Virginia
Medicaid Managed Care
2013 Annual Report

A Year of CHANGE
Inside AND Out

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Medicaid Managed Care 2013 Annual Report Introduction

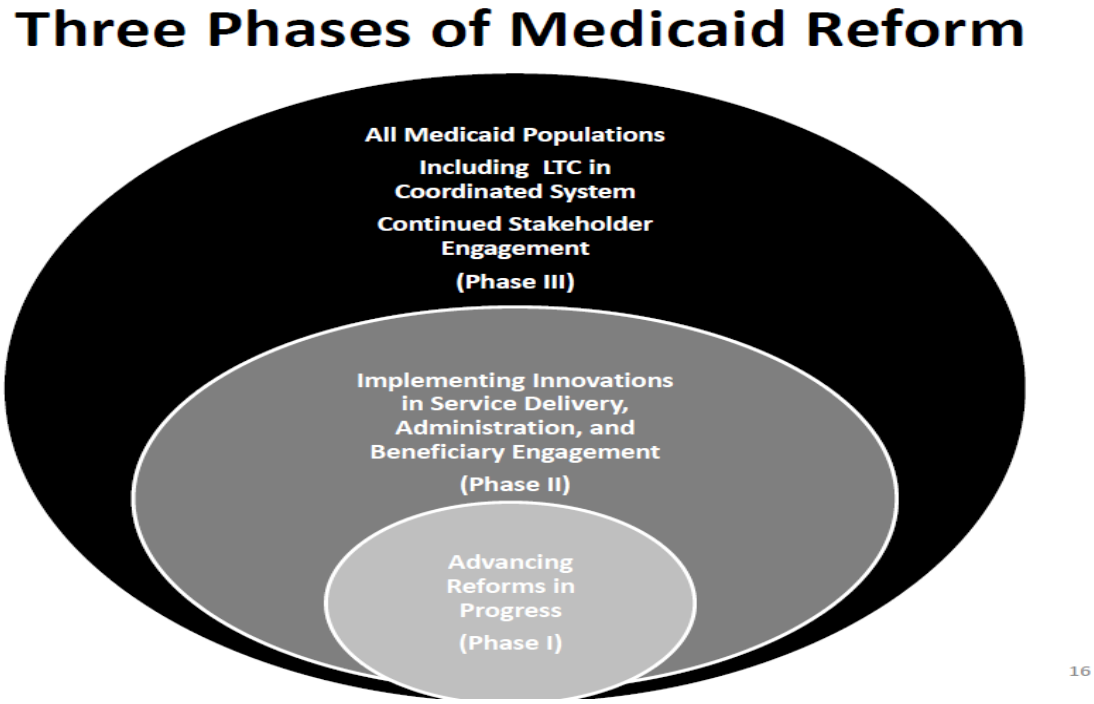
The theme of this year's annual report - Changes, Inside and Out, sums up 2013 — a year of rapid changes in the Medicaid program— some were DMAS initiated and others came from external factors. The convergence of these changes resulted in improvements to the way Medicaid is administered in Virginia. <u>The Changes are Already Producing Favorable Results, Such as:</u>

- The introduction of Medallion 3.0 which significantly changes and reforms managed care: new quality, partnerships, reporting, and compliance
- Eligible Virginians with Medicare & Medicaid coverage may choose to participate in the Commonwealth Coordinated Care Program
- Eligible children in foster-care are receiving more timely, coordinated, patient centered care as a result of being in the managed care delivery system
- Medicaid eligibility determinations are standardized and more efficient
- Program Integrity (PI) enhancements recovering significant amounts of potential dollars lost
- Medicaid enrollees with behavioral health issues are now receiving both medical and mental health services through an integrated delivery system
- Two comprehensive value-based purchasing programs were launched in 2013 — both are designed to take managed care quality and patient centered care to higher levels.

Without a doubt, changes to Virginia Medicaid *will continue* and DMAS will apply a forward thinking approach to capturing all changes as opportunities for improvement.

Medicaid Innovation and Reform Commission – MIRC

The Medicaid Innovation and Reform Commission's (MIRC) purpose is to review, recommend and approve innovations and reform proposals affecting the Virginia Medicaid and Family Access to Medical Insurance Security (FAMIS) programs, including eligibility and financing for proposals set out in Item 307 in the Virginia budget for Department of Medical Assistance Services. Specifically, the Commission shall review (i) the development of reform proposals; (ii) progress in obtaining federal approval for reforms such as benefit design, service delivery, payment reform, as well as quality and cost containment outcomes; and (iii) implementation of reform measures. The MIRC continues to meet and participate in shaping the future of Virginia Medicaid through a three-phase process.



The following pages highlight key Medicaid reforms in 2013

Phase I Phase II

Check-Up: The Contract between DMAS & Managed Care Organizations

Medallion 3.0

Just as a routine check-up from a doctor is crucial to attaining optimal health, contract check-ups are imperative to maintaining highly effective business agreements. That's why, in 2013, the contract between DMAS and MCOs underwent a comprehensive check -up and subsequent changes were made.

DMAS began the contract check-up by identifying best practices through research of 13 states' Medicaid managed care contracts. DMAS was able to leverage the knowledge shared by other states in revamping the structure of the Medicaid MCO contract for the July 1, 2013 effective date.

The resultant contract clearly "connects the dots" between regulations, policies, accreditation requirements, reporting requirements, increasing oversight, and accountability.

Even Further, DMAS Added New Sections to the Contract, Such As:

chronic care and assessments; wellness programs; maternity program enhancements; standardized data submission and analysis; electronic reporting; and, enhanced program integrity requirements. In order to assure the utmost level of monitoring and tracking - a technical manual was also developed. The Managed Care Technical Manual enables DMAS as the payer – to monitor compliance by each MCO – and, the MCOs, as the purchaser of health care services, to efficiently and effectively meet DMAS' reporting expectations while addressing the health care needs of Medicaid managed care members.

Phase II

Reforming Virginia Medicaid: Incentives for Higher Performance

The ongoing quality requirements by DMAS of its contracted Medicaid MCOs reach far beyond regulatory compliance and into the realm of improving the structure, process, and outcomes of care. It is time for change – and DMAS has raised the bar even higher – through two high-performance incentive programs – already in progress.

Value Based Purchasing Through Pay-for-Performance Initiative – provides incentives for MCOs to achieve higher levels of quality in administrative processes and outcomes of care. This initiative is expected to increase members' use of important preventive services – measured through the use of NCQA's Healthcare Effectiveness Data and Information Set (HEDIS) and increase efficiencies in administrative processes- measured by the use of high-priority deliverables in the contract between DMAS and the MCOs.

Medallion Care System Partnership (MCSP) — enables innovation in systems designed to integrate primary, acute, and complex health services provided by the MCOs through health care homes or other MCSP arrangements. The MCSP is built upon partnerships between the MCOs and their providers and/or health care systems. As part of this arrangement, MCOs enter into contractual arrangements that include gain and/or risk sharing, performance-based incentives, or other incentive reforms tied to Commonwealth-approved quality metrics and financial performance.

Phase II

New Managed Care Plans Bring More Consumer Choice & Market Consolidation to Northern Virginia

During the 2012 acquisition of Amerigroup by Anthem HealthKeepers Plus, it was surmised that once these two competing health plans merged, only one MCO would remain operational. Because CMS requires at least 2 MCOs in every region, this merger would have meant the end of managed care and the reintroduction of fee-for-service in Northern Virginia.

In order to preserve managed care and provide 2 MCOs in the region, it was determined that the Amerigroup-Virginia health plan must be severed from the acquisition. The Amerigroup Virginia business was purchased by INOVA health system, and later officially named INTotal Health. HealthKeepers retained its service areas in Northern Virginia.

During this same time period, Kaiser Permanente was developing a Virginia Medicaid product and, by the third quarter of 2013, signed a contract with DMAS to begin serving members in northern Virginia on November 1, 2013.

While offering different models, Kaiser and INTotal provide comprehensive networks of providers which include hospitals, specialty medical groups, and other physicians. This enables the MCOs to focus on care delivery networks and provider and practitioners access points to serve membership and provider needs.

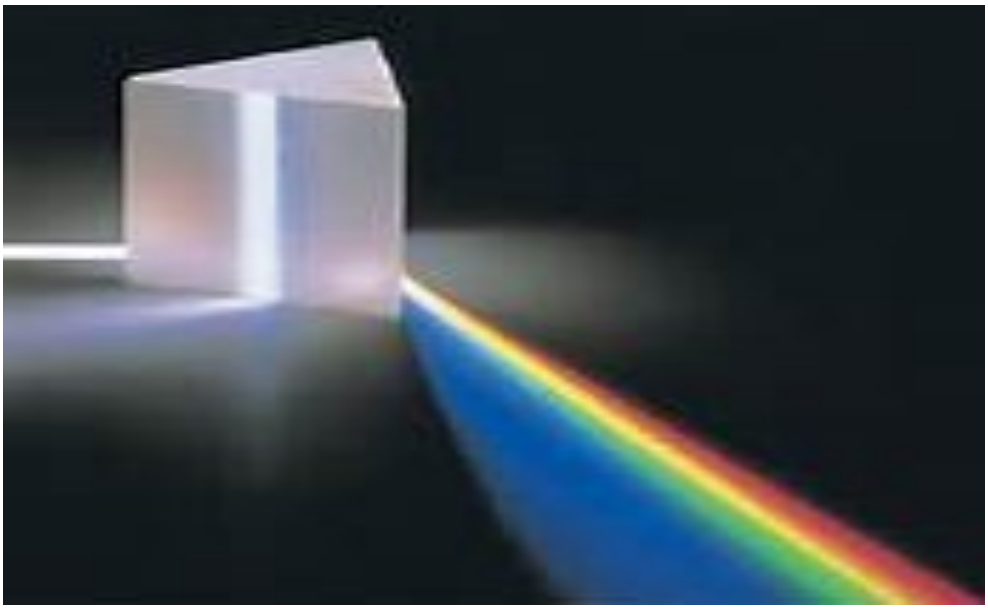
Eligible enrollees in most areas of northern Virginia will now have three MCOs to choose from: Anthem HealthKeepers Plus, INTotal Health, and Kaiser Permanente.

Managed Care Quality Improvement
Process Changes
Change Lives

How do you know if quality improvement initiatives are working?

The Fourth Annual Medicaid Managed Care Quality Best Practice Session of 2013 featured outstanding presentations by each of the MCOs– these best practices showed that quality improvement works *and* changes lives!

The next six pages of this report feature the 2013 best practices presented by Virginia's Medicaid MCOs.



Don't miss the 2014 Virginia Medicaid Managed Care Best Practice Session, June 24, 2014

Anthem HealthKeepers Plus:
Follow-Up After Inpatient Stay for Behavioral Health

The Measure: The percentage of discharges for members 6 years and older who were hospitalized for a certain mental health disorder and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. 1) within **30 days after discharge and** 2) within **7 days after discharge**

Improvements in Action!

- Improved the flow of information between care managers and outreach specialists
- Condensed the number of member letters from five to two
- Contacted member within 24 hours of discharge
- Called members to remind them about appointments & and to confirm appointments were kept
- Maintained an internal data base used to monitor outreach efforts
- Partnered with community services boards (CSBs) to follow if member appointments were kept and to facilitate referrals with utilization management
- Referred members to MCO's case management for ongoing care

Results:

	2010	2011	2012	% Change
7 Day	36.21	43.78	55.43	19.22
30 Day	62.51	74.9	87.3	24.79

INTotal Health
Huddles for Complex Cases

The Challenge: Members with ongoing complex needs require tailored, intensive, and ongoing case management to enable timely access to quality care and supports.

Solution: INTotal Health implemented a Clinical Huddle— a weekly gathering on complex needs. Members are placed on the Huddle List based on utilization of services, referrals from providers, claims data and other sources of referral. The Huddle List is detailed and maintained by Case Management Leadership and must have:

- Detailed demographics
- Lead case manager
- Narrative summary of case
- Recent developments
- Next Steps

The Clinical Huddle meeting is attended by Senior Leadership including:
CEO, CAO, CMO, VP Clinical Services, AVP Operations, Leads of Case Management, Quality, Compliance, and Provider Relations

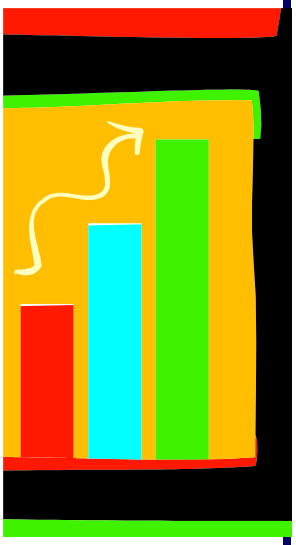
Results!

- Prevents duplication of health and social services
- Prevents administrative duplication at the health plan level
- Places the member at the center of care
- Enables the member to receive timely access to quality care—tailored for their complex needs
- May enable members to increase their use of condition management and reduce the use of emergency care

MajestaCare

Analysis of Regional Demographics and Trends

The Challenge: In July of 2012, MajestaCare added 7,000 members from the far southwest region of the state to its existing membership in the Roanoke/Alleghaney region. After 6 months of service delivery to the new members, MajestaCare recognized significant—unfavorable—changes to utilization trends for pharmacy, emergency department (ED), and inpatient admissions.



Solution: MajestaCare's Integrated Care Management (ICM) team used a predictive modeling tool—*Consolidated Outreach and Risk Evaluation* (CORE) which uses a methodology to identify high risk members who need outreach and assessment.

Key Features:

- Dedicated Case Management Staffing
- Member Identification through CORE, inpatient admissions, ED use
- Medical Needs + Bio-Psycho-Social Needs
- Multi-faceted outreach and education to providers, coalitions, and members
- Biweekly Case Rounds coordinated with Home Health, Carilion PCMH Care Coordinators, Medical and Behavioral Health Providers, Pharmacy Consultants

Improvement! The strategic, data driven approach to prioritizing the high-needs/ high-impact opportunities for improvement has enabled the MCO to focus on:

- ED/Inpatient Utilization by region
- Pharmacy Utilization and Costs
- Prenatal Care
- Common Diagnoses and Conditions
- Transportation

CoventryCares of Virginia: Breast Cancer Screening

The Measure: The percentage of women 40-69 years of age who had a mammogram to screen for breast cancer in 2010 or 2011.

Improvement in Action: CoventryCares used a wrap-around approach in addressing the health care needs of members:

1) Member Outreach:

- Member incentive
- Educational mailings (brochures and care tips) & community events
- Member reminder calls
- Mobile mammography vans
- Transportation services for medical appointments

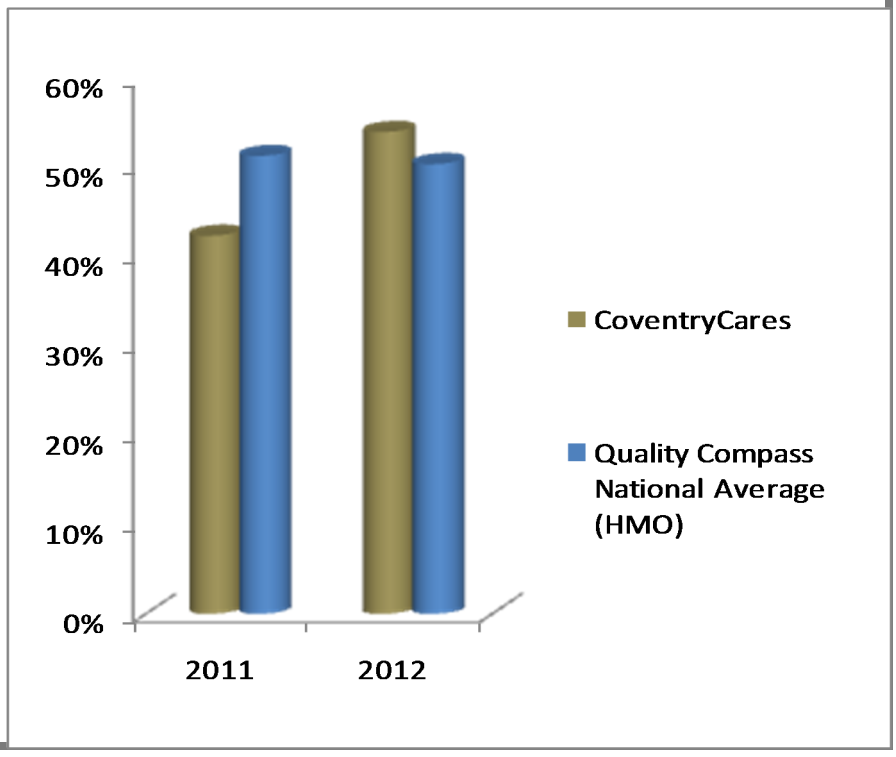
2) Provider Education: Provider visits, portal enhancements, and newsletter

3) Health Plan Enhancements:

- Member call tracking system improvements
- Ongoing HEDIS workgroups include members from various departments
- Identifying and gathering supplemental data

Results:

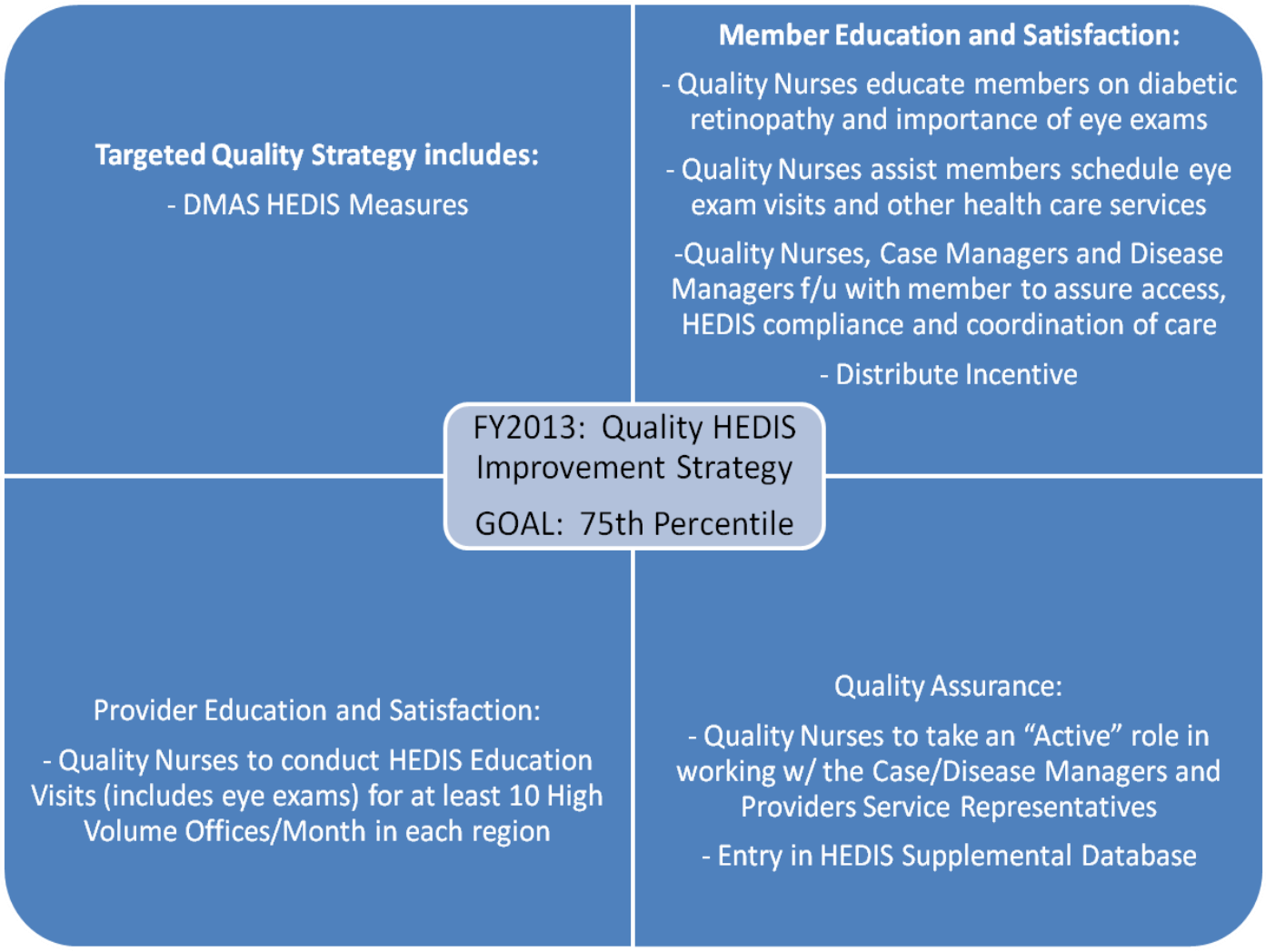
Mammography rate improved by 11.63 percentage points from 42.4% (HEDIS 2011) to 54.03% (HEDIS 2012), moving the MCO from the 10th to the 50th national percentile.



Virginia Premier Health Plan
Eye Exams for People with Diabetes

The Measure: The percentage of members aged 18—75 with Type I or Type II diabetes who received a retinal eye exam in the measurement time period.

Improvement in Action:



Results: More than 50% (55%) of members with diabetes received a retinal eye exam in the measurement period (HEDIS 2012). This exceeds the national 50th percentile.

Optima Family Care
Weight Assessment & Counseling

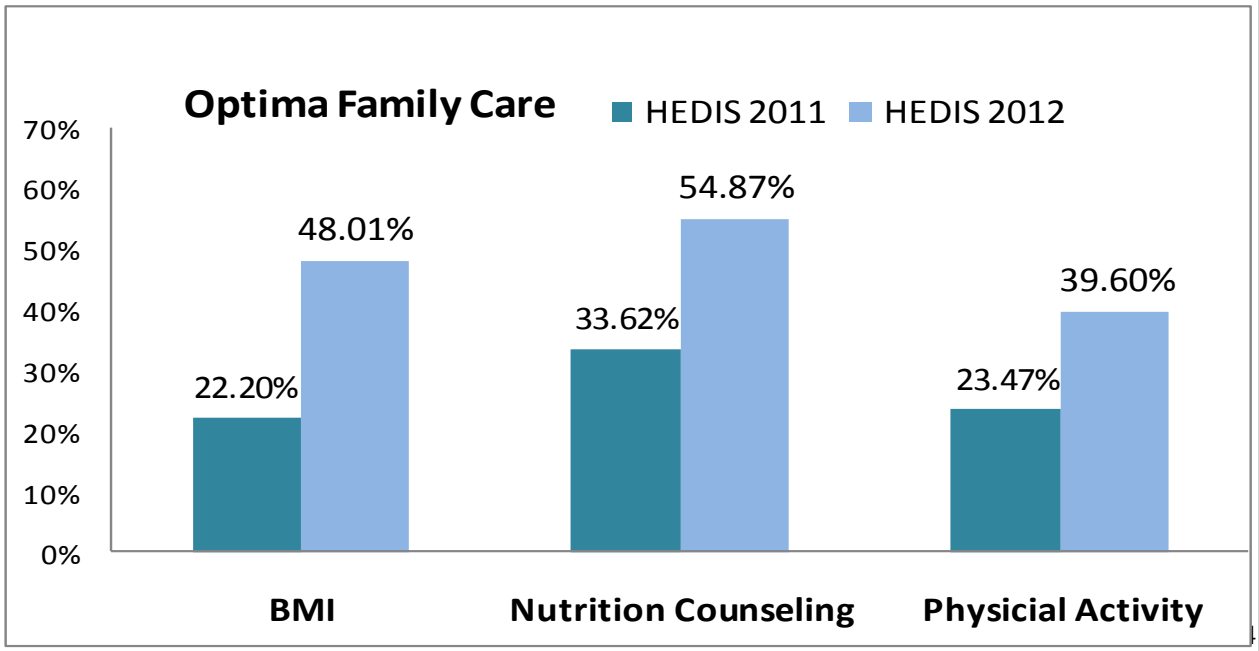
The Measure: Percent of members age 3 – 17 years who had at least one visit with a primary care physician that included body mass index, counseling for nutrition, and counseling on physical activity.

Improvements in Action - Optima developed and distributed a number of resources to primary care providers of the MCOs 3-17 year old Medicaid members. The tools were designed to raise the level of awareness about the important role of providers in addressing patients' weight, nutrition, and physical activity. The tools given to providers included:

- Early Periodic Screening and Diagnostic Tool (EPSDT) with sections for documenting BMI and nutrition/physical activity counseling
- Evidence-based clinical guidelines on BMI
- BMI wheels and patient education materials

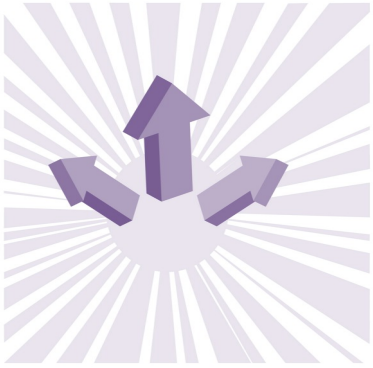
Optima also educated members (parent/guardian) about taking the initiative to discuss BMI, nutrition, and physical activity with their doctors. This form of in-reach occurred through various communication methods, such as -- the internet, newsletters, guides, and calendars.

Results



Transforming the Care of Children in Foster Care

Inter-Agency Collaboration DSS & DMAS



While the Virginia Departments of Social Services (DSS) and Medical Assistance Services (DMAS) have distinct roles in supporting the well-being of children in foster care—There has been an underlying need for DSS and DMAS to work together to achieve lasting improvements in the foster care system.

Immediately after the trauma of being separated from home and family, children transitioning into foster care should receive comprehensive care for physical and emotional health.

This year was the ideal time to work collaboratively, as both agencies were making changes to the processes behind the delivery of health care and support services. Both agencies have worked together to prevent both over-utilization and under-utilization of psychotropic medications among children in foster care. Both agencies have also partnered to provide in-person training for local DSS staff and, outreach and education to foster care parents throughout the state. To date, hundreds of professionals and parents have received this tailored education.

The DSS and DMAS collaboration will continue through 2014. DMAS will also continue its efforts to provide a more comprehensive, patient-centered approach to health care by completing the transition of eligible foster care children into the managed care delivery system– which includes case management as a benefit. By July 2014, nearly all children in foster care will be enrolled in a Medicaid managed care organization— increasing the likelihood of better health and quality of life.

Phase I

NCQA Accreditation of MCOs Required by DMAS *Uncompromised*

Changes in the managed care industry are ongoing and Virginia Medicaid is no exception. The past few years have included MCO mergers, acquisitions, the start-up of new Medicaid health plans, and managed care integration with health systems. Throughout these ongoing changes, DMAS has never compromised on its high performance expectations of managed care. Virginia is one of only 12 states that REQUIRE Medicaid MCOs to be accredited by the National Committee for Quality Assurance (NCQA).

As of November 1, 2013, seven Medicaid MCOs are fully operational in Virginia and are collectively delivering care to more than 75% of Medicaid enrollees.

The following Virginia Medicaid MCOs are NCQA accredited:

Congratulations!

CoventryCares
HealthKeepers, Plus
INTotal Health
Optima Family Care
Virginia Premier
***MajestaCare**

The seventh MCO, Kaiser Permanente, is leveraging the benefits of its current NCQA accredited health plans' in the Mid-Atlantic region, and is on the fast track to accreditation by the end of 2014!

*** Kudos to MajestaCare for achieved accreditation in less than two years!**

Virginia's Medicaid Managed Care Model Experience Tapped for National Groups

A number of DMAS staff members were tapped for their expertise by participating as members of national advisory groups. Their participation enables mutually beneficial knowledge sharing between DMAS, the advisory groups, and conference attendees—many of whom are from other states' Medicaid agencies.

National Advisory Groups with DMAS Representation

Centers for Medicare & Medicaid Services

- Oral Health Technical Advisory Group
- Quality Improvement Technical Advisory Group
- Medicaid Managed Care Technical Advisory Group

National Academy for State Health Policy, vice chair, executive committee

National Association of Medicaid Directors, Board of Directors, Region IV Representative

Medicaid Leadership Institute, a Robert Wood Johnson Foundation Initiative, directed by the Center for Health Care Strategies.

National Committee for Quality Assurance, Public Sector Advisory Council

Medicaid and CHIP Value Based Purchasing: Managed Care Innovations Learning Collaborative, facilitated by the Center for Health Care Strategies

sharing knowledge inside out

Medicaid Enrollment Process Improvements

Healthier Pregnancy for Healthier Babies

January 1, 2014, Virginia Medicaid will begin using "Presumptive Eligibility" determination for pregnant women seeking access to Medicaid services.

Presumptive Eligibility (PE) is an important Medicaid eligibility determination improvement strategy for accelerating access to prenatal care by low-income pregnant women. It allows authorized providers such as Obstetricians and Gynecologists to begin treating pregnant women when they first seek prenatal care rather than several weeks later after waiting for a final determination by the state regarding the applicants Medicaid eligibility. Hospitals approved as a Medicaid provider also have the authority to make presumptive eligibility determinations.

Access to early prenatal care can lead to healthier pregnancies, healthier moms & babies, and reduced health care costs.

Effective October 1, 2013, Medicaid coverage begins immediately after self-attestation rather than requiring pregnancy verification ("proof of pregnancy") through an authorized provider. Benefits extend to the last day of the next month while benefits are being determined. This early start to an effective patient-provider relationship between the expectant mom and her prenatal care provider is critical to both the health of the mom and the baby.

Phase I

Maximizing Pharmacy Rebates through Managed Care Data Improvements

One of the defining features of the new managed care contract between DMAS and the MCOs is the standardization of data collection - specifically with regards to collection methods; timelines; completeness; reporting formats; data quality; and reliability. This heightened level of accountability also includes financial penalties if an MCO falls short of contractual requirements.

Return on Investment through Standardization of Encounter Data

The comprehensive improvements to encounter data were very resource intensive for DMAS and the MCOs. This front-end investment of resources has resulted in efficiencies and more confidence in data quality. Even further, there is a return on investment for DMAS as the Medicaid payer, detailed below.

Thanks to the hard work of DMAS and the MCOs in standardizing weekly encounter files, DMAS has been able to analyze and report on key pharmacy data that resulted in the collection of at least **85 million dollars** in pharmacy rebates in the first half of 2013 alone!

Phase II

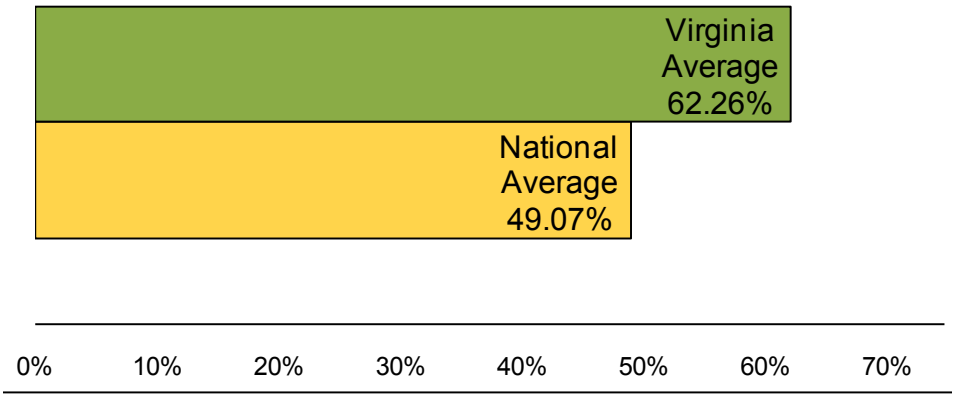
Virginia's *Smiles for Children* Dental Program Making a Difference In Virginia and Across the Country

Virginia's ***Smiles For Children*** (SFC) dental program continues to excel and is recognized by the Centers for Medicare & Medicaid Services as a model for other states.

Virginia's SFC program achieved the following in 2013:

- Chosen as one of only seven states– through a competitive application process— to participate in a National Oral Health Learning Collaborative— co-facilitated by The Center for Healthcare Strategies and the Centers for Medicare & Medicaid Services
- Implemented the Preventistry Sealant Program, a partnership between DMAS & SFC providers to increase the use of sealants on susceptible teeth
- Launched a Dental Home pilot project to establish early and ongoing coordination of all aspects of oral health care between dentists and their patients
- Reached a milestone of more than 1800 unique providers in the SFC network
- Partnered with statewide agencies and organizations to promote the role of oral health in overall health and well-being: Virginia Department of Health; Virginia Dental Association; and, the Virginia Oral Health Coalition
- **Continued to exceed the national average for annual dental visit.**

Percent Medicaid & CHIP Enrollees Ages 2-21 Who Received a Dental Visit in 2012



***Data Sources:**
Virginia Medicaid/CHIP Average
Provided by Denta-Quest using 2013 HEDIS Technical Specifications. National Averages were collected from Quality Compass 2013, National Committee for Quality Assurance.

The Ins and Outs of Program Integrity

What's In? Virginia's Program Integrity Collaborative—a Nationally Recognized Best Practice

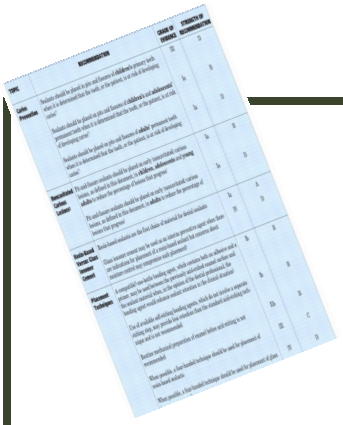
DMAS continued to host quarterly collaborative meetings that provide a venue where Program Integrity (PI) staff from the Medicaid MCOs and DMAS share information about their PI functions and identify opportunities to improve overall Medicaid program integrity. This collaborative has enhanced the individual MCOs program integrity activities and provided the opportunity for a more comprehensive approach to fraud and abuse prevention across all Virginia Medicaid payers.

DMAS staff presented the collaborative approach to Program Integrity at a variety of national conferences—by invitation— as a model for other states.

What's Out? Improper Payments to Providers

Through the first two quarters of 2013, MCOs already avoided or recovered over $1.3 billion as a result of their PI activities. Notably, the vast majority of these dollars ($1.1 billion) were savings that resulted from preventative controls, which stop improper payments before they are made. While prevention of improper payments has been a common practice by the MCOs for a number of years, the structured approach set forth by DMAS has enabled more standardized processes and measurable results across the Medicaid program. DMAS and the MCOs continue to develop and improve their processes to further ensure the integrity of the Virginia Medicaid program.

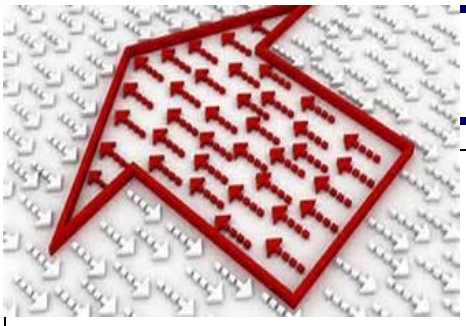
Tax Records Enable Standardization of Medicaid and CHIP Eligibility Determination



States' methodologies for determining Medicaid and children's health insurance program (CHIP) income eligibility vary widely, primarily due to differences in the application of income disregards. On January 1, 2014, that will change to a standardized method for determining income based on modified adjusted gross income (MAGI).

As added by a *mandatory* section of the Affordable Care Act, for the Medicaid program and CHIP, states will use the MAGI-based methodology for determining the income of an individual and the individual's household, as applicable, for purposes of eligibility for Medicaid or CHIP. Under the statute, MAGI-based income methodologies will not apply to determinations of Medicaid eligibility for elderly and disabled populations. MAGI and household income are defined in the Internal Revenue Code (IRC).

Virginia is an early adopter of this change and received approval from CMS to begin implementing, on a state-wide basis, MAGI-based eligibility determination methods for populations subject to MAGI rules beginning October 1, 2013 through December 31, 2013. Virginia will thus avoid having to two sets of rules in place for determinations of medical assistance eligibility for the same groups of people during the open enrollment time period. The state will test and evaluate how the early adoption of the MAGI-based methodology, as a more coordinated open enrollment process, will help ensure the state's capacity to process applications in a timely fashion.



Other Initiatives:

A Change in Direction for Virginians with Medicaid & Medicare

Virginia is proud to have been chosen as a participant in the CMS sponsored Duals Demonstration – a payment reform pilot through managed care that is designed to test the impact on Medicaid/Medicare member health and on the costs of care. Virginia has named the Duals Demonstration "Commonwealth Coordinated Care" (CCC). The milestones achieved in 2013 set the stage for DMAS and the CCC-MCOs to deliver quality care that is seamless, timely, and accessible.

New Behavioral Health Services Administrator

DMAS has contracted with Magellan Health Services, as its behavioral health services administrator (BHSA), to serve eligible enrollees as of December 1, 2013. Magellan is responsible for: authorizing services; paying claims; developing a provider network; and coordinating care between various settings and treating providers. Magellan's role is contingent upon (and will augment) the delivery system serving the enrollees' medical needs:

- Magellan administers *all behavioral health* services for enrollees who receive medical care through the Medicaid fee-for-service delivery sys tem.
- Medicaid enrollees who are enrolled in an MCO will continue to receive medical care AND inpatient/outpatient mental health services through their MCO. MCO members will receive community mental health and rehabilitation services through Magellan rather than through DMAS' FFS.

Phase I

More Change

- Ongoing evaluation of pilot projects
- Medicare-Medicaid (Commonwealth Coordinated Care) implementation
- Integrated care with behavioral health and physical health
- Data improvements
- Continue transition of fee-for-service populations to managed care
- Ongoing enhancements to program integrity
- More timely access to prenatal care for better birth outcomes
- Enhanced quality strategies with incentives
- More standardization of administrative processes
- Collaborative approach between MCOs and providers for patient centered medical homes
- Continued partnership between DSS and DMAS for children in foster care
- More pharmacy rebates