



Virginia Department of Medical Assistance Services
And
Medicaid Managed Care Organizations

ENSURING GREATER ACCESS TO QUALITY HEALTH CARE FOR MEDICAID
BENEFICIARIES WHILE DELIVERING COST EFFICIENCIES & BUDGET CERTAINTY TO THE
COMMONWEALTH FOR 17 YEARS



Anthem. HealthKeepers Plus
Offered by HealthKeepers, Inc.



COVENTRYCARES™
of Virginia
formerly known as CareNet



IN Total Health™
Every Time. Every Touch.

MajestaCare™
A Health Plan of **CARLION CLINIC**

Optima 
Health
Family Care

VA Premier
Health Plan, Inc.



Managed Care is guided on the principles of providing better coordination of care for Virginia Medicaid beneficiaries at a lower cost to taxpayers



Medicaid is an important safety net program for nearly 1 million financially vulnerable Virginians, and a rising number rely on the program to meet their daily health care needs. It is also the largest driver of the Commonwealth's exponential budget growth.

But, by building on the existing successful and mature managed care program while implementing a number of innovative ideas, Virginia can achieve comprehensive, high-quality care and services and cost efficiencies for taxpayers.

Virginia Medicaid Managed Care 101

- The MCO has total responsibility and is at financial risk for the health of a defined population.
- For this defined population, the MCO is responsible for the entire spectrum of care, ranging from primary prevention to screening, diagnosis, treatment, rehabilitation and support care. Because the MCO's responsibility extends beyond just providing care when patients seek it, the contacts are initiated not only by the recipients, but also by the MCO.
- MCOs work proactively to identify at-risk membership and collaborate with providers to deliver and coordinate care, especially with regard to the most chronic and acute segments of the membership.

While the number of people served by Medicaid in Virginia has grown 10 percent over the last decade (fiscal years 2002-11), total state General Fund (GF) expenditures have increased by eight times that amount, from \$1.6 billion to \$2.8 billion to now consume nearly 21% of the state budget. The main drivers of growth are increases in enrollment, health care costs, and utilization of long term care and behavioral health services.

For 17 years, the Department of Medical Assistance Services (DMAS) has contracted with Managed Care Organizations (MCOs) to provide Medicaid and Children's Health Insurance Program (CHIP) services through the Medallion II and Family Access to Medical Insurance Security (FAMIS) programs. The majority of the existing Virginia managed care population consists of financially vulnerable mothers and children. Nearly 70 percent of the Virginia Medicaid beneficiaries are enrolled in managed care; yet, it only accounts for approximately 30% of Medicaid expenditures.

The Virginia Managed Care Program provides all medical benefits to Medicaid beneficiaries while also building in strong consumer protections and aligning financial incentives in order to help ensure that the right care is provided in the right place and the right time. This full-risk program also provides for a single point of entry to help Medicaid managed care members efficiently navigate the health delivery system.

Managed Care Organizations ensure Medicaid beneficiaries receive the appropriate mix of services that provide high quality of care while helping to control the costs of the Virginia Medicaid Program, including but not limited to:

- Programs to coordinate care for beneficiaries with multiple chronic conditions;
- Integrated networks across delivery settings;
- Enhanced access to services and providers;
- Programs dedicated to the specific needs of prenatal and children care;
- Provider education, outreach and quality incentive programs;
- Outreach and education initiatives to promote prevention and healthy living;
- Data analytics to measure and demonstrate cost of health care;
- Improved health outcomes;
- 24/7 Call Center and Helpline for Medicaid beneficiaries;
- Efforts to facilitate beneficiaries' access to non-medical support, such as social services or transportation; and
- A focus on providing cost-efficient services.



**Benefits of Medicaid Managed Care vs.
Primary Care Case Management and Fee-For-Service**

Benefits to Virginia Medicaid Beneficiaries	MMC	PCCM	FFS
Identification card proving coverage	✓	✓	✓
A designated primary care physician	✓	✓	
Case management of primary care services	✓	✓	
Disease Management	✓	✓	
Comprehensive case management	✓		
Quality standards and continuous quality improvement programs	✓		
National quality accreditation	✓		
Cost Containment and Risk Assumption for the Commonwealth	MMC	PCCM	FFS
Claims analysis	✓		
Utilization review	✓		
Improved generic utilization	✓		
Using the right level of care at the right setting at the right time	✓		
Cost predictability and budget certainty	✓		
Assumption of risk	✓		

ENHANCED ACCESS AND CARE COORDINATION

Coordinated care is an approach to delivering and financing health care aimed at improving the quality of care while also saving costs. The fundamental idea is twofold: (1) to improve access to care and coordination of care by assuring enrollees have a medical home with a primary care provider and (2) to rely more heavily on preventive and primary care. MCOs negotiate payment rates with providers that are typically well above fee-for-service provider payments; therefore, Medicaid MCO enrollees often enjoy better access to providers than those in traditional Medicaid.

MCOs coordinate care for Medicaid populations with special needs, including those with multiple chronic conditions, through primary care coordination and disease management programs. Disease management (DM) has been demonstrated to be an important part of the effective delivery of medical services for beneficiaries with chronic conditions. In a disease management program, care is delivered through a multidisciplinary team of providers that can include primary care physicians, specialist physicians, nurses, therapists, nutritionists, pharmacists, and others to educate individuals about their condition and manage their care. The programs use evidence-based medicine in developing the treatment regimen.

Virginia MCOs develop disease management programs to address many different conditions, including, but not limited to, programs for diabetes, prenatal/postnatal care, asthma, and people with multiple chronic conditions. Chronic Obstructive Pulmonary Disease (COPD) is an additional example of a chronic disease that Virginia MCOs help affected members manage.

Chronic Care

- Disease and case management programs and tools targeted to Medicaid populations
- Focus on high impact diagnoses such as behavioral health, diabetes, COPD, etc. and other high risk conditions to coordinate care, make appointments and develop individualized follow-up to prevent readmissions
- Transition of care programs
- Home visits to assess patient compliance and need



Through MCO condition management programs, case managers are available to help members experience efficient and effective coordinated care.

Goals of Medicaid Managed Care

- Providers deliver high-quality care in an environment that manages or controls costs
- The care delivered is medically necessary and appropriate for the patient’s condition
- Care is rendered by the most appropriate provider
- Care is rendered in the most appropriate, least-restrictive setting

MCOs focus a tremendous amount of their efforts on outreach and education initiatives in improving Medicaid beneficiary access to health care by informing beneficiaries about the importance of preventive care and other steps they can take to improve their health and overall wellness. These programs include reminding members of medical appointments, assessing medical conditions, and implementing treatment regimens. This allows MCOs to identify early medical conditions in order to design targeted, proactive programs to address member needs.

Care coordination models are one of the premier opportunities for participating plans to demonstrate innovative approaches and show the power of program integration. DMAS should continue to focus on specifying the outcomes desired rather than on the details of the process of care, which should be individualized to the particular needs. MCOs are piloting a number of community-based care models that accomplish “high touch” in an economically viable manner. MCOs demonstrate proficiency at implementing person-centered strategies that have shown measurable results at reasonable price points. The capitation arrangement provides different financial incentives versus fee-for-service. MCOs work with their physician networks to support practice management systems that emphasize prevention, early diagnosis and treatment, and coordinated management of patient care.

The contracted MCOs are constantly innovating and evolving to change the delivery system in Virginia Medicaid. Within the MCO framework, the health plans are implementing innovative delivery systems like Accountable Care Organizations (ACOs), Patient Centered Medical Homes, MCO owned clinics, risk and gain share payment incentives and provider networks and contractual arrangements tailored to address regional provider and access differences.

Medical home initiatives focus on both primary care and the importance of coordinating a beneficiary’s health needs across the care continuum. The overriding purpose of these models is to improve quality of life through disease prevention, early detection, prompt treatment and meeting Virginia Medicaid beneficiaries’ health care needs.

Care coordination can be improved by engaging providers and holding them accountable for results. For example, adapting reimbursement policies to compensate for care coordination activities aligns their incentives. Reimbursement policies foster gaps in care and lack of accountability. Current reimbursement policies that do not reimburse providers for care coordination activities impede a provider’s ability to take responsibility as a health home. Incentives that reward providers for overall cost and quality gains, rather than transactions, have proven successful.

Empowering Physicians

- Diverse practice models which compete and support the marketplace (physician owned, hospital owned, commercially owned)
- Telemedicine
- Web-based access to care delivery tools, care management programs
- Embedded case managers
- Enhanced care management for patients identified with significant medical and behavioral needs
- Provider incentive payments based on quality driven performance
- Stable administration consistent with commercial business practices
- Provider access to electronic patient history

In the 2014 contract year, DMAS and the MCOs will have a new focus to reflect the program priorities in population (ABD, children, pregnant women) and reporting. Additions to the MCO contract include a technical manual that outlines reporting requirements and provides for standardization, new chronic care language to replace existing disease management language, and new requirements for maternity programs as well as inclusion of foster care and adoption assistance children.



DELIVERING COST EFFICIENCIES AND BUDGET CERTAINTY

Virginia contracts with six Medicaid MCOs in order to provide Medicaid beneficiaries with consumer choice while also catalyzing innovation in care coordination models by establishing a competitive environment. This program design yields the following benefits:

- Realizes the cost efficiencies inherent in marketplace forces through a competitive process
- Lowers program administration costs (i.e., fewer payors for the Commonwealth to manage)
- Reduces agency-unique administrative burden and staff resource limitations
- Improves exchange of information between health plans, DMAS, members and providers
- Minimizes confusion among members and providers; comparison and choice are more easily made for members, and providers are not being asked to contract with numerous payors
- Enhances quality, both from an oversight perspective (i.e., small group to monitor) and a delivery perspective; few companies have the infrastructure, experience and know-how to deliver best-in-class service coordination
- Attracts and retains the highest quality, most experienced MCOs with an attractive marketplace and long-term, diverse business opportunity

There is long-held myth that MCOs deny care to increase profits. In actuality, MCOs deliver cost savings to the state and earn a marginal profit by influencing and promoting better health outcomes. MCOs improve access to quality health care for Virginia Medicaid beneficiaries through activities that promote preventive care in integrated delivery systems. Members of MCOs are more likely to maintain healthy lifestyles that avoid the use of preventable hospitalizations. MCOs help ensure that the right care is provided in the right place and the right time; thereby, health care is delivered in the most clinically appropriate and cost-effective manner. MCOs have strong clinical teams who develop protocols, review variances, and develop programs to control both over and under utilization of health care services. This allows for ease in forecasting utilization trends and identifying opportunities for both clinical and administrative improvements.

In achieving cost savings, managed care can succeed in two ways. It can lower costs for individual services, and it can improve the efficiency of service across the spectrum of an individual’s illness. By providing more effective care early, managed care may avoid more costly care subsequently; or, by substituting less costly modes of care (for example, outpatient instead of inpatient surgery, creative outpatient treatment plans instead of hospital care), it may achieve the same ends as the FFS model at a lower cost.

Capitation gives Virginia more cost predictability and control. Contracts with MCOs offer the state a mechanism, through quality measurement and improvement requirements, for holding them accountable for the quality of care they provide to Virginia Medicaid enrollees. MCOs achieve cost-savings for Virginia while outperforming the fee-for service program on key quality measures. Virginia takes an additional step in ensuring a sustainable Medicaid Managed Care Program by imposing an underwriting gain limitation on the MCOs. This ensures that any efficiency gains in the form of favorable returns over the limitation are returned back to the Commonwealth.

MCOs are constantly developing business efficiency and cost effectiveness initiatives through a combination of unit cost, utilization, and administration efficiency activities. It is important to note that year-to-year the MCOs face favorable trends (like a decrease in inpatient admissions) and unfavorable trends (like a flu epidemic) that are hard to predict. The MCOs

Predictive Modeling and Data Analytics

- 17 years history with managed care to assess and identify utilization and practice patterns
- Detailed information systems to provide Medicaid-relevant data
- Access experience from other markets (both commercial and Medicaid) and other states to enhance Virginia Medicaid Program
- Leverage expertise
- Modeling tools
- Central repository for encounter data
- Data analytics to identify inappropriate utilization and make necessary interventions (ER and EPSDT Diversion Programs)
- Analytics based on diagnosis to determine interventions
- Specific metrics developed for Medicaid population



provide the state with predictable costs and budget certainty by assuming the risk of the Medicaid beneficiaries they serve. If the cost of care exceeds the paid rate, the MCO is liable as opposed to the Virginia Medicaid Program.

Access to data is incredibly important in order to identify potential savings, costs and projections. MCOs have mature data infrastructures and data analytic procedures that support reporting on quality and cost for primary, specialty and hospital care.

QUALITY ASSURANCE & IMPROVEMENT

One of the most significant benefits of Medicaid Managed Care is quality measurement and improvement. State and federal rules provide consumer protections for Medicaid MCOs, such as appeals and grievances, network adequacy, and the provision of culturally and linguistically appropriate services. Virginia requires its contracted MCOs to not only meet federal and state regulatory requirements, but also achieve accreditation from the National Committee for Quality Assurance (NCQA). The contracted MCOs have achieved this NCQA accreditation - meeting a nationally recognized standard for demonstrating the delivery of high quality care.

The Healthcare Effectiveness Data and Information Set (HEDIS) benchmarks are a national set of quality, access and effectiveness-of-care measures for coordinated care that have been adopted to include measures applicable to the Medicaid population. MCOs are required to report performance measures, such as HEDIS, to the state. Performance measures provide valuable data to health plans, states, researchers and policymakers for demonstrating the quality of care in Medicaid programs, identifying gaps in care, and creating quality improvement projects.

2012 VIRGINIA MANAGED CARE REPORT CARD	
VA Medicaid MCOs Ranked in the Top 75 on the NCQA's Health Insurance Plan Ranking List for their High Quality Scores	✓
The Resultant 2012 Scores from VA's Medicaid Managed Care Adult Members' CAHPS Surveys were better than the National 75 th Percentile in Three Composite Measures: All Health Care, Managed Care Organization and Personal Doctor *	✓
On average, there are only 1.1 grievances per month for every 1,000 Medicaid Managed Care Members in Virginia	✓



Through performance measurement, the quality of care in Medicaid health plans has improved.

COLLABORATION TO IMPROVE AND REFORM

Collaboration between DMAS and the MCOs has enabled the state to implement innovative delivery system reforms like patient centered medical homes as well as focus on best practices in managed care. These include MCO collaboratives focused on quality improvement initiatives and program integrity.

DMAS has also established two innovative programs with the goal of improving health outcomes for Medicaid members through a system designed to integrate primary, acute, and complex health services provided by contracted MCO, including:

- Examples of DMAS Sponsored Collaboratives for MCOs**
- Managed Care Work Group
 - Managed Care Quality Collaborative
 - Program Integrity Collaborative
 - Dental Advisory Committee
 - Mental Health Support Services Stakeholders
 - Childrens Health Insurance Advisory Committee

Managed Care Performance Quality Based Incentive Model

During each contract year, DMAS will withhold an approved percentage of the monthly capitation payment from the MCO.

- Funds will be used for the MCO's quality performance incentive awards
- Awards will be made to each MCO according to criteria established by DMAS
- Criteria will include assessment of performance in quality of care and member experience, including, but is not limited to, scores on a subset of HEDIS measures; composite scores on CAHPS adult and child measures; performance in EQRO-conducted activities; and other measures determined by DMAS



- Awards will be proportionate to the extent to which the MCO achieves benchmarks for each performance measure.

This will be implemented through a three-year phased-in implementation schedule.

Medallion Care System Partnership (MCSP)

MCSP requires:

- Each MCO implement at least two MCSPs to improve health outcomes for Medicaid members through a system designed to integrate primary, acute, and complex health services.
- The MCO provider network must include local medical groups (including individual medical providers) designated as Health Care Homes. The Health Care Home designation shall demonstrate adherence to the core set of Medical Home principles.
- Gain and/or risk sharing, performance-based incentives, or other incentives, reforms tied to Commonwealth-approved quality metrics and financial performance, and partnerships with providers and/or health care systems.
- Integrated provider health care delivery systems participation, improvement of member health outcomes as measured through risk adjusted quality metrics, and alignment of administrative systems to improve efficiency and member experience.

PROGRAM INTEGRITY: PREVENTION OF FRAUD, WASTE, AND ABUSE

Fraud, waste, and abuse plague the health care industry and account for billions of lost program dollars. The United States spent \$2.34 trillion on health care in 2008 with projections annually increasing by 6.4 percent through 2019.¹ Estimated annual losses due to fraud range from 3² to 10³ percent, amounting to \$70 billion to \$270 billion. Medicaid managed care has experienced significantly less fraud and abuse than traditional Medicaid fee-for-service. CMS reported that in FY 2011 payment error rates for Medicaid managed care were 0.5% compared to 3.6% for Medicaid fee-for-service. MCOs have a financial incentive to find and prevent improper payments and fraud.

The work in progress by the Virginia Managed Care Program Integrity Collaborative can reverse the propensity of higher costs of care, program spending levels, imposed beneficiary cost sharing and taxes triggered by fraud losses. Through a collaborative approach, program integrity reports and reporting processes were standardized for efficiency and accuracy by DMAS. 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.

In 2012, DMAS conducted a Program Integrity Compliance Audit (PICA) of each MCO's Medicaid policies and procedures for identifying fraud, waste, or abuse by members or providers. After final reviews, Virginia MCOs achieved a 95% compliance rate.

Virginia is implementing innovative Medicaid program enhancements through stringent managed care contract requirements, provider and pharmacy lock-in programs, and investment in an All Payer Claims Database (APCD) is expected to result in less fraud, waste, and abuse. Setting clear and specific contract requirements for provider network credentialing standards, performance penalties, prepayment review standards, and aggressive overpayment recovery and improper payment audit processes ensure Virginia to benefit from existing managed care plans with robust fraud, waste, and abuse programs. Instituting a provider and pharmacy (i.e. enrollment) lock-in program is expected to prevent up to 25,000 health plan switches annually⁴ resulting in decreased occurrences of multiple delivery of the same services or prescriptions by multiple providers across different health plans.

Through the inherent transparency of APCDs, claims data are aggregated across public and private payers to provide a system-wide view of health care cost, quality, and access; thus alleviating any critical gaps in information within current systems. Existing Medicaid managed care plans with robust program integrity plans will be able to design innovative programs around addressing specific gaps of care or areas of need in Virginia's Medicaid population, resulting in savings from potential healthier Medicaid beneficiaries.



MEDICAID REFORM OPPORTUNITIES

Medicaid is an important safety net program for financially vulnerable Virginians, and a rising number rely on the program to meet their daily health care needs. A number of innovative ideas can help Virginia achieve comprehensive, high-quality care and services and cost efficiencies for taxpayers.

The Secretariat of Health and Human Resources (HHR) along with the Department of Medical Assistance Services (DMAS) are exploring innovative solutions to the cost and health care delivery challenges facing the Virginia Medicaid program. MCOs have the capabilities and experience to effectively introduce and implement innovative models of care while also reducing the costs for the Commonwealth and improving the lives of members.

The utilization of private sector solutions - like managed care - enable the Commonwealth to achieve upfront cost savings, budget predictability, lower future cost trends, and provide accountability for quality and superior service for Virginia Medicaid beneficiaries.

By encouraging managed care organizations (MCOs) to assume the Commonwealth's risk on a capitated basis, Virginia can budget for Medicaid at a fixed amount, allowing MCOs, along with their provider partners, to develop innovative programs to contain costs while improving quality of care. MCOs will also be able to leverage their community-based networks to better serve the expansion populations in a more cost-efficient manner, emphasizing wellness and quality outcomes.

To address costs and continue to achieve long-range savings, Virginia must pursue transformative change in Medicaid, with the most cost savings opportunity found in the fee-for-service (FFS) population currently excluded from managed care. The utilization of private sector solutions- like managed care- will enable the Commonwealth to achieve upfront cost savings, budget predictability, lower future cost trends, and provide accountability for quality and superior service for Medicaid beneficiaries.

www.dmas.virginia.gov/Content_pgs/mc-home.aspx

*Proudly Offered by Virginia-Contracted Medicaid Managed Care Organizations
in Collaboration with
Virginia's Department of Medical Assistance Services*

¹ Centers for Medicare & Medicaid Services, Office of the Actuary, "National Health Expenditure Projections, 2009–2019" (September 2010).

² National Health Care Anti-Fraud Association, "The Impact of Health Care Fraud on You!" From http://www.nhcaa.org/eweb/DynamicPage.aspx?webcode=anti_fraud_resource_centra&wpscocode=TheProblemOfHCFraud (accessed Nov. 23, 2010).

³ Federal Bureau of Investigation, "Financial Crimes Report to the Public, Fiscal Year 2009" From <http://www.fbi.gov/stats-services/publications/financial-crimes-report-2009> (accessed Nov. 23, 2010).

⁴ The Lewin Group, "Managed Care Lock-In: Analysis of Impact on Medi-Cal" (March 2000).