Implementing Health Care Reform in Virginia

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Medicaid Innovation and Reform Commission

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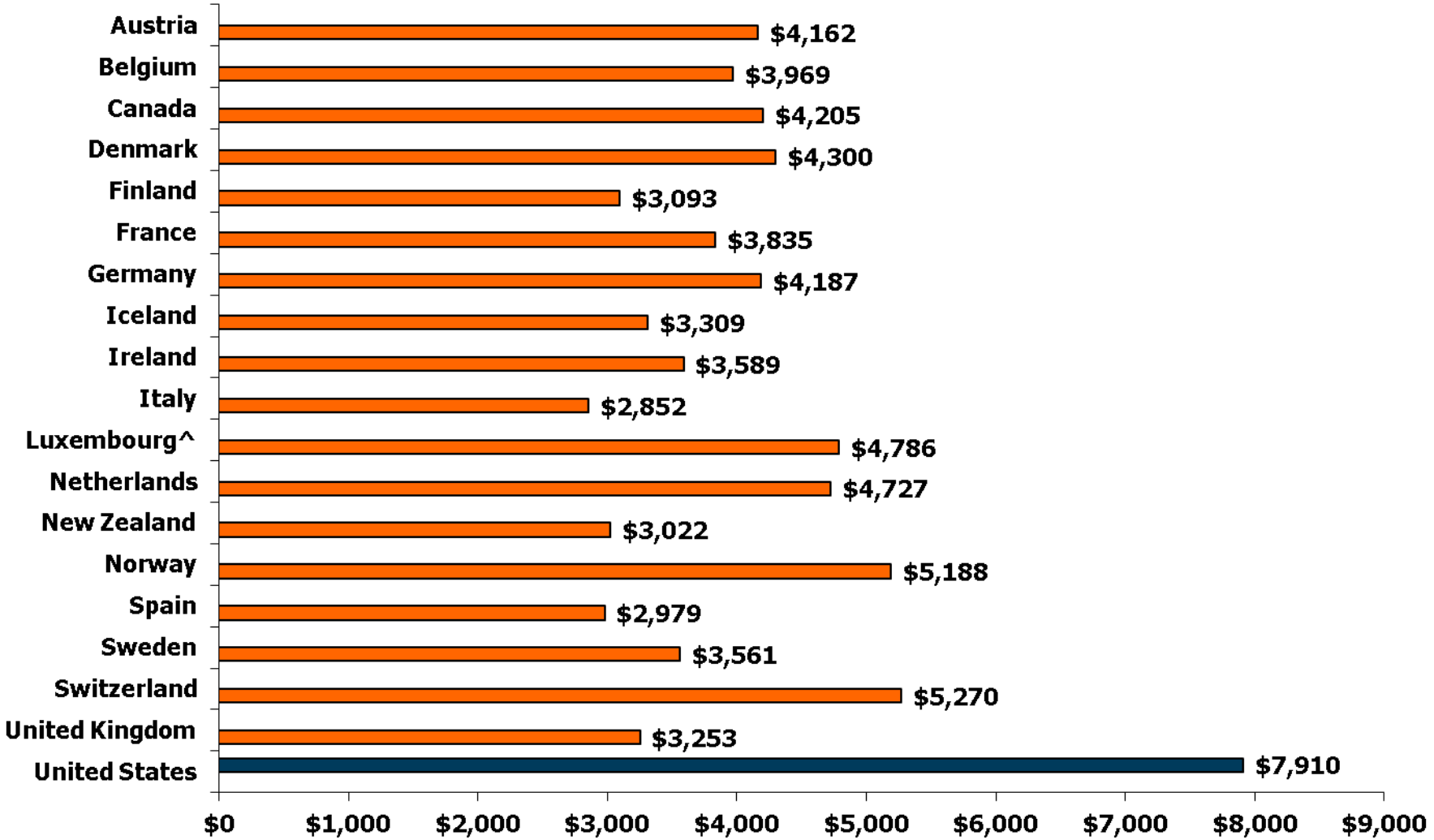
Per Capita Total Current Health Care Expenditures, U.S. and Selected Countries, 2010

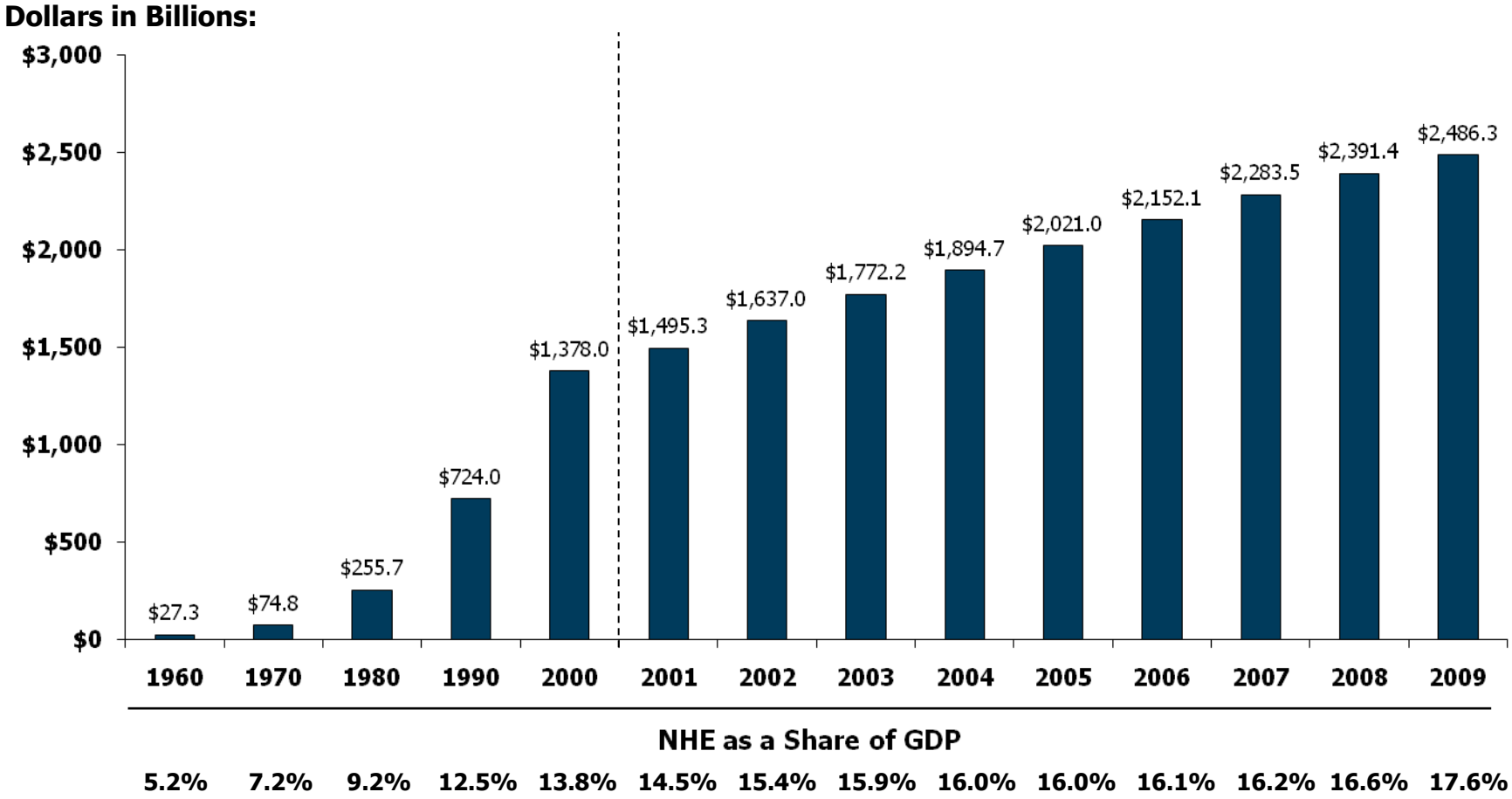


Notes: Amounts in U.S.$ Purchasing Power Parity, see www.oecd.org/std/ppp; includes only countries over $2,500. OECD defines Total Current Expenditures on Health as the sum of expenditures ^ 2009 data

on personal health care, preventive and public health services, and health administration and health insurance; it excludes investment.

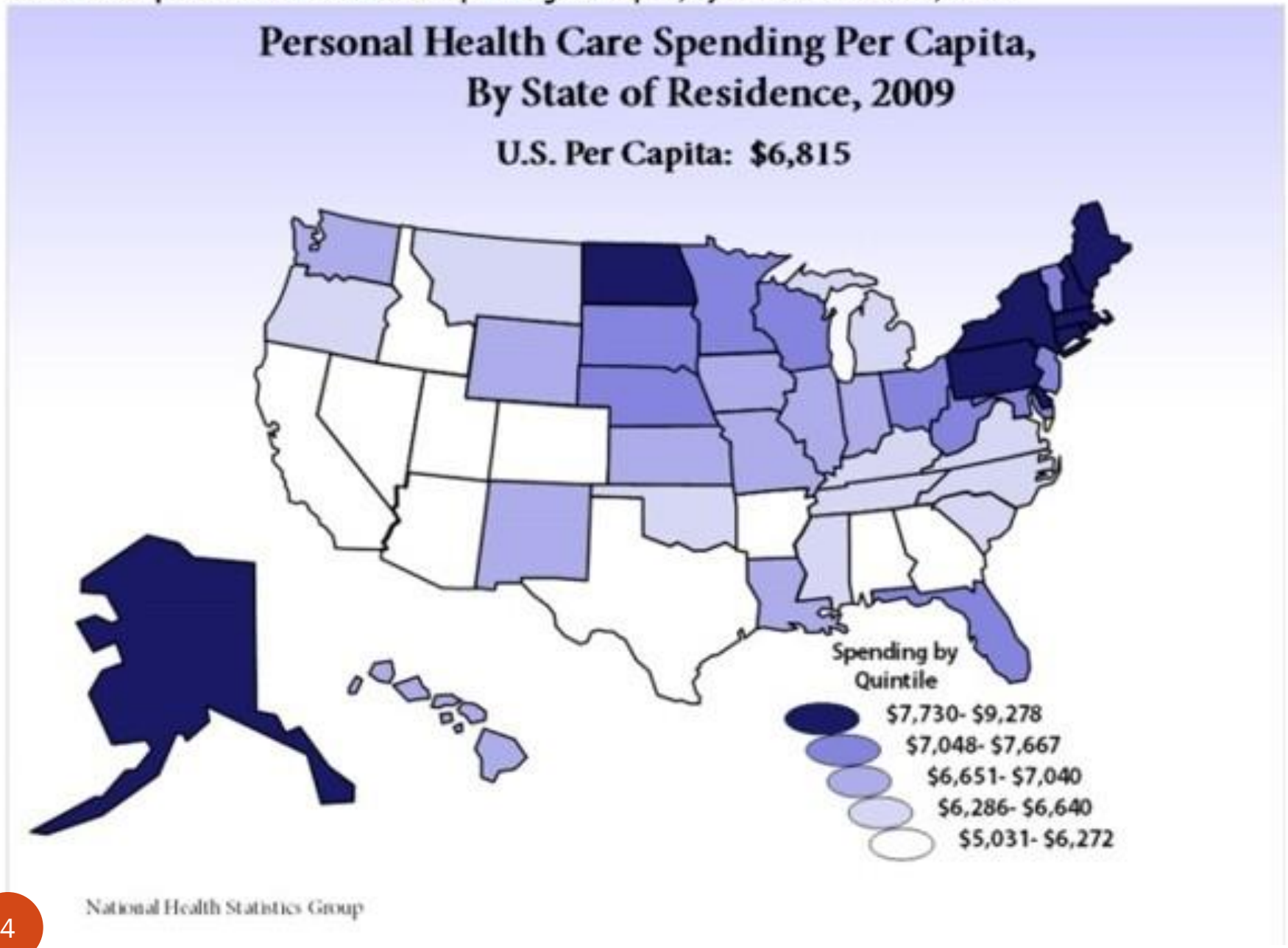
Source: Organization for Economic Co-operation and Development. "OECD Health Data: Health Expenditures and Financing", OECD Health Statistics Data from internet subscription database. http://www.oecd-library.org, data accessed on 08/23/12.

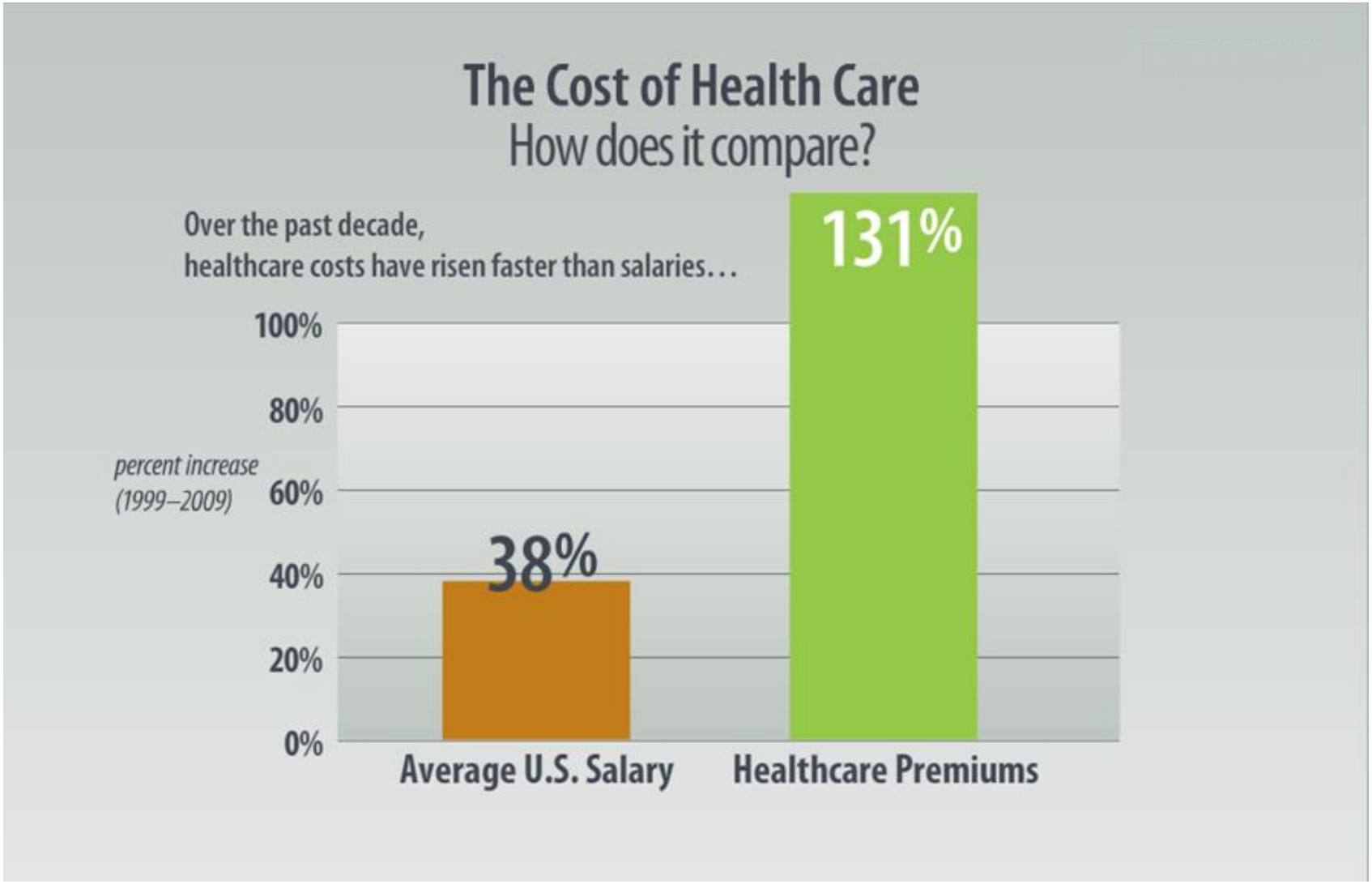
National Health Expenditures and Their Share of Gross Domestic Product, 1960-2009



Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at http://www.cms.hhs.gov/NationalHealthExpendData/ (see Historical; NHE summary including share of GDP, CY 1960-2009; file nhegdp09.zip).

Exhibit 1. Map of Personal Health Care Spending Per Capita, by State of Residence, 2009.





Source: Institute of Medicine: *The Healthcare Imperative: lowering costs and improving outcomes*

The Cost of Health Care
How does it compare?

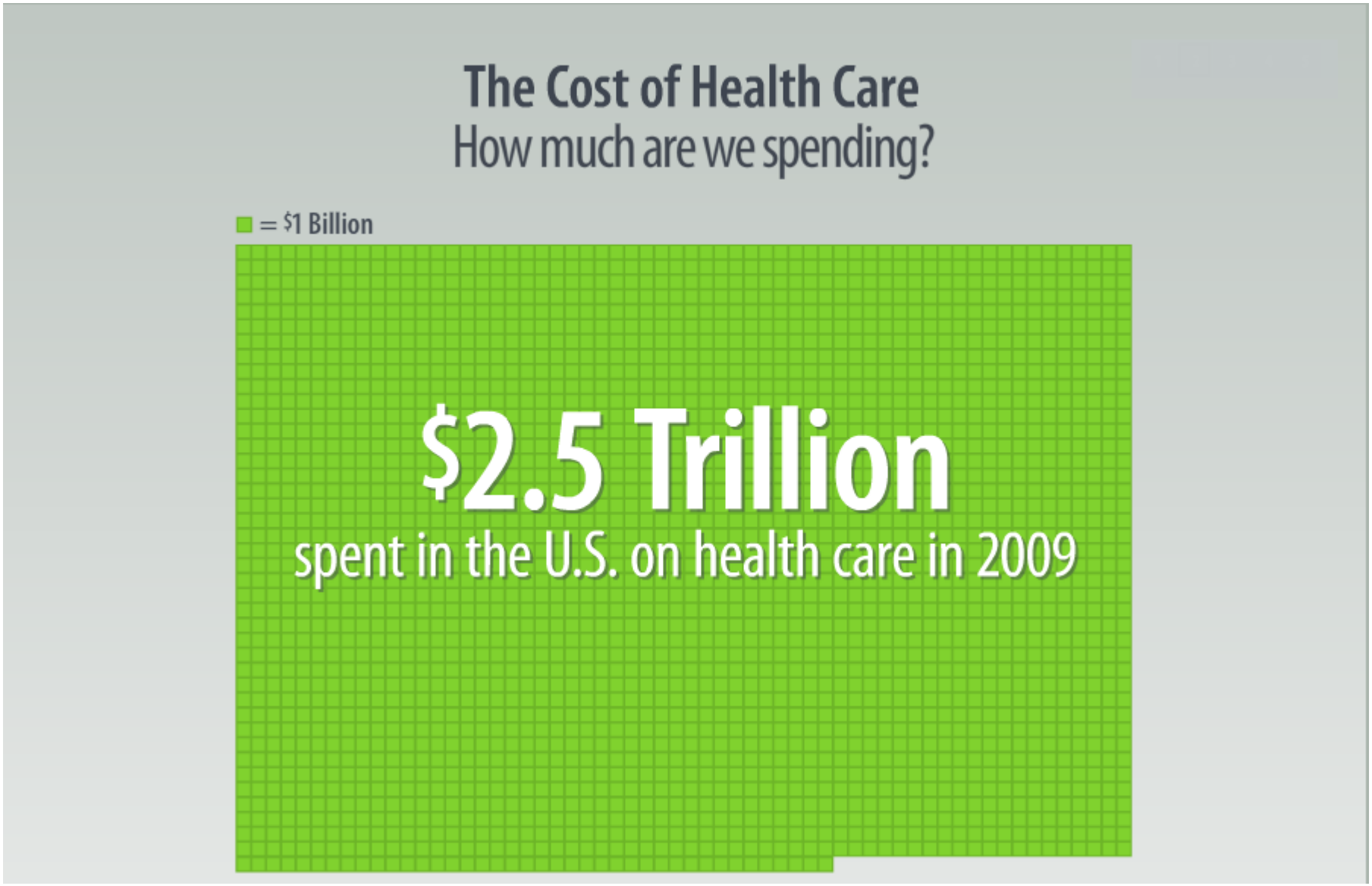
If other prices had grown as quickly as healthcare costs since 1945…

a dozen eggs
would cost
$55

a gallon of milk
would cost
$48

a dozen oranges
would cost
$134

Source: Institute of Medicine: *The Healthcare Imperative: lowering costs and improving outcomes*



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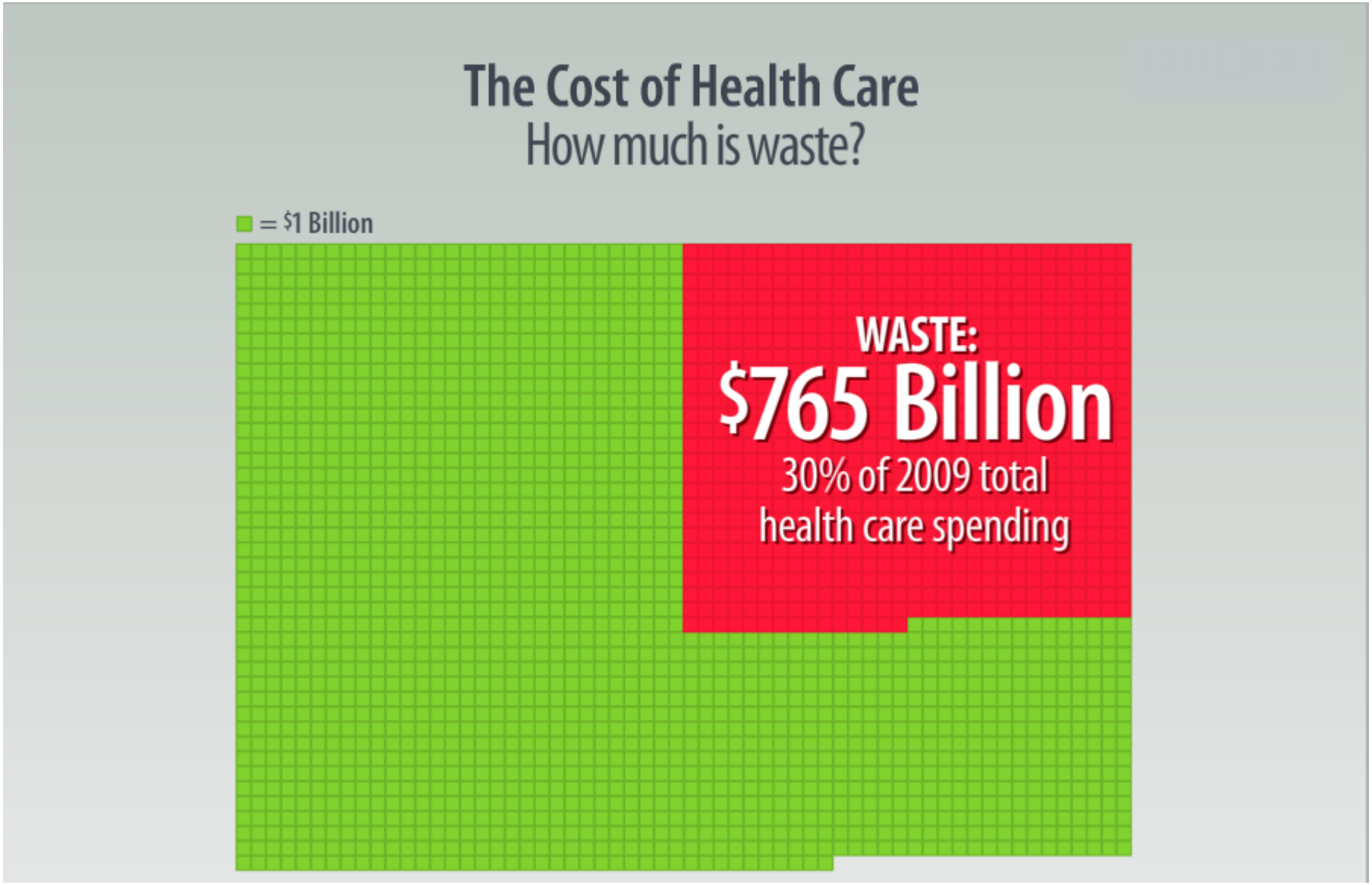

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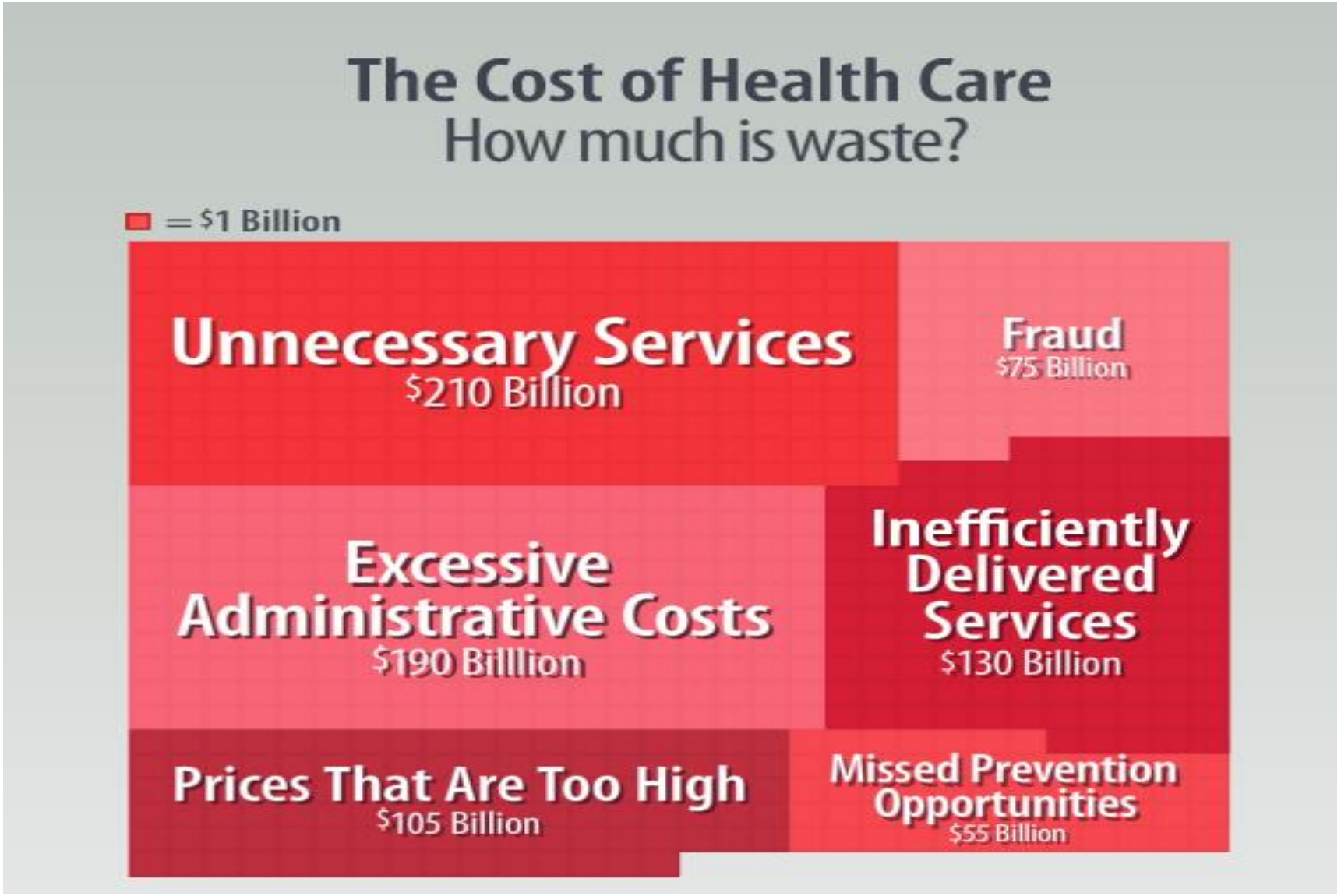

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In Virginia,
Reform is Bigger than Just Medicaid

Virginia
Health Reform
Initiative

VIRGINIA CENTER FOR HEALTH INNOVATION

Goals of Medicaid Reform

Improve Service Delivery

Service delivery should be efficient, cost effective, and provide quality services.

Improve Administration

DMAS should be accountable, streamlined, and transparent.

Increase Beneficiary Engagement

Individuals should be engaged in, responsible for, and active participants in their health care.

Improve Service Delivery

Vision

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.

Improve Service Delivery

- DMAS needs a service delivery system that demonstrates the value of health care provided, where people who can get healthier do so, and costs are contained. These reforms should work in parallel with other service delivery reforms.

- Through reform, DMAS will improve service delivery by coordinating services and measuring and rewarding effective innovation and high quality outcomes.

- Examples of specific reforms to improve service delivery include:
  - Dual Eligible project
  - Paying for quality (Quality Improvement Incentives)
  - Parameters to test innovative local pilot programs (agreed upon by CMS)
  - Coordinated long-term care

Improve Administration

Vision

DMAS is efficient, streamlined, and user-friendly. Tax payer dollars are used effectively and for their intended purposes.

Improve Administration

- DMAS should operate as a first class organization where fraud, waste, and abuse is mitigated and beneficiaries, providers, and stakeholders are able to understand the program.

- Through reform, DMAS seeks to improve administration by standardizing processes and procedures, increasing accountability, and working with CMS to make the program more responsive and nimble.

- Examples of specific reforms to improve administration:
  - Fighting Fraud, Waste and Abuse through Program Integrity
  - Establishment of a Data Analytics Unit
  - Veterans Benefit Program (joint venture between DMAS, VDSS, DVS)
  - eHHR

Increase Beneficiary Engagement

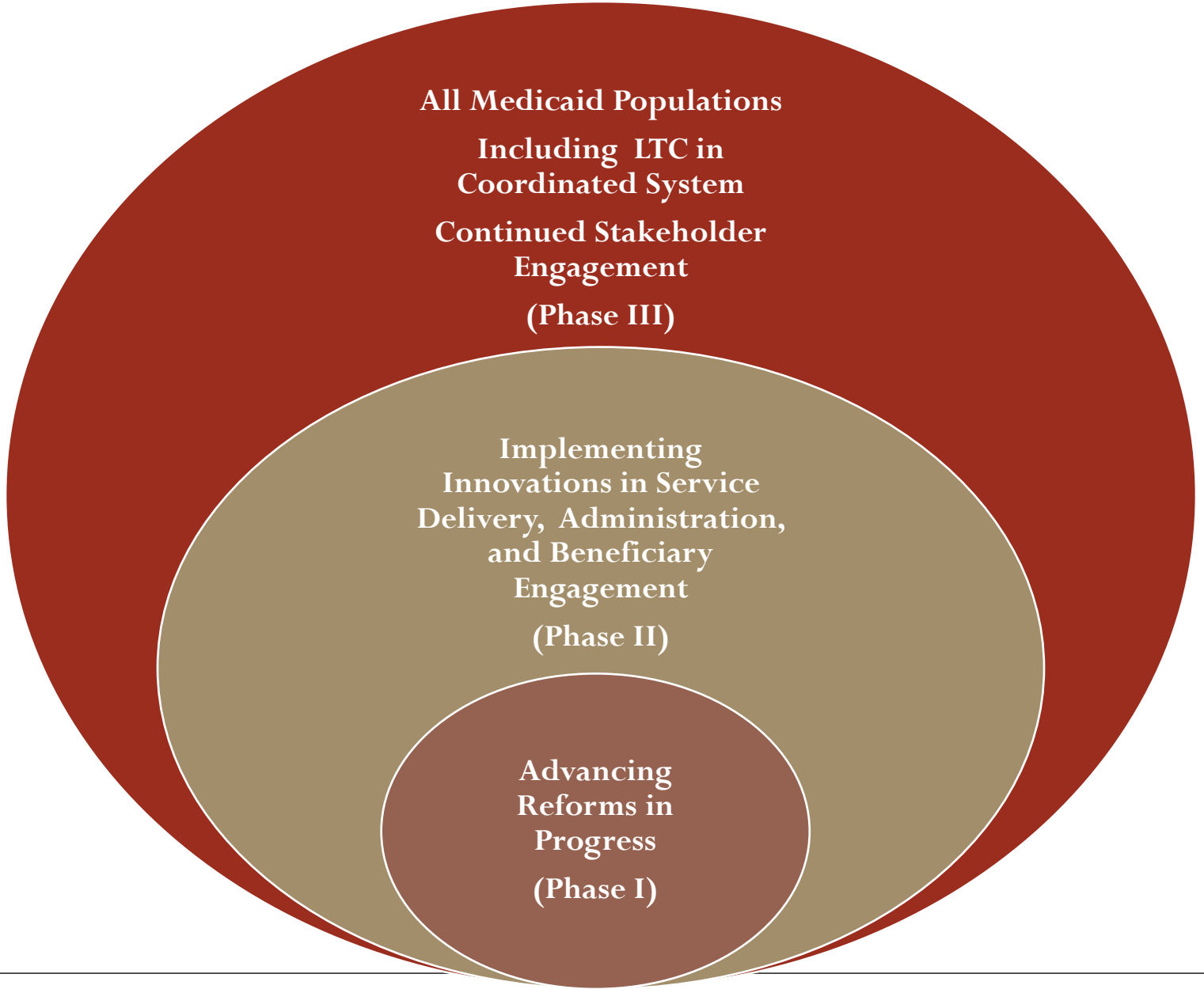
Vision

Beneficiaries take an active role in the quality of their health care and share responsibility for using Medicaid dollars wisely.

Increase Beneficiary Engagement

- DMAS should implement policies that ensure beneficiaries are accountable for their health care.
- Through reform, DMAS will identify avenues and strategies to encourage appropriate use of the health care system.
- Examples of specific reforms addressing this include:
  - Cost sharing for adults
  - Wellness incentives
  - Penalties for using inappropriate care settings (e.g. using the ER when not needed) or not showing up for appointments

Three Phases of Medicaid Reform



Virginia Must Implement Medicaid Reform in Three Phases

- **Phase 1: Advancing Current Reforms**
  - Dual Eligible Demonstration
  - Enhanced Program Integrity
  - Foster Care
  - New Eligibility and Enrollment System
  - Veterans
  - Behavioral Health

Virginia Must Implement Medicaid Reform in Three Phases

- **Phase 2: Improvements in Current Managed Care and FFS programs**
  - Commercial like benefit packages and service limits
  - Cost sharing and wellness
  - Coordinate Behavioral Health Services
  - Limited Provider Networks and Medical Homes
  - Quality Payment Incentives
  - Managed Care Data Improvements
  - Standardization of Administrative Processes
  - Health Information Exchange
  - Agency Administration Simplification
  - Parameters to Test Pilots

Virginia Must Implement Medicaid Reform in Three Phases

- **Phase 3: Coordinated Long Term Care**
  - Move remaining populations and waivers into cost effective and coordinated delivery models
  - Report due to 2014 General Assembly on design and implementation plans

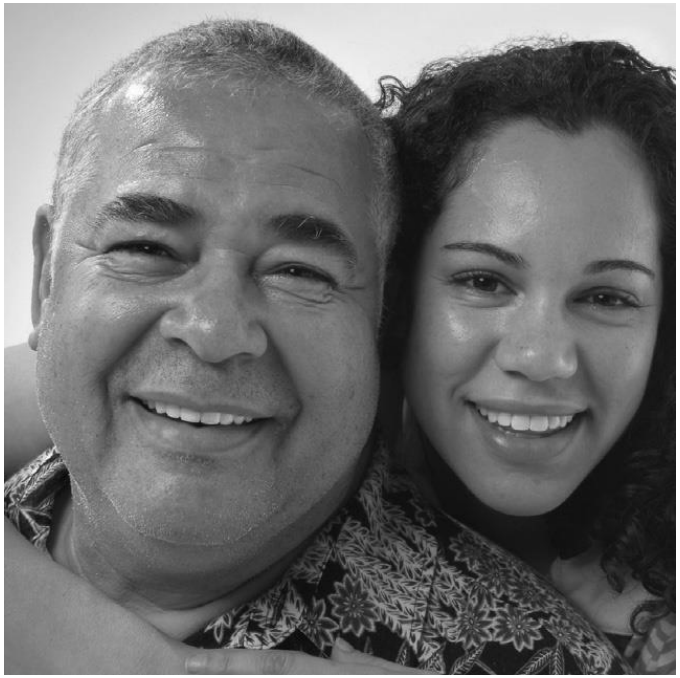
Medicaid Reform Strategy Highlights

- Commonwealth Coordinated Care
- Behavioral Health Services
- Eligibility System Changes
- Managed Care
- Program Integrity

Virginia's Dual Eligible Demonstration
Improving Care for Medicare-Medicaid Enrollees

Medicare-Medicaid Enrollees?

- Receive both full benefit Medicare and Medicaid coverage
- 58.8% age 65 or older
- 41.2% under age 65
- Often have multiple, complex health care needs.



Over 9 million Americans are eligible for Medicare and Medicaid (known as Medicare-Medicaid enrollees)

Medicare and Medicaid Today

- Medicare and Medicaid are not designed to work together resulting in an inefficient, more costly delivery system
- Costs of serving individuals on Medicare and Medicaid are rising exponentially
- Each program has its own set of rules, regulations, requirements and coverage
- At the national level we are spending 39% of Medicaid funds on 15% of the population

We can't afford to continue to support rising costs without intervention

Who Pays for Services in Virginia?

MEDICARE

- Hospital care
- Physician & ancillary services
- Skilled nursing facility (SNF) care (up to 100 days)
- Home health care
- Hospice
- Prescription drugs
- Durable medical equipment

MEDICAID

- Nursing facility (once Medicare benefits exhausted)
- Home- and community-based services (HCBS)
- Hospital once Medicare benefits exhausted
- Optional services: personal care, select home health care, rehabilitative services, some behavioral health
- Some prescription drugs not covered by Medicare
- Durable medical equipment not covered by Medicare

What does care look like for Medicare-Medicaid enrollees now?

WITHOUT COORDINATED CARE INDIVIDUALS MAY HAVE:
XThree ID cards: Medicare, Medicaid, and prescription drugs
XThree different sets of benefits
XMultiple providers who rarely communicate
XHealth care decisions uncoordinated and not made from the person-centered perspective

The Solution: Commonwealth Coordinated Care

- Provides high-quality, person-centered care for Medicare-Medicaid enrollees that is focused on their needs and preferences

- Blends Medicare's and Medicaid's services and financing to streamline care and eliminate cost shifting

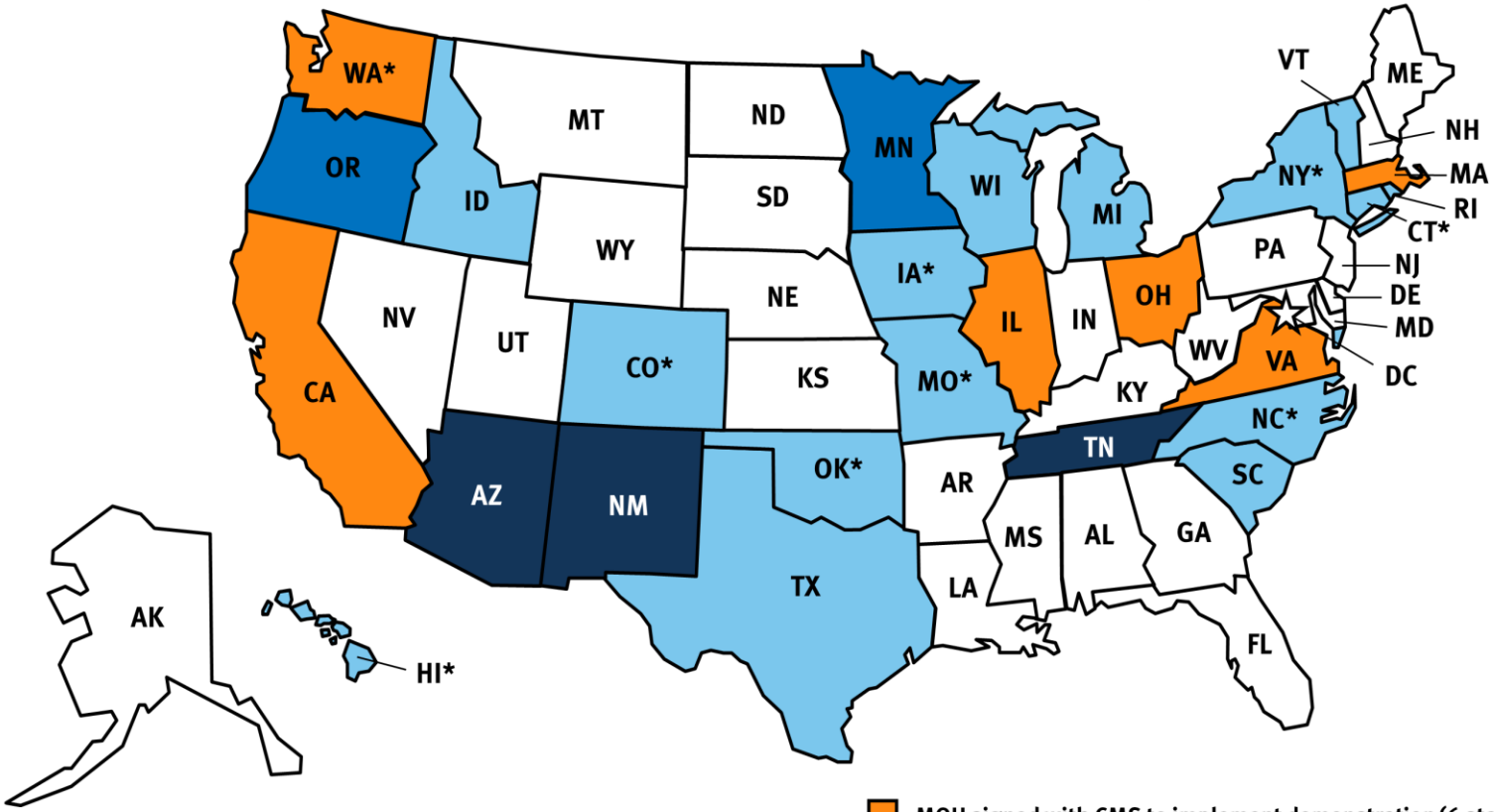
Commonwealth Coordinated Care
Medicare & Medicaid working together for you

The Solution: Commonwealth Coordinated Care

- Creates a single program to coordinate delivery of primary, preventive, acute, behavioral, and long-term services and supports
- Promotes the use of home- and community-based behavioral and long-term services and supports
- Supports improved transitions between acute and long-term facilities

Commonwealth Coordinated Care
Medicare & Medicaid working together for you

State demonstration proposals to integrate care and align financing for dual eligible beneficiaries, May 2013



MOU signed with CMS to implement demonstration (6 states)

Proposal pending with CMS (15 states and WA's capitated proposal)

Proposal submitted, will not pursue financial alignment but may pursue other administrative or programmatic alignment (2 states)

Proposal withdrawn (3 states)

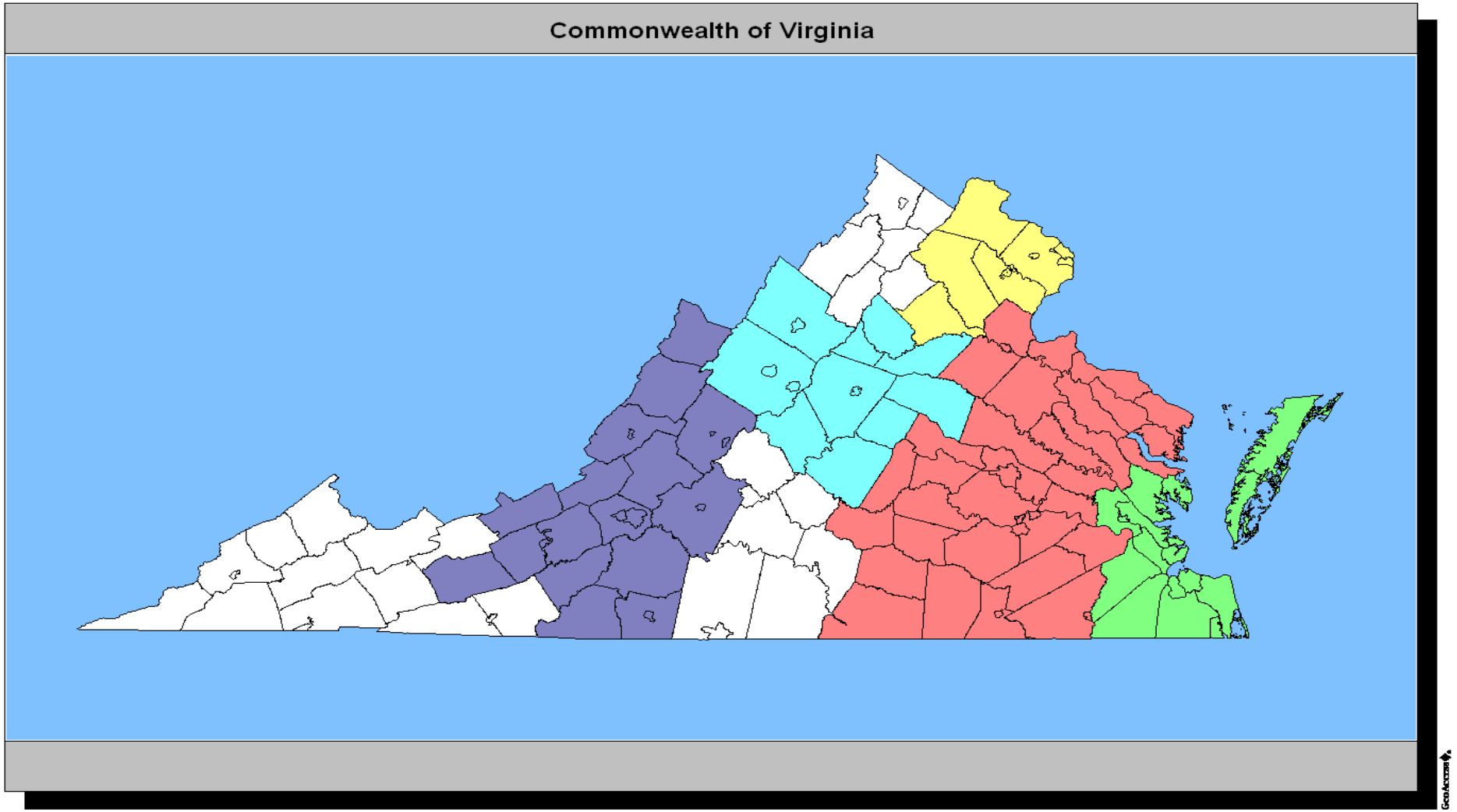
Not participating in demonstration (24 states and DC)

THE HENRY J. KAISER FAMILY FOUNDATION

Who is Eligible?

- Full benefit Medicare-Medicaid Enrollees including but not limited to:
  - Participants in the Elderly and Disabled with Consumer Direction Waiver, and
  - Residents of nursing facilities
- Age 21 and Over
- Live in designated regions (Northern VA, Tidewater, Richmond/Central, Charlottesville, and Roanoke)

Commonwealth Coordinated Care Service Regions



Medicare-Medicaid Enrollees in Virginia eligible for Commonwealth Coordinated Care

Approximately 78,600 Medicare-Medicaid Enrollees

Region	Nursing Facility	EDCD Wavier	Community Non-waiver	Total
Central VA	4,430	3,762	16,135	24,327
Northern VA	1,935	1,766	12,952	16,653
Tidewater	3,031	2,492	12,575	18,098
Charlottesville	1,477	842	4,427	6,747
Roanoke	2,833	1,355	8,583	12,771
Total	**13,706**	**10,217**	**54,672**	**78,596**

Benefits for Virginia

- Promotes and measures improvements in quality of life and health outcomes
- Eliminate cost shifting between Medicare and Medicaid and achieve cost savings for States and CMS
- Reduce duplicative or unnecessary services
- Streamline administrative burden with a single set of appeals, auditing and marketing rules, and quality reporting
- Efficiencies gained through this program are likely to yield financial savings to Virginia. DMAS budget forecast for state fiscal year 2014 included $11.3 million in general fund savings.

Stakeholder Input and Support

- Created a formal Advisory Committee
- Requests put in the MOU
  - Required behavioral health homes for SMI population
  - Emphasis on transitions between settings of care
  - Waived Skilled Medicare hospital stay
  - Followed Medicaid rules for Telehealth
  - Required standard fiscal agent for consumer directed services
  - Required Plans to describe how they will reimburse nursing facilities; minimize administrative burdens

In the coming weeks….

- Announcement of the selection of Health Plans participating in Commonwealth Coordinated Care
- Formation of workgroups to design and implement various components of Commonwealth Coordinated Care
- Continued Outreach and Education

Efforts to Improve Quality of Care for Individuals Receiving Community Mental Health Rehabilitative Services

Community Mental Health Rehabilitative Services (CMHRS)

- State Plan Option (SPO) Services
  - Not a part of the mandatory Medicaid package, but are services that the legislature requested to be included in the Virginia Medicaid program
  - Once added, however, they become available to all Medicaid beneficiaries who meet criteria for the service(s)
  - Examples include: psycho-social rehab, intensive community treatment, and mental health support services
- SPO behavioral health services are not typically covered by private insurers
  - Those typically covered are already in managed care (i.e., psychotherapy, psychological assessments)

Who benefits from CMHRS?

- Children who have a serious emotional disturbance (SED) who need behavioral health supports and services
- Adults who have a serious mental illness (SMI) who need behavioral health supports and services
- Adults who are substance users (including pregnant women) who are in need of substance abuse services

Concerns Regarding CMHRS

- Behavioral health services have grown significantly over the past several years
  - One of the top four fastest growing areas in Medicaid
  - Quality of services in question; care tends to be uncoordinated
- DMAS noticed the increase and took measures to control costs and ensure quality care
  - Implemented prior authorization and increased utilization review activities;
  - Decreased the rate for Intensive In-Home services;
  - Formed the Office of Behavioral Health in January 2010

Behavioral Health Service Utilization

- Behavioral Health Expenditures in 2012 reached $682,749,358 for non-traditional services
  - FY 2000 expenditures - $3.6 million (non-traditional services opened up to private providers in this year)
- This total represents 9% of expenditures for the Medicaid/FAMIS programs, representing over 109,000 covered individuals
- Expenditures for these services have increased by 18% between 2009 to 2012

DMAS Activities to Improve Services

- Regulated marketing tactics
- Tightened staff qualifications
- Implemented an independent clinical assessment process for children under 21 years of age
- New regulations expected Fall 2013 to improve staff qualifications and documentation requirements for CMHRS
- Emergency regulations under development to revamp Mental Health Support Services
- Development of the Behavioral Health Services Administrator contract

The Need for Coordinated Care and Improved Health Outcome Monitoring

- Data showed a majority of children receiving more intensive behavioral health services had not been previously known to behavioral health service delivery system or to their MCOs as having behavioral health needs
- This trend is now occurring with adults
- Virginia does not currently collect quality outcome data to show how Medicaid members are benefitting from these services

Authority

- The 2011, 2012, and 2013 Acts of Assembly directed DMAS to implement a coordinated care model for individuals in need of behavioral health services that are not currently provided through a managed care organization

Improved Care Coordination for Behavioral Health Services

- In December 2011, DMAS released a Request for Proposals for an Administrative Services Organization (ASO) to coordinate behavioral health services

- The ASO is a non-risk model where a Behavioral Health Services Administrator (BHSA) will be paid a per member, per month administrative fee to coordinate behavioral health services

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Value Added Services

Beginning in December 2013, the BHSA will provide:

- Management of a 24/7 centralized call center to provide information on eligibility, benefits, claims, referral assistance and appeals;
- Quality Care Initiatives –psychotropic medications, integrated care;
- Interface with Medicaid MCOs;
- Service Authorization and Utilization Management; and
- Member outreach and education.

Service Providers

The BHSA will manage the behavioral health network by :

- Enrolling and credentialing fee-for-service behavioral health providers (Federal and State compliant) ;
- Conducting provider performance reviews;
- Maintaining open communication regarding patient care needs and options;
- Processing and paying claims; and
- Analyzing geographical access needs.

Eligibility and Enrollment Changes for Medicaid

eHHR Connection to Medicaid Reform

- Automation in VaCMS and Rules engine will help reduce VDSS and LDSS workload over time
- Data and analysis tools integrated through eHHR agencies can guide Medicaid Reform changes
- Benefit Policy changes defined by Medicaid Reform can more easily be made in the rules engine (weeks vs. months)
- Access to real-time data from the Federal Data Service Hub (FDSH) and COV sources can help automate eligibility criteria defined in Medicaid Reform

eHHR Key Dates

2013

- July – VaCMS system testing scheduled to begin with CMS
- October – New VaCMS eligibility system goes live for new Medicaid/FAMIS; Begin taking Medicaid/FAMIS applications based on PPACA/MAGI

2014

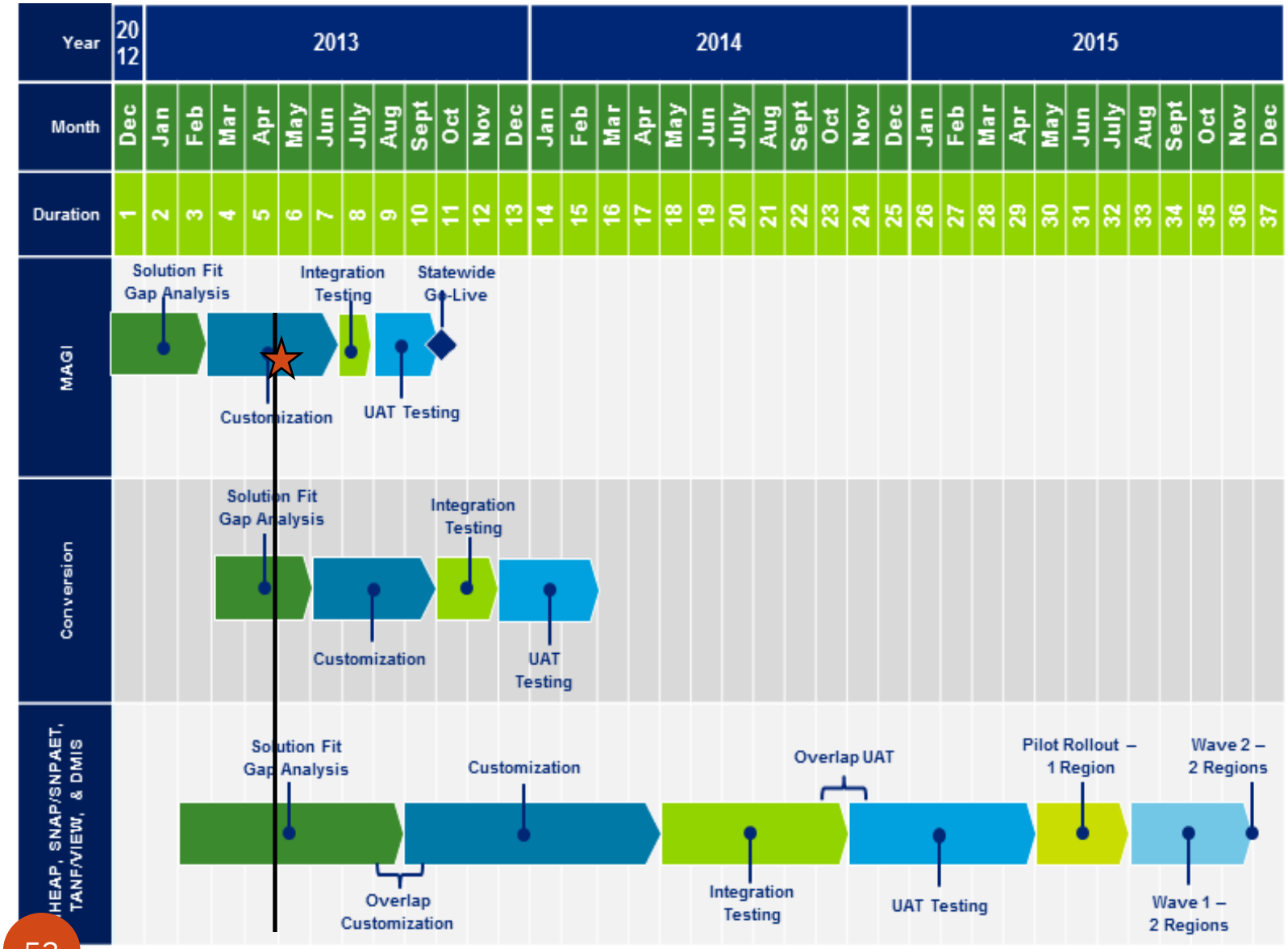
- January – Eligibility based on ACA/MAGI rules required to begin
- April – Current Medicaid/FAMIS customers start migrating to the new VaCMS eligibility system

eHHR Key Dates

2015

- October - Other programs (SNAP, TANF, LIHEAP, etc.) go live on new VaCMS system
- December– Complete all eHHR development funded by CMS (federal end date for the funds to be used)
- Begin retirement of the ADAPT mainframe

eHHR Timelines



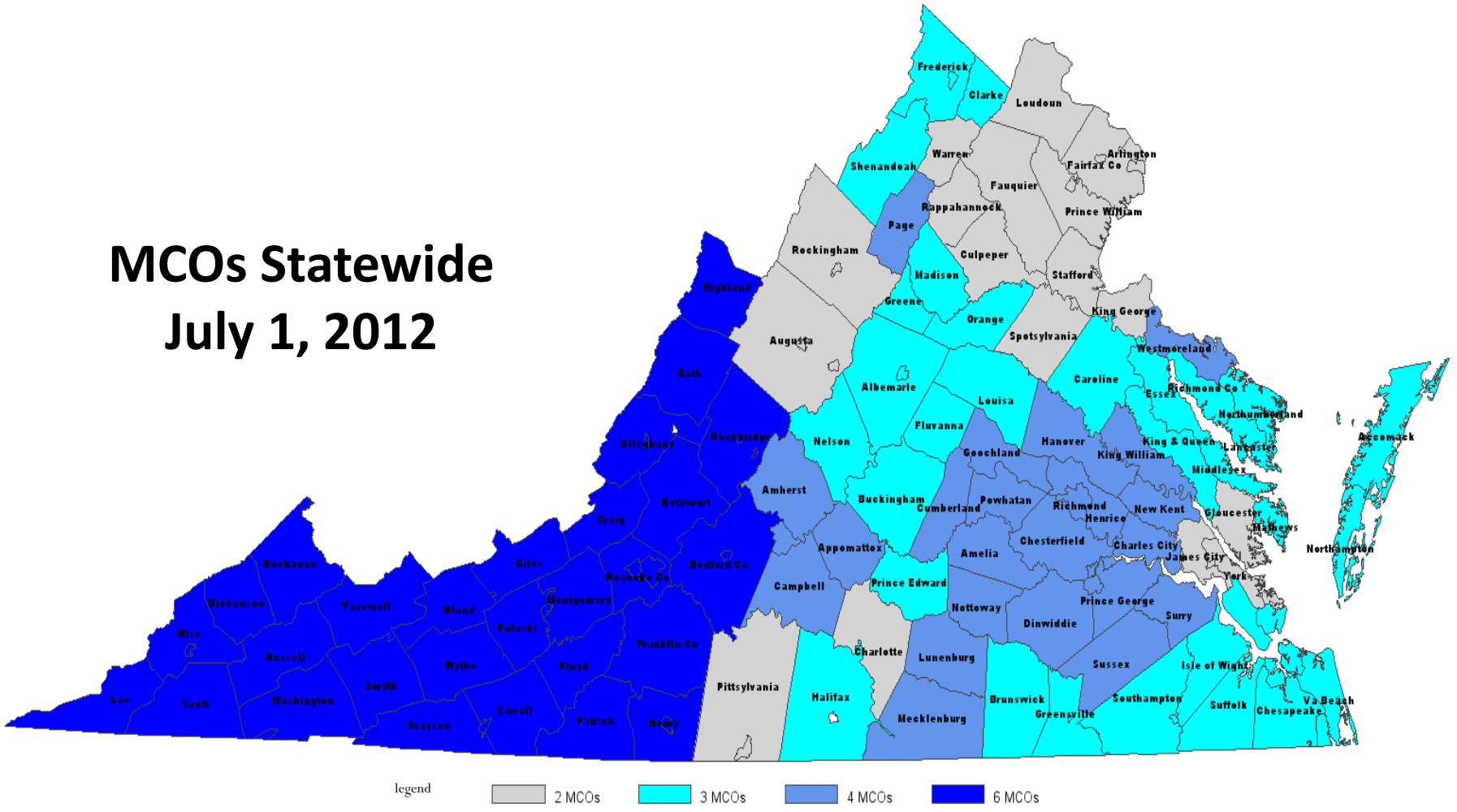
Status

MAGI project is on-schedule, yellow status.

Conversion and Migration projects are green and on-schedule

Changes to the Managed Care Program

MCOs Statewide
July 1, 2012






700,000 enrollees in Medallion II




MEDALLION 3.0 Reforms

July 1, 2013:

- New Contract / New Program
- Total revamping after researching best practices of 13 states and 2 state site visits
- Collaboratives with CHCS, NASHP, and NAMD
- Created 4 business units
  - Operations
  - Financial
  - Reporting and Systems
  - Business Analysis and Development

MEDALLION 3.0 Reforms

Includes more commercial plan benefit features, enhanced services and reporting, increased innovation:

- Chronic Care and Assessments
- Wellness Programs
- Maternity Program Changes
- Enhanced Data and Reporting
- New Populations
- New Rate and Data Analysis
- Enhanced Program Integrity Requirements

MEDALLION 3.0 - Top 3 Upgrades

1. Quality Incentive Program

- Withhold an approved percentage of the monthly capitation payment from the MCO
- Funds will be used for the MCO's performance incentive awards
- Criteria to include assessment of performance in quality of care and member experience; composite scores on CAHPS adult and child measures; performance in EQRO-conducted activities; and other measures determined by the Department
- Awards proportionate to MCO benchmarks achievements for each performance measure
- Implemented in a three-year phased-in schedule

MEDALLION 3.0 - Top 3 Upgrades

2. Medallion Care Partnership System (MCSP) – new payment/delivery model

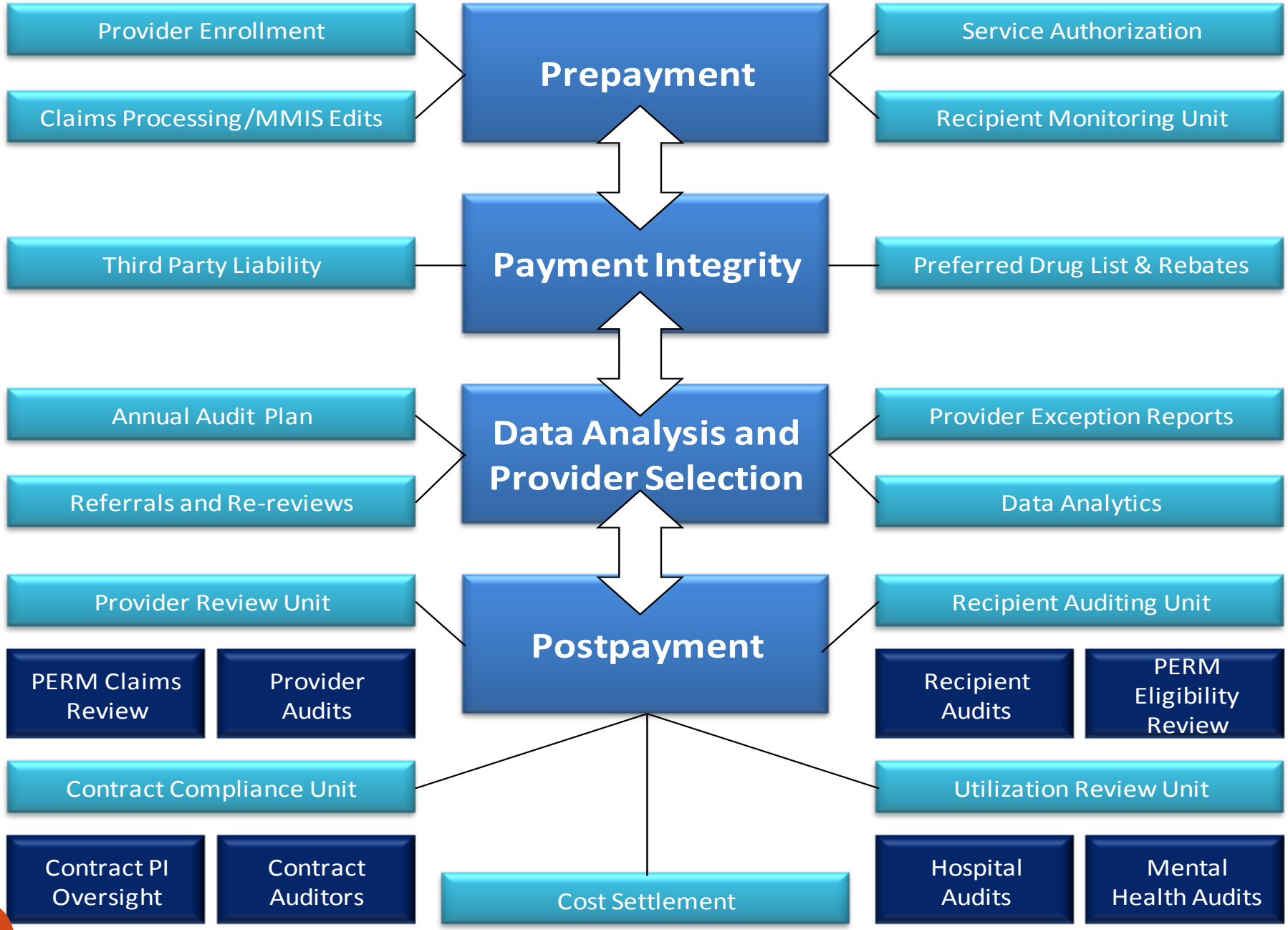
- Each MCO to implement at least two MCSPs to improve health outcomes for Medicaid members through a system designed to integrate primary, acute, and complex health services
- Gain and/or risk sharing, performance-based incentives, or other incentive reforms tied to Commonwealth-approved quality metrics 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

MEDALLION 3.0 - Top 3 Upgrades

3. Plan Collaboratives

- Quality - open discussion on challenges, best practices, and lessons learned
- Program Integrity – address state, federal, and CMS initiatives
- Innovation and Reform – explore innovative solutions to the cost and health care delivery challenges
- Foster Care – address the requirements of the Virginia Health Care Oversight and Coordination Plan

Spotlight on Program Integrity


Provider Enrollment
Claims Processing/MMIS Edits
Prepayment
Service Authorization
Recipient Monitoring Unit
Third Party Liability
Payment Integrity
Preferred Drug List & Rebates
Annual Audit Plan
Referrals and Re-reviews
Data Analysis and Provider Selection
Provider Exception Reports
Data Analytics
Provider Review Unit
Postpayment
Recipient Auditing Unit
PERM Claims Review
Provider Audits
Recipient Audits
PERM Eligibility Review
Contract Compliance Unit
Utilization Review Unit
Contract PI Oversight
Contract Auditors
Cost Settlement
Hospital Audits
Mental Health Audits

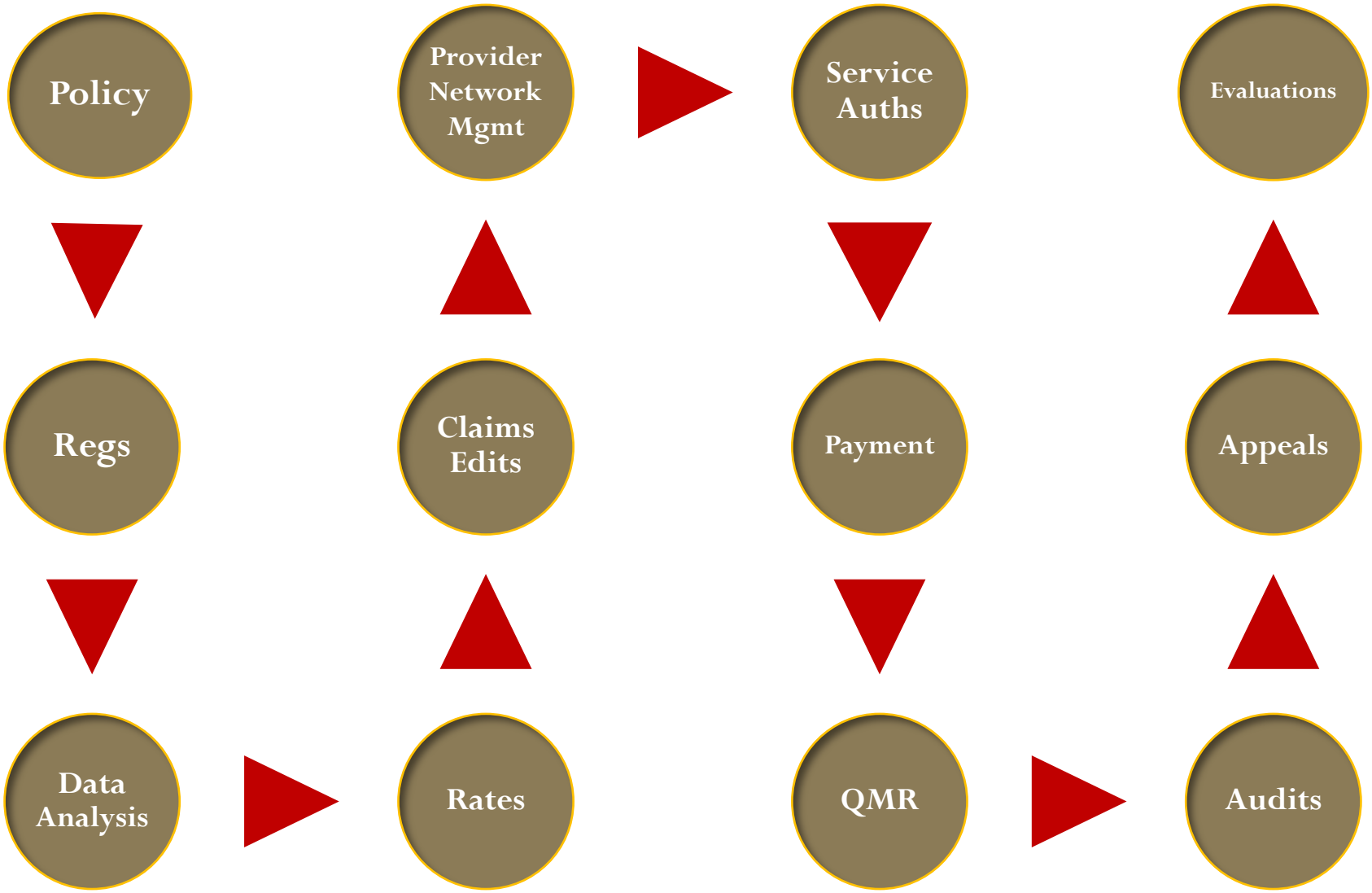
Prepayment

- **Prepayment** processes enhance cost avoidance by preventing improper expenditures on services that are not medically necessary, or providers who are not eligible to participate in Medicaid and ensure claims are paid according to DMAS policy
  - Provider Enrollment – Screening and managing the FFS network
  - Service Authorizations – 1300 procedures saving $190M annually
  - Claim Edits – ClaimCheck and CCI edits saved $39M
  - Data Analysis and tests
  - VICAP and Magellan, Inc – BHSA - Community mental health (future)

Post-payment

- **Post-payment** processes identify instances of improper provider billings through data and risk analysis, investigation of referrals and audits of paid claims
  - Staff and Contractor's Audits – 900 audits annually
  - Contractors: HMS Inc, Meyers Stauffer and Xerox/ACS
  - New Contracts: Fraud, Waste and Abuse, Recovery Audit
  - Third Party Liability
  - MCO Collaborative
  - MFCU Referrals, Qui Tam, and $55M in prosecutions

DMAS Program Integrity Life Cycle



Mandatory Affordable Care Act Provisions

Compliance with the Affordable Care Act

- Extended coverage for Foster Care Children
- Changes to Notifications (letters), Appeals and Complaints processing
- New Presumptive Eligibility workflow for hospitals
- Applications for coverage must be coordinated in real-time with the Federal Exchange and include electronic transfer between Medicaid and subsidized (exchange) coverage

Compliance with the Affordable Care Act

Complete replacement of Medicaid eligibility criteria:

- Modified Adjusted Gross Income (MAGI): As of January 1, 2014, PPACA modifies the way states will calculate income for many existing coverage groups, primarily children, pregnant women, and low-income adults with children
- Applications must be accepted on paper, on-line, by phone and by fax

Compliance with the Affordable Care Act

- **A new Eligibility and Enrollment (E&E) system and administrative structural changes** are required to comply with MAGI and other provisions of PPACA for the existing population. Requires Call Center.
- Eligibility criteria must be checked real-time with Social Security Administration, IRS, Homeland Security

Payment/Provider Provisions with a Substantial Impact on Virginia

- The ACA contains substantial payment/provider reforms:
  - Mandated reductions in federal Disproportionate Share Hospital (DSH) payment under Medicaid (if maintained, recently proposed rules will modify implementation timing)
  - Two year mandated increase in payment for Primary Care Physician Services (up to Medicare payment levels)
  - Significant federal changes and state administrative complexity in Medicaid provider screening, enrollment and termination requirements

Implementing Medicaid Reform

Medicaid Reform to Date

- The 2013 General Assembly mandated that DMAS make reforms to the existing Medicaid program
- Outlined Medicaid reforms in 3 phases
- Medicaid Reform Matrix posted in May to solicit stakeholder responses on DMAS' current plans to implement Medicaid Reform
- Virginia Health Reform Initiative (VHRI) met last week (June 12) to provide feedback to DMAS

Summary of Medicaid Reform Activities

- Modernizing the Medicaid Program
- New Managed Care Contract
- Behavioral Health Services Administrator
- Commonwealth Coordinated Care
- Transitioning populations still in FFS into managed care for basic health services
- Transitioning all remaining long-term care services into managed care