Creating a Coordinated Delivery System for Medicare-Medicaid Enrollees
May 24, 2016 from 1:00 to 3:00 pm
Conference Room 7A and B, DMAS
600 East Broad Street
Richmond, VA 23219

I.Welcome	Department of Medical Assistance Services (DMAS)	1:00 pm
II. National Update	Lindsay Barnette Technical Director, Medicare-Medicaid Coordination Office CMS	1:05 pm
III. Virginia CCC Update	Jason Rachel, PhD Manager, Integrated Care DMAS	1:15 pm
IV. Maximus presentation on new contract additions	Aubrey Lucy Project Manager Maximus	1:30 pm
V. Health Plan Highlights	Anthem: Gaps in Medical Care/CSB Coordination Model Virginia Premiere: Transitioning Member from NF to Community Humana: Pharmacy Program	1:45 pm
VI. HSAG: 2015 Audit Results	Maureen McGurrin, Executive Director, Health Services Advisory Group (HSAG)	2:30 pm
VII. Public Comment	Meeting Attendees sign up for 3 minutes of open public comment	2:45 pm
VIII. Closing Remarks	DMAS	2:55 pm

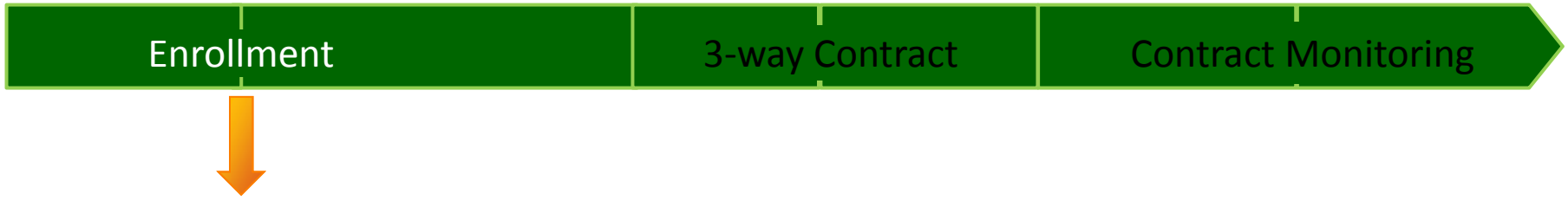
Virginia Update

Commonwealth Coordinated Care
Medicare & Medicaid working together for you

Jason Rachel, Ph.D., Manager, Integrated Care
Virginia Department of Medical Assistance Services

Advisory Committee
May 24, 2016

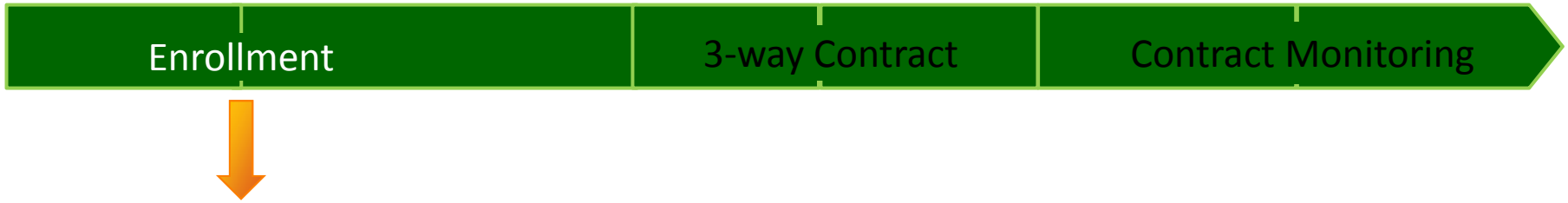
Virginia Update



CCC Enrollment as of May 2, 2016

MMP NAME	Active	Passive	Total
VaPremier	1036	5167	6203
HealthKeepers	3009	9432	12441
Humana	1969	8761	10730
Total Optins	**6014**	**23360**	**29374**
Total Optouts			**30345**

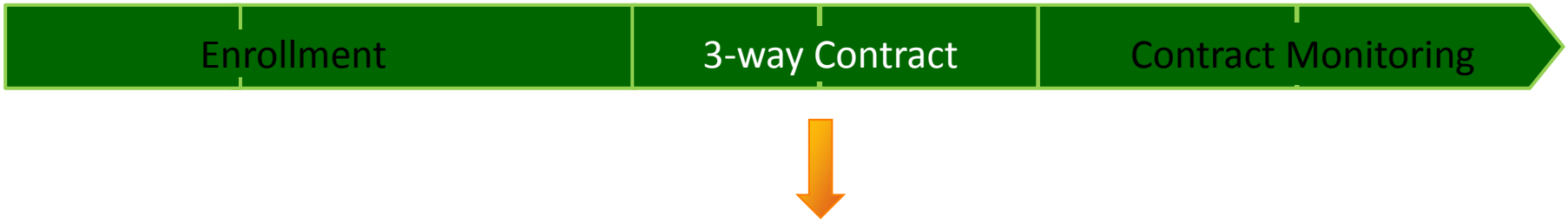
Virginia Update



New Localities

- Mecklenburg County
  - Open for Opt-in Only Effective June 1
- Fauquier County
  - Eligible for Passive Assignment Effective July 1

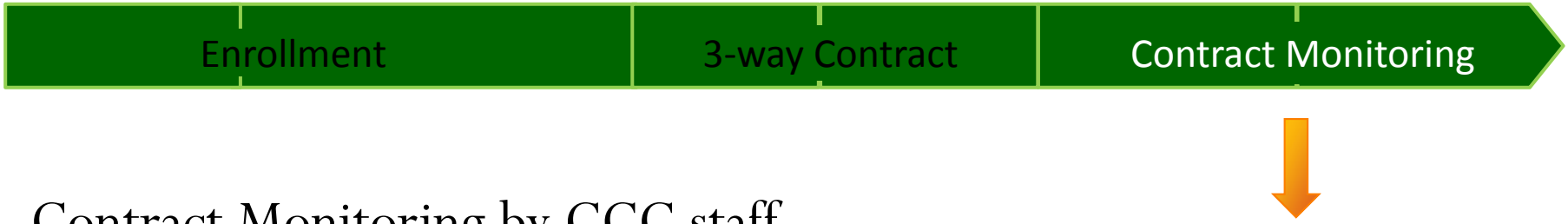
Virginia Update



The 3-Way Contract between CMS, DMAS, and each of the MMPs was amended in April 2016. Highlights include:

- Added standard federal language regarding services to members of federally recognized Indian Tribes;
- Clarification on requirements and procedure for discretionary involuntary disenrollment;
- Clarification on composition of ICT and requirements to invite standard ICT participants and solicit input if ICT member unable to attend.
- Updated regulatory citations (VAC); and,
- Included required Substance Use Disorder services to be included as covered services as they become available under Medicaid.

Virginia Update



Contract Monitoring by CCC staff

- Ongoing monitoring of contract requirements via review of dashboard data submitted and monthly joint CMS/DMAS Contract Monitoring Team calls with each MMP;
- Follow-up to HSAG audit
  - Worked with each MMP to approve a plan for correction of findings from HSAG audit, including completion dates,
  - Ensuring that required materials are submitted to DMAS no later than the completion due date,
- Review of materials to determine if full compliance is met;
  - Plan on-site reviews this summer to each MMP
- Scope of review is still in development

Virginia Enrollment Broker Implementation

May 24, 2016

MAXIMUS®

HELPING GOVERNMENT SERVE THE PEOPLE®

All contents of this presentation are proprietary and confidential.

Agenda

Topic
MAXeb
Enrollment Website
MAXKnowledge
IVR Self Service
DecisionPoint™ for Business Intelligence Reporting
NICE IEX Workforce Management System

MAXeb – 10/1/2016

ENROLLMENT BROKER CALL CENTER AGENT

User:Nate Thomson Logged In As:Enrollment Counselor/CSR:
My Account | Knowledge Base | Logout | Change Role

Call Record Id: 1512 (Inbound) Started:11/06/2008 06:58 PM
Caller Last Name:*
Caller First Name:
Calling From:
Caller Type:* --Please Select--
Caller Spoken Language:* English

Call Done | Call Actions

Subject: Category: Call
Content:*

Save | Return | Cancel

Case / Consumer | Provider | Plan | Complaint | Outreach | Task | Forms | Exemption & Exclusion | Offices | Misc

CASE/CONSUMER SEARCH

Search Criteria

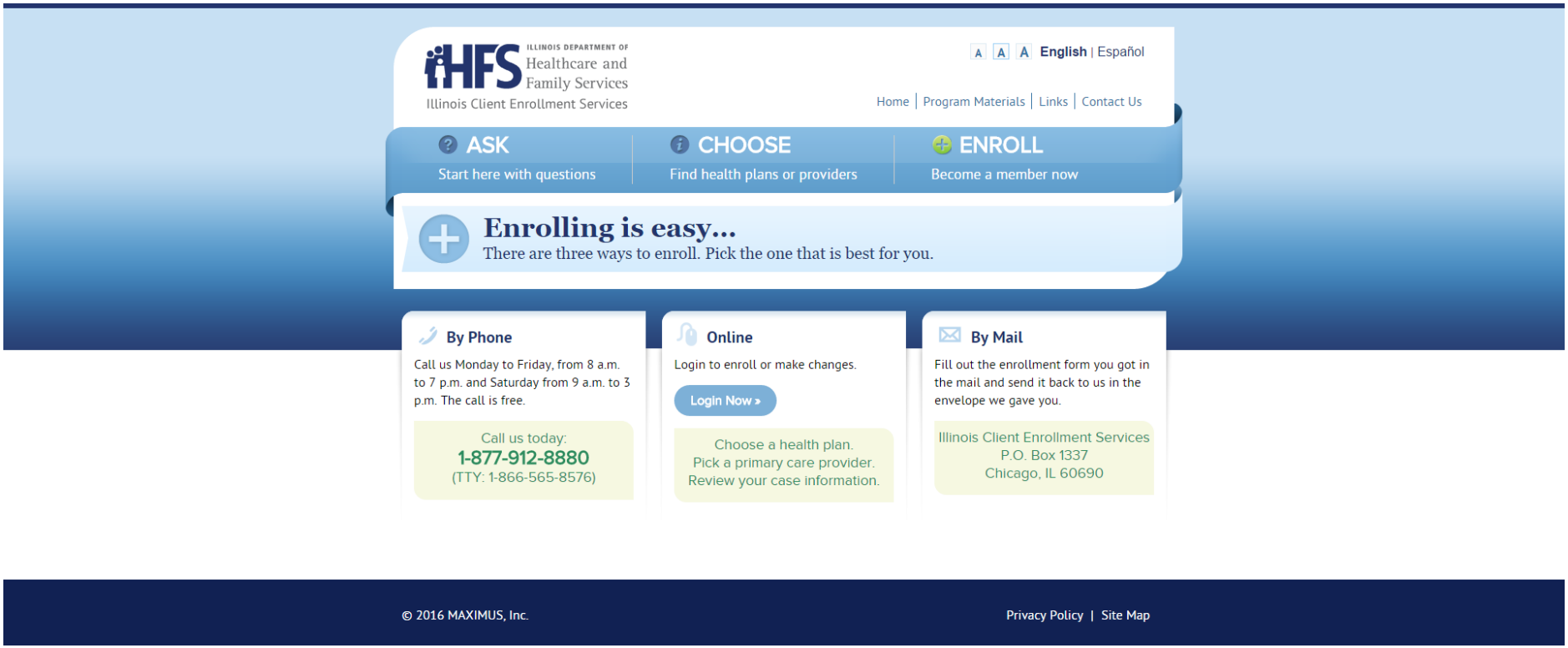
Last Name: Starts With
First Name: Starts With
CIN:
SSN:
Case ID:
Gender: --Please Select--
DOB: mm/dd/yyyy to: mm/dd/yyyy
Zipcode:
County: --Please Select--
Status: --Please Select--
Type: Medicaid

Search | Reset

MAXeb – 10/1/2016

- MAXeb, along with DecisionPoint, brings the ability to track, monitor, and efficiently distribute enrollment tasks in a far more efficient manner than previously done.
- MAXeb will facilitate communication between the enrollment website, VaMMIS, the Department and MAXIMUS staff while maintaining diligent and auditable records of all transactions and workflow
- The system also allows the Department to see the status of all tasks directly in the workflow system and use MAXeb task queues to review issue escalations, good cause requests, and other items currently sent to the Department via email or other means
- There will also be the capability to track all CSR actions, facilitate both quality control and quality assurance steps, and use activity data to analyze accuracy and efficiency in a way that enables continuous quality improvement
- Updating this technology also allows for Computer Telephony Integration (CTI) to provide CSRs with caller information as a call is directed to them from the new IVR.

Enrollment Website 10/1/2016



Enrollment Website 10/1/2016

- The new enrollment and interactive functionality of the website will allow consumers to:
  - Enroll in a new plan during expedited or open enrollment
  - Change plans during allowable periods
- The enrollment website will also offer plan and provider look up by location
- Consumers will be able to fill out and submit their Health Status Assessment via the website
- Additional information will be included on the site to try and assist consumers with every day questions and concerns.

MAXKnowledge - Complete

MAXIMUS KNOWLEDGE PORTAL

Welcome | Announcements | Calendar | Medallion 3.0 | Commonwealth Coordinated Care (CCC) | Resource Library | Staff

MAXKnowledge > Health Services > VA Enrollment Broker Services > Welcome

Welcome to Virginia EBES Employee Website

Commonwealth Coordinated Care
Medicare & Medicaid working together for you

Virginia Medicaid Managed Care
The Virginia Department of Medical Assistance Services (DMAS)

Virginia Enrollment Broker & Education Services

- *10 S. 6th Street Suite 201*
- *Richmond, VA 23220*
- *(804) 253-1052*

Proudly serving Virginia with the Medallion 3.0 and Commonwealth Coordinated Care (CCC) Projects

Quick Links

Awards & Recognition!

October Monthly Award Winners

- Perfect Attendance: **Yanni Castro; Melany Herrera; Gloria Redfearn; Wendy Menjivar; Dena Duran; Virginia Smith**
- Kudos: **Whitney Hinnant (Three times!)**
- Star of the Month:**Virginia Smith; Thomas White**
- Most Improved: **Gloria Redfearn; Karla Orellana**

CONGRATULATIONS TO ALL THE MONTHLY WINNERS!

Survey Transfer Instructions

Search

Everything

Sign In

You are signed in as Larry Gittin.

What's the Latest News?

FOR UPDATES AND INFORMATION,

PLEASE SEE THE ANNOUNCEMENTS PAGE

MAXKnowledge - Complete

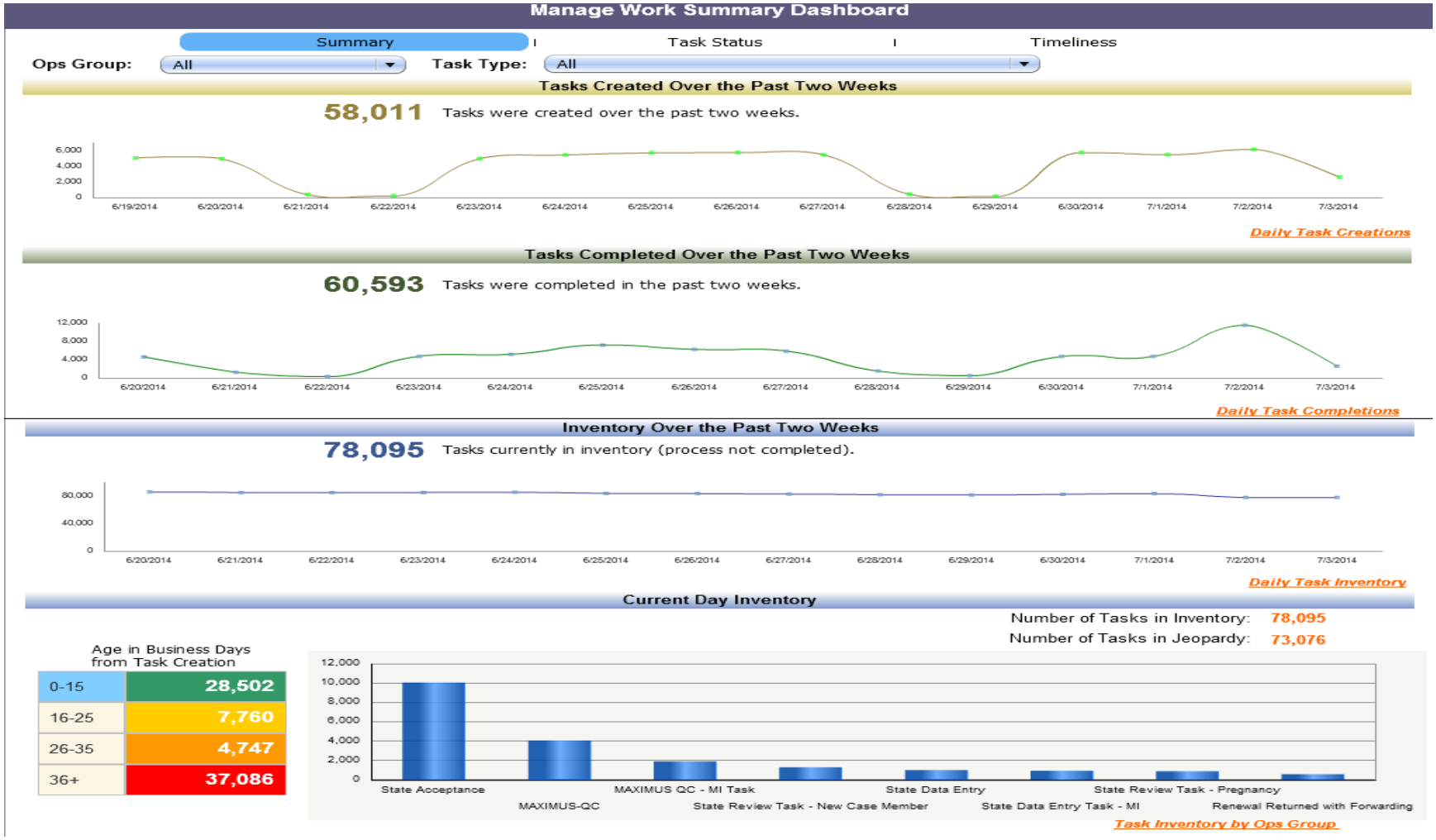
- MAXIMUS staff have access to all new and existing enrollment materials, policies, scripts, reference materials, and referral listings through the MAXKnowledge Knowledge Management System (KMS)
- MAXKnowledge is easy-to-use, searchable, and enables version control of all materials
- MAXKnowledge will include the regional health plan comparison charts, which MCO/MMPs serve each city/county, contracting hospitals, specialist networks, and standard and special services by plan

IVR Self Service – 10/1/2016

- The introduction of IVR self-service will offer additional opportunities for consumer engagement and a new channel for them to conveniently access information at any time of day
- Callers can get quick answers to frequently asked questions in the IVR, such as:
  - HelpLine office hours
  - Mailing address and fax numbers
  - Website addresses for the MEDALLION 3.0 and CCC websites
  - General information on the MEDALLION 3.0 and CCC Programs.
- Callers can be authenticated in the IVR by using options such as Medicaid ID numbers or Social Security Numbers.
- After being authenticated, the IVR is able to provide specific information such as which plan the call is currently enrolled with and which plan they will be enrolled in within the next 30 to 60 days
- If a caller has been authenticated in the IVR and reaches a CSR, the CSR is automatically presented with the caller's MAXeb™ record on their computer screen through the use of CTI technology.

DecisionPoint™ for Business Intelligence Reporting

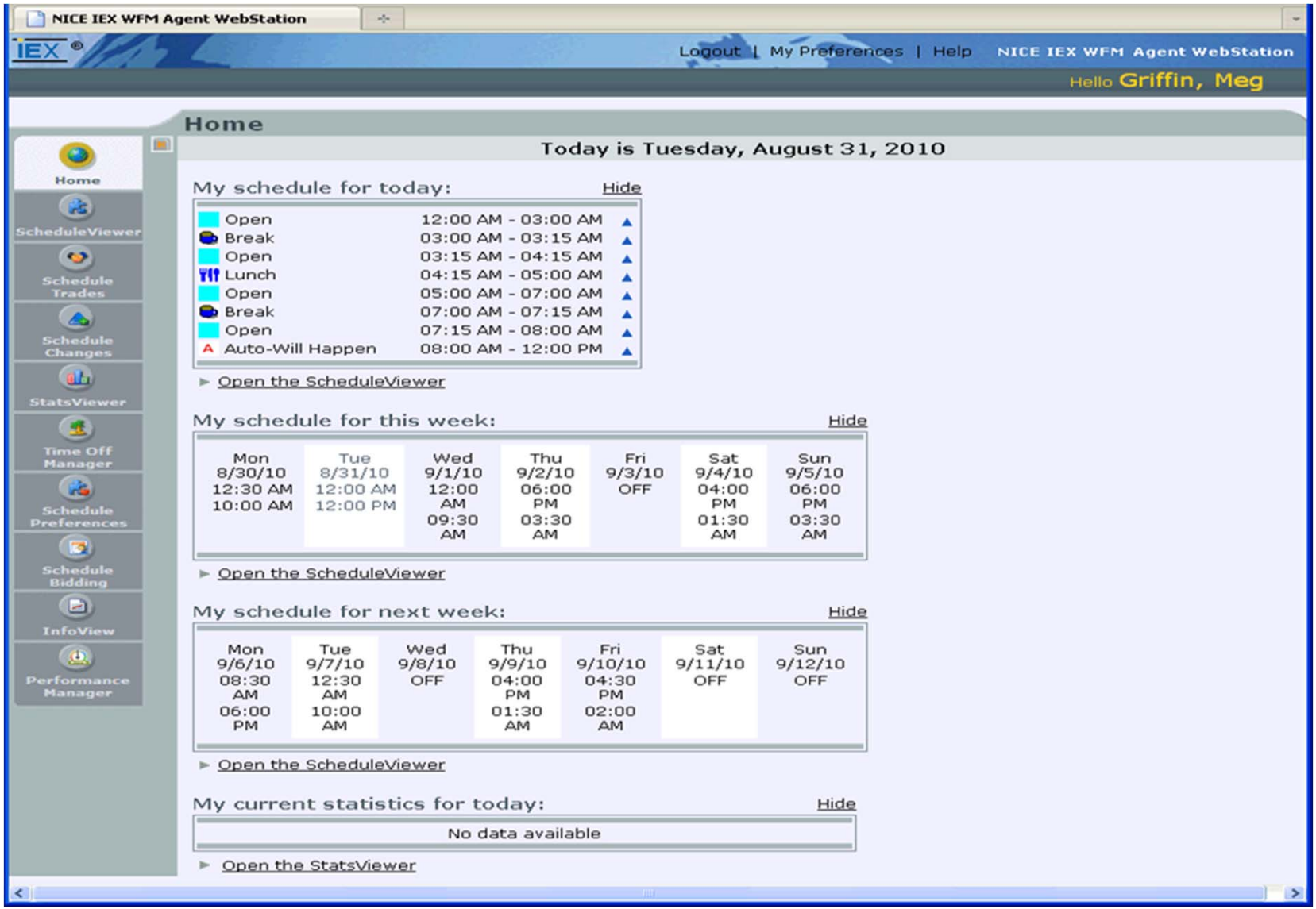
Telecom – 6/17; Back Office – 10/1



DecisionPoint™ for Business Intelligence Reporting

- Provides “Day 1” management visibility into project operations and performance by enabling near real-time monitoring, supplying a vehicle to drive meaningful process improvement and support adherence to performance standards.
- Provides project management visibility into every production-oriented task: work received (intake), work completed (completions) and inventory (work received but not completed or disposed, including work not yet started or work in progress).
- Supports self-service: does not require special skills to access data and perform trend analyses.
- Actionable operational reports and alerts detect problems as they happen. Aggregated reports with drill-down capability to individual transactions enable staff to hone in on what needs action.
- Supervisors can monitor and manage productivity at the individual worker level to achieve high levels of project efficiency.

NICE IEX Workforce Management System 8/1/2016



NICE IEX Workforce Management System

- Included in the NICE IEX solution are:
  - Simulation based call volumes and AHT forecasts based on actual historical trending
  - A planning simulation based tool to estimate staffing requirements in operational and “what if” scenarios
  - A scheduler tool that will create shifts/schedules optimized for efficient agent utilization
- These tools provide a number of enhancements for the project including:
  - Supervisor time savings
  - Improved adherence to given schedules
  - Forecast, Requirements & Occupancy Accuracy
  - Reduced Agent Turnover

Anthem HealthKeepers
Offered by HealthKeepers, Inc.

Anthem HealthKeepers Medicaid-Medicare Plan (MMP), a Commonwealth Coordinated Care plan

What is ECC?

Enhanced coordinated care

Integrating and coordinating primary and behavioral health services through CSB case management for members with both a serious mental illness (SMI) and a chronic medical condition.

The focus of ECC is to improve member health by closing "gaps in care."

The management of most medical and psychiatric conditions is influenced by gaps in care.

What does “gaps in care” mean?

“Gaps in care” refers to the discrepancy between recommended best practices and the care that is actually provided.

- We define gaps in care as gaps in office visits, screenings, lab tests, procedures and pharmaceuticals.
- Gaps in care are usually the result of obstacles preventing members and physicians from implementing care recommendations.
- Specifically, HealthKeepers, Inc. looks at gaps in care as they relate to the following conditions and measures: diabetes, cardiovascular diseases, respiratory diseases, preventive services and behavioral health.

Health care initiatives and focus

- Each initiative and focus for ECC is driven by gaps in care for individual members.
  - HealthKeepers, Inc. will provide a member-specific gaps in care report or health care usage report to the CSB for each initiative.
- Initiatives are rolled out categorically.
  - Preventive care, emergency room usage, diabetic care
- Anthem HealthKeepers, Inc. behavioral health care managers work with the CSBs to determine the initiatives that will be rolled out.

ECC Training – Gaps in Care

- 16 Active Community Service Board Programs
- 280 MMP members engaged in services

7 Trainings conducted in April/May

- RBHA, Region 10, MPNN, Colonial, D19, HNN, RACSB

5 Trainings scheduled for June

- Henrico, VA Beach, Chesapeake, Norfolk, Portsmouth

Patient 360 Demonstrations are conducted onsite with each training

Webinar scheduled for June 15

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ECC Training – Gaps in Care

HealthKeepers, Inc. care managers (CM) will provide the CSB ECC program with initiative materials:

- A list of ECC members who qualify for specific initiatives as determined by gaps in care
- A “how to” guide on arranging needed services
- Appropriate resources

An example: Diabetic care initiative

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Begins with gaps in care for Diabetes

- PCP or Endocrinologist:
  - HbA1c testing at least twice per year
  - Blood pressure monitoring at each appointment
  - Weight at each appointment
  - Cholesterol screening yearly
- Ophthalmologist:
  - Dilated eye exam yearly
- Dentist:
  - Dental exam every six months
- Podiatrist:
  - Routine foot care every three months

Example: Introductory initiative flier

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Diabetes initiative

Closing gaps in care
Enhanced care coordination (ECC)

Assessment and management of diabetes in serious mental illness (SMI) population

Diabetes is a permanent disorder of food metabolism where the body either doesn't make enough insulin, can't use the insulin it does make well, or both. Over 29 million Americans and 9.3% of the population have diabetes. Vulnerable populations such as the SMI population are at a higher risk of developing this disease and not managing it properly. There are different types of diabetes — type 1, type 2 and a condition called gestational diabetes.

Diabetic screening and education

Members with high blood pressure, history of abnormal cholesterol levels, obesity, history of high blood sugar or a family history of diabetes should be screened for diabetes.

It is imperative that members with diabetes are educated on the serious nature of this disease. Members can potentially avoid health problems caused by diabetes if they learn how to take good care of themselves.

Comprehensive diabetes care

To manage diabetes, HealthKeepers, Inc. members enrolled in Anthem HealthKeepers Medicare-Medicaid Plan (MMP), a Commonwealth Coordinated Care plan, are encouraged to work with their health care team, which may include their PCP, endocrinologist, opthalmologist and podiatrist, to make a plan to help reach their goals.

Anthem HealthKeepers MMP pays for screenings related to managing diabetes with a $0 copay for members, if received through an in-network provider.

Diabetes self-management, services and supplies

People with diabetes must manage their diabetes on a day-to-day basis. It is important to make healthy food choices, manage weight, be active and learn to cope with stress. Advocate for checking blood sugars and taking medications as prescribed, even if the person feels fine. Checking their feet regularly and informing their providers if they notice any changes is also recommended. Ensure a newly-diagnosed diabetic knows how to use their equipment and understands the recommendations made by their provider.

Diabetes care

Specialist visits, diabetic screenings, eye exams, foot care, nutritional counseling, diabetic self-management training, diabetic supplies, free gym membership

https://mediproviders.anthem.com/va

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Example: Diabetes specific initiative flier

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Closing gaps in care

Enhanced care coordination (ECC)

Diabetes

Step 1: Diabetic screening and education

Coverage

Anthem HealthKeepers Medicare-Medicaid Plan (MMP), a Commonwealth Coordinated Care plan, will pay for a diabetes screening if a member has any of the following risk factors:

- High blood pressure (hypertension)
- History of abnormal cholesterol and triglyceride levels
- Obesity
- History of high blood sugar

Depending on test results, members may qualify for up to two diabetes screenings every 12 months. Anthem HealthKeepers MMP also offers educational programs to help members manage chronic conditions, such as diabetes.

Helpful resources

- http://www.niddk.nih.gov/health-information/health-communication-programs/ndep/living-with-diabetes/Pages/index.aspx

Types of diabetes

Type 1 diabetes – the body does not make insulin. Insulin helps the body use glucose from food for energy. People with type 1 need to take insulin every day. This is usually diagnosed in childhood or adolescence.

Type 2 diabetes – the body does not make or use insulin well. People with type 2 often need to take pills or insulin, but can also be influenced by one's lifestyle. Type 2 is the most common form of diabetes and can be diagnosed throughout one's lifetime.

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Example of a workflow

Workflow for Diabetes Mellitus

What is Diabetes Mellitus?

Diabetes Mellitus is a disease of the pancreas, an organ that produces the hormone insulin. Insulin helps the body use food for energy. When a person has diabetes, the pancreas either cannot produce enough insulin, uses the insulin incorrectly, or both. Insulin works together with glucose (sugar) in the bloodstream to help it enter the body's cells to be burned for energy. If the insulin isn't functioning properly, glucose cannot enter the cells. This causes glucose levels in the blood to rise, creating a condition of high blood sugar or diabetes, and leaving the cells without fuel.

Type 1 diabetes occurs because the insulin-producing cells of the pancreas are damaged. In type 1 diabetes, the pancreas makes little or no insulin. Type 1 diabetes is treated with insulin.

Type 2 diabetes occurs when the pancreas makes insulin, but it either doesn't produce enough insulin or the insulin does not work properly. Type 2 diabetes can be controlled with diet, weight management and exercise. However, treatment also may include medications or insulin injections.

Diabetes Management

- Ensure members have an assigned primary care physician for routine blood glucose monitoring.
- Encourage members to record blood glucose readings as ordered and take to all doctor appointments.
- Ensure member has a current glucometer.
  - If member needs a glucometer.
    - ✓ Contact PCP to request diabetic supplies (strips, alcohol pads, and lancets) and glucometer prescription are called in to members' pharmacy.
    - ✓ Provide PCP with current glucometer brand.
    - ✓ Inform member to contact the pharmacy to see if prescription has been filled.
- Ensure member has annual lab work to include HGB A1C, BUN and creatinine (kidney function) test.
- Member should be educated on the importance of medication adherence (PO meds and/or insulin). *Please see the "Helpful Resources" on Diabetic Care Step 1 Initiative Flyer.
- Refer member to diabetic and nutrition classes to encourage diabetic diet and healthy eating. Member's PCP or endocrinologist may have these available through their practice.
- Ensure member has annual podiatry (foot) and ophthalmology (eye) exams. No referrals are needed. *To locate providers please see workflow for provider search.
- Diabetics are encouraged to have preventive dental care every 6 months. *See workflow for dental services.

Blood Test Levels for Diagnosis of Diabetes and Prediabetes

	A1C (percent)	Fasting Plasma Glucose (mg/dL)	Oral Glucose Tolerance Test (mg/dL)
Diabetes	6.5 or above	126 or above	200 or above
Prediabetes	5.7 to 6.4	100 to 125	140 to 199
Normal	About 5	99 or below	139 or below

Definitions: mg = milligram, dL = deciliter
For all three tests, within the prediabetes range, the higher the test result, the greater the risk of diabetes.

Source: Adapted from American Diabetes Association. Standards of medical care in diabetes—2012. *Diabetes Care*. 2012;35(Supp 1):S12, table 2.

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Example of disease specific resource

Health Tips

Make Health Happen

TYPE 1 DIABETES

mss.anthem.com/ccc

If you have Type 1 diabetes, you can help control your blood sugar level with insulin shots, healthy eating and exercise.

It's important to know what to do if your blood sugar gets too low or high. Your doctor can tell you what blood sugar range is right for you. Here are a few tips:

	Low blood sugar	High blood sugar
What is it?	Ask your doctor what low blood sugar is for you. You may feel shaky, dizzy, confused or hungry. You may have a headache or sudden mood change.	Ask your doctor what high blood sugar is for you. You may feel thirsty, tired or itchy. You may have blurred vision or have to pee a lot.
To prevent it...	• Take your medication as prescribed. • Eat at the same times every day. • Test blood sugar before, during and after exercise. • Keep a fast-acting snack handy.	• Take your medication as prescribed. • Follow your meal plan. • Watch portion sizes during meals. • Tell your doctor if you are sick
To treat it...	• Eat a fast-acting snack. • Test again in 15 minutes – if still low, eat another snack • If you have two low readings in one day, call your doctor.	• Test your blood sugar every two hours. • Drink 8 ounces of water every hour. • Talk to your doctor about when to call about high readings.

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Helpful phone numbers for members of Anthem HealthKeepers Medicare-Medicaid Plan (MMP), a Commonwealth Coordinated Care plan
Member Services/24-hour Nurse HelpLine: 1-855-817-5787 (TTY 1-800-855-2880)
Monday through Friday, 8 a.m. to 8 p.m. local time

Y0071_H0147_14_19525_I03/25/2014

VADUALSHT-DIA1-CHL-0712 E
HP-C-1259-14 04.14

Health Tips

TYPE 1 DIABETES

When to call your doctor:

- Constant thirst or very dry mouth.
- Levels or symptoms of too high or too low blood sugar.
- Have to pee a lot.

When to go to the emergency room:

- Chest pain or pressure.
- Shortness of breath or trouble breathing.
- Fruity-smelling breath.
- Stomach pain, nausea or vomiting.
- Unusually tired or disoriented.
- Decreased consciousness or dizziness.
- Seizures.

Learn more about Type 1 diabetes at **diabetes.org**.

American Diabetes Association, diabetes.org.

You can get this information for free in other languages. Call 1-855-817-5787 (TTY 1-800-855-2880). The call is free.

Puede recibir esta información sin cargo en otros idiomas. Llame al 1-855-817-5787 (TTY 1-800-855-2884). La llamada es gratuita.

Health Tips is published by HealthKeepers, Inc. to give information. It is not a way to give personal medical advice. Get medical advice directly from your doctor.

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Example: CSB-created individualized plan to manage diabetes

CSB Consumer- Individualized Plan to Manage Diabetes

9/24/15

Name of CSB Consumer: _____

Plan to Manage My Diabetes:

- I will see Dr. (insert name of PCP) at least _____ times per year for routine medical exams so he/she can monitor/treat my diabetes.
- I will become more aware of the ways that I can better manage my diabetes by doing the following (insert disease management education/activities): _____ _____.
- I will take all medications prescribed by my doctors to treat my medical and mental health conditions (See Attached List of Medications).
- I will eat three healthy meals a day and snack on healthy food such as _____ at the following times of the day: _____.
- I will engage in the following exercise related activities_____ _____ at least _____ times per week, and will write them on the calendar given to me by my CSB Case Manager.
- I will take my insulin as prescribed every day at the following times: _____.
- I will monitor my diabetes by testing my blood glucose levels every day at the following time(s): _____.
- I will write every day the amount of insulin that I give to myself and my blood glucose levels on the calendar given to me by my CSB Case Manager .
- I will call my CSB Case Manager and tell him/her if:
  - my blood glucose levels are high & between _____ and _____, or
  - my blood glucose levels are low & between _____ and _____, * and/or
  - if I start feeling bad due to my diabetes.
  - If this occurs at night or over the weekend, I will call and leave a message for my CSB Case Manager. I will also call my insurance company's 24 hour phone number and talk to someone about my glucose levels and symptoms.
- I will go to the (insert the name of the immediate access medical center selected by the consumer, such as Patient First, etc.) if:
  - my blood glucose levels are high & between _____and _____, or
  - my blood glucose levels are low & between_____ and _____, * and/or
  - I start experiencing any of the following:
    - Weakness or feeling tired,
    - Shaking,
    - Sweating,
    - Headache,
    - Hungry even though I have eaten,
    - Feeling uneasy, nervous, or anxious,
    - Feeling cranky,
    - Trouble thinking clearly,
    - Double or blurry vision, or
    - Fast or pounding heartbeat, *and*
  - I will call my CSB Case Manager as soon as I can to tell them that I am going or have been to (insert the name of the immediate access medical care center).
  - If this occurs at night or over the weekend, I will call and leave a message for my CSB Case Manager. I will also call my insurance company's 24 hour phone number and talk to one of their specialists.
- I will immediately call 911 if:
  - my blood glucose levels are high and between _____ and _____, or
  - my blood glucose levels are low and between_____ and _____, * and/or
  - I start experiencing any of the following:
    - Weakness or feeling tired,
    - Shaking,
    - Sweating,
    - Headache,
    - Hungry even though I have eaten,
    - Feeling uneasy, nervous, or anxious,
    - Feeling cranky,
    - Trouble thinking clearly,

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Measurements for outcomes

HealthKeepers, Inc. will be evaluating CSBs involved in the ECC program in the following ways:

- Medical admission and readmission rates
- Psychiatric admission and readmission rates
- ER visits
- PCP usage
- Gaps in care closure

Anthem HealthKeepers
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Commonwealth Coordinated Care
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How will we measure progress?

- Claims based
- Each CSB will receive quarterly reports featuring their progress in the ECC programs
- Reports will include all registered ECC members for the CSB

Gaps in care

- Quarterly
- Based on initiatives completed

Outcomes of health care usage

- Quarterly
- CSB total and by member, if requested

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Thank you!

mediproviders.anthem.com/va

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It Takes a Village ….

VPCC Medical Management

Team Roanoke

May 24, 2016

It takes a village …

VA Premier Health Plan, Inc.

71 yr old male who rented apartment from nephew for 17 years and lived with supportive elderly sister

No PCP…

No doctor seen in several years…

No awareness of health…

It takes a village …

VA Premier Health Plan, Inc.

ER 2/12/2016

Diabetes

Gangrene

It takes a village …

VA Premier Health Plan, Inc.

Course of Hospital stay – 10 days

It takes a village …

VA Premier Health Plan, Inc.

- Skilled Nursing Facility
  - Admitted 2/22/2016
  - Rehabilitation Services
  - Wound Care
  - Diabetic Teaching

It takes a village …

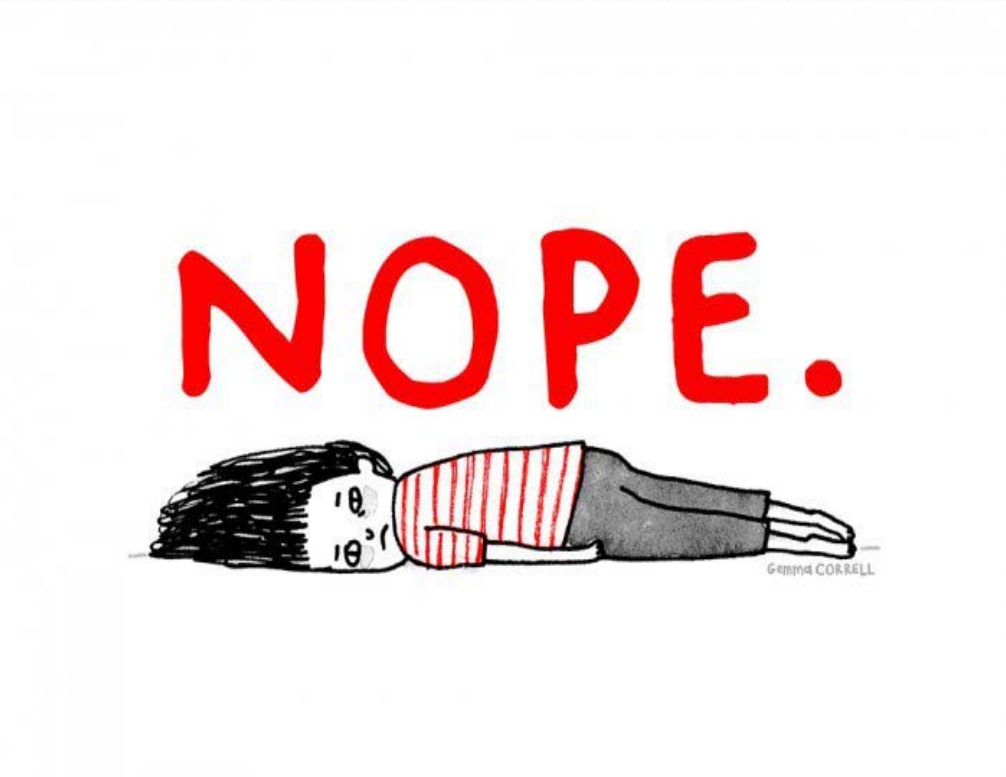
Upon discharge:

- Member was essentially homeless
- Facility and VPCC CM coordinated a move into an independent living apartment

It takes a village …

Member possessed:

- No furniture
- No food
- No household goods
- No hygiene products
- No family support



Our fabulous team!

It takes a village …

- Our team Social Worker raided our emergency food pantry for canned goods and basic food ….

It takes a village …

- Our "Red Bag" program; set up to help our members with hygiene products came in handy to stock the bathroom cabinet ….

It takes a village …

- The staff of The Woodlands Health and Rehabilitation Center contributed the bed and dresser …..

It takes a village …

- The VPCC Case Manager took care of his living room furniture needs …..

It takes a village …

Complete with an afghan for those cold Virginia nights ….

It takes a village …

- His VPCC Case Manager assisted him to apply for SNAP benefits and Assurance cell phone ….

SM

SNAP

Supplemental
Nutrition
Assistance
Program

Putting Healthy Food
Within Reach

It takes a village …

The member met with DSS, his UAI was completed, and EDCD services were in place to begin the day he moved into his new apartment ….

It takes a village …

- Home Health services were set up to assist with the transition …and he is receiving skilled nursing and physical therapy …

It takes a village …

VPCC CM assisted the member to find a new PCP…

And made his first appointment to establish care at the VPHP Medical Home with Dr. W Vaughn

It takes a village …

VA Premier Health Plan, Inc.

But, for him, the best part is ……

It takes a village …

VA Premier Health Plan, Inc.

His sister moved in next door!

Virginia CCC Stakeholder Advisory Committee Meeting

Pharmacy Overview

Mark Malone

Market Director

May 24, 2016

Humana®

Humana Pharmacy continues to grow in size and scale

10+ million lives

National scale and capabilities (including nearly 8M Medicare) – 80% individuals picking health plan

415 million / 35 million

Administers over 400M prescriptions and dispenses over 35 million prescriptions annually

60,000+

Network pharmacies ensuring all members have easy and fast access to the medications they need

~25%

Individual Medicare mail order usage rate

5,000

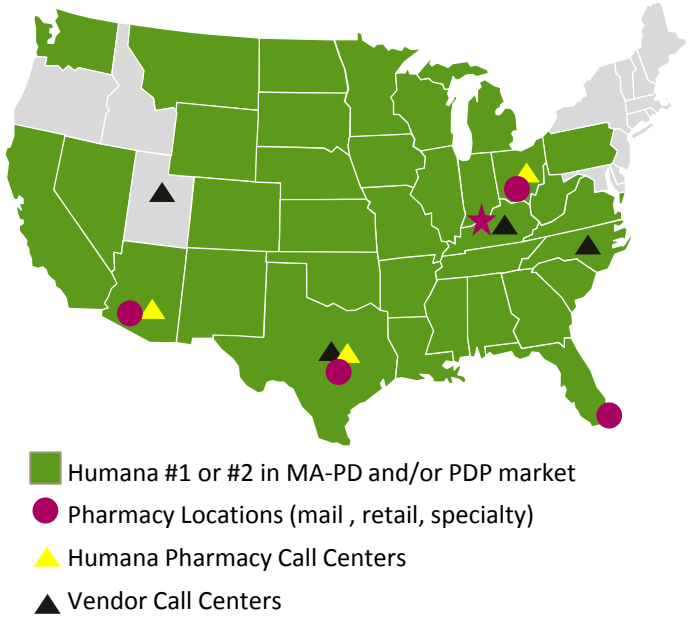
Dedicated individuals, working together, to engage and help members (another 1,500 FTEs outsourced)

750

In-house pharmacists focused on quality distribution and safe utilization of prescription medications

36 states

A market-leading Medicare position in 36 states



Humana

- Market rankings based on CMS Medicare Enrollment Data as of November 2015
- Prescriptions are 30-day equivalent scripts. Dispensed prescriptions are actual prescriptions (largely 90-day scripts)

Humana Pharmacy Solutions – Who We Are

Our mission is to provide safe and affordable pharmacy care to the people we serve. Our vision is to improve their health by knowing them, giving them a simple customer experience, integrating pharmacy at all points of care, and continuing to transform pharmacy into a driver of health outcomes.

- Humana Pharmacy is celebrating a big win — announcing that it has been named the top U.S. mail order pharmacy for customer satisfaction in the 2015 J.D. Power U.S. Pharmacy Study

- The study measures customer satisfaction among U.S. pharmacies across four categories — mail order, brick & mortar, supermarket and chain drug store

Humana Gold Plus Dual Demonstration – RX Benefits

- **Enrollment**
  - One coverage record, One Rx claim, pays as “once and done”
  - Does not require a secondary claim
- **Formulary and Copays**
  - Tier 1- ($0 - $2.95 copay)- Part B/D generic medications for a 30 day supply
  - Tier 2- ($0 - $7.40 copay) - Part B/D brand medications for a 30 day supply
  - Tier 3- ($0 copay) - CMS excluded medications payable under Medicaid
  - Tier 4- ($0 copay) – OTC drugs payable under Medicaid
    - Copays for covered medications depend on formulary tier, member’s income, and institutional status for a 30 day supply
    - $0 copay for Medicaid-covered medications

Mail Order Prescriptions

- If members take a medicine for an ongoing health condition, they can have their medicines mailed to their home
- If they choose this option, their medicine comes right to their door
- They can schedule their refills and reach a pharmacist if they have questions
- Pharmacists check each order for safety
- Members can order refills by mail, by phone, online, or they can sign up for automatic refills
- Mobile app that allows individuals to scan prescription bottle for refill
- Members can sign up for this service in one of three ways
  - Call Humana Member Services at 1-855-280-4002
  - Go to HumanaPharmacy.com. Then log in and sign up for Mail Delivery. If the member says it's okay, Humana Pharmacy will call their provider to get a prescription.
  - Ask the member's provider to write a prescription for a 30 or 90 day supply with up to one year of refills. The member's provider can send their prescription directly to Humana Pharmacy or other mail order pharmacies to be filled.
- For more information, call Humana Pharmacy: 1-800-379-0092

Formulary

Why do we have a formulary?

- Formularies are designed to refer members to the covered medications that the plan has chosen to cover in each therapeutic class. It also includes utilization management features to ensure proper usage of the medications (e.g. quantity limits, age edits, gender edits, etc.)
- Formularies direct members to certain preferred medications that the plan may have negotiated rebates for with the manufacturer
- The formulary for each plan can be found on the Humana website as a PDF document (Called a Prescription Drug Guide)
- Non-formulary medications are covered under Transition during the member's initial enrollment period to allow the member to work with their prescriber on the correct medication going forward without interrupting their current therapy
- VA CCC - https://www.humana.com/medicare/medicaid-dual/virginia/pharmacy/

Formulary Changes from 2015 to 2016

VA CCC Dual Demonstration

Below is a list of some commonly used medications that have Humana Gold Plus Integrated formulary limitations or utilization management edits in 2016 (e.g., prior authorization requirements, tier changes and non-formulary changes). Humana members are asked to talk to their health care providers about possible alternatives.

Impacted Drug	2016 Alternative Drug
PROAIR HFA	VENTOLIN HFA AEROSOL INHALER
CYCLOBENZAPRINE	TIZANIDINE
NEXIUM	PANTOPRAZOLE
NAMENDA	MEMANTINE
PREDNISOLONE ACETATE	DEXAMETHASONE EYE DROPS
ABILIFY	ARIPIPRAZOLE
CARISOPRODOL	TIZANIDINE
GLYBURIDE	GLIMEPIRIDE TABLET

Common Member Interactions with Pharmacy

- **"My drug is denying as non-formulary."**
  - Talk to your doctor about using a formulary alternative
  - If you cannot take the formulary drug, have your doctor request a formulary exception
- **"The pharmacy said my claim was rejected for refill too soon."**
  - Common error
  - Dosage change – have pharmacy call helpdesk for override
  - Going on vacation – have pharmacy call helpdesk for override
- **"Why does my drug require a prior authorization?"**
  - To ensure proper utilization of certain drugs, the health plan will ask for information from your doctor and review for appropriate usage

Common Member Interactions with Pharmacy

- **"How does my doctor request a prior authorization or formulary exception?"**
  - **Phone requests:** Call 1-800-555-CLIN (2546) between 8 a.m. and 6 p.m. local time, Monday through Friday.
  - **Fax requests:** Complete the applicable form and fax it to 1-877-486-2621.
  - **Online:** www.Covermymeds.com (see appendix A)
- **"How long will it take for a decision on my prior authorization or formulary exception request?"**
  - VA CCC – 72 hrs (Standard); 24 hrs (Expedited)
- **"How do I order Over The Counter (OTC) products under my plan?"**
  - OTC products covered on the formulary require a doctor to write the prescription and the pharmacy will dispense the product for you
  - OTC Allowance is a monthly dollar amount provided to order from catalog of products (order form can be found on website) and the product will be shipped to you

Monthly OTC Allowance

- Humana Gold Plus allows the members to have an OTC Allowance for purchasing OTC items outside the normal pharmacy benefit via a mail order vendor
- The OTC benefit gives the member up to a certain amount per month to purchase OTC products. See Humana website link below to get a copy of the OTC Allowance Form.
  - VA CCC – $35 per member per month; https://www.humana.com/medicare/medicaid-dual/virginia/pharmacy/
- Members receive the generic item that is comparable to the brand item – both are listed on the form
- Orders are shipped to the member's home by UPS or the US Postal Service. There are no shipping charges and the order should be received within 10-14 working days from when the order is received.
- Unused benefit does not accrue from month to month, must use the benefit within the month
- Prefer fax or mail of order form but order can be facilitated through a phone call
- Prefer that order is received by 20th of month to receive it that month
- Humana Pharmacy address: P.O. Box 1197, Cincinnati, OH 45201-1197
- Humana Pharmacy phone: 1-855-211-8370; fax: 1-800-379-7617

OTC Allowance Changes from 2015 to 2016

Additions

- Allergy Nasal Spray
- Children's Allergy Liquid 5 mg
- Eye Itch Relief 0.025 % Eye Drops
- Nasacort Allergy 24 hour - generic
- Acetaminophen 325 mg
- Oral Pain Relief - Benzocaine 20%
- Wart remover liquid
- Antioxidant tablets
- Ferrous Sulfate 5 gr
- Gummy Multi-Vitamin
- Gummy Vitamin C 250 mg
- Gummy Vitamin D 2000 IU
- Magnesium oxide 400mg
- Potassium gluconate 595 mg
- Miconazole 3

Deletions

- Children’s Diphenhydramine (50mg)
- Diphenhydramine (25mg)
- Glucose Tablets
- Diaper Rash Cream
- Sunblock
- Acetaminophen, Diphenhydramine HCl
- Diphenhydramine HCl (25 mg)
- Oxybutynin

Plan Information

Humana Gold Plus Integrated H3480-001 (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and the Virginia Department of Medical Assistance Services to provide benefits of both programs to enrollees.

HSAG HEALTH SERVICES ADVISORY GROUP

2014–2015 External Quality Review of Compliance With Standards *for* Commonwealth of Virginia Medicare-Medicaid Plans

Maureen McGurrin, Executive Director, HSAG

May 24, 2016

Background

- Code of Federal Regulations (CFR) at 42 CFR 438.358 describes activities related to review of compliance with standards, one of three federally mandated activities for Medicaid managed care organizations (MCOs).
- Because the Commonwealth Coordinated Care (CCC) program includes a Medicaid component, these regulations apply to the CCC-contracted Medicare-Medicaid plans (MMPs).
- Compliance reviews are to be conducted every 3 years.

Background (cont.)

- Review standards established by the State to comply with the requirements of 42 CFR 438.204(g):
  - Access to care
  - Structure and operations
  - Quality measurement and improvement
- The review also included elements of the Memorandum of Understanding (MOU) and three-way contract between the MMPs, Centers for Medicare & Medicaid (CMS), and DMAS.

Background (cont.)

- An on-site Operational Systems Review (OSR) was conducted by HSAG to cover the review period of April 1, 2014–March 31, 2015.
- 14 standards were reviewed:

Adequacy and Availability of Services	Enrollment and Disenrollment
Coordination and Continuity of Care	Grievance System
Coverage and Authorization of Services	Practice Guidelines
Provider Selection, Credentialing, and Recredentialing	Quality Assessment and Performance Improvement
Subcontractual Relationships and Delegation	Health Information Systems
Enrollee Rights and Protections	Confidentiality of Health Information
Enrollee Information	Program Integrity

Background (cont.)

- Case file reviews were also conducted for:

Provider Credentialing and Recredentialing
Grievances
Clinical Service Denials
Appeals
Delegation

Scoring Methodology

Three-point scoring methodology applied to compliance requirements:

Met *(value: 1 point)* indicates full compliance defined as *both* of the following:

- All documentation and data sources reviewed for a regulatory provision, or component thereof, are present and provide supportive evidence of congruence.
- Staff members provide responses to reviewers that are consistent with each other, with the data and documentation reviewed, and with the regulatory provision.

Scoring Methodology (cont.)

Partially Met *(value: 0.5 points)* indicates partial compliance defined as *either* of the following:

- There is compliance with all documentation requirements, but staff members are unable to consistently articulate processes during interviews.
- Staff members can describe and verify the existence of processes during the interviews, but documentation is incomplete or inconsistent with practice.

Scoring Methodology (cont.)

Not Met *(value: 0 points)* indicates noncompliance defined as *either* of the following:

- Documentation and data sources are not present and/or do not provide supportive evidence of congruence with the regulatory provision.
- Staff members have little or no knowledge of processes or issues addressed by the regulatory provisions.

Not Applicable designation was applied only if the specific requirement was not applicable during the period covered by the review (April 1, 2014, through March 31, 2015).

Standard Compliance Scores

Overall Compliance Scores

MMP	Compliance Score
HealthKeepers	90.45%
Humana	90.28%
VA Premier	80.82%
MMP Aggregate	87.20%

Overall Compliance Scores (cont.)

Observations:

- Opportunities for improvement in consistent policy and procedure development, approval, and implementation.
  - Driver for *Partially Met* and *Not Met* scores.
- Corporate structure strengths:
  - HealthKeepers—Effective collaboration/communication between local and corporate operations.
  - Humana—Corporate collaboration led to efficiencies and consistency in certain functional areas.
  - VA Premier—Local presence, credible knowledge of geographic areas and communities served.

MMP Next Steps

- Develop and implement a Corrective Action Plan (CAP) for any score of *Partially Met* or *Not Met* within 45 calendar days following receipt of the report.
- DMAS and the Contract Management Team (CMT) review and approve CAPs.
- CAP activities are implemented after approval.
- Follow-up monitoring of CAPs implementation by DMAS and CMT.

Conclusions

- Successful partnership between CMS, DMAS, and the MMPs.
- MMPs compliant with the majority of requirements:
  - New program implementation
  - First Operational Systems Review
- Policy and procedure documentation had significant impact on compliance scores.

Recommendations

- MMPs review and update their policy and procedure systems.
- CMS/DMAS clarify certain areas of Three-Way Contract language.
- CMS/DMAS update enrollee handbook model language.
- CMS/DMAS consider a targeted review of care management case files.

HSAG HEALTH SERVICES ADVISORY GROUP

QUESTIONS?

HSAG HEALTH SERVICES ADVISORY GROUP

Thank you to all the MMPs for your collaboration with the operational systems review.

The partnership between CMS, DMAS, and the MMPs in the implementation of the CCC program resulted in the overall compliance with standards scores.

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