop and implement 3 episodes; analysis of membership size and utilization for select conditions indicates strong potential for episodic payments

PROGRAM INTEGRITY

- The Program Integrity Managed Care Unit was created to strengthen the partnership with the MCOs
- The Unit is dedicated to the oversight of MCOs through audits of MCO providers and onsite reviews of the MCO's program integrity activities

COLLABORATIVE MEETINGS

DMAS holds quarterly Managed Care Program Integrity Collaborative meetings that provide the MCOs and DMAS with the opportunity to share information regarding program integrity issues

The meetings also provide a forum to:

- Identify problematic providers and fraudulent schemes
- Mitigate and avoid abusive schemes
- Collaborate with Medicaid Fraud Control Unit (MFCU), who provide updates on fraud investigations and discuss potential fraud referrals

PROGRAM INTEGRITY ACTIVITIES

QUARTERLY REPORT

PID created the PID Quarterly MCO Report, which includes details on MCO program integrity allegations, investigations, prevention, and other MCO activities. This report is reviewed every quarter by each dedicated PID Analyst to ensure:

- The MCOs are following reporting requirements and progressing towards established program integrity goals
- Required PI policies and adequate staffing
- Ensure adherence to Payment Suspension Guidelines
- Internal monitoring and audit plan adequacy
- Ensure MCO payments are utilizing exclusion databases (i.e. LEIE, SA Death Master File, etc.)

ONSITE VISITS

The onsite visit affords the MCOs an opportunity to provide a detailed explanation of program integrity programs and processes

FADS

The Fraud and Abuse Detection System (FADS) from Optum is a suite of complimentary, web-based components that mine provider, member and claims data for potential fraud, waste and abuse; provide software research tools; and track subsequent investigation activity. FADS also contains a case tracking system. This system is a collaborative effort between DMAS Divisions, Optum and additional stakeholders.

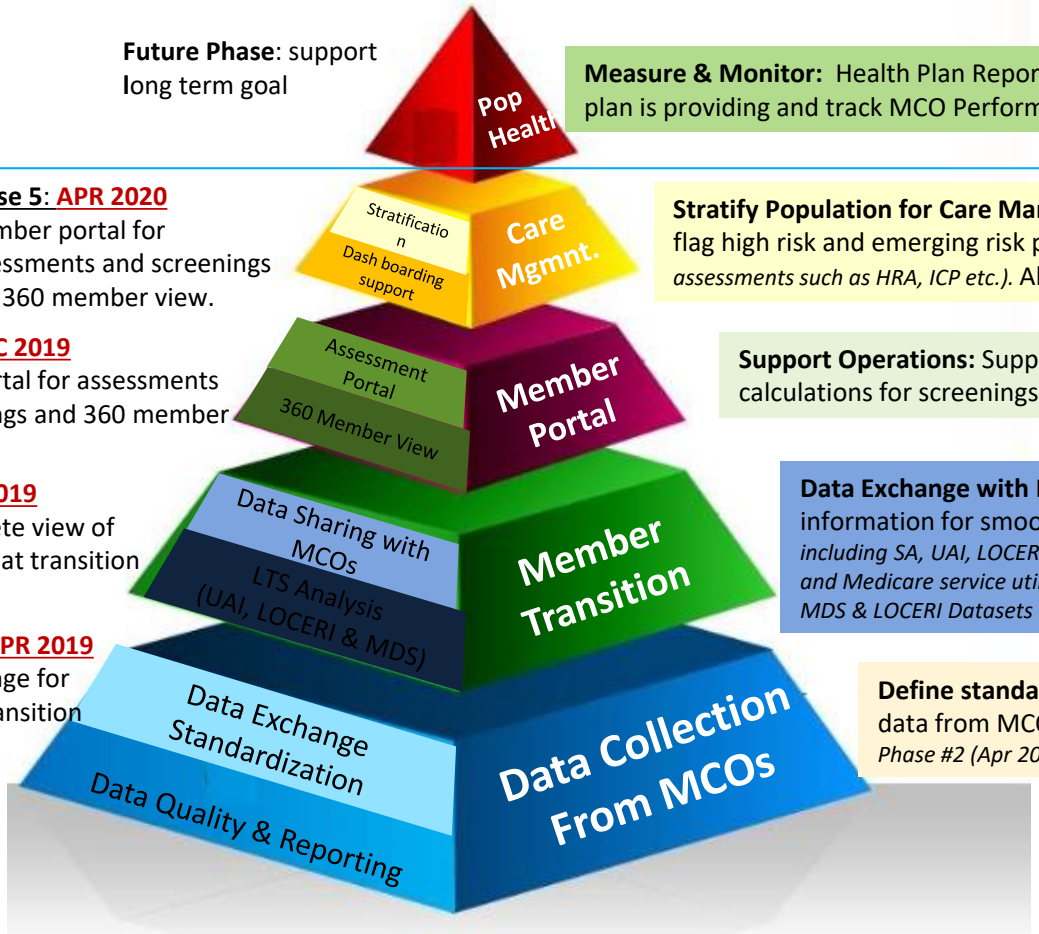
NEW AND ONGOING INITIATIVES

New Contract New Rate Process	Social Determinants Of Health and Supportive Services	Women's Health Family Planning	Maternity Care Prenatal and Postpartum
Early Intervention	Transition Planning To Help Teens and Young Adults	Infant and Early Childhood Physical and Mental Health	Behavioral Health Transformation CMHRS, ARTS, SUD
Value-Based Purchasing Arrangements Clinical Efficiencies	Quality Strategy and Office of Quality and Population Health	Program Integrity	EPS Encounters
System Improvements	Foster Care	Provider Enrollment and Screening Provisions per the Federal CURES ACT	EVV

CARE MANGEMENT SYSTEM COMING SOON

Care management IT solution that will support data sharing between MCOs

Future Phase: support long term goal



Measure & Monitor: Health Plan Report Card that presents the quality of care a health plan is providing and track MCO Performance.

Phase 5: **APR 2020**
Member portal for assessments and screenings and 360 member view.

Stratify Population for Care Management and Compliance check: Apply logic to flag high risk and emerging risk patients to track compliance (*Ex. Track timeliness of assessments such as HRA, ICP etc.).* Ability to track gaps in care and care needs

Phase 4: **DEC 2019**
Member portal for assessments and screenings and 360 member view.

Support Operations: Support UAI and LOCERI processing, and payment calculations for screenings. Provision a portal for member centric view.

Phase 3: AUG 2019
Create a complete view of member record at transition

Data Exchange with MCOs: Provide MCOs with seamless access to information for smooth member transition (*Comprehensive **MTR** including SA, UAI, LOCERI, MDS, PUMS, HRA, ICP, Carve out services, Medicaid and Medicare service utilization, immunization history, lab data etc.). Analysis of MDS & LOCERI Datasets*

Phase 1 & 2: **JAN/APR 2019**
Enable data exchange for smooth member transition

Define standards and collect data: Develop standards to collect data from MCOS *Phase #1 (Jan 2019): SA, PUMS, HRA; Phase #2 (Apr 2019): ICP and Demographic information*

REFERENCES

- Medicaid Managed Care 101 presentation by Bailit Health, Oct 3, 2019 https://www.dmas.virginia.gov/files/links/5107/VA%20Medicaid%20Managed%20Care%2010-2-2019_final%20draft.pdf
- Medicaid and FAMIS Eligibility Information – https://coverva.org/eligibility/
- Managed Care Contracts
  - CCC Plus - http://www.dmas.virginia.gov/#/cccplusinformation
  - Medallion 4.0 - http://www.dmas.virginia.gov/#/med4
- Technical Reporting Manuals
  - CCC Plus - http://www.dmas.virginia.gov/#/cccplushealthplans
  - Medallion 4.0 - http://www.dmas.virginia.gov/#/managedcares
- Virginia Managed Care Annual Report - http://www.dmas.virginia.gov/#/cccplusinformation
- MCO Compliance Reports - http://www.dmas.virginia.gov/#/med4reports
- Managed Care Corrective Action Plans
  - CCC Plus - http://www.dmas.virginia.gov/#/cccplusinformation
  - Medallion 4.0 - http://www.dmas.virginia.gov/#/med4reports
- Code of Federal Regulations - https://www.ecfr.gov
- COMPASS Waiver - http://www.dmas.virginia.gov/#/1115waiver
- Federal CURES ACT – Requires compliance with ACA Federal Provider Screening rules(42 CFR 438.602), - https://www.medicaid.gov/medicaid/program-integrity/affordable-care-act-program-integrity-provisions/index.html
- Timely Claims Payment (42 CFR 447.45 and 46) - https://www.ecfr.gov/cgi-bin/text-idx?SID=e81b03a08e675ba758d55dd1e14f60e7&mc=true&node=pt42.4.447&rgn=div5#se42.4.447_146

QUESTIONS?