Update on Status of Medicaid Reforms

The Honorable William A. Hazel, Jr., M.D.
Secretary of Health and Human Resources
Medicaid Innovation and Reform Commission

April 7, 2014

Updates to Reforms

Budget language passed by the 2013 General Assembly established a series of reforms to Medicaid as well as the Medicaid Innovation and Reform Commission.

All Reforms are Underway

Phase 1: Advancing Reforms in Progress

Phase 2: Implementing Innovations in Service Delivery, Administration, and Beneficiary Engagement

Phase 3: Moving forward with Coordination of Long-Term Services and Supports

Virginia Medicaid Reform Goals

Coordinated Service Delivery	•DMAS provides a health system where services are coordinated, innovation is rewarded, costs are predictable, and provider compensation is based on the quality of the care.
Efficient Administration	•DMAS is efficient, streamlined, and user-friendly. Tax payer dollars are used effectively and for their intended purposes.
Beneficiary Engagement	•Beneficiaries take an active role in the quality of their health care and share responsibility for using Medicaid dollars wisely.

Phase 1 Reforms

Budget Language: In the first phase of reform, the Department of Medical Assistance Services shall continue currently authorized reforms of the Virginia Medicaid/FAMIS service delivery model that shall, at a minimum, include...

Phase 1 Reforms & Savings

Title & Description	Budget Language	Status
Dual Eligible Demonstration Pilot The Commonwealth Coordinated Care program for Medicare-Medicaid enrollees ("Dual Eligibles"), whose complex needs account for 41% of the Medicaid budget, provides services through one of three managed care organizations.	(i) implementation of a Medicare-Medicaid Enrollee (dual eligible) Financial Alignment demonstration as evidenced by a Memorandum of Understanding with the Centers for Medicare and Medicaid Services (CMS), signing of a three-way contract with CMS and participating plans, and approval of the necessary amendments to the State Plan for Medical Assistance and any waivers thereof	**Requirement Met** **SFY14-16 Total Savings included in December 2013 Introduced Budget ($44,028,619)** ***Update: April 1, 2014, voluntary enrollment in the program in Central and Tidewater regions began, more than 1,400 individuals receiving coverage.***
Enhanced Program Integrity Extensive enhancement to Medicaid program integrity, including the Recovery Audit Contract, service authorizations, the Medicaid Fraud Control Unit, Payment Error Rate Measurement Review, MMIS Claims Processing Edits, MCO Collaboration, Provider and Recipient Audits.	(ii) enhanced program integrity and fraud prevention efforts to include at a minimum: recovery audit contracting (RAC); data mining; service authorization; enhanced coordination with the Medicaid Fraud Control Unit (MFCU); and Payment Error Rate Measure (PERM);	**Requirement Met** **SFY14-16 Total Savings included in December 2013 Introduced Budget ($17,066,946)** ***Update: <u>Prevented</u> $247+ M in improper payments, 123 MCFU referrals (19) accepted, data analytics contractor identified $44 M in potential recoveries, $187,723 in restitution and imprisonment in some cases as fraudulent eligibility, service authorizations avoided $216 M in costs, MCOs avoided or recovered over $417 M.***

Title & Description	Budget Language	Status
Foster Care: DMAS is transitioning 10,700 children in Virginia's foster care and adoption assistance programs from Medicaid Fee For Service into DMAS contracted MCOs. For further information regarding this transition, please visit: http://www.dmas.virginia.gov/Content_pgs/ialtc-plt.aspx	(iii) inclusion of children enrolled in foster care in managed care;	**Requirement Met** **SFY14-16 Total Savings included in December 2013 Introduced Budget ($13,940,351)** ***Update:*** ***Tidewater****: September 1, 2013 (**LIVE**);* ***Central VA****: November 1, 2013 **(LIVE);*** ***NOVA****: December 1, 2013 **(LIVE);*** ***Charlottesville****: March 1, 2014 **(LIVE);*** ***Lynchburg****: April 1, 2014 **(LIVE);*** ***Roanoke****: May 1, 2014; and,* ***Far Southwest****: June 1, 2014.* *By June 2014, more than 10,000 children will be enrolled in MCOs.*
eHHR: For Further Information on new Medicaid financial eligibility requirements (referred to as "MAGI"), please visit: http://aspe.hhs.gov/health/reports/2013/MAGIConversions/rb.pdf For access to Virginia's new eligibility website, known as the Commonhelp Portal, please visit: https://commonhelp.virginia.gov	(iv) implementation of a new eligibility and enrollment information system for Medicaid and other social services	**Requirement Met** **SFY14-16 Total Savings included in December 2013 Introduced Budget ($22,400,000)** ***Update:*** ***October 2013*** *– Met MAGI deadline. New VaCMS eligibility system went live for new Medicaid/FAMIS applications; now taking Medicaid/FAMIS applications using new financial requirements -MAGI; referrals to Federal Facilitated Marketplace* ***January 1, 2014*** *– Additional eligibility rules began (e.g., coverage up to age 26 for foster care youth); hospital presumptive eligibility*

Title & Description	Budget Language	Status
Veterans DMAS, Virginia Department of Veterans Services, and Virginia Department of Social Services are working together to identify protocol and procedures to ensure qualifying Veterans and their family members have access to needed services. Assisting veterans to obtain benefits and avoid Medicaid expenditures when services are more appropriately funded by the Federal Government. The 2012 budget language created this opportunity for the Veterans Benefit Enhancement Program.	(v) improved access to Veterans services through creation of the Veterans Benefit Enhancement Program; and	**Requirement Met** Focus on quality improvement
Behavioral Health In an effort to strengthen the integrity of DMAS' behavioral health program and ensure access to quality behavioral health providers, DMAS has hired a contractor, Magellan of Virginia, to oversee the community behavioral health provider network, authorize services that are not currently being provided through Medicaid MCOs, and reimburse providers for services delivered.	(vi) expedite the tightening of standards, services limits, provider qualifications, and licensure requirements for community behavioral health services.	**Requirement Met** **SFY14-16 Total Savings included in December 2013 Introduced Budget ($133,960,168)** ***Updates:*** *December 2013 implementation of strengthened regulations to improve integrity and quality and implementation of the new Behavioral Health Services Administrator (Magellan).*

Savings Estimates for Medicaid Reform for Virginia: Phase 1

	SFY 2014 **Total Funds/GF**	SFY 2015 **Total Funds/GF**	SFY 2016 **Total Funds/GF**	SFY 14 – SFY 16 **Total Funds/GF**
•Dual Eligible Demonstration Pilot	(1,412,218)/ (706,109)	(28,186,175)/ 14,093,088)	(14,430,226)/ (7,215,113)	(44,028,619)/ (22,014,310)
•Enhanced Program Integrity	(5,688,982)/ (2,844,491)	(5,688,982)/ (2,844,491)	(5,688,982)/ (2,844,491)	(17,066,946)/ (8,533,473)
•Foster Care to Managed Care	(2,440,351)/ (1,220,176)	(5,750,000)/ (2,875,000)	(5,750,000)/ (2,875,000)	(13,940,351)/ (6,970,176)
•Ehhr – 75% enhanced FFP for eligibility and enrollment functions (GF savings)	(6,000,000)/ (6,000,000)	(8,200,000)/ (8,200,000)	(8,200,000)/ (8,200,000)	(22,400,000)/ (22,400,000)
•Behavioral Health Regulations Changes	(20,737,969)/ (10,367,532)	(54,615,905)/ (27,304,419)	(58,606,294)/ (29,295,626)	(133,960,168)/ (66,967,577)
TOTALS FOR PHASE 1	(36,279,520)/ (21,138,308)	(102,441,062)/ (55,316,998)	(92,675,502)/ (50,430,230)	(231,396,084)/ (126,885,536)

Phase 2 Reforms

Budget Language: In the second phase of reform, the Department of Medical Assistance Services shall implement value-based purchasing reforms for all recipients subject to a Modified Adjusted Gross Income (MAGI) methodology for program eligibility and any other recipient categories not excluded from the Medallion II managed care program. Such reforms shall, at minimum, include the following:

Phase 2 Reforms

Title & Description	Budget Language	Status
Commercial-like benefit package DMAS is aligning medical benefits offered through the Medicaid program with those provided in the commercial marketplace. This will facilitate a less disruptive transition for an individual moving from the Medicaid program into private health coverage; including coverage offered through the federally facilitated (exchange) marketplace.	(i) the services and benefits provided are the types of services and benefits provided by commercial insurers and may include appropriate and reasonable limits on services such as occupational, physical, and speech therapy, and home care; with the exception of non-traditional behavioral health and substance use disorder services;	**Requirement Met** **Fall 2013:** Completed side-by-side comparison of DMAS medical services compared to the Essential Health Benefits required for exchange plans under the ACA. This was implemented for the Medicaid Buy-In Program Jan 1. Similar benefit package would be needed to close the coverage gap.
Cost Sharing and Wellness DMAS views this as an opportunity to guide beneficiaries to the appropriate care setting and become engaged in their overall healthcare. DMAS and the MCOs are working together on innovations in cost sharing and wellness.	(iii) patient responsibility is required including reasonable cost sharing and active patient participation in health and wellness activities to improve health and control costs	**Requirement Met** **July 2013** Managed Care Changes • Chronic Care and Assessments • Maternity Program Changes •Wellness Programs
Coordinate behavioral health services Aligning and coordination of behavioral health services through the behavioral health services administrator contract	Any coordination of non-traditional behavioral health services covered under contract with qualified health plans or through other means shall adhere to the principles outlined in paragraph RR. e	**Requirement Met** BHSA implementation in **December 2013**

Title & Description	Budget Language	Status
Limited Provider Networks and Medical Homes Creating an agreement with the federal government that allows for limited provider networks would afford Virginia's MCO's, health systems, and health care providers to create innovative models of comprehensive care specific to a region, chronic condition, or co-occurring medical situations that span across physical and mental health. While number of providers may be reduced with a limited network, qualifying beneficiaries could receive higher quality coordinated care through a limited network arrangement.	(i) limited high-performing provider networks and medical/health homes;	**Requirement Met** **July 2013** Managed Care Changes including implementing the Medallion Care Partnership System (MCSP) **November 2013**: Addition of Kaiser Health Plan (limited network, medical home model)
Quality Payment Incentives Virginia Medicaid MCOs must all attain National Committee on Quality Assurance (NCQA) accreditation, and are reviewed based on Consumer Assessment of ***Healthcare*** Providers and Systems (***CAHPS***) and Healthcare Effectiveness Data and Information Set (HEDIS) performance measures. Incorporating incentives and conversely, withholds for lower performance, will continue to encourage accountability within the Medicaid provider and MCO communities.	(ii) financial incentives for high quality outcomes and alternative payment methods,	**Requirement Met** **July 2013 (for MCOs):**Program implemented to establish the baseline target **July 2014:** Quality withholds begin

Title & Description	Budget Language	Status
Parameters to Test Innovative Pilots	Outline agreed upon parameters and metrics to provide maximum flexibility and expedited ability to develop and implement pilot programs to test innovative models that (i) leverage innovations and variations in regional delivery systems; (ii) link payment and reimbursement to quality and cost containment outcomes; or (iii) encourage innovations that improve service quality and yield cost savings to the Commonwealth.	**Requirement Met** **•Commonwealth Coordinated Care Program** **•Medallion Contract Innovations**

Phase 3 Reforms

Budget Language: In the third phase of reform, the Department of Medical Assistance Services shall seek reforms to include all remaining Medicaid populations and services including long-term care and home- and community- based waiver services into cost-effective, managed, and coordinated delivery systems. The department shall begin designing the process and obtaining federal authority to transition all remaining Medicaid beneficiaries into a coordinated delivery system. A report shall be provided to the 2014 General Assembly regarding the progress of designing and implementing such reforms.

Phase 3 Reforms

Title	Status
ID/DD Waiver Redesign	**Requirement Met** **October 2013** - First Phase of DBHDs Study completed *Underway* • **July 2014** –ID/DD Waiver Renewal Due/ Redesign; second phase of DBHDS study to be complete • **July 2015-** Additional revisions to the ID/DD Waiver systems implemented as needed
All non-dual EDCD waiver enrollees in Managed Care for medical needs	**Requirement Met** **October 2014:** Managed care implementation- DMAS moves non-dual EDCD waiver enrollees into one of 7 health plans for medical needs; Home and community-based waiver services remain out of managed care until 2016 and provided through fee-for-service
All inclusive Coordinated Care for LTC Beneficiaries (coordinated delivery for all LTC Services)	**Requirement Met** **July 2016-** Complete the transition of all non-dual waiver recipients in the six home and community based care waivers and their community long term care services into coordinated care networks.
Complete statewide Commonwealth Coordinated Care, including children **This is the final phase of the Duals project, which cannot begin until the demo is over.*	**Requirement Met** (as Phase 1 duals process) **July 2018-** After the Commonwealth Coordinated Care (Duals) demonstration is completed, expand statewide with all the remaining dual populations and all their medical, behavioral, and long term care services.

Reports on Phase 3 Reforms

Reports regarding Phase 3 reforms can be accessed online:

•HD6 (2014) *Implementing Medicaid Reform in Virginia* (this is the Phase 3 report)
http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/HD62014/$file/HD6.pdf

•RD63 (2014) *Report on the Progress of Implementing Care Coordination* (status update on all DMAS care coordination activities for our vulnerable populations)
http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/RD632014/$file/RD63.pdf

•RD60 (2014) *Development of the Commonwealth Coordinated Care Program* (as of November 2013)
http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/RD602014/$file/RD60.pdf

McAuliffe's Introduced Budget

	FY2015			FY2016	
	General Funds	Total Funds		General Funds	Total Funds
McDonnell Introduced Budget	**$3,925**	**$8,496**		**$4,113**	**$8,761**
Spending Initiatives	$0	$523.0		$0	$1,694.4
Reductions/Savings	($82.4)	($140.5)		($131.6)	($257.9)
McAuliffe Introduced Budget	**$3,843**	**$8,879**		**$3,981**	**$10,198**
Net Change	($82.4)	$382.5		($131.6)	$1,436.5

- Highlights
  - Eliminates Funding for a Federal Disallowance Payment that has been Resolved
  - Provides Authority for Coverage of Uninsured and includes Funding Amendments

***Appropriation and amendments reflect the DMAS Medicaid budget program (45600), in millions**

Administrative costs of ACA to DMAS and DSS

DMAS Administrative Costs

	SFY 2015*			SFY 2016		
	GF	NGF	Total	GF	NGF	Total
System and Operational Costs	3,303,424	11,884,271	15,187,694	2,220,620	4,556,508	6,777,128
Claims Processing	1,509,014	3,593,323	5,102,337	2,991,891	6,480,743	9,472,634
Enrollment Processing and Recipient Support	8,157,407	13,489,020	21,646,427	4,682,109	12,613,740	17,295,849
Expansion of Existing Administrative Activities to Larger Population	2,569,612	3,069,612	5,639,224	3,268,987	4,180,851	7,449,838
SUBTOTAL: DMAS Administration	15,539,457	32,036,226	47,575,683	13,163,607	27,831,842	40,995,449

DSS Administrative Costs

	SFY 2015*			SFY 2016		
	GF	NGF	Total	GF	NGF	Total
System and Operational Costs	2,720,256	9,974,119	12,694,375	493,675	1,098,825	1,592,500
5 Regional Specialists	214,450	214,450	428,900	214,450	214,450	428,900
SUBTOTAL: DSS Administration	2,934,706	10,188,569	13,123,275	708,125	1,313,275	2,021,400

Net Savings of Coverage

$259 Mil in savings - $34 Mil in costs

= ($225 Mil in total savings)