



# MANAGED CARE OVERSIGHT UPDATE

**JULY 8, 2021**


***DMAS***

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# Agenda

- Brief Overview of Managed Care
- Contract Monitoring and Oversight
- Network Adequacy
- Project Cardinal
- Transparency

# MANAGED CARE

# DMAS Mission & Values

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

# Who Does Medicaid Serve?

Children — 774,000

Pregnant Women — 25,000

Older Adults — 80,000

Individuals with Disabilities — 152,000

Adults — 700,000

***Medicaid plays a critical role in the lives of over 1.8 million Virginians***



DMAS Data June 15, 2021

# Managed Care Rationale

For best results and efficiency, the health care delivery and payment system must:

- ***recognize*** more than the volume of care
- ***value*** primary care, prevention, coordination & outcomes
- ***reward*** quality and efficient care delivery

Nationally Medicaid agencies contracted with health plans to support this rationale

Similar to national trends, Virginia managed care program has emerged as the primary delivery system in Virginia for its ability to provide high-quality care to Medicaid members at a budget-predictable value to the Commonwealth

# Managed Care Focuses On The Holistic Perspective Of The Member

- Focused on improving the member experience:
- Member services, including educating members on benefits, 24/7 nurse advice line, social media, mobile apps, home visiting, wellness programs, etc.
- Care coordination
- Prevention and population focused services and programs
- Comprehensive networks
- Assistance with social determinants of health, such as food, housing, and barriers that could have an impact on health equity, and the member's health and well-being

# Care Coordination

## Members with complex needs and services have access to care coordination services

### 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

# Current MCO Delivery System

***Over 96% of full-benefit Medicaid & FAMIS members are served through MCOs***

| | Medallion 4.0<br>1,401,512 Members | Commonwealth Coordinated Care Plus (CCC Plus)<br>276,741 Members |
|---|---|---|
| **Covered Groups** | ▪ Serving infants, children, pregnant members, caretaker adults and Medicaid expansion adults | ▪ Serving older adults, disabled children, disabled adults, medically complex newly eligible adults; includes individuals with Medicare and Medicaid (full-benefit duals) |
| **Covered Benefits** | ▪ Commercial like benefits plus ARTS, transportation and community mental health rehabilitation services; excludes LTSS | ▪ Full continuum of services (same as Medallion), but also includes long-term services and supports (LTSS) in the community, nursing facilities, and hospice<br>*Participants in the Developmental Disability (DD) Waivers are included in CCC Plus; however, DD Waiver services are carved-out and paid through the Department* |

**Health Plans**

**Same Six Health Plans Operate Statewide for Both Programs**

- Aetna Better Health of Virginia
- Anthem HealthKeepers Plus
- Molina Complete Care
- Optima Health Family Care
- UnitedHealthcare
- VirginiaPremier



*DMAS Monthly Enrollment as of June 2021*

# Areas of MCO Monitoring & Oversight

***Since achieving a fully integrated managed care delivery system in 2018, DMAS has focused on improving quality, accountability, transparency and oversight in managed care***

**Federal and State Approval and Review -** CMS approval of waiver, contract, and rates, BOI and VDH, PERM

**Contract Development and Compliance Monitoring -** Ensures contracts and MCO operations are consistent with federal, state, and program requirements

**Program Integrity -** Ensures MCO practices support goal to invest tax dollars wisely to further our mission; -audits MCO providers and reviews MCOs' program integrity activities

**Quality Performance and Improvement -** Measures MCO performance with NCQA e.g., HEDIS, facilitates focused quality-improvement projects as part of an overall strategy to promote continuous quality improvement

**Financial Oversight -** Ensures health plans spend capitation payments on direct medical expenses or quality improvement and monitor profit margins through minimum loss ratios (MLR) and profit caps. Ensures plans meet solvency criteria as licensed by the Bureau of Insurance.

**Value Based Purchasing -** Advances performance accountability activities, including Performance Withhold and Clinical Efficiency Programs

**Transparency and Ongoing Stakeholder Engagement –** Several external committees allow for ongoing stakeholder engagement and oversight on managed care-related concerns, changes, and improvements. See appendix

**Network Adequacy Monitoring -** Ensures MCO networks meet specified accessibility criteria, including time and distance standards


Examples of monitoring activities shown in next slides

# Compliance Monitoring

## 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 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.

DMAS implemented encounter process system (EPS), which is used for reporting, analysis and rate setting.

Agency analyzes encounter data to determine timeliness, completeness, accuracy and reasonableness. Provide technical assistance to health plans on identified problem areas.

DMAS monitors appeals and complaints and responds to concerns from members, advocates and providers


DMAS takes compliance action, such as issuing Corrective Action Plans and financial penalties, when needed if 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 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 place funding for MCOs at risk contingent upon quality attainment and improvement

# Financial Oversight and Transparency

- Plans are required to be licensed by the Bureau of Insurance (BOI), a division of the Virginia State Corporation Commission, and meet solvency requirements
- DMAS reviews the MCO quarterly and annual filings to BOI and annual audits and monitors medical loss ratios and administrative expense ratios
- MCOs must meet minimum medical loss ratio requirements and are subject to profit caps
- Rates are determined by our actuary, certified as actuarially sound, and approved by DPB and CMS
- External Financial Review Council (quarterly meetings)
- MCO Expenditures and Financials Dashboards
  - Expenditures dashboard breaks down Virginia Medicaid expenditures by program as well as service category to help identify sectors and services that drive spending and offer insights related to program changes. https://dmas.virginia.gov/open-data/mco-expenditures/
  - Financials Dashboard shows the operating margins, administrative expenses and medical loss ratios. https://dmas.virginia.gov/open-data/mco-financials/

# NETWORK ADEQUACY

# MCO Network Management

MCOs have a comprehensive infrastructure in place to develop and maintain high-quality provider networks toward ensuring timely access to care for their membership

# MCO Network Adequacy

- DMAS conducts network reviews to ensure that MCOs maintain provider networks consistent with contractually specified accessibility criteria
  - ✓ *Travel time and distance*
  - ✓ *Timely access to care*
  - ✓ *Out of network care*
  - ✓ *Population and service needs*
  - ✓ *Continuous quality improvement*
- *DMAS receives notice of network adds, deletes, and modifications*

**Federal Rules Around Network Adequacy Dimensions**

**Staffing**
**Number and mix of providers**
**Hours of operation**

**Accommodations**
**for physical disabilities**
**Translation services**

**Geographic Proximity**
**Time and Distance Standards**
**Provider to Member**
**Member to Provider**

**Provides flexibility for MCOs to operate with selective networks, i.e., sufficient to meet the needs of its member population**

# MCO Provider Agreement Changes

**MCOs must inform members and DMAS of any network changes that impact member access/quality of care and must provide assistance with provider transitions**

## Provide Notice to the Member

- MCOs send within the later of 30 calendar days prior to the effective date of the termination, or 15 calendar days after receipt or issuance of the termination notice.

*Notice to the provider follows the terms in the MCO / Provider agreement*

## Provide Notice to DMAS

- MCOs send
  - ✓ Within 30 days where a member's access could be reduced
  - ✓ Within 5 days for inability to meet access standards
  - ✓ ASAP or within 48 hours of suspected fraud/abuse
  - ✓ Immediately for inability to contract or re-contract with hospitals
  - ✓ Immediately for serious quality of care issues/loss of provider license

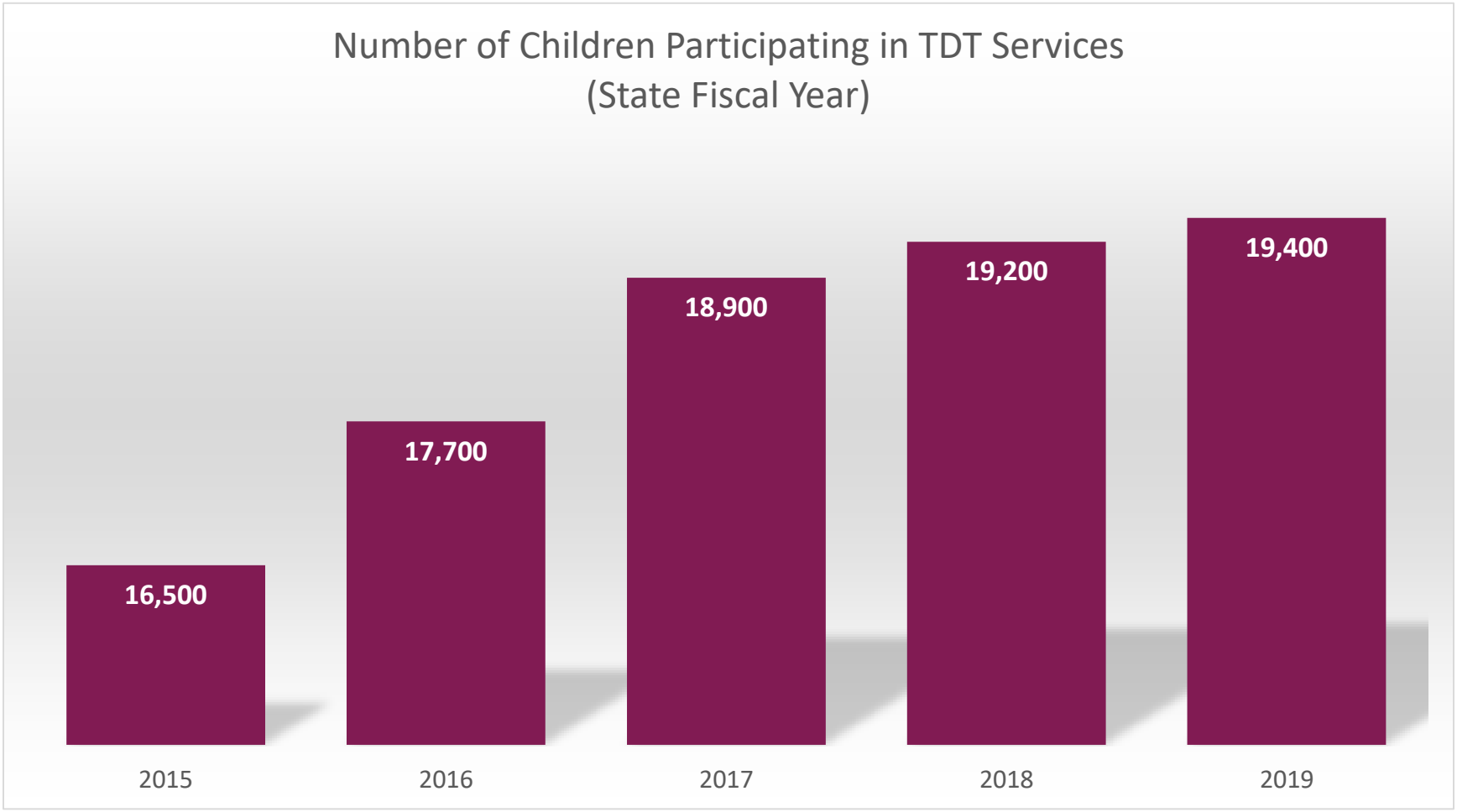
## Transition Member to Network Provider

- MCOs transition members to a new provider within 30 calendar days prior to the effective date of the cancellation, for providers who are a main source of care for the member
- *For community mental health provider changes, MCOs closely monitor and work to ensure that transitions occur without any disruption of service to the member*

# Holistic Model of Care

# THERAPEUTIC DAY TREATMENT

# Youth Serviced in Therapeutic Day Treatment

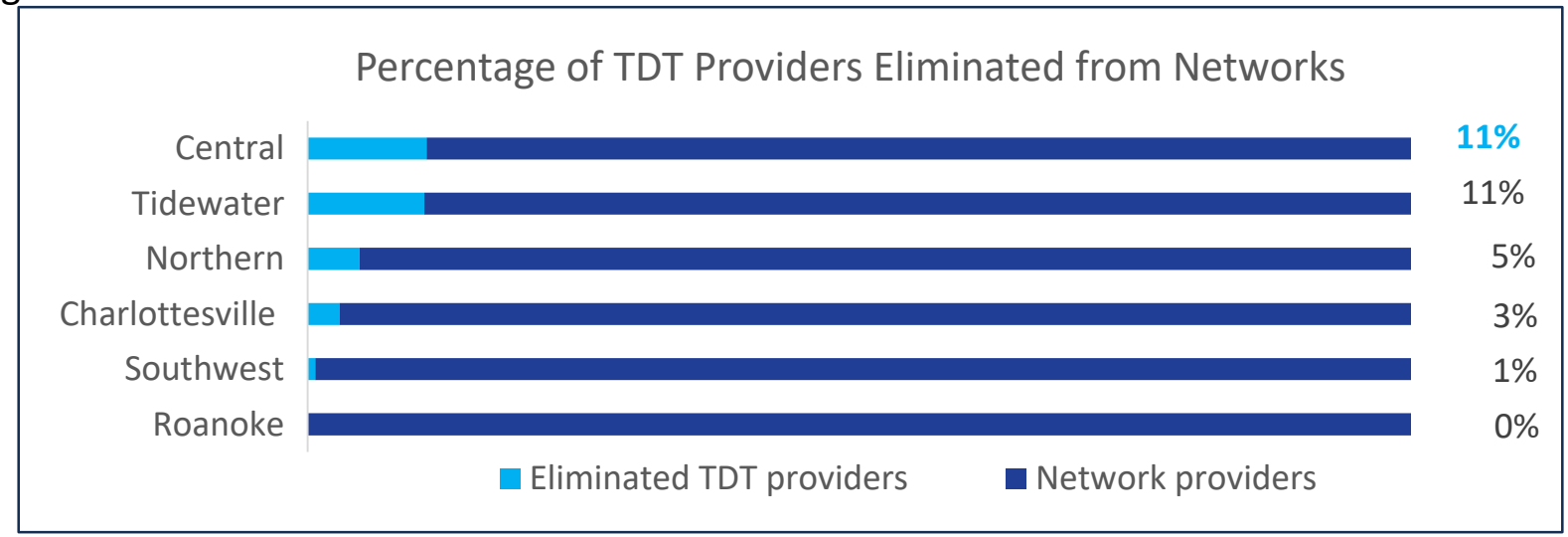


# Therapeutic Day Treatment Network Changes

All regions of the Commonwealth have sufficient numbers of networked TDT providers

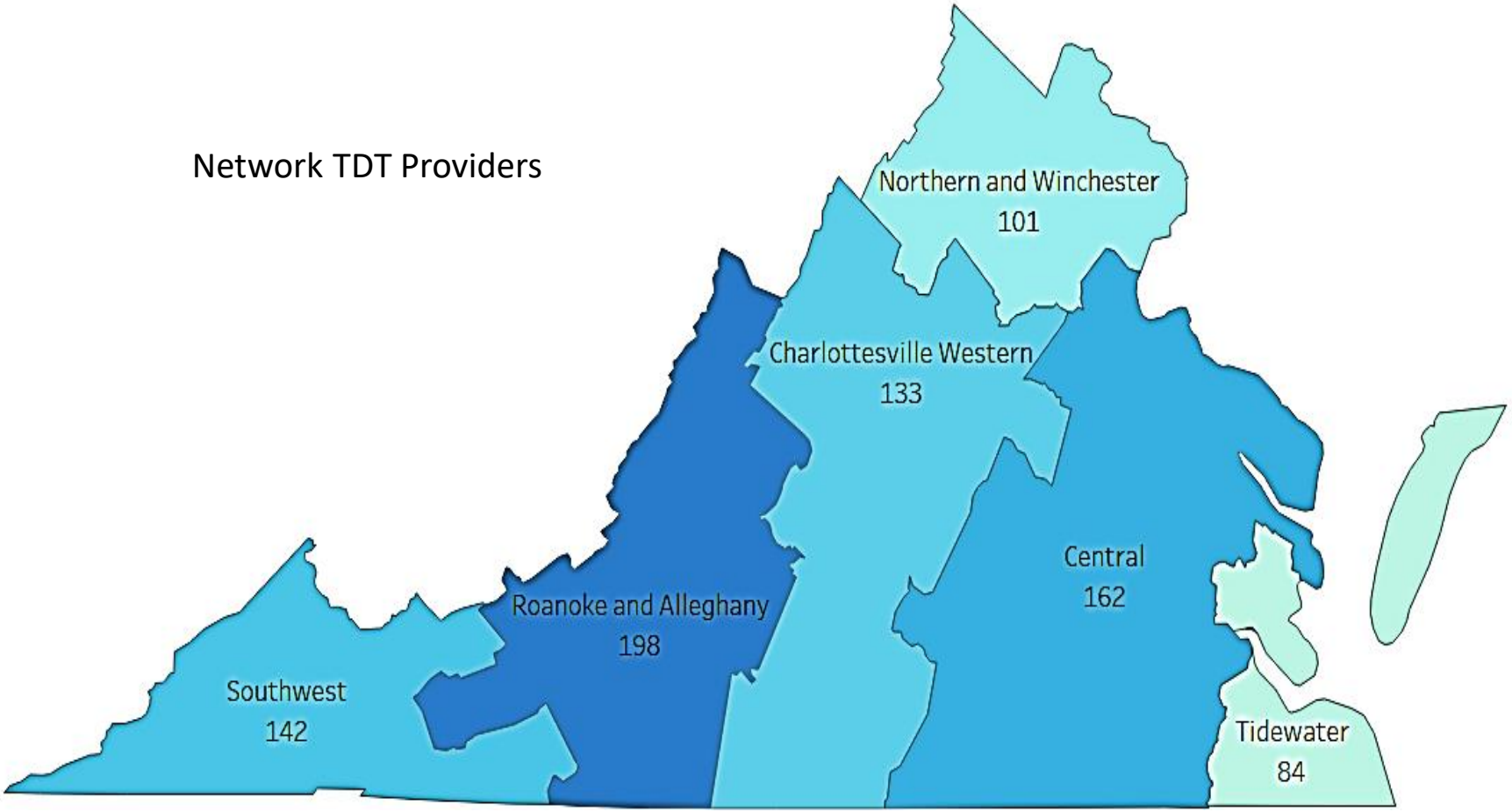
In October 2019, managed care organizations removed some TDT providers from their networks.

- Most of these providers were largely inactive where of those removed, **10% had not billed Medicaid for *any* Community Mental Health Rehabilitation Services (CMHRS) since January 2018.**
- Following the provider terminations in the fall of 2019, at least 89% of TDT providers remained in each region.



# Therapeutic Day Treatment Provider Participation by Region

Network TDT Providers



# General Assembly Reporting for Community Mental Health Rehabilitation Services

In accordance with the 2021 Virginia Acts of Assembly, effective July 1, 2021, MCOs must report to the Department on a quarterly basis on the termination of mental health service providers, including:

- ✓ The number of providers in their network and their geographic locations;
- ✓ The total number of provider terminations by year since fiscal year 2018 and the number terminated with and without cause;
- ✓ The localities the terminated providers served; and
- ✓ The number of Medicaid members the providers were serving prior to termination of their provider contract.

# CURRENT INITIATIVES

# Cardinal Care Key Focus Areas

*Cardinal Care will implement a single, streamlined MCO contract, and modernize the Department's overall Medicaid delivery system, to better achieve our mission to provide high quality, equitable care to our members at a maximum value to the Commonwealth, with greater accountability, transparency, and managed care oversight*

**Streamlining and aligning managed care contract requirements & MCO administrative tasks, such as reporting requirements**

**Rebranding the fee-for-service & managed care programs under a single name, Cardinal Care Virginia**

**Strategically aligning care management and model of care principles**

**Setting rates based on population characteristics as opposed to program; combining medical loss ratios (MLRs) and underwriting gain provisions**

**Streamlining managed care enrollment at initial enrollment, open enrollment and renewal**

**Strengthen Compliance and Oversight Processes, Including Network Adequacy**

# Current Status

- Developed high-level implementation plan for consolidating the managed care programs, as reported to the General Assembly in November 2020
- Contracted with a national expert to serve as comprehensive support for the design and implementation of Cardinal Care
  - Providing project management, strategic guidance, and technical assistance
  - Facilitating state policy priorities and national best practice design sessions, including with relevant stakeholders
  - Ensuring *consolidated contract* includes all of the following:
    - ✓ Most recent federal managed care rules, flexibilities, and guidance;
    - ✓ Sufficient levers for transparency, contractual oversight and compliance monitoring;
    - ✓ Best practices, especially for key focus areas, such as model of care, reporting, and network adequacy;
    - ✓ Elements that drive the Commonwealth's priorities to improve access, quality and efficiency
  - Identifying changes needed strengthen organizational infrastructure for improved monitoring, oversight, and transparency

Report to the General Assembly - https://rga.lis.virginia.gov/Published/2020/RD567/PDF

# Data and Transparency

**Website Redesign**

- **Quality and Population Health webpage** – Includes MCO compliance reviews, quality strategy, reports from an external quality review organization (Complete)
- **Value-Based Purchasing (VBP) webpage** – Includes materials related to MCO performance metrics and VBP initiatives (Complete)
- **Reorganizing placement of studies and reports** to promote transparency (in progress)
- **Behavioral health webpage** – Will include quality metrics by plan and population, studies and reports, and information on provider networks

**Public Dashboards**

- **Behavioral Health –** Community-based services by service and member characteristics (expected Fall 2021)
- **Service Authorization data** – Service authorization and denial data by service and health plan. Data received in late Spring 2021. Data is currently undergoing quality review.
- **Appeals and grievances** – Appeals by type and health plan. Data systems went live in late Spring 2021. Data is currently undergoing quality review.
- **Health Plan Networks**– Provider type by regions by health plan (expected with Cardinal launch)
- **MCO expenditures** – Monitor MCO expenditures by service category (live)
- **MCO Financial Performance** – Monitor MCO financial performance to ensure viability and that MCOs are meeting requirements to expend 85% of capitation payments directly on medical care and quality improvement activities (live)
- **Enrollment and health plan membership –** Health plan enrollment (live)

# APPENDIX

# Brief History of Managed Care in Virginia

*Over the past 25 years, the Virginia Department of Medical Assistance Services (DMAS) has expanded its managed care programs to cover the entire Commonwealth, while adding new eligibility populations and including additional services*

***1993 – 2013***
**PCCM, Options, and Medallion**

Virginia's managed care system started as Medallion in the early 1990s, primarily serving:

- Pregnant members,
- Children,
- Low-income adults,
- Aging population not enrolled in Medicare, and
- Blind and disabled individuals.
- *Early program excluded long-term services and supports (LTSS) and community behavioral health services*

***2014 - 2017***
**Commonwealth Coordinated Care**

The CCC Plus program was implemented in 2017 and added:

- Long term services and supports (LTSS), including nursing facility and community based care
- Dual-eligible (with Medicare and Medicaid coverage) populations
- Transitioned aged, blind and disabled populations from Medallion to CCC Plus

***2018***
**Community Behavioral Health**

Beginning in 2018, community behavioral health services were added to both CCC Plus and Medallion 4.0 contracts

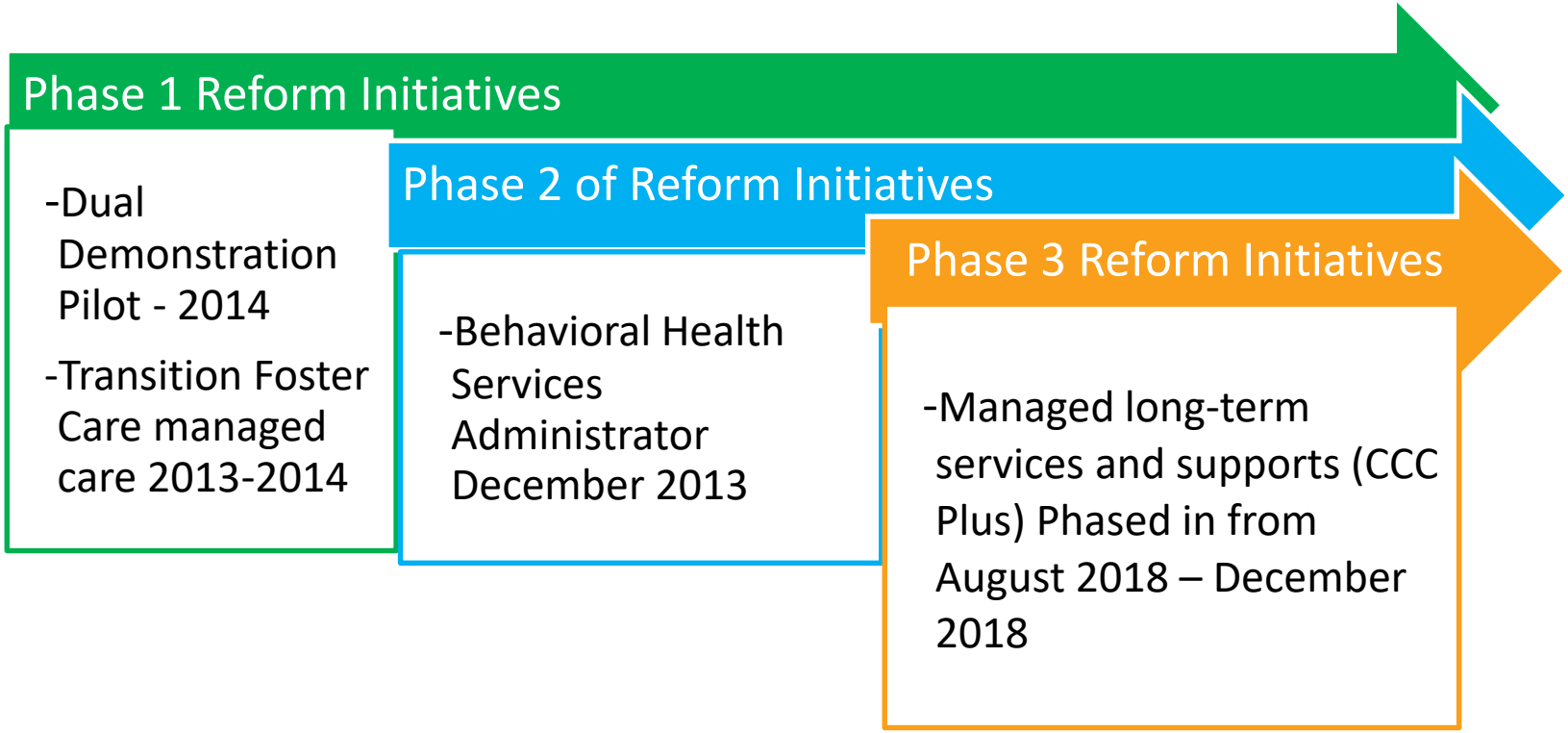
***2019***
**New Populations and Services**

In 2019, both programs added the Medicaid expansion populations, with the medically complex expansion population served through CCC Plus.

These expansion efforts incorporated numerous program improvements, including as part of the three phases of Medicaid reform recommended by the Medicaid Innovation and Reform Commission (MIRC), and as recommended by the Joint Legislative Action Review Committee (JLARC) in 2016.

# Managed Care History - Medicaid Reform Initiatives

Consistent with Virginia General Assembly directives from 2011 - 2016 and Medicaid Innovation and Reform Commission (MIRC) recommendations, DMAS launched a three phased effort to transition individuals from fee-for-service delivery models into coordinated care and managed care delivery models




Medicaid Innovation and Reform Commission: mirc.virginia.gov

# Virginia Medicaid Managed Care Plans

Aetna Better Health® of Virginia

Anthem HealthKeepers Plus
Offered by HealthKeepers, Inc.

Molina Complete Care

On July 1, *Magellan Complete Care of Virginia* becomes *Molina Complete Care*

OptimaHealth Family Care

UnitedHealthcare Community Plan

VirginiaPremier™
Powered by VCU Health

# Examples of Monitoring and Oversight Activities

**MCO financial performance:**

- ensuring that plans are spending at least 85% of cap payments on direct medical services or quality improvement initiatives (MLR) and not making inappropriately high profit margins

**Quality performance:**

- Require all to be NCQA accredited
- Require plans to submit quality measures on preventive health, behavioral health, maternal health, chronic condition measures
- Consumer Decision Tool

**Value-Based Purchasing:**

- Performance Withhold Program Clinical efficiencies program for potentially preventable ED visits, readmissions
- Discrete Incentives program for successful transitions from nursing facilities to community settings

**Network Adequacy:**

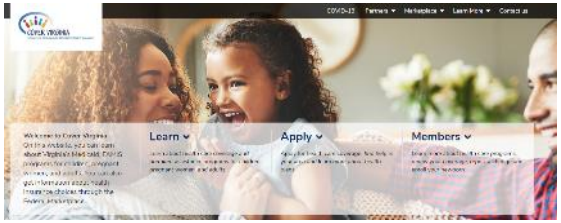
- Monthly or quarterly scorecards on networks or critical provider types
- Secret shopper survey to determine maintenance of network files, and to determine whether provide is accepting members

# External Stakeholder Advisory/Oversight Committees

| Committee | Purpose/ Authority | Membership/Meeting Frequency |
|---|---|---|
| **External Financial Review Council (EFRC)** | Ensure financial transparency and oversight of managed care programs<br>As required by the 2019 Appropriations Act HB1700 (Chapter 854) Item 307.B.1 | Secretary of Finance, Secretary of Health and Human Resources, or their designees, and appropriate staff from the Department of Planning and Budget, House Appropriations and Senate Finance Committees, and Joint Legislative Audit and Review Commission<br>• **Meets Quarterly** |
| **Medicaid Managed Care Advisory Committee (MMCAC)** | To obtain stakeholder input related to the Medicaid Managed Care programs: Medallion 4.0, Commonwealth Coordinated Care Plus, and PACE, including the Department's Quality Strategy | VA Association of Centers for Independent Living, Virginia Hospital and Health Care Association, Medical Society of Virginia, VA Association of Community Services Boards, DARS/Ombudsman, VA Poverty Law Center, Virginia Association for Home Care and Hospice, Virginia Health Care Association, Virginia Academy of Family Physicians, Lake Country AAA, American Academy of Pediatrics, Virginia Association of Health Plans, Virginia Community Healthcare Association, Virginia Healthcare Foundation, National Association for Mental Illness – VA, Virginia Interagency Coordinating Council, Behavioral Health Organizations (rotate) - VNPP/Caliber/VABA/VCOPPA/VACBP (VNPP 2021), Association of Free Clinics, DBHDS, VDSS, VDH, Department of Health Professions, American College of Obstetricians and Gynecologists, Board for People w/Disabilities, BMAS Member, PACE Alliance<br>• **Meets 3 Times Per Year** |
| **Medicaid Physician and Managed Care Liaison Committee (MPMCLC)** | The 2020 Appropriation Act, Item 313.PP; Federal regulations for a Medical Care Advisory Committee - 42CFR§431.12 and 42CFR§438.334 | DMAS MCOs, Va Academy of Family Physicians; Va Chapter of the American Academy of Pediatricians, the Va College of Emergency Physicians; the Va chapter of American College of Obstetrics and Gynecology, Va Chapter American College of Radiology; the Psychiatric Society of Va; the Va Medical Group Management Association; and the Medical Society of Va. the Va Association of Health Plans, Va Council of Nurse Practitioners, the Va Nurses Association, the Va Affiliate of the American College of Nurse Midwives, the Va Academy of Clinical Psychologists, DBHDS, VDSS, and VDH.<br>• Meets semi-annually, or more frequently as requested by the Department/ committee. |
| **Member Advisory Committee** | Medicaid member focus group provides input and recommendations to the director on the agency's programs, policies, services and communications | Medicaid members, including member authorized representatives<br>• **Meets Quarterly** |

# Transparency: Digital Communications


**DMAS website**
www.dmas.virginia.gov




**CoverVA website**
www.coverva.org


**CubreVirginia website**
www.cubrevirginia.org

**Email**
dmas.info@dmas.virginia.gov

**CoverVA Facebook**
https://www.facebook.com/coverva/

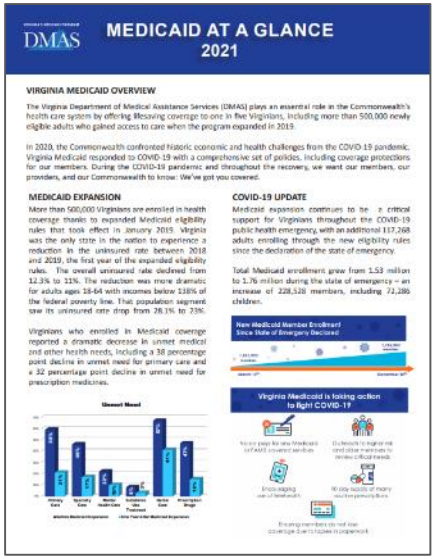
**YouTube**
https://www.youtube.com/channel/UCbE_bPvIPQTJfCS2MfCmVHA

**Twitter**
https://twitter.com/VaMedicaidDir

**Instagram**
https://www.instagram.com/cover_va/

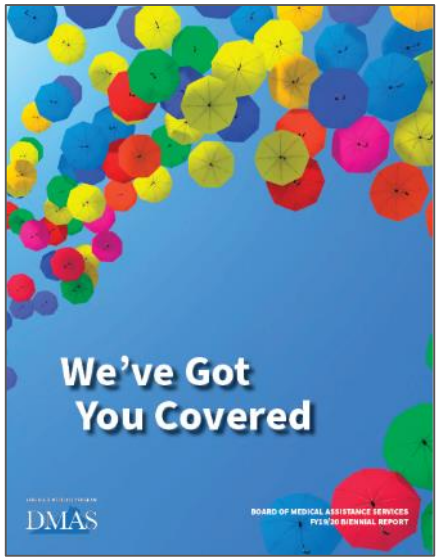
**Email/text campaigns**
Sign up at www.coverva.org

# Transparency: Publications



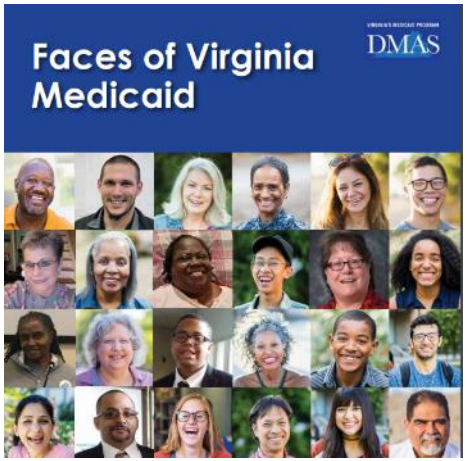

**2021 Medicaid At A Glance**

https://dmas.virginia.gov/about-us/medicaid-at-a-glance/




FY 19-20 Biennial Report

https://dmas.virginia.gov/about-us/board-of-medical-assistance-services/




**Faces of Virginia Medicaid**

https://dmas.virginia.gov/media/3040/faces-of-medicaid-e-version-final-1.pdf