

Medicaid Innovation and Reform Commission

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Secretary of Health and Human
Resources

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Medicaid Service Delivery Structure (Current)

Fee-for-Service

- Directly administered by the state.
- Participants typically fall into these groups:
 - New enrollees waiting for MCO assignment
 - Individuals receiving Home- and Community-Based services
 - Individuals in LTC settings
 - Individuals with other insurance
 - Dual eligibles (Medicaid and Medicare enrollees) (moving to MCOs in 2014)
 - Foster Care Children (moving to MCOs this year)

Contracted

- MCO: Managed care organizations provide care to beneficiaries through contracts with the state. Sometimes the MCOs do not provide certain services. These services are referred to as being “carved out.” (E.g., community mental health and dental for children)

Medicaid Managed Care in Virginia

- Began in 1996
- Today Managed Care is statewide and includes:
 - 500,000 Children
 - 79,000 Caretaker Adults (<28% FPL with children under 18 in home)
 - 56,000 Individuals with Disabilities (including 3,500 HCBS waiver recipients)
 - 11,000 Pregnant Women (1/3 of the births in Va)

6 Managed Care Plans



Value of Managed Care

Commonwealth gets a large ROI for the dollar:

- Increase in board certified networks
- Increase in care management
- Plans are NCQA accredited and highly ranked
- Provide predictive modeling and chronic care management
- Sophisticated purchaser – leveraging buying power to improve care and reduce costs
- Budget certainty
- Create new jobs in the Commonwealth
- Plans are solvent but have no excess profits

Even with a Strong Program there are Overheard Criticisms of Medicaid

1. Medicaid is pervasive with Fraud
2. Medicaid is worse than no coverage at all
3. Medicaid administrative costs are too high
4. Medicaid just pays the bills and does not focus on quality healthcare
5. Medicaid Providers are inadequately reimbursed
6. Medicaid is a “Top Tier” health plan

Overheard
**Medicaid is
pervasive with
Fraud**

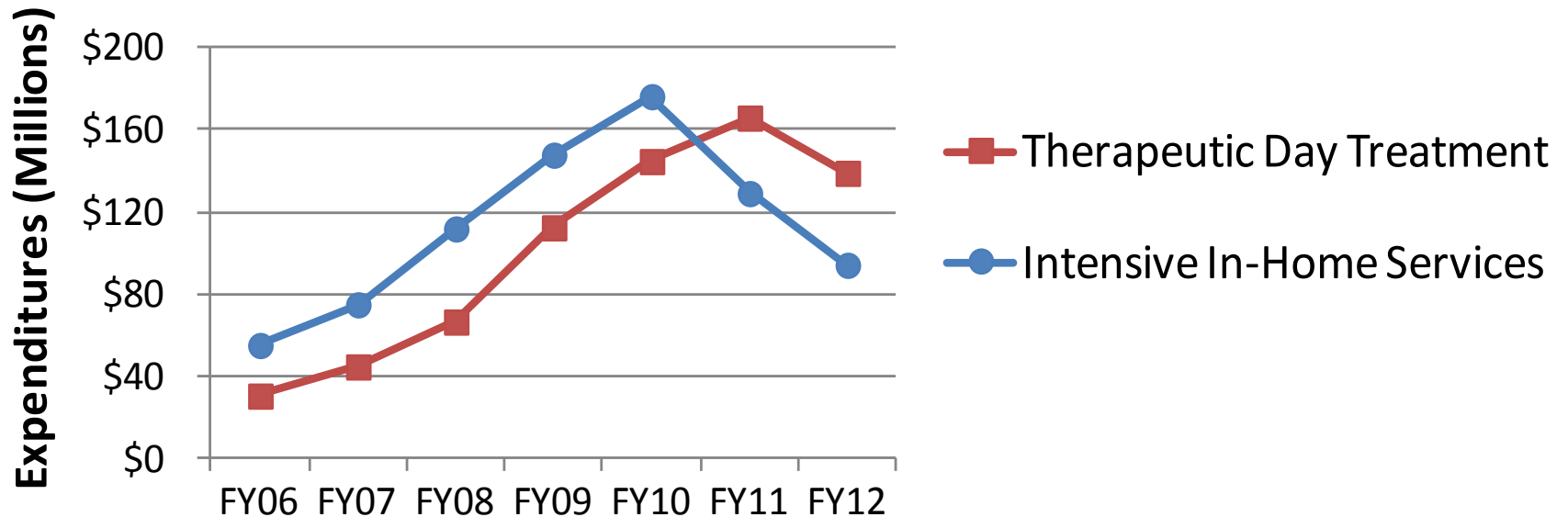


- As of June 26, 2013, the Estimated Payment Error Rate Measurement (PERM) for Medicaid is 0.47%
- Program Integrity Efforts are applied both pre and post payment
- Example of efforts: program integrity data analysis yielded concerns in the significant growth in Community Behavioral Health Services during 2008-2010. Through support of General Assembly DMAS created the VICAP program, addressing the misuse of these services.

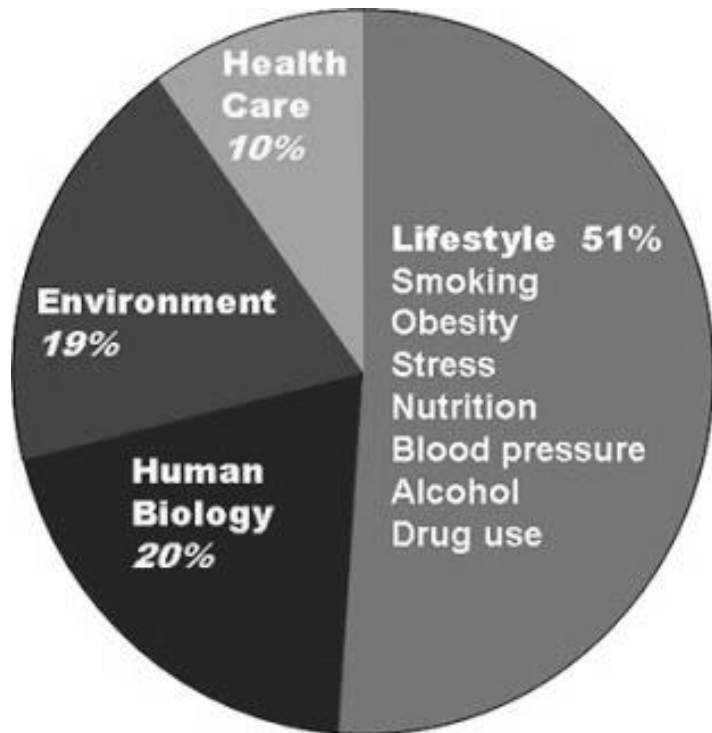
Program Integrity Efforts Prevent Improper Use of Services through Assessment and Authorization

The “sentinel effect” of the combination of the VICAP program and Service Authorization is illustrated in the following graph as

- IIH expenditures decreased \$82.1M (47%) from \$176.5M in FY 2010
- TDT expenditures decreased \$26.9 M (16%) from \$166.1M in FY 2011



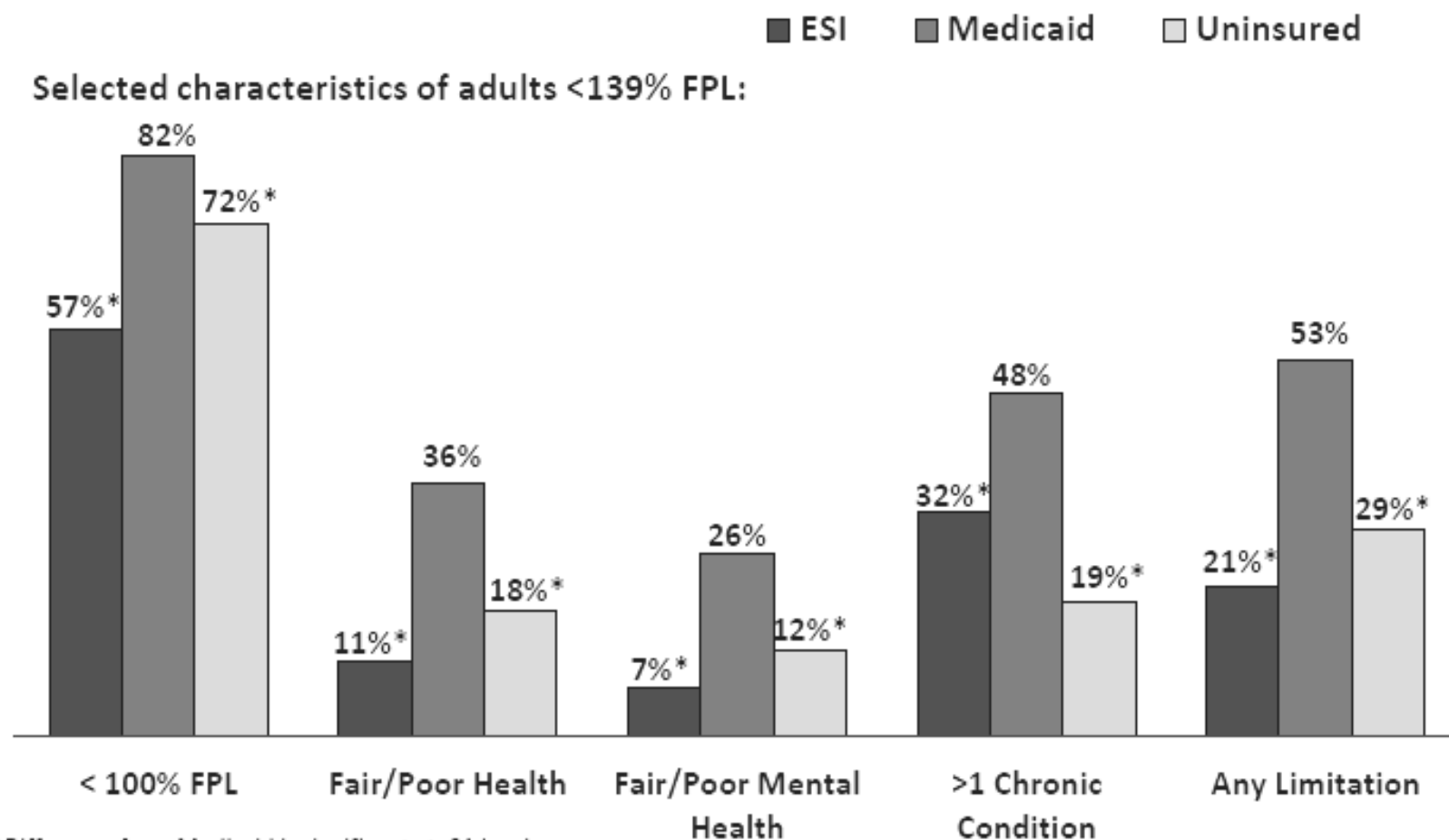
Overheard
**Medicaid is
worse than no
coverage at all**



- Medicaid was designed to provide health coverage for low-income children and families who lack access to private coverage because of limited finances, health status, and/or severe physical, mental health, intellectual or developmental disabilities.

- Because of Medicaid's eligibility criteria and the strong correlation between poverty and poor health and disability, Medicaid beneficiaries are poorer and have poorer health profiles compared with privately insured and the insured.

Adults with Medicaid are both poorer and sicker than low-income adults with private health insurance.

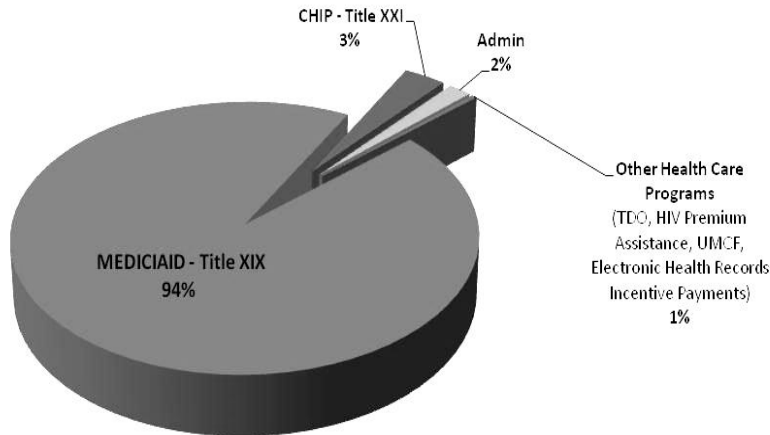


*Difference from Medicaid is significant at .01 level.

SOURCE: Coughlin T et al., *What Difference Does Medicaid Make: Assessing Cost Effectiveness, Access, and Financial Protection under Medicaid for Low-Income Adults*, Kaiser Commission on Medicaid and the Uninsured, May 2013. Appendix Table 1, data from 2003-2009 MEPS.

Overheard Medicaid Administrative Costs are too High

DMAS SFY 2013 Budget
by Program



•Nationally, administrative overhead for private health insurance companies is 12 percent. *DMAS' administrative budget is only 2 percent of its overall budget.*

•Per capita cost growth for Medicaid is consistently lower than private coverage averaging 2.8 percent annually for Medicaid from 2006-2011 compared to 4.2 percent for private insurance.

Park and Broaddus, Center on Budget and Policy Priorities , 2012

Overheard
**Medicaid just
pays the bills
and does not
focus on
quality
healthcare**



2013 MCO Contract Enhancements

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
- 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 DMAS
- Awards proportionate to MCO benchmark achievements for each performance measure
- Implemented in a three-year phased-in schedule

Overheard
Medicaid
Providers are
inadequately
reimbursed

- In 2008, Virginia paid Medicaid primary care physicians on average 88% of what Medicare pays.
 - *2 year primary care bump (100% Medicare rate) 2013-2014 as a result of the ACA*

- DMAS does not have authority, absent General Assembly mandate, to adjust provider reimbursement rates.



Overheard
**Medicaid is a
“Top Tier”
health plan**



- Medical services covered through Virginia’s Medicaid program are very similar to those offered through commercial health plans. Service limits offered is the biggest difference between the two.
- Medicaid is different because it covers long-term care, community mental health, and for children, EPSDT services. These are often not covered by commercial products.
- Medicaid benefit redesign will include making the Medical benefit even more “commercial like” in applying CMS approved service limits and patient engagement strategies.

Summary of Medicaid Reform Activities as Directed by 2013 Budget Language

Modernizing the Medicaid Program through Innovation

New Managed Care Contract

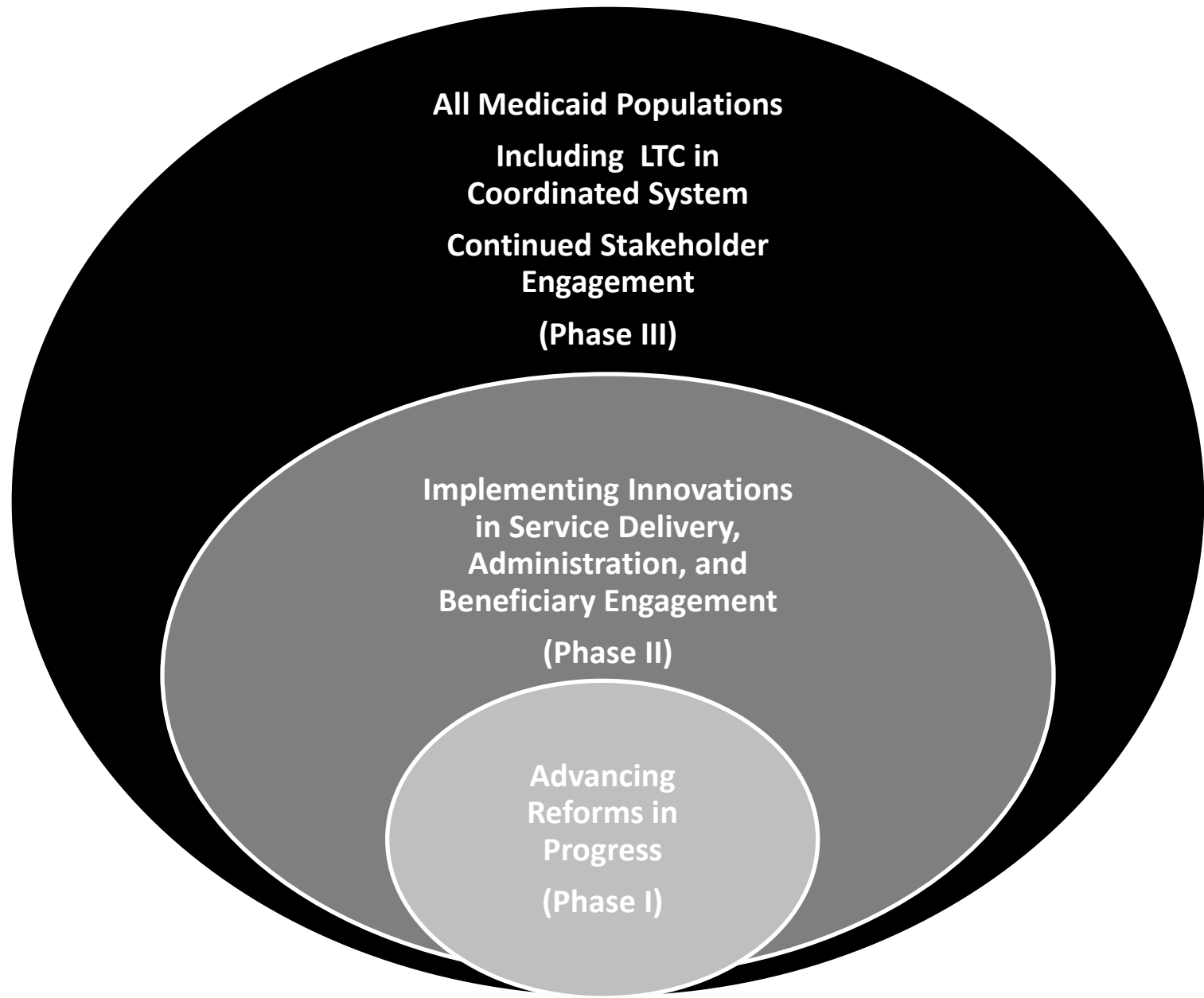
Behavioral Health Services Administrator

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

Three Phases of Medicaid Reform



Working with CMS to Implement Reforms in Virginia

Key CMS Approvals/Support

- Medicare-Medicaid Enrollee (dual eligible) Financial Alignment
- Significant Reforms to the Managed Care Organization Contracts
- Fast Tracking Reviews of Eligibility and Enrollment Changes
- Additional Required Medicaid Reforms

Two Key Questions:

1. What Reforms Can be Implemented with the Existing Medicaid Population under Current Authority?
2. What Reforms Can be Implemented with the Existing Medicaid Population that Require Additional CMS Authority or Waivers?




Working with CMS to Implement Reforms In Virginia

- On August 15, 2013, DMAS submitted a concept paper to CMS, entitled ***“Implementing Medicaid Reform in Virginia: A summary of planned reforms for review by the Centers for Medicare and Medicaid Services and interested stakeholders”***
- Contents
 - Purpose
 - Overview of the Medicaid Program
 - Existing Federal Authority for the Virginia Medicaid Program
 - Reforming Virginia’s Medicaid Program
 - Next Steps for Virginia

Status of Phase 1 Reforms

Title	Progress	Timeline/Target Date
Dual Eligible Demonstration Pilot	6 th State in the Nation to have signed MOU with CMS	<ul style="list-style-type: none"> • July 2013 - Negotiations started with selected health plans • August 2013 - Readiness Reviews • September 2013 - Contracting, Rates • January 2014 – Regional phased-in enrollment begins
Enhanced Program Integrity		Ongoing
Foster Care Enrollment into MCOs		September 2013 – Begin expansion to Central, Tidewater, and Northern Virginia Spring 2014 – Rest of the state

Status of Phase 1 Reforms

Title	Progress	Timeline/Target Date
Eligibility and Enrollment System		<ul style="list-style-type: none"> •October 2013 – New VaCMS eligibility system goes live for new Medicaid/FAMIS; Begin taking Medicaid/FAMIS applications based on new financial requirements MAGI •January 1, 2014 - Eligibility based on MAGI rules required to begin
Access to Veterans Benefits for Medicaid Recipients		Ongoing
Integrity and Quality of Medicaid Funded Behavioral Health Services		December 2013 – Implementation of strengthened regulations and a new Behavioral Health Services Administrator (Magellan)

Status of Phase 2 Reforms

Title	Progress	Timeline/Target Date
Commercial Like Benefit Package	Yellow	• July 2014 for MCOs and FFS
Cost Sharing and Wellness	Yellow	• July 2014 for MCOs and FFS
Limited Provider Networks and Medical Homes	Green	• July 2013 for MCOs
	Yellow	• July 2014 for FFS
Quality Payment and Incentives	Green	<ul style="list-style-type: none"> • July 2013 (for MCOs) – Program implemented to establish the baseline target • SFY 2015 quality withholds begin
Parameters to Test Innovative Pilots	Yellow	• July 2014 for MCOs and FFS

Status of Phase 3 Reforms

Title	Progress	Timeline/Target Date
Medicare-Medicaid (Duals) Enrollees Demonstration		<ul style="list-style-type: none"> •January 2014
ID/DD Waiver Redesign		<ul style="list-style-type: none"> •October 2013 - First Phase of DBHDs Study completed •July 2014 –ID/DD Waiver Renewal Due/Redesign
All HCBC Waiver Enrollees in Managed Care for Medical Needs (waiver services remain out)		October 2014
PACE Program for ID/DD or other Pilot Coordinated Care Programs		July 2015

Status of Phase 3 Reforms

Title	Progress	Timeline/Target Date
All Inclusive Coordinated Care for HCBC Waiver Clients, now including all HCBC waiver services		July 2016
Complete Medicare-Medicaid (Duals) Coordinated Care across the State, including children		July 2018

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

Announced August 15: Virginia's Marketplace Navigators

Virginia Poverty Law Center, Inc. (Anticipated grant amount: \$1,278,592)

The Virginia Poverty Law Center (VPLC) is a non-profit organization that serves Virginia's legal aid system by providing advocacy, training, and litigation support on civil justice issues that affect low-income Virginians based in Richmond. It provides training and technical assistance to the legal aid community and others and works on health care issues with a wide range of statewide organization and partners. It will be working with a statewide consortium of nine well-established legal services programs in the commonwealth.

Advanced Patient Advocacy, LLC* (Anticipated grant amount: \$483,433)

For nearly 14 years, Advanced Patient Advocacy has partnered with health care providers and state and local governments in 21 states to provide services to communities to help educate and enroll uninsured consumers. Advanced Patient Advocacy will work with medical centers to identify uninsured individuals and provide education and assistance to help them make informed decisions about enrollment in the Marketplaces.