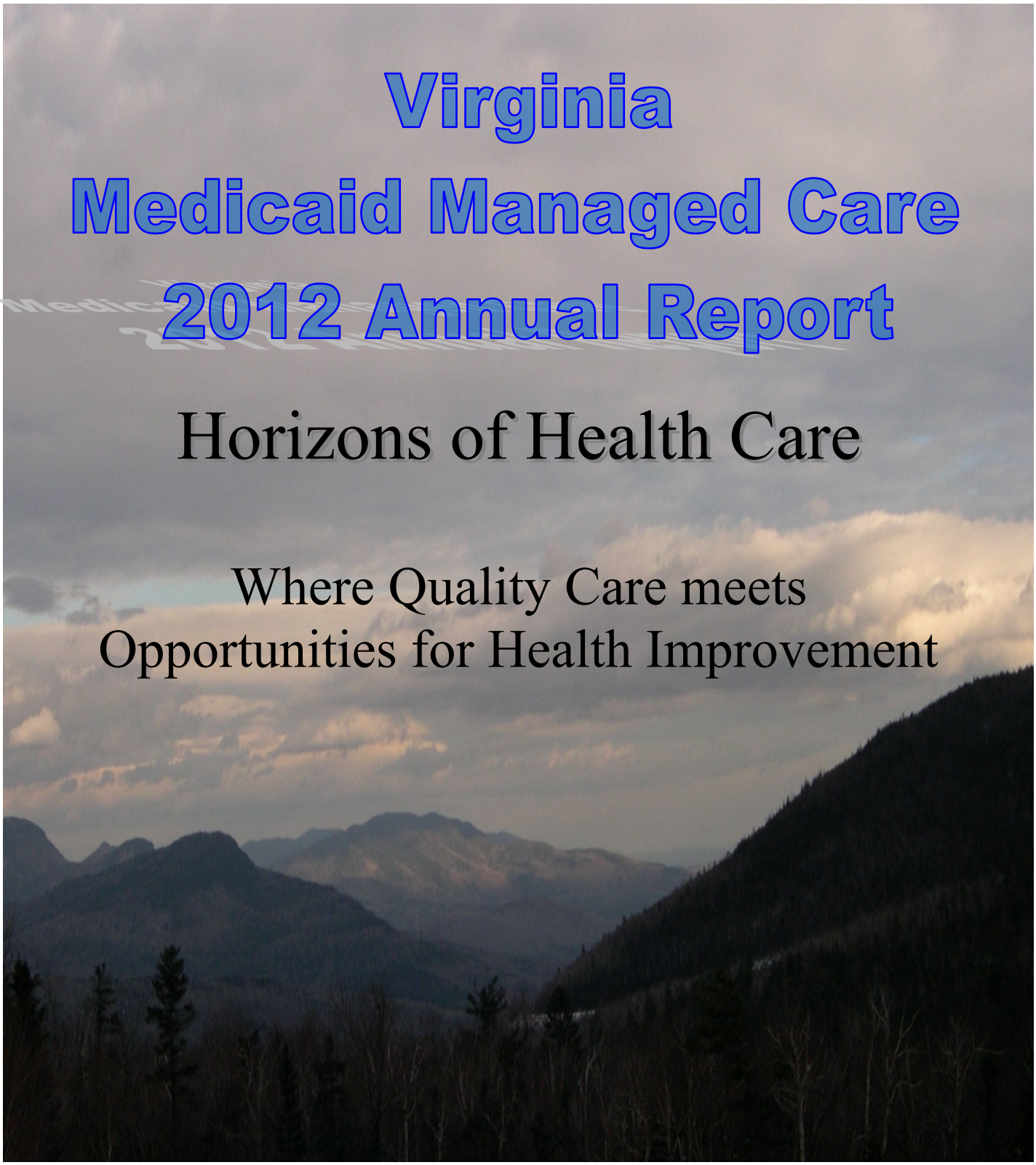

Virginia Medicaid Managed Care 2012 Annual Report

Horizons of Health Care

Where Quality Care meets Opportunities for Health Improvement

Virginia Department of Medical Assistance Services
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Richmond, Virginia 23219
WWW.DMAS.Virginia.Gov

Inside this Year's Report:

Welcome from the Director

I can always count on magnificent horizons in Virginia. Whether I am in Richmond—looking across the James River; in Abingdon— scanning the mountains; in Virginia Beach—watching the sunrise; or in Arlington— viewing the horizon across the Potomac.

The Virginia Department of Medical Assistance Services (DMAS) is continuously challenged to expand its horizons of health care for Medicaid and CHIP—with the ultimate aim of providing quality care that reaches beyond our very own field of vision. Even though we continue to be encouraged by the favorable indicators of consumer experience and health outcomes, we will never settle for "good enough."

This annual report highlights a number of improvements implemented in 2012. We could not have done it without the valuable contributions received through our transparent governmental approach during open forums, collaboratives, work groups, town hall meetings, and public comments.

We look forward to more shared decision making in 2013……. After all, Medicaid reform is not far beyond the horizon.

Wishing you a healthy 2013

Cynthia B. Jones, Director,
Virginia Department of Medical Assistance Services

Transparency through Collaboration with Key Stakeholders

2012 was a year of shared decision making through open forums, town hall meetings, collaboratives, community outreach, and more!

In essence, collaboration changes the way organizations work together. Collaboration moves organizations from competing to building consensus; from working alone to including others; from diverse cultures, fields, and settings; from thinking mostly about activities, services, and programs to looking for complex, integrated interventions; and, from focusing on short-term accomplishments to broad systems changes. (Winner and Ray, 1994, p.24)

Look for continued opportunities in 2013

Managed Care Throughout the Roads Less Traveled

There are individuals behind each of the numbers used for determining the health and human resource needs for an under-resourced community. Each person also has a unique health care experience and story to tell.

The outreach activities conducted by DMAS and the MCOs in the western rural areas of Virginia were intended to inform the providers and new-to-managed care Medicaid beneficiaries about managed care. However, the experience proved to be mutually beneficial for DMAS, the MCOs, providers, as well as the enrollees. These open forums enabled each of these stakeholders to "walk-a-mile" in each others' shoes.

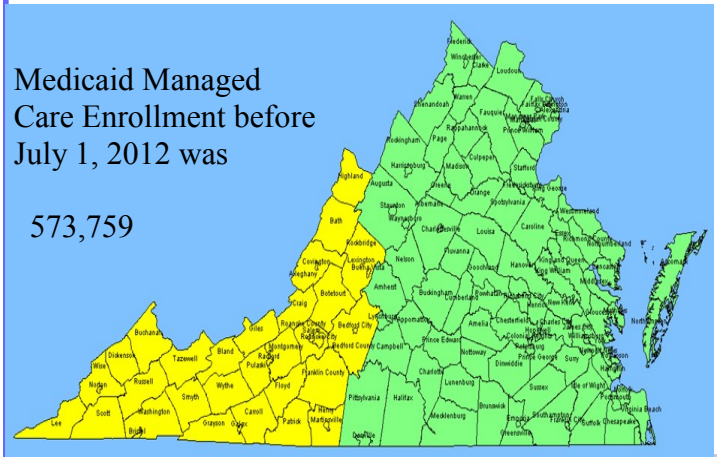
Hundreds of (fee-for-service) Medicaid enrollees flocked the community open-forums and shared their stories of day-to-day struggles with their chronic illnesses, some with their oxygen tanks in tow, due to chronic obstructive pulmonary disease (COPD).

COPD is just one example of a chronic disease that all Virginia Medicaid MCOs help affected members with managing—rather than letting COPD manage the member's quality of life. Through MCOs' condition management programs, case managers are available to help members experience efficient and effective coordinated care. Before managed care was delivered to these rural areas, the members were served through a traditional fee-for-service (FFS) delivery system—with no access to condition management. This meant, if an individual with Medicaid had COPD, they had to rely on themselves to navigate through the health care system– which often led to frustration, high use of emergency care, and low use of condition management services.

Now, thanks to the partnership between DMAS and six Medicaid MCOs, effective July 1, 2012, approximately 70% of Medicaid enrollees in Virginia, including the rural southwest region, have access to customized resources from their MCO to help manage COPD and certain other chronic conditions. This "expansion" of managed care required a rapid and flawless process to ensure there were no interruptions in care to the more than 100,000 Medicaid enrollees that were previously in FFS. The maps below show the reach of and enrollment in **managed care (in green)** before and after July 1 2012:

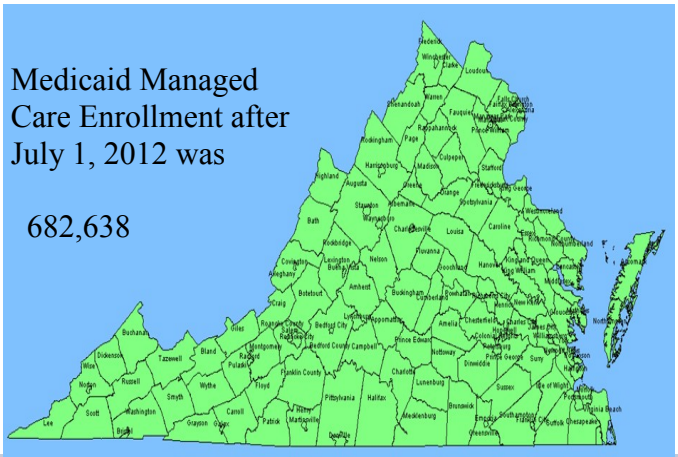
Medicaid Managed Care Enrollment before July 1, 2012 was

573,759



Medicaid Managed Care Enrollment after July 1, 2012 was

682,638



A Telescopic View: Program Integrity

In order to mitigate any vulnerabilities to the integrity of publicly funded health care, there must be a structure and supportive processes for ongoing legal and administrative oversight. This year DMAS accelerated its efforts to ensure that any threat to the integrity of its fiscal accountability is promptly and effectively mitigated, to include, if necessary, monetary and legal action. The accomplishments from 2012 for enhancing Program Integrity include the following:

Program Integrity Compliance Audit (PICA): DMAS conducted a legal and administrative desktop review of each Managed Care Organization's (MCO's) Medicaid policies & procedures for identifying fraud; waste; or abuse by members or providers. After final reviews, Virginia's Medicaid MCOs achieved a 95% compliance rate.

Program Integrity Collaborative: Through a collaborative approach, program integrity reports and reporting processes were standardized for efficiency and accuracy. By establishing consistencies in the method and content using ongoing interactive meetings with the MCOs, DMAS developed and facilitated a Fraud/Waste/Abuse Case Referral process and feedback loop.

> MCOs began sharing fraud cases with DMAS, who in turn redact and share basic information with other plans. This process enables the MCOs to identify potential "plan-jumping" by members or providers engaged in fraudulent behaviors. Even further, it enables all Medicaid delivery systems— fee-for-service and managed care - to identify potential fraud/abuse/waste.

Pharmacy Lock-In Program: The lock-in program requires members with poly-pharmacy issues of concern to obtain their prescriptions from one pharmacy only. This year, the collaborative established processes for DMAS and the MCOs to identify and intervene when members change their MCO enrollment in order to avoid the lock-in program. DMAS also shares case information from the Client Medication Management program in order to minimize Commonwealth exposure to drug-seeking behaviors and associated costs.

Inter-Agency Collaboration between DMAS and the Virginia Office of the Attorney General's Medicaid Fraud Control Unit (MFCU): The MFCU now sends a quarterly update of cases under review to DMAS, who in turn shares relevant information with the MCOs for ongoing monitoring.

DMAS Program Integrity Division Director is on the CMS Program Integrity Technical Advisory Group and is the Lead for the CMS Program Integrity MFCU, National Collaborative

Stretching Quality Beyond Compliance

Regulatory compliance by managed care organizations (MCOs) is imperative, but compliance is not synonymous with quality care. That's why Virginia requires its MCOs to not only meet Federal and State regulatory requirements, they must also achieve accreditation from the National Committee for Quality Assurance (NCQA). In fact, Virginia is one of only 13 jurisdictions that requires Medicaid MCOs to achieve and maintain accreditation from the NCQA. This esteemed emblem of quality is rigorous, ongoing, and is structured to enable continuous quality improvement in processes and outcomes.

Each year, the National Committee for Quality Assurance (NCQA) works in partnership with the Consumers Union of America to publish the NCQA's Health Insurance Plan Rankings. Three lists are published: one each for Medicaid, Medicare, and Commercial plans. The rankings are based on each MCO's performance, including consumer experience, prevention, and treatment.

Making the list of the **top 75** is no easy feat, in fact a total of 115 Medicaid managed care plans received a ranking. An additional 113 plans either provided "insufficient data" or "no data" which resulted in no ranking at all. These counts amount to a grand total of 228 (an increase of 15 from last year) Medicaid MCOs listed by NCQA. Similar to most rankings, 1 is the most favorable, and 115 is the lowest.

Congratulations to Virginia's Medicaid MCOs
on their rankings and for serving our populations so well

 # 28 Virginia Premier Health Plan

 # 29 Anthem HealthKeepers

 # 45 CareNet

 # 49 Optima Health Plan

 # 63 Amerigroup

* **MajestaCare,** a newly formed Medicaid MCO, is already reaching aggressive milestones for attaining NCQA accreditation within the next year.

Consumer Experience in Managed Care: The Survey Results are Bright Again

Medicaid managed care members are surveyed annually to enable DMAS and the Managed Care Organizations (MCOs) to understand the consumers' experiences with the delivery of their care. As with previous years, the 2012 Consumer Assessment of Health Plan Performance Surveys' (CAHPS) results have validated the numerous benefits of delivering care through MCOs.

The Resultant 2012 Scores from Virginia's Medicaid Managed Care Adult Members' CAHPS Surveys were better than the **National 75th Percentile*** in these three Composite Measures:

Virginia MCOs Are Above the **National 75th Percentile**

All Health Care

Managed Care Organization

Personal Doctor

*75th percentile indicates that Virginia MCOs' average score was better than more than 75 percent of all other Medicaid MCOs that reported CAHPS scores to the National Committee for Quality Assurance

Congratulations to Virginia Medicaid Managed Care Organizations and their Provider Networks!

Did you know, on average, there are only 1.1 grievances per month for every 1,000 Medicaid managed care members in Virginia ?

WOW!

Managed Care Quality:
Best Practices Illuminated

The Medicaid Managed Care Quality Collaborative meeting in January served as the annual session for presentation of best practices. In January of 2012, each MCO presented an exceptional 2011 HEDIS® measure and the intervention strategies attributed to the exceptional score:

Amerigroup targeted the percentage of adolescent enrollees, 12-21 years of age, who had at least one comprehensive well care visit with a Primary Care Provider (PCP). Amerigroup provided education to parents/guardians through phone-based, in-person, and community events. Providers received reminders about their patients needing services. **Result:** Annual well-care visits for adolescents increased from 43.93% in 2008 to 47.10% in 2010.

Anthem, HealthKeepers, Inc.'s Future Moms Program provided individualized support of expectant moms to help achieve healthier pregnancies, healthier deliveries and healthier babies. The program emphasizes early-risk assessment by obstetrical nursing support from the first trimester through post-delivery follow-up. **Result:** Eighty nine percent of participants delivered at full term and normal birth weight; and, the program demonstrated a 16% decrease in expenses per mother from 2009 to 2010.

CareNet implemented a Perinatal Program to increase the percentage of women who had a postpartum visit on or between 21 and 56 days after delivery. Interventions included educational mailings, transportation services, home visits, enrollee incentives, case management services for high-risk women, and post-partum screening for depression with behavioral health services. **Result:** Post-partum visits have steadily increased since 2008 and are comparable to the 75th percentile nationally.

Optima Family Care aimed to improve the percentage of enrollees with asthma who were appropriately prescribed medication. Optima worked closely with primary care providers, provided telephonic outreach to enrollees admitted to a hospital with asthma, and utilized case managers to coordinate care and conduct home visits when necessary. **Result:** Enrollees receiving the recommended asthma medication increased from 2009 to 2010 and the measure exceeds the national HEDIS® average.

Virginia Premier Health Plan, Inc. targeted their youngest enrollees to improve the percentage of children who had at least 6 well-child visits with a PCP within the first 15 months of life. The focused efforts involved internal MCO actions, enrollee outreach and education and coordinated initiatives with providers. **Result:** Infant visits increased by 8.03 percentage points from 2010 to 2011, a rate that is 15.8 percentage points above the HEDIS 75th Percentile.

Rising to the Challenge: Turning Mundane into Meaningful

One look at the 150+ monthly reports that all MCOs combined were submitting to DMAS evoked a common reaction: "Is DMAS doing something with this information?" and, if not, "should it still be required?" Undoubtedly, at some point during the 16 years of Medicaid managed care, each report had meaning to the MCOs and DMAS. With the expansion of managed care in 2012, it was a good time to pause and reassess the need for each report, and to identify opportunities to consolidate, standardize, and automate the collection of useful information.

In less than 12 months, DMAS was able to reduce the plethora of reports it received from each MCO to only 18 sub-reports! Even further, all 18 have been filtered to remove unnecessary or duplicative information and consolidated into one standardized template. Manual entry is no longer needed with the built-in automated analysis functions.

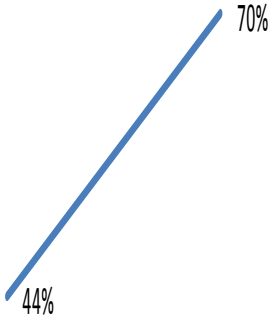
This efficiency in monthly reporting is in the implementation phase, and continues through the improvement process by integrating lessons learned each month. This effort will continue through 2013 to ensure the information collected is timely, consistent, and useful to the MCOs, DMAS, and policy and program managers.

This rapid cycle improvement process resulted in:

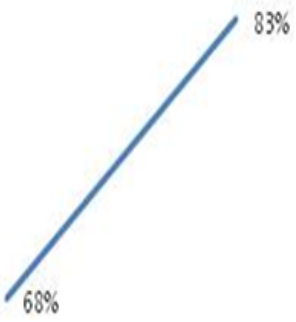
150+ Monthly Reports Reduced to Just 6!

Measuring Quality: Year 10 on the Horizon

2013 will mark the ten-year anniversary of DMAS' lofty requirement that all Medicaid MCOs have NCQA (National Committee for Quality Assurance) accreditation in order to deliver care in Virginia. The rigorous and ongoing requirements for NCQA accreditation reach far beyond measuring compliance with Federal and State regulations. It takes into account the structure, processes, and outcomes of care received by the populations served. The two measures listed below are examples of the long-term commitment to quality improvement that is shared by DMAS and its contracted MCOs:



Six or More Well-Child Visits by 15 months of age — Up from 44% to 70% Based on the NCQA's 2004 HEDIS technical specifications, in 2003 only 44% of infants who turned 15 months old had received at least 6 comprehensive well-visits since birth. Compared to national data, Virginia's MCOs averaged below the 50th percentile. A collaborative improvement approach between DMAS and the MCOs has resulted in an astounding level of improvement to an average of nearly 70% (rounded from 69.65% 2012 HEDIS). This places Virginia's MCOs just .05% from the 75th percentile nationally!



Condition Management for People with Diabetes— Up from 68% to 83% In 2003, 68% of managed care members with diabetes had at least one A1-C test during the year. A1-C test is an essential lab test for ascertaining how well blood glucose levels are managed over time. High blood glucose can harm the heart and blood vessels, kidneys, feet, and eyes of people with diabetes. Virginia's average has increased to 83.21% in HEDIS 2012.

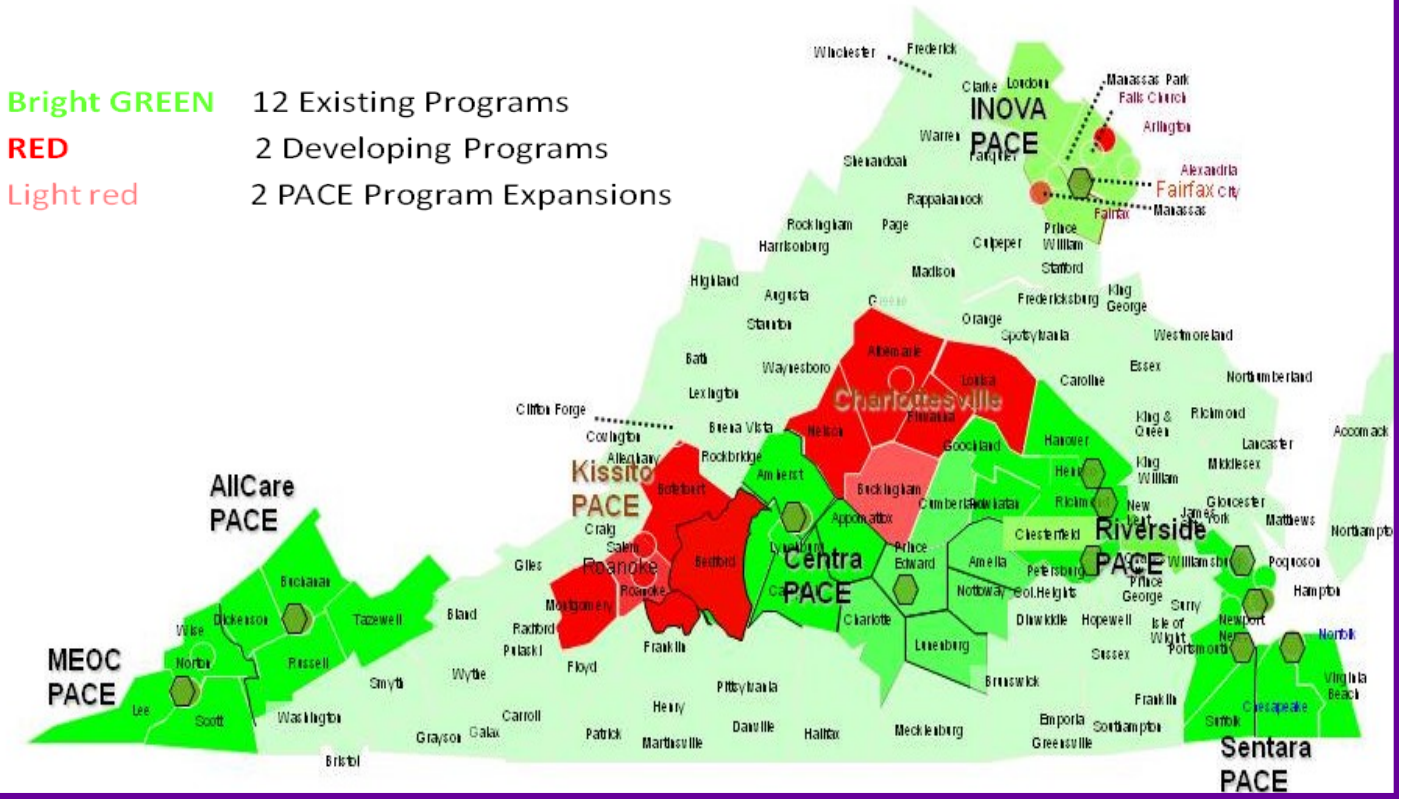
Aging *PACE*fully in Virginia

For more than 800 (and growing!) Medicaid enrollees in Virginia, gone are the days when being ill enough to meet the criteria to live in a nursing facility meant just one choice: to live in a nursing facility. Thanks to Virginia's Program of All-Inclusive Care for the Elderly (PACE), these 800+ enrollees are exercising the option of staying in their communities while having their medical care needs met. With an average of 112 beds per nursing facility in Virginia, that's equivalent to the capacity of nearly 8 nursing homes combined!

The PACE program is designed around an efficient and effective patient-centered model of care that includes the full spectrum of health and long-term care needs. In essence, PACE is structured as a health-neighborhood and mainstay that enables eligible consumers to remain in their communities of interest for as long as they can, and want to. It is a choice.

The complex care needs (6 medical conditions on average) for PACE participants is provided through a multi-disciplinary team of medical and social supports. Much of the support can be attained on a daily basis- on location—at a PACE site. This uniquely designed program is administered through a capitated payment system (per-member-per-month) between DMAS and the contracted PACE organizations and is funded by Medicaid and Medicare. This payment system can lower the cost of care for both the purchaser and payer while also improving the quality of care and life for participants.

As of December of 2012, there were 12 PACE sites throughout Virginia, with more on the horizon.



NEW PROGRAM INITIATIVE:

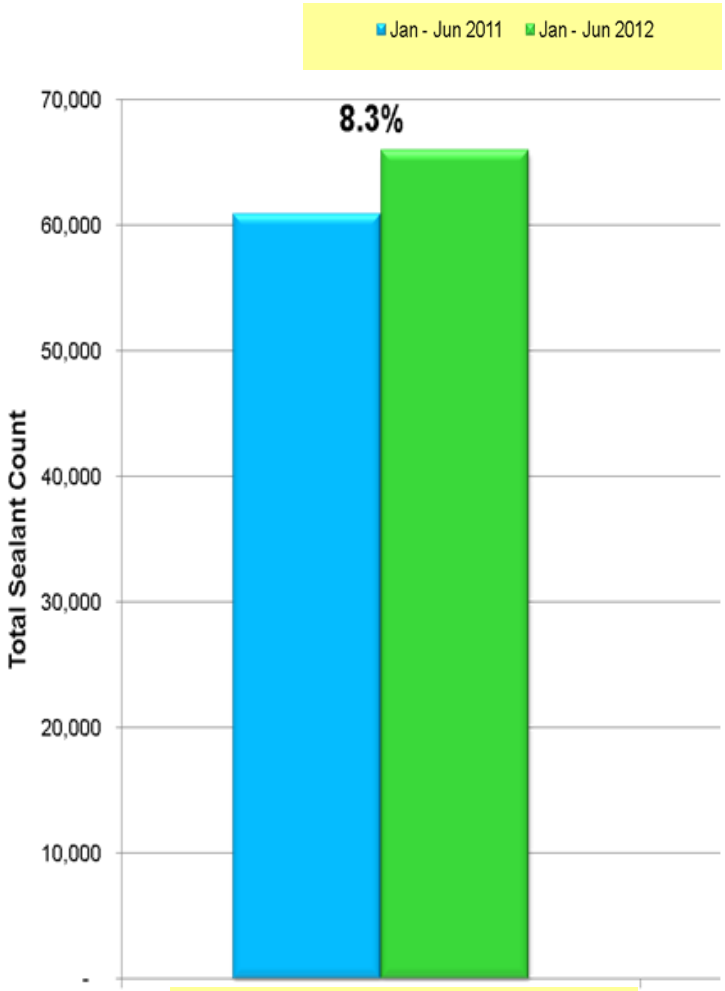
Preventistry℠ Sealant Program

Virginia's Smiles for Children Program was one of the recipients of a new prevention initiative administered by DentaQuest, the Medicaid dental program administrator for a number of states, including Virginia. The initiative, **Preventistry℠ Sealant Program,** is a multifaceted intervention designed to increase providers' adherence to the American Dental Association's clinical recommendations on the use of dental sealants. Evidence-based literature supports the use of dental sealants for prevention of tooth caries in certain age groups. The program was implemented in Virginia in February 2012 with the appropriate age groups of children and adolescents and included the following direct mailing to dentists in the Smiles for Children network:

- **Introductory letter**
- **Preventistry Sealant Program Brochure**
- **List of the dentists sealant-eligible patients**
- **Sample Preventistry Patient Report**

The interim data have already shown an increase in the use of dental sealants for those children who are in the age-based categories included in the preventistry initiative. The children in these age groups experienced an overall increase of 8.3% in dental sealants during the most recent 6 month period when compared to the same months the year before.

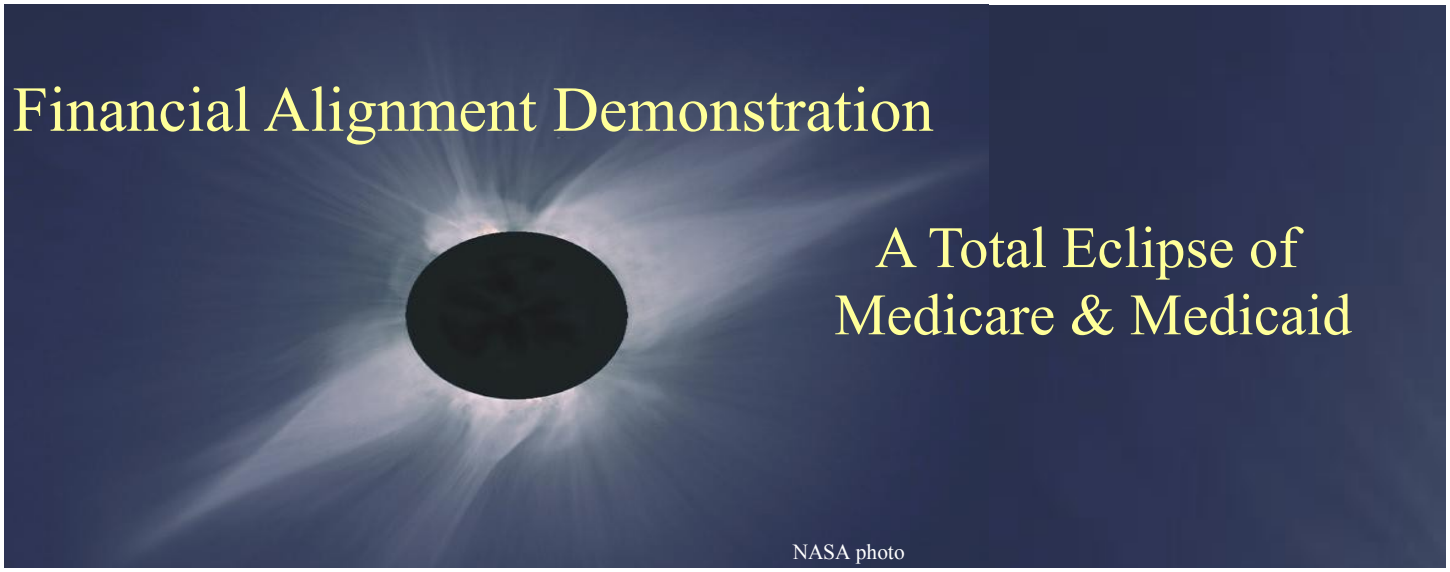
These early findings suggest the multi-faceted approach is effective and should be continued. DMAS and DentaQuest will continue to monitor the utilization trends over time for sealants and will modify the strategies as needed.



Percent Eligible Children with Sealants

Financial Alignment Demonstration

A Total Eclipse of Medicare & Medicaid



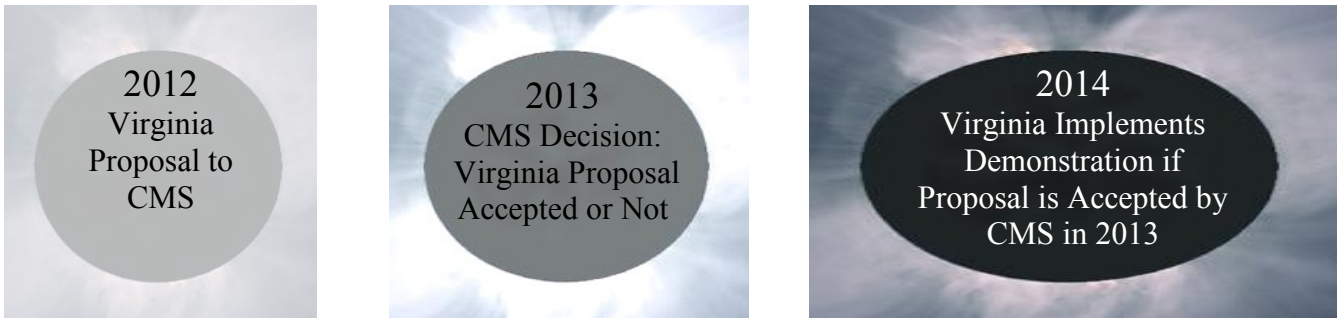
NASA photo

Ask anyone who is covered by both Medicare & Medicaid about their experience with navigating the health care system and, chances are, the discussion will focus on the complexities of payments, authorizations, approvals, scheduling, etc. These are all administrative issues that are very burdensome and costly when there are two payers involved—specifically, Medicare & Medicaid. Additionally, with two payers, the patient often experiences inefficiencies in timely access to quality care.

For these reasons, Virginia has submitted a proposal to participate in the Centers for Medicare & Medicaid Services (CMS) Financial Alignment Demonstration. The Demonstration seeks to test payment models to integrate Medicare and Medicaid services, rules and payments under one delivery system for individuals who are eligible for both Medicare and Medicaid (*dual eligible individuals*). Virginia's proposal includes using a capitated model whereby managed care organizations will provide all Medicare Part A, B, and D benefits and the vast majority of Medicaid benefits.

The goals of the demonstration include: reducing fragmentation; providing high quality and coordinated care; improving the health and lives of participants; reducing the need for avoidable services, such as hospitalization and emergency room use; encouraging individual participation in treatment decisions; and, supporting the goal of providing treatment in the least restrictive, integrated setting. The model will include a strong, person-centered service coordination/case management component, rigorous quality monitoring, and ongoing stakeholder participation in program design, implementation, and evaluation.

DMAS submitted a proposal to CMS in May 2012 and expects a decision by April 2013 on whether or not it will be accepted for implementation beginning January 2014.



Virginia's Medicaid Managed Care Model
Fueling National Dialogue

The Virginia Department of Medical Assistance Services is highly sought after to provide professional leadership during national meetings and conferences pertaining to managed care. Below are a number of examples from 2012:

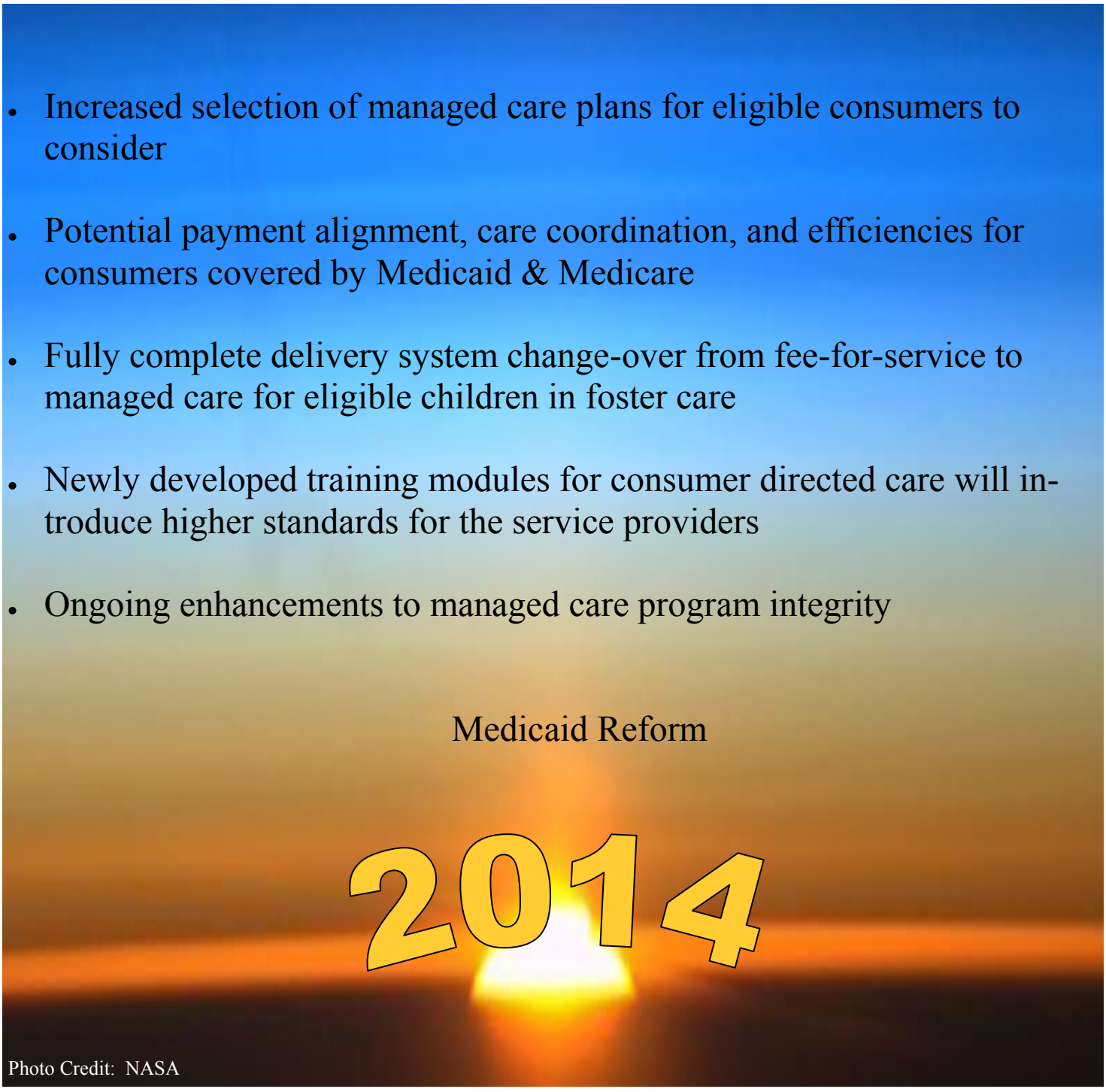
Medicaid Leadership Institute. Virginia's DMAS Director was one of only six Medicaid directors chosen to participate in the 2013 class of the Medicaid Leadership Institute. The Center for Health Care Strategies, Inc. directs the Robert Wood Johnson Foundation-funded initiative to build the capacity of Medicaid directors to transform their programs into national models for accessible, cost-effective care. The Director was also re-appointed to the Board of Directors for the National Association of Medicaid Directors.

National Academy for State Health Policy. DMAS' Deputy Director of Programs was selected to present during the 25th Annual NASHP State Health Policy Conference, Promoting Excellence Today and Tomorrow; and also serves as Vice-Chair of Health System Performance and Public Health. The Deputy Director is also a member of the Centers for Medicare & Medicaid (CMS) National Technical Advisory Group for Medicaid Managed Care.

Virginia was chosen by the CMS for presentation as a best practice for its collaborative approach to Medicaid/CHIP Managed Care Quality Improvement. This best practice was co-presented by DMAS' Quality Improvement Analyst and the Program Manager from Delmarva Foundation for Medical Care during a plenary session at the CMS 2nd Annual Medicaid/CHIP Quality Conference in June 2012.

The CMS Oral Health Technical Advisory Group (OTAG) is chaired by the DMAS Senior Health Care Services Manager. The OTAG is made up of CMS oral health staff and State dental program leadership from around the country. The OTAG meets monthly to share information and discuss salient topics regarding the performance of Medicaid oral health programs.

On the Horizon of 2013



- Increased selection of managed care plans for eligible consumers to consider
- Potential payment alignment, care coordination, and efficiencies for consumers covered by Medicaid & Medicare
- Fully complete delivery system change-over from fee-for-service to managed care for eligible children in foster care
- Newly developed training modules for consumer directed care will introduce higher standards for the service providers
- Ongoing enhancements to managed care program integrity

Medicaid Reform

Photo Credit: NASA