Meeting of the Board of Medical Assistance Services
Virginia Community Healthcare Association
3831 Westerre Parkway
Henrico, Virginia
September 15, 2015
DRAFT Minutes

Present:
Mirza Baig
Michael H. Cook, Esq.
Alexis Y. Edwards
Brian Ewald
Maureen Hollowell
Peter R. Kongstvedt, M.D.
McKinley L. Price, D.D.S.
Karen S. Rheuban, M.D.
Chair
Erica L. Wynn, M.D.
Marcia Wright Yeskoo

Absent:
Maria Jankowski, Esq.

DMAS Staff:
Linda Nablo, Chief Deputy Director
Scott Crawford, Deputy Director for Finance
Seon Rockwell, Sr., Programs Advisor to Deputy Director for Administration
Abrar Azamuddin, Legal Counsel, Office of the Attorney General
Raven Weaver, DMAS Intern
Craig Markva, Director, Office of Communications, Legislation & Administration
Nancy Malczewski, Public Information Officer, Office of Communications, Legislation & Administration
Mamie White, Public Relations Specialist, Office of Communications, Legislation & Administration

Speakers:
Karen S. Rheuban, MD, BMAS Chair
Cynthia B. Jones, Director of DMAS
Cheryl Roberts, Deputy Director for Programs
Karen E. Kimsey, Deputy Director for Complex Care Services
Suzanne Gore, Deputy Director for Administration
Rebecca Mendoza, Division Director for Marketing and Enrollment Services
William Lessard, Division Director for Provider Reimbursement Division

Guests:
Rick Shinn, VACHA
Steve Ford, VHCA
Jennifer Wicker, VHHA
Kenneth McCabe, DPB
Tyler Cox, HDJN
Lindsay Berry, Anthem
Marcus Peterson, Anthem
Patrick W. Finnerty, PWF Consulting
Mary Anne Bailey, VHCA

CALL TO ORDER

Dr. Karen S. Rheuban called the meeting to order at 10:04 a.m. Dr. Rheuban welcomed Board members and asked members to introduce themselves and others in attendance.

APPROVAL OF MINUTES FROM JULY 28, 2015 MEETING

Dr. Rheuban asked that the Board review and approve the Minutes from the July 28, 2015 meeting. Dr. Price made a motion to accept the minutes. The vote was unanimous. 9-**yes (Baig, Cook, Edwards, Ewald, Hollowell, Kongstvedt, Price, Rheuban, and Yeskoo); 0-no.**

APPROVAL OF BY-LAWS AND ROLE OF BOARD

Dr. Rheuban asked that the Board review and approve the By-laws distributed at the July 28, 2015 meeting. Mr. Cook made a motion to accept the minutes, and Ms. Yeskoo seconded. The vote was unanimous. 9-**yes (Baig, Cook, Edwards, Ewald, Hollowell, Kongstvedt, Price, Rheuban, and Yeskoo); 0-no.**

Dr. Rheuban thanked Abrar Azamuddin, Legal Counsel, Office of the Attorney General, for facilitating the discussion and explanation of the structure, general duties and authorities of the Board at the July meeting.

Dr. Rheuban asked members to indicate their area of interest to staff so their expertise could be utilized and to continue to forward specific topics for discussion at future meetings to her.

Dr. Rheuban requested members complete the Conflict of Interest training by October 1 and forward certificates to the Board Secretary.

DIRECTOR'S REPORT AND STATUS OF KEY PROJECTS

Ms. Cynthia B. Jones, Director of DMAS, provided a status update on Medicaid Managed Long Term Services and Supports (MLTSS) initiatives, the Affordable Care Act (ACA) Medicaid expansion estimate as of August 2015, and an overview of one year later for the *A Healthy Virginia* Program. (See attached handouts.)

COVER VIRGINIA AND CHILDREN'S OUTREACH ACTIVITIES

Rebecca Mendoza, Division Director for Marketing and Enrollment Services, provided an overview of the Cover Virginia call center and application processing center operations and monthly volumes. She also presented highlights from the expanded outreach efforts and new

marketing initiatives to increase children's enrollment including a viewing of the new TV and radio ads. (See presentation attached.)

Dr. Wynn joined the meeting at the end of this presentation.

UPDATE ON DELIVERY SYSTEM REFORM INCENTIVE PROGRAM (DSRIP)

Ms. Suzanne Gore, Deputy Director for Administration, provided an update on the Delivery System Reform Incentive Payment Program (DSRIP). DMAS and other state agency partners, along with the Virginia Center for Health Innovation (VCHI), are in the beginning stages of a public comment process for a high-level concept of a potential DSRIP program in Virginia and are presenting at Accountable Care Community meetings being held around the state. Ms. Gore stated the concept paper for public comment will be sent to members as soon as it is available. For more information on the planned 1115 waiver and DSRIP concept, please see presentation attached.

At 12:10 p.m. the Board adjourned for break and reconvened working lunch at 12:30 p.m. Mr. Baig left the meeting.

ENSURING QUALITY OF CARE IN MANAGED CARE

Cheryl Roberts, Deputy Director for Programs, provided an overview of how the National Committee for Quality Assurance (NCQA), Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) are used to measure standards for providing health care quality and accrediting Virginia's Medallion managed care organizations. (See presentation attached.)

Ms. Roberts stated the 2015 Medallion Managed Care Annual Report and Program Integrity Annual Report will be sent to members. It was suggested that discussion of program integrity be included on the BMAS December agenda.

Karen Kimsey, Deputy Director for Complex Care, explained methods for assessing quality performance and program improvement for Virginia's Medicaid Managed Long Term Services and Supports (MLTSS) and behavioral health programs. (See presentation attached.)

The Behavioral Health Services report will be sent to members as soon as it is available.

Dr. Rheuban asked to change the order of the agenda as Dr. Price had to leave and she wanted to cover the dental issue being followed up from the previous meeting included under Old Business.

OLD BUSINESS

Ms. Jones provided cost estimate information (attached) on dental coverage for adults to follow up discussion from the July BMAS meeting. Members expressed their overall support for dental initiatives and asked Ms. Jones to share their sense of support to the Secretary as he prepares future budget.

Dr. Price and Ms. Edwards left the meeting.

THE IMPACT OF THE AFFORDABLE CARE ACT ON DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

William Lessard, Division of Director for Provider Reimbursement Division, explained what disproportionate share hospital (DSH) payments were and what the current DSH policy is in Virginia. (See presentation attached.)

REGULATORY ACTIVITY SUMMARY

The Regulatory Activity Summary is included in the Members' books to review at their convenience. (See attached handout.)

ADJOURNMENT

Dr. Rheuban announced the next meeting will be December 8 at the Department of Medical Assistance Services and asked members to submit their agenda items. Dr. Kongstvedt made a motion to adjourn the meeting at 1:45 p.m. and Mr. Ewald seconded. The vote was unanimous. 7-**yes** (**Cook, Ewald, Hollowell, Kongstvedt, Rheuban, Wynn and Yeskoo); 0-no.**

Fact Sheet: Virginia's Managed Long Term Services and Supports (MLTSS) Initiative

(Revised September 14, 2015)

Consistent with Virginia General Assembly directives in years 2011 through 2015, over the next couple of years, the Department of Medical Assistance Services (DMAS) will transition the majority of the remaining Medicaid fee-for-service populations into a managed long-term services and supports (MLTSS) program. DMAS intends to launch an MLTSS program that provides a coordinated system of care that focuses on improving quality, access, and efficiency.

The MLTSS populations will include: (1) individuals with full Medicaid and Medicare benefits (known as dual eligibles) and (2) individuals who receive Medicaid and long term services and supports (LTSS) either through an institution or through one of DMAS' six (6) home and community based services (HCBS) waivers. At this time, Medicaid managed care for individuals enrolled in the Day Support for Persons with Intellectual Disabilities (DS); Intellectual Disabilities (ID); and, Individual and Family Developmental Disabilities Support (DD) Waivers is being considered for their acute and primary care services, only. While DMAS is exploring the feasibility of managed or integrated care models for the ID, DD, and DS Waivers, these individuals will continue to receive their home and community-based LTSS through Medicaid fee-for-service until the Department of Behavioral Health and Developmental Services (DBHDS) completes the redesign of these Waivers.

The DMAS MLTSS program design is briefly described in the table below.

Managed Long-Term Services and Supports (MLTSS) Program Design

Included Populations	Integrated Benefit Design	Health Plans	Program Roll-Out
✚ Approximately 50,000 duals with full Medicaid benefits ✚ Approximately 20,000 non-dual individuals receiving long-term services and supports* ✚ CCC participants when the CCC demonstration ends (December 2017)	✚ MLTSS will operate using an integrated benefit design ✚ Services will include primary and acute, long-term services and supports, behavioral health, and substance use disorder services** ✚ Care coordination will be available through the health plans.	✚ Health plans will be selected through a competitive (RFP) procurement process ✚ Selected plans must have or be working towards obtaining: 1) NCQA accreditation, and 2) approval by CMS to operate as a Dual Special Needs Plan (D-SNP) ✚ MLTSS will operate state-wide; plans may vary by region; there must be at least two health plans per region	✚ MLTSS will be phased-in regionally beginning in the Spring of 2017 ✚ CCC demonstration participants will be transitioned when the CCC demonstration program ends on December 2017. *(Individuals who opt-out of CCC may transition into MLTSS earlier, i.e., when CCC ceases to enroll new participants starting June 30, 2017)*

**Individuals enrolled in the ID, DD, and DS Waivers will continue to receive their home and community-based LTSS through Medicaid fee-for-service until the Department of Behavioral Health and Developmental Services completes the redesign of these Waivers. Individuals residing in ICF-IID facilities will be excluded from MLTSS until after the completion of the redesign.*

***Services that will be carved-out of the health plan contract include: dental services, which will be covered through the DMAS Smiles for Children program, school health services, which will be provided through the DMAS fee-for-service program, and ID, DD, and DS Waiver services (per above). Other carved-out services are being considered.*

Please visit the DMAS website at http://www.dmas.virginia.gov/Content_pgs/mltss-home.aspx for more information about the MLTSS program. Updates regarding the status of the program will be posted to the website on a regular basis. For questions, contact DMAS at VAMLTSS@dmas.virginia.gov.

ACA Medicaid Expansion Estimate - August 2015 Update

- Expanding Medicaid will cost $200M GF over the FY17-18 biennium but generate **savings of ($352M) GF**

	Estimated COSTS of a 1/1/17 Expansion		
	State Funds	Federal Funds	Total Funds
SFY2017	$32,151,611	$767,598,220	$800,049,831
SFY2018	$162,808,760	$2,483,340,287	$2,646,149,048
SFY2019	$196,758,432	$2,578,896,852	$2,775,655,284
SFY2020	$259,762,871	$2,615,759,404	$2,875,522,275
SFY2021	$313,346,268	$2,666,517,392	$2,979,863,660
SFY2022	$324,711,763	$2,763,412,327	$3,088,124,090

	Estimated SAVINGS of a 1/1/17 Expansion		
	State Funds	Federal Funds	Total Funds
SFY2017	($91,323,426)	($56,281,385)	($147,604,811)
SFY2018	($260,495,015)	($179,951,420)	($440,446,435)
SFY2019	($280,628,733)	($199,346,668)	($479,975,401)
SFY2020	($293,530,034)	($211,580,634)	($505,110,668)
SFY2021	($307,282,459)	($224,270,986)	($531,553,446)
SFY2022	($321,565,013)	($236,157,512)	($557,722,526)

	Estimated Net Effect of a 1/1/17 Expansion		
	State Funds	Federal Funds	Total Funds
SFY2017	($59,171,815)	$711,316,835	$652,445,020
SFY2018	($97,686,254)	$2,303,388,867	$2,205,702,612
SFY2019	($83,870,301)	$2,379,550,184	$2,295,679,884
SFY2020	($33,767,163)	$2,404,178,770	$2,370,411,607
SFY2021	$6,063,809	$2,442,246,406	$2,448,310,215
SFY2022	$3,146,750	$2,527,254,814	$2,530,401,564

- **Every month we don't expand Medicaid, Virginia spends $15M in state funds that we could have saved**
  - And foregoes approximately $200 million in federal funds

- Updated Virginia population figures
  - There are an estimated 400,000 Uninsured adults 18-64 <138% FPL
  - There are an estimated 85,000 adults <138% FPL enrolled on the Health Insurance Exchange
  - There are an estimated 230,000 Privately-Insured adults 18-64 <138% FPL

- Of the potentially-eligible population, **an estimated 350,000 individuals are estimated to enroll**
  - Potentially-eligible population is adjusted to account for inelgibility due to current citizenship status
  - Estimate 75% of eligible Uninsured (change from previous 69%)
  - Estimate 90% of eligible HIE enrollees
  - Estimate 15% of eligible privately-insured adults

ACA Medicaid Expansion Estimate - August 2015 Update

- Estimated to enroll population is higher than previous estimate to start but grows at a much slower annual rate
  - Number estimated to enroll is 31% higher in FY17 than previous estimate but only 16% higher in FY22

- Assume approximately 1,000 adults will enroll in current Medicaid program as a result of ACA Expansion ("Woodwork'
  - Reduction from previous estimate
  - Assume woodwork related to FFM is in Medicaid trend data

- Estimated expenditures assume a straight Medicaid expansion with a standard benefit package and the current delive model through the existing six Medicaid MCOs. Any changes to the model in terms of benefits, cost sharing, reimbursement increases, or other delivery models will change both the cost and savings estimates, as well as the tim of implementation.
  - Higher PMPM assumption (approx 12%) - reflects updated base year data, inclusion of maternity costs; higher Behavioral Health and other initial care costs
  - Revised Pregnant Women savings model - 75% from 17%
  - Added Disabled/MN savings - 15% of new enrollees estimated to divert
  - Incorporated local jails into savings for incarcerated inpatient hospital services
  - Savings for the GAP program are reflected through FY 2022 because the program was assumed to continue unt Expansion

- Sources included:
  - DMAS analysis of Kaiser Family Foundation's work analyzing Current Population Survey (CPS) data with data updated to 2012.
  - SHADAC analysis of the 2013 American Community Survey (ACS) and 2008 Survey of Income and Program Participation.
  - DMAS evaluation of enrollment data of Expansion states (Arkansas, Maryland, Washington, Colorado) pre- and post-expansion
  - HHS data released in July on county level breakdown of HIE plan selections across variables, including FPL.
  - PriceWaterhouseCoopers evaluation of projected PMPM costs for newly eligible population. PwC reviewed recent publications and capitation rate books for selected states including early-expander states (California, Connecticut, Minnesota, New Jersey, Washington, Washington DC,) as well as other states that have a longer history of covering childless adults (Arizona, Oregon, and Wisconsin), updated the projected rates using more recent actual base data and added the maternity costs to the calculations.
  - Consultation with Manatt on key assumptions

- ACA Medicaid Expansion Federal Match Rates

FFY	Percentage Rate		SFY	Percentage Rate
2014	100%		2014	100%
2015	100%		2015	100%
2016	100%		2016	100%
2017	95%		2017	97.5%
2018	94%		2018	94.5%
2019	93%		2019	93.5%
2020	90%		2020	91.5%
2021	90%		2021	90.0%
2022	90%		2022	90.0%

A Healthy Virginia
Health Care Report

Governor McAuliffe

Helping over 200,000 Virginians

One Year Later

More Coverage for Urgent Health Needs

4,300
People with serious mental illness receive access to health care

920
State employees or their children receive affordable, quality, comprehensive health care

2,600
Pregnant women receive comprehensive dental coverage

Outreach on Available Options

245,871
Virginians **newly** enrolled in Federal Marketplace for health care coverage

17,000
Children newly enrolled in Medicaid/FAMIS

390,000
Visits to Cover Virginia website to learn about health care options

Innovating Health Care in Virginia

Launched Pilots Across 5 Regions
Virginians with serious mental illness get help in health homes by receiving coordinated care for medical and behavioral health needs

Saving Lives
Legislation significantly strengthened the Prescription Monitoring Program and increased the availability of the life-saving over dose reversal drug Naloxone

Accelerating Veterans' Access to Care
Veterans across Virginia benefit from improved access to care with shorter wait times and expanded options

Transforming Health Care Delivery
Multi-interdisciplinary private, public, and non-profit teams are working together to transform health care delivery in Virginia

Department of Medical Assistance Services

Cover Virginia & Children's Enrollment Initiatives

Rebecca Mendoza, Director
Marketing & Enrollment Services Division
Virginia Department of Medical Assistance Services

BMAS Meeting
September 15, 2015

Department of Medical Assistance Services

Overview

Initiatives discussed today:

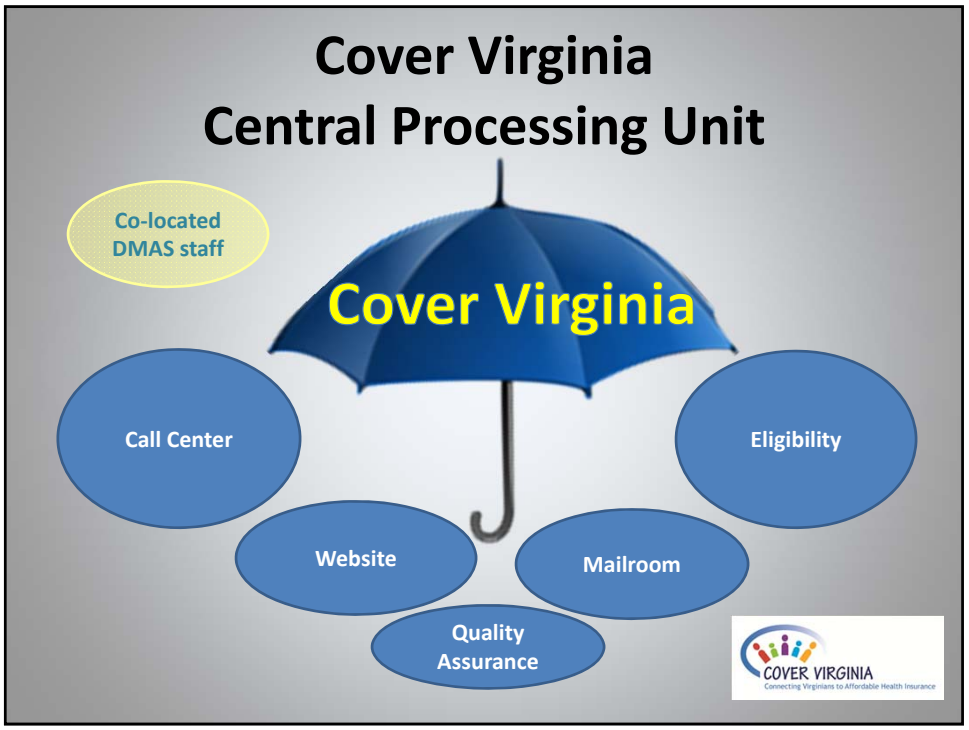
- Cover Virginia
- Children's Enrollment & Outreach
- New Marketing Campaign

Department of Medical Assistance Services

Cover Virginia

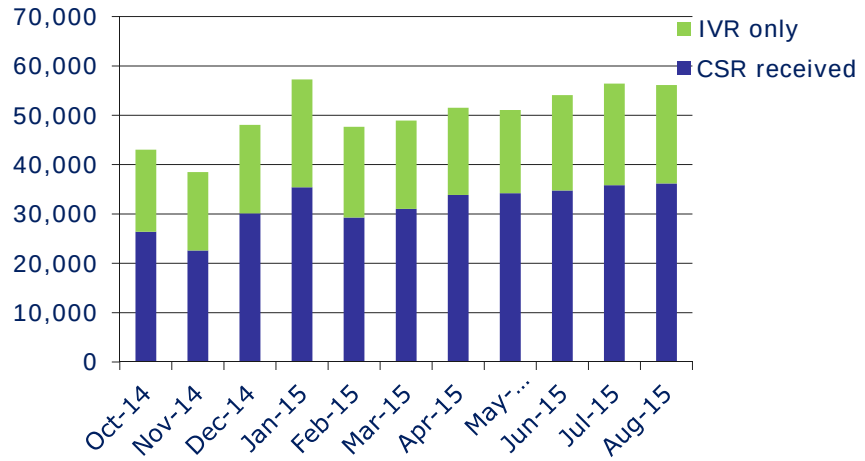
www.dmas.virginia.gov

Cover Virginia
Central Processing Unit



Department of Medical Assistance Services

Cover Virginia Call Volume

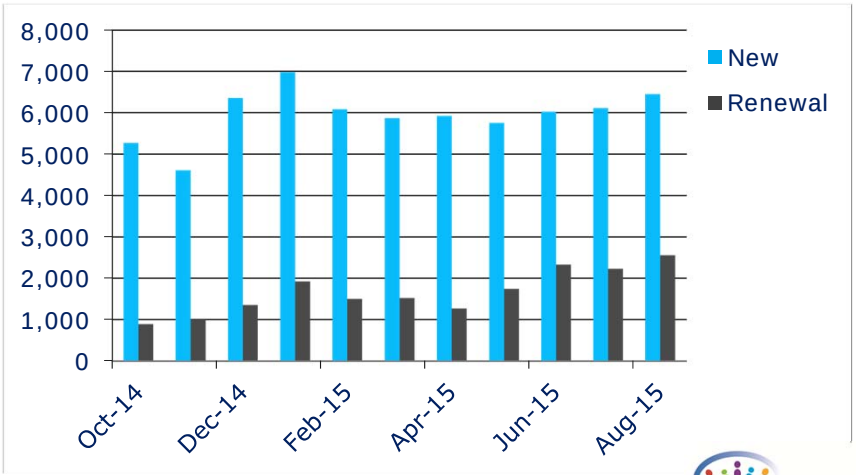


www.dmas.virginia.gov

COVER VIRGINIA
Connecting Virginians to Affordable Health Insurance

Department of Medical Assistance Services

Telephonic Applications



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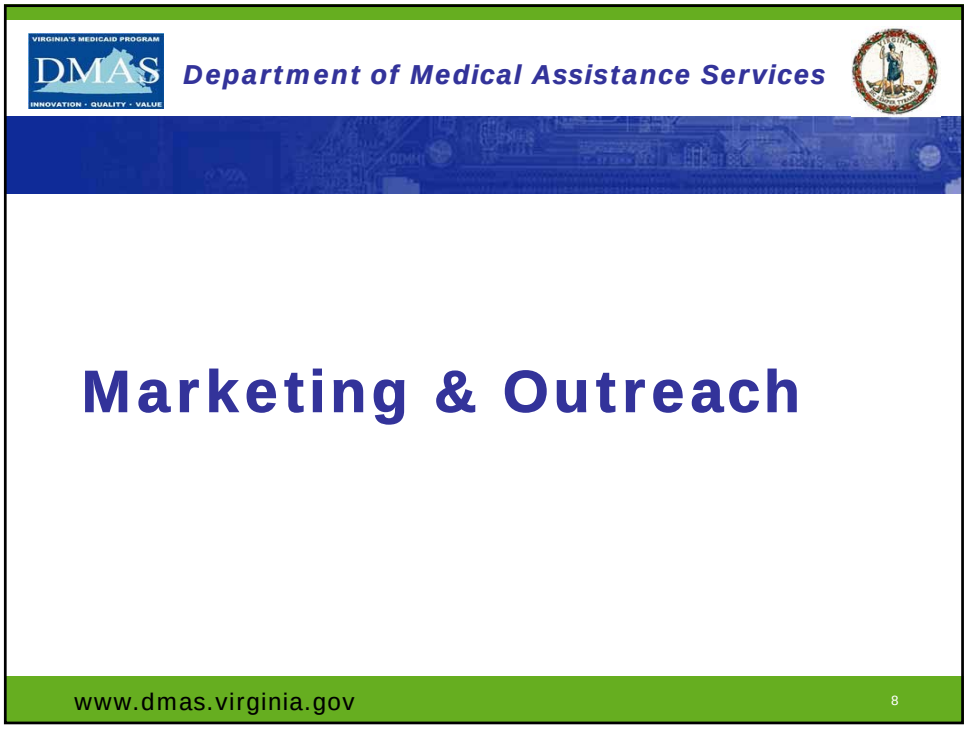
COVER VIRGINIA
Connecting Virginians to Affordable Health Insurance

Application Processing at Cover Virginia CPU

Source	Application Period	Volume
Federally Facilitated Marketplace (FFM) Transferred Applications		
1st Federal OPE & 2014 special enrollments	10/1/13 – 6/30/14	46,828
Additional 2014 backlog	7/1/14 – 11/14/14	11,240
2nd Federal OPE	11/15/14 – 2/15/15	35,998
Ongoing 2015 special enrollments	2/16/15 – 8/17/15	21,172
Telephonic Applications		
Telephonic applications	4/13/15 – 8/17/15	15,300
Specialty Applications		
GAP applications	1/12/15 – 8/17/15	8,382
State Employee FAMIS applications – Expedited	4/20/15 – 8/17/15	719
Total apps. received & processed	**8/18/14 – 8/17/15**	**139,639**
Expedited Enrollments		
Hospital Presumptive Eligibility	1/1/14 – 8/17/15	2,564
Electronic "Deemed" Newborns	1/1/14 – 8/17/15	23,918



Department of Medical Assistance Services

Marketing & Outreach

- Governor's goal to enroll 35,000 more children in FAMIS and FAMIS Plus (children's Medicaid)
- As of September 1st total children's enrollment in FAMIS & FAMIS Plus increased by 15,220 children since September 1, 2014.
- Expanded outreach activities through expanded contract with Virginia Health Care Foundation and added 5 Community Outreach Coordinators

Department of Medical Assistance Services

Back-to-School Campaign

- 1.5 million FAMIS Back-to-School flyers in English & Spanish distributed to every public school in Virginia in August - September
- 450,000 Inserts sent to families enrolled in Free and Reduced Lunch program

Department of Medical Assistance Services

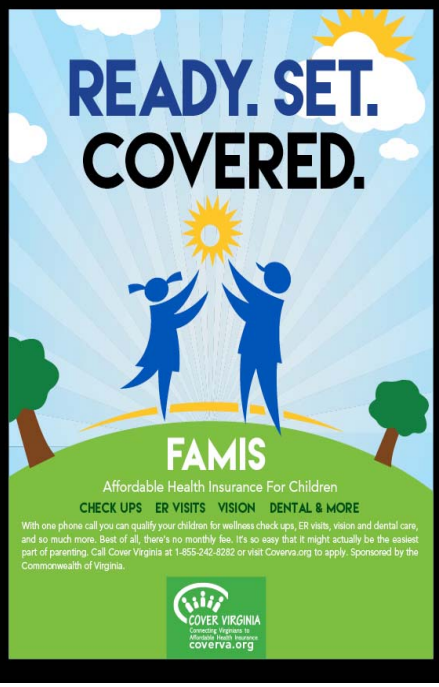
Back-to-School Campaign

- Partnered with Department of Education to post links to FAMIS page on DOE website
- Scheduled to attend more than 15 Back-to-School events throughout Virginia

Department of Medical Assistance Services

New Marketing Campaign for Children's Coverage

POSTER



BANNER

Department of Medical Assistance Services

TV Ad

Department of Medical Assistance Services

Radio Ad

Department of Medical Assistance Services

Social Media

FAMIS and Cover Virginia Facebook pages at:

- **www.facebook.com/FAMISprograms**
- **www.facebook.com/coverva**

Please like us!

Cover Virginia Twitter account - @coverva

Department of Medical Assistance Services

Cover Virginia & Children's Enrollment Initiatives

Questions

Accelerating Delivery System Transformation in Virginia

Presented at Accountable Care Community Meetings

September 2015

Agenda

- Introduction
- Case for Change
- Concept for Transformation
- Opportunity for Public Comment

Delivery System Reform Incentive Payment Program: The Basics

Common Features Include:

State has clear vision for a transformed Medicaid delivery system

State identifies activities intended to transform the delivery system

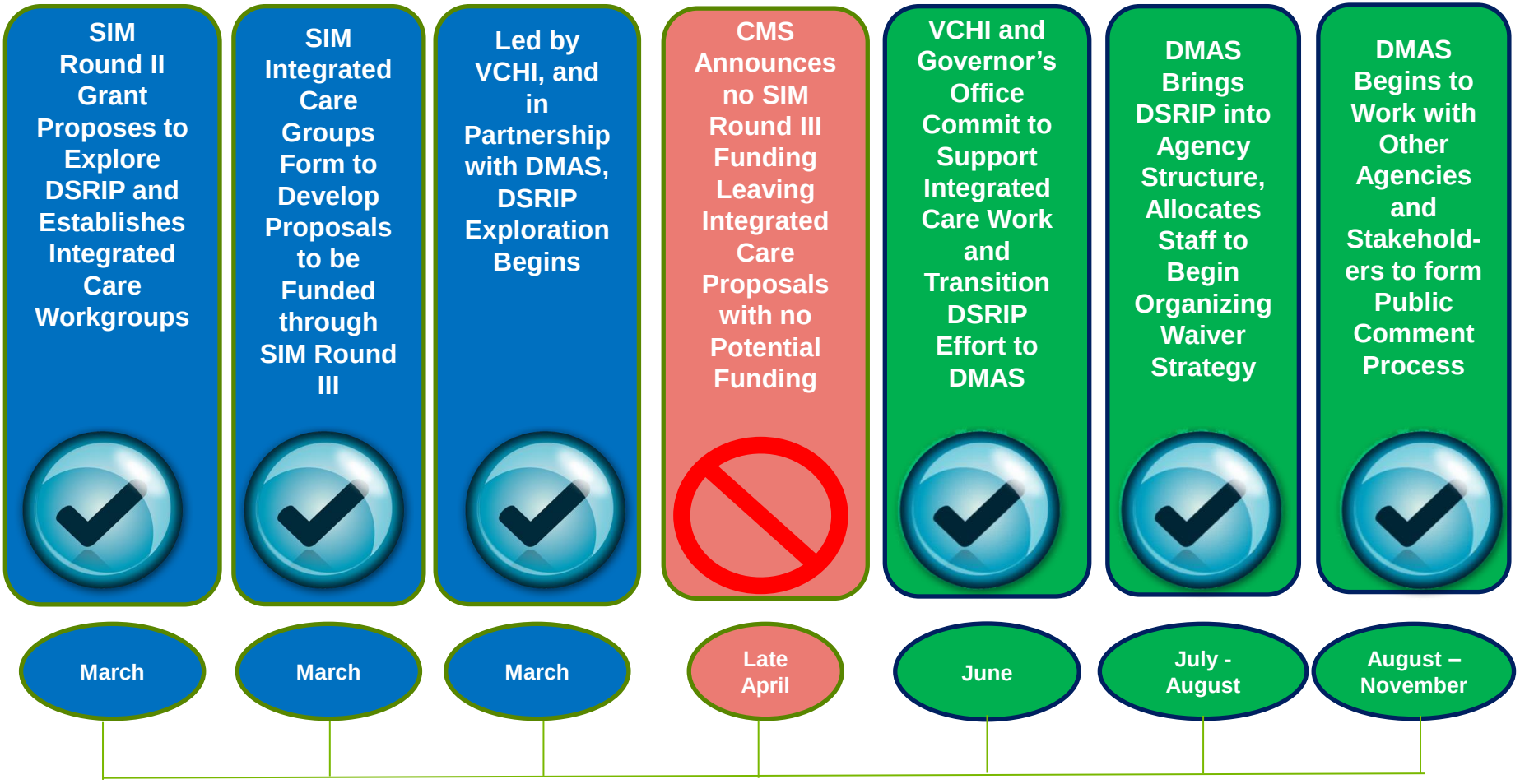
Providers join together to undertake transformation activities

State funds providers based on achievement of specified milestones/metrics

NY, NJ, CA, TX, MA, and KS have implemented DSRIP programs

Virginia's DSRIP Waiver Application Status

Where are we related to DSRIP?



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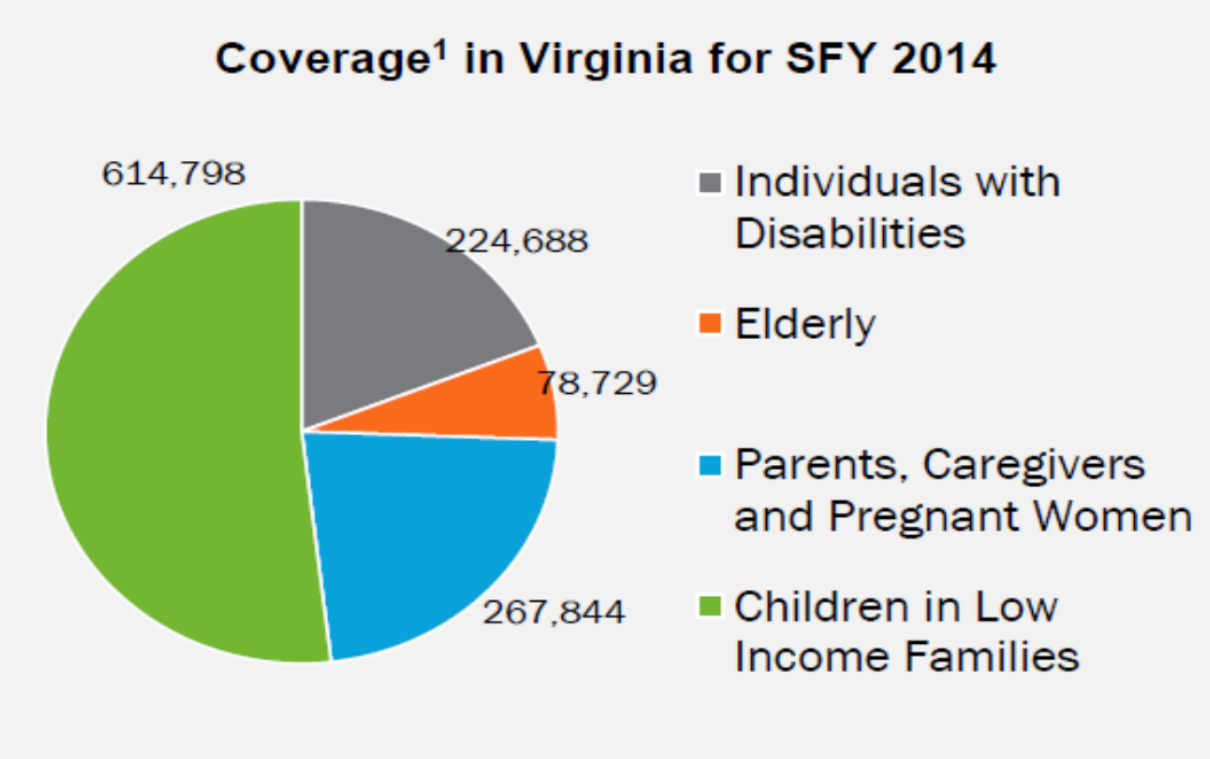
Virginia's Medicaid Population

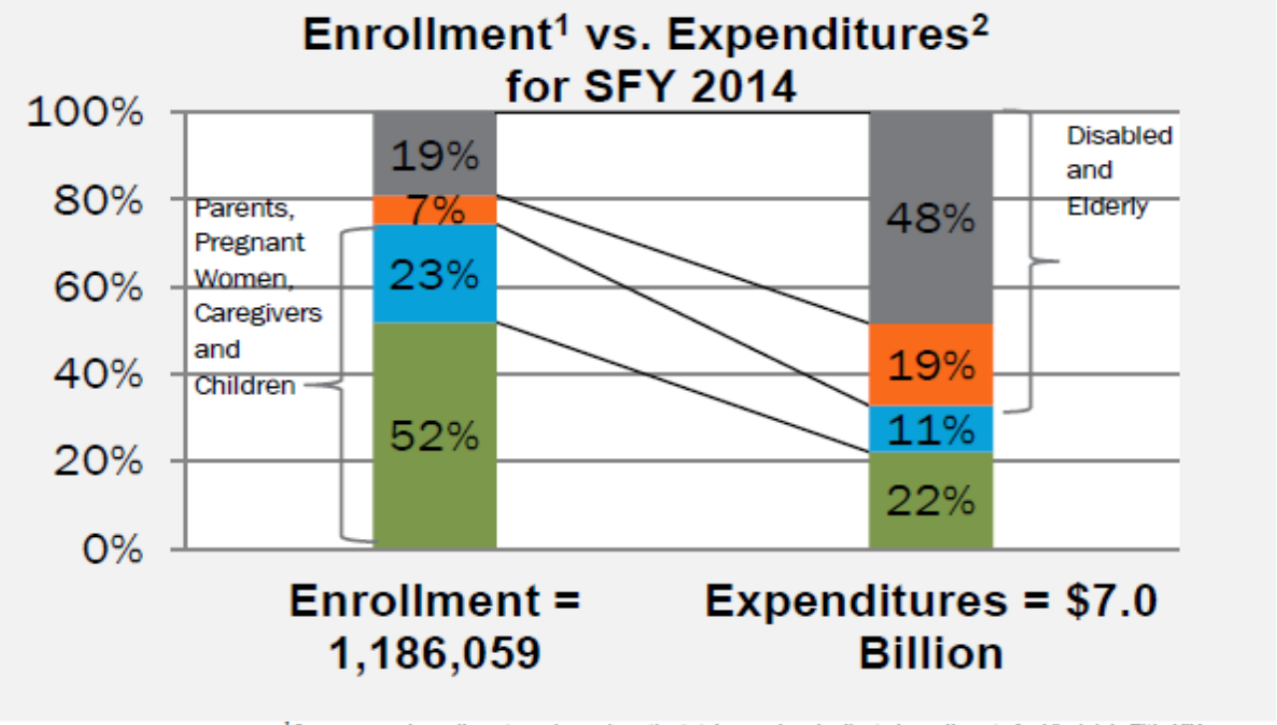
DSRIP will invest in integrated care and community infrastructure for Virginia's most vulnerable and high-cost Medicaid populations



Medicaid coverage is primarily available to Virginians who are children in low-income families, pregnant women, elderly, individuals with disabilities and parents meeting specific income thresholds.

Virginia's Medicaid Enrollment vs. Spend

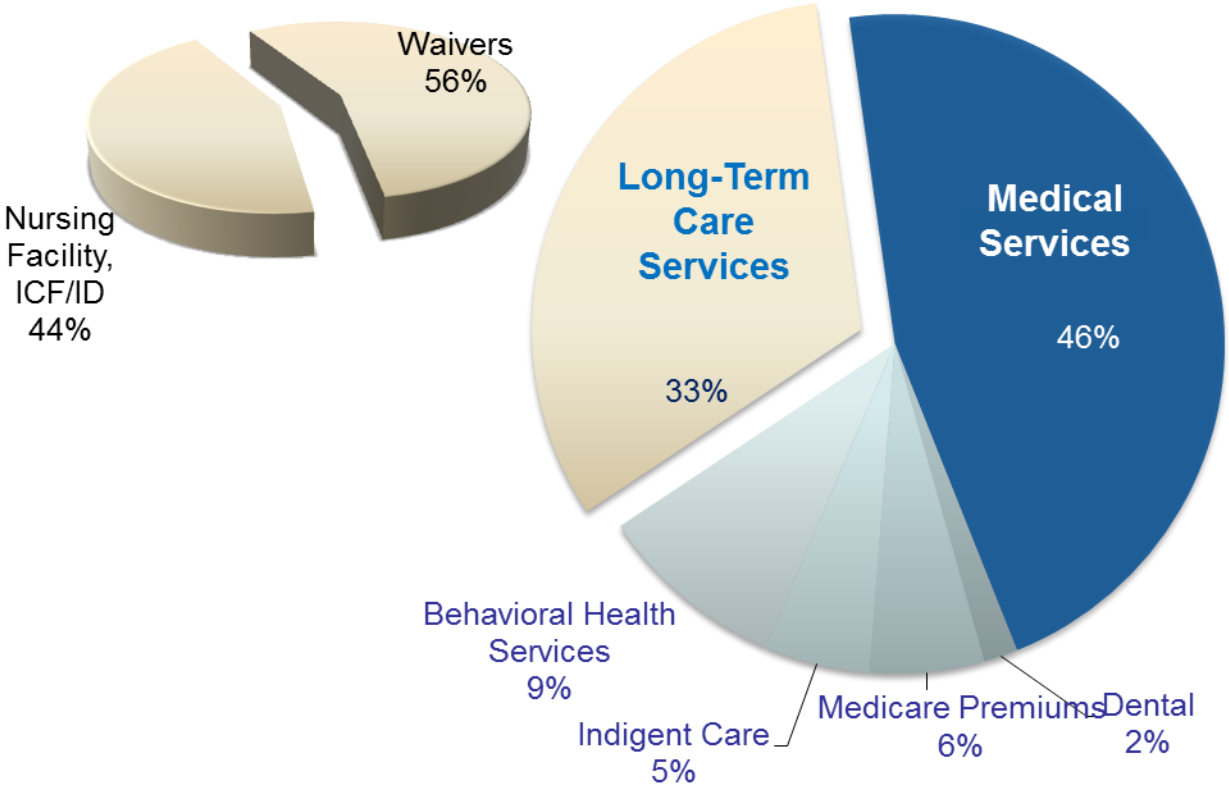
Medicaid expenditures are disproportionate to the Medicaid population. Seniors and individuals with disabilities make up nearly 25% of the total population, yet almost 70% of expenditures are attributed to this group.



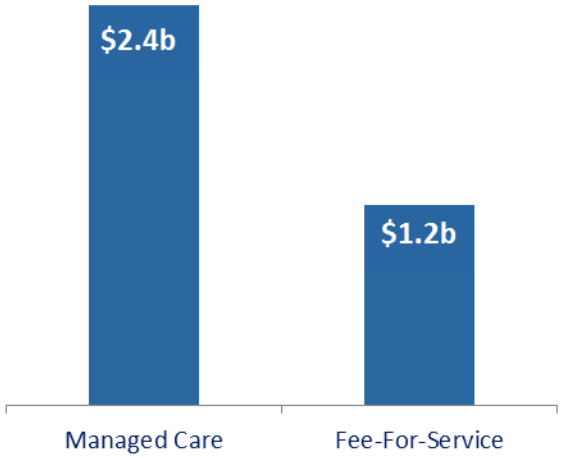
[1] Coverage and enrollment numbers show the total annual unduplicated enrollments for Virginia's Title XIX program
[2] Expenditures represent claims expenditures for Virginia's Title XIX program

Virginia's Medicaid Expenditures Breakdown

Long-Term Care Expenditures



Medical Services by Delivery Type



Current Challenges in Virginia's Medicaid System

Full transformation in Virginia Medicaid's delivery system is constrained by limitations in our infrastructure and how we pay for services.

Specific challenges include:

Disparate Community Capacity

- Community-treatment options differ
- Expertise in serving individuals of varying ability levels is inconsistent
- Over-reliance on institutionalization

Limited Clinical and Social Data Integration

The Medicaid program is not yet able to:

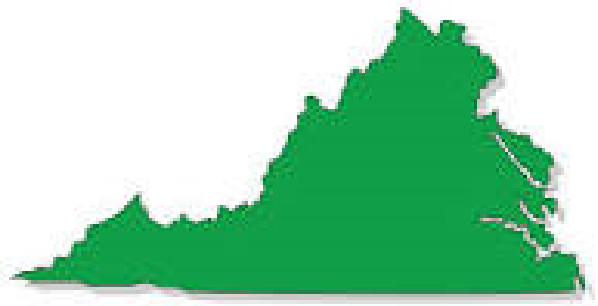
- Provide optimal person-centered coordinated care
- Sufficiently leverage social supports and community resources
- Encourage timely care in the most appropriate setting

Positive Outcomes and High Quality Care is Not Financially Rewarded

- Medicaid reimbursement based upon volume of utilization
- Providers have limited capacity and capability to support alternative payment models
- Limited financial incentive for interdisciplinary community-based care

Current Challenge: Disparate Community Capacity

Virginia needs to strengthen the availability of community resources and expertise of our workforce



Indicators of Community Capacity Challenges

Workforce:
- Primary care professionals lack behavioral health knowledge
- Behavioral health professionals lack primary care knowledge
- Less than one psychiatric nurse practitioner per region

Crisis Management:
- Insufficient resources for children and adults to mitigate escalation that leads to avoidable hospitalization

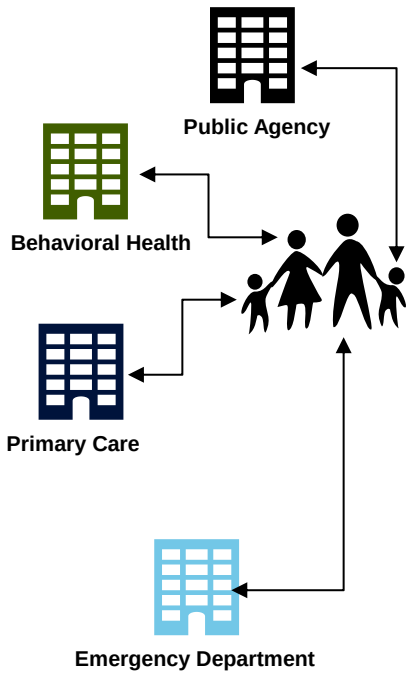
Access:
- Lack of access to community resources throughout the state, and compounded issues to accessibility in various communities

Institutionalization:
- Often either the only resort for care or the path of least resistance

Current Challenge: Limited Clinical and Data Integration

Virginia lacks the integrated clinical and social data infrastructure to optimally serve Medicaid enrollees

Traditional Program-Focused Model



Indicators of Lack of Clinical and Data Integration

Missing Information to Measure Outcomes:
- Lack of right data to measure outcomes
- Mostly limited one-way interfaces

Fragmented Care Delivery:
- Limitations in optimally providing person-centered coordinated care
- Siloed care teams (including across public and private providers for medical and social services)
- Behavioral and medical care is not integrated
- Disjointed care transitions between care settings
- Challenging to establish and maintain home and community based services

Timely Care in Most Appropriate Settings:
- Over reliance on Emergency Departments and institutional care

Current Challenge: Pay for Volume Instead of Value

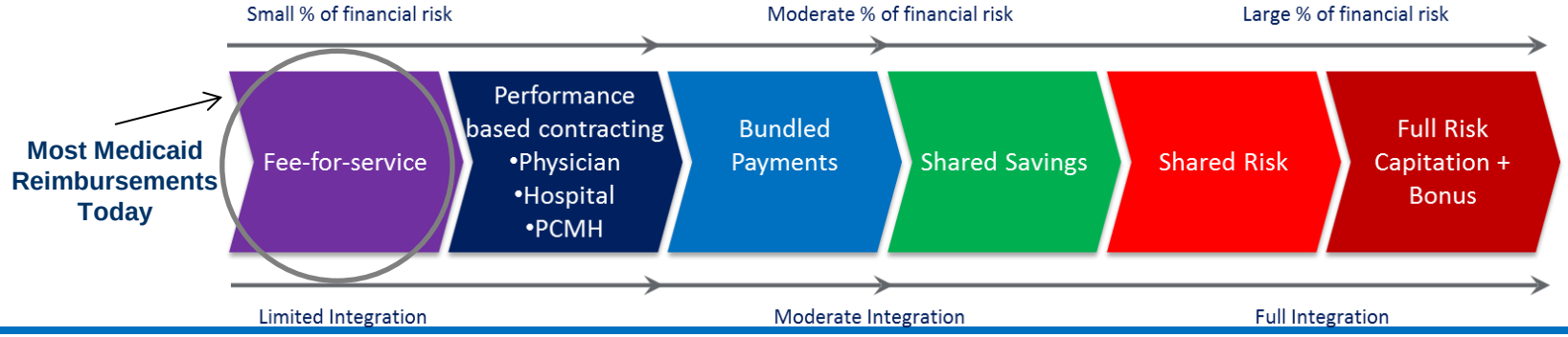
Virginia's Medicaid structure pays providers based on utilization. Medicaid currently pays for visits, not wellness

Indicators of Inefficiencies in Payment System

Utilization:
- Most Medicaid reimbursement is currently tied to utilization and rather than outcomes

Provider Readiness for Alternative Payment Models:
- Current system is set up to primarily support Fee For Service models
- Processes, data, and technology does not currently support alternative payment models

Alignment of Financial Incentives:
- Limited incentives in place for interdisciplinary community-based care



Agenda

- Introduction
- Case for Change
- **Concept for Transformation**
- Opportunity for Public Comment

Greatest Opportunity for Virginia's Medicaid System

DSRIP program is a great opportunity for Virginia to transform

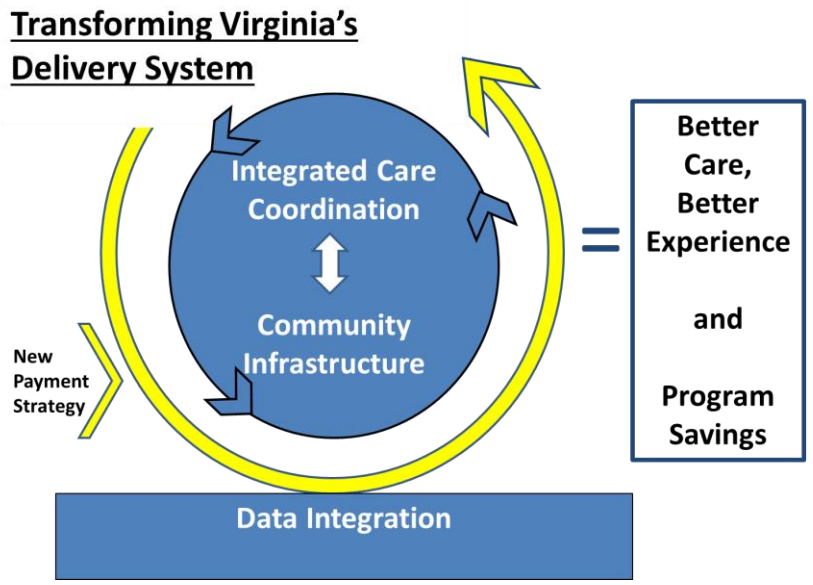
- ✓ The future is a Medicaid delivery system that **reimburses** based on high-value care
- ✓ Ensure that even the most medically **complex enrollees** with significantly behavioral, physical, and developmental disabilities can live safely and thrive in the community
- ✓ To accomplish either of these, significant investment in **data infrastructure** at the provider and state level is imperative

Transforming Virginia's Medicaid Delivery System

In 5 years, Virginia envisions a Medicaid delivery system where high-value care is the norm and even the most medically complex enrollees with significant behavioral, physical, and developmental disabilities can live safely and thrive in the community

Four Transformation Steps:

1. Integrate Service Delivery
2. Invest in Data Integration
3. Expand Community Capacity
4. Advance How DMAS Pays for Services



Transformation Concepts for Medicaid Delivery System

Four key steps to transform Virginia's Medicaid delivery system are:

Transformation Step	Goal
1 Integrate Service Delivery	Eliminate siloed care between medical, behavioral, and community supports
2 Build Data Platform for Integration and Usability	Build the integrated clinical, behavioral, social and support data platform to accelerate provider integration and enable value-based payment
3 Build Community Capacity	Keep individuals safe and facilitate a life of meaning in the community
4 Focus on Value Based Payment Strategy	Establish readiness within Medicaid Providers and Plans to implement and accept value-based payments

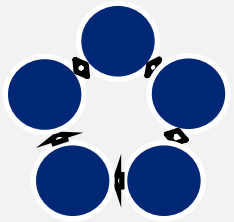
Transformation Step #1: Integrate Service Delivery

Transformation Step # 1: Virginia seeks DSRIP funding to back groups of providers through Virginia Integration Partners (VIPs)

What are Virginia Integration Partners?

Multi-Provider Partnership:

- Coalitions of willing providers interested in forming partnerships
- Public and Private interdisciplinary partnership of providers focused on care coordination
- Partnership may include social worker, medical care and behavioral health providers, and mobile care teams



Coordinating Entity:

- One coordinating entity serves in leadership role across the partnership
- State contracts with coordinating entity for DSRIP funding

State provides planning funds to providers to support formation of VIPs

State consults VIPs to establish a menu of projects to achieve integrated service delivery

VIPs select projects that will equip them to meet outcome goals

State funds VIPs based on achieving pre-determined metrics and outcomes

Transition to value based payment and reimbursement based on attainment of outcomes

Transformation Step #1: Integrate Service Delivery *continued*

Virginia envisions creation of VIPs who are ready to transform to provide team-based, person-centered, integrated care and share in risk and reward of optimal service delivery

Team-based, integrated behavioral health and primary care	▪ Increase interdisciplinary care teams to achieve holistic, person-centered care as the norm ▪ Integrate behavioral and medical care no matter where the individual initiates care (bidirectional)
Mobile Care Teams	▪ Increase access to primary and behavioral care in all regions ▪ Increase access to primary and behavioral care for adults and children with limited mobility or who are otherwise hard to reach through home visits
Care Transitions & Diversions from Institutional Care	▪ Implement comprehensive interdisciplinary care coordination models like the Coleman Model to increase success when transitioning enrollees between care settings (e.g., hospital discharge, nursing facility to home, Psychiatric Residential Treatment Facility) ▪ Transform transition protocols and develop pathways so that home and community based services are easy to establish and maintain
Emergency Department Super-Utilizer Diversions	▪ Implement evidenced-based protocols to reduce non-emergency ED visits for super-utilizers ▪ Expand access for urgent care through extended hours and new providers

Transformation Step #2: Build Data Platform

Virginia seeks DSRIP funding to design the data architecture and build the data platform to enable providers to connect with each other and payors, track outcomes, and be reimbursed for high-value care

Data System Development within VIPs	▪ Build integrated clinical, behavioral, social, and support data platform to accelerate provider integration ▪ Establish data-readiness for providers to conduct team-based care ▪ Establish data-readiness for providers to be reimbursed for outcomes ▪ Develop near real-time data exchange between providers ▪ Develop capacity for business intelligence ▪ Develop capacity for data analytics
Providers Link to a Statewide Care Management System	▪ Build integration to statewide care management system which serves as a central system to enable integrated clinical, behavioral, social data
Statewide Set of Minimum Data Standards	▪ Define and implement evidenced-based data standards to enable transparency and tracking of meaningful measures

Transformation Step #3: Build Community Capacity

Virginia seeks DSRIP funding to build the array of needed community services and providers in a way that is self-sustaining within 5 years

Training for Workforce and Caregivers & Peers	▪ Enhance training for medical professionals so that behavioral health can be integrated as an extension of primary care ▪ Enhance training for medical professionals so that providers are competent and confident to work with people of all ability levels ▪ Expand scope of practitioners to meet capacity and geographic access needs
Statewide Crisis Management	▪ Expand crisis management for children and adults to support and stabilize individuals in their homes and limit the escalation of a crisis that leads to hospitalization
Telehealth	▪ Expand home monitoring for chronic condition management, long-term services and support monitoring, crisis prevention and safety ▪ Expand access to preventative screenings via telehealth ▪ Expand access to providers via telehealth; especially for behavioral health treatment
Housing & Employment	▪ Establish a statewide process for recruiting and tracking safe, affordable housing for Medicaid enrollees ▪ Establish a process for recruiting and tracking employers committed to employing individuals with SPMI or of varying abilities ▪ Develop a platform to make this information available to providers, care managers, and individuals

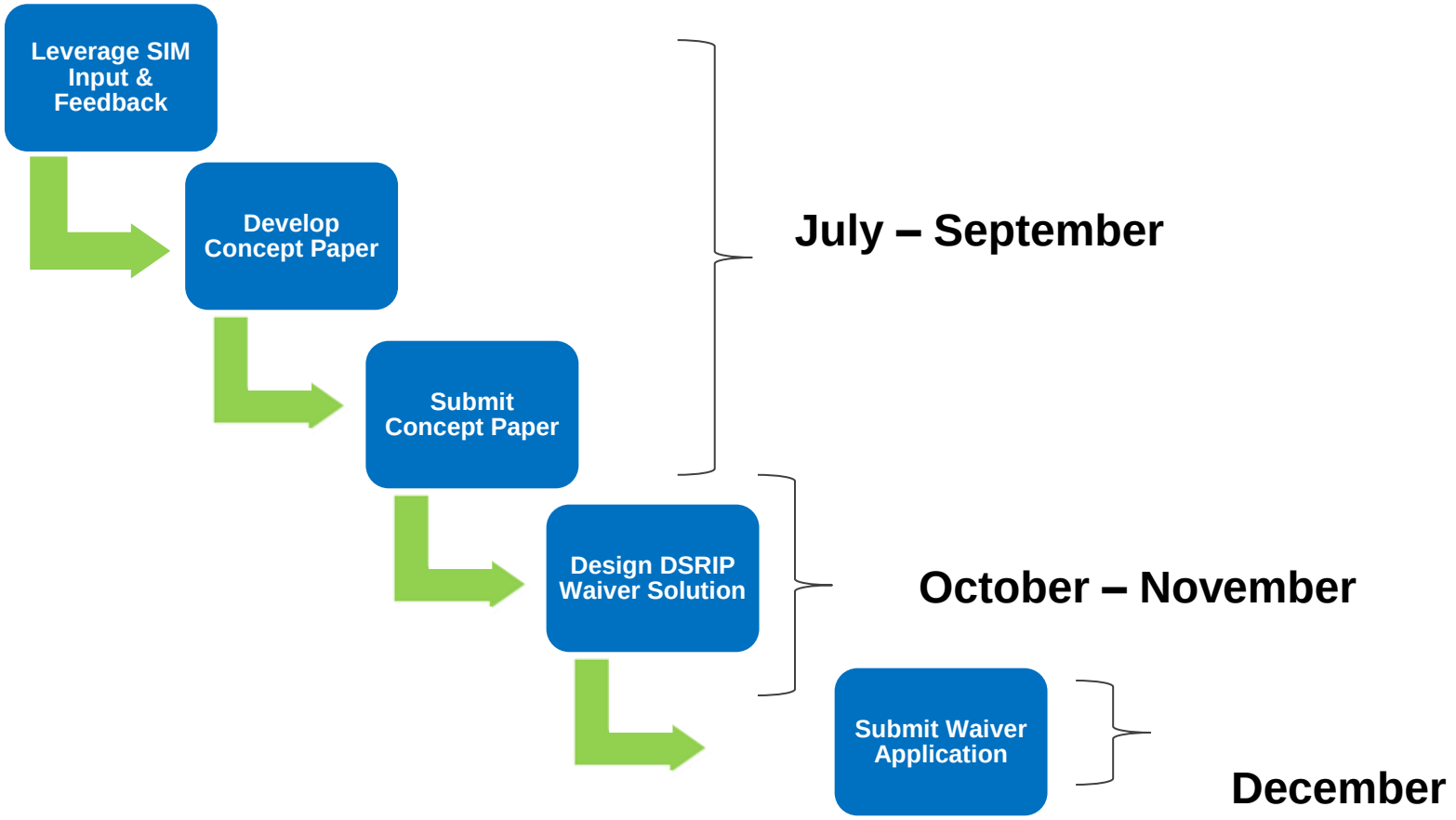
Transformation Step #4: Advance Payment Strategies

Virginia seeks DSRIP funding to prepare Medicaid providers for value-based payment strategies

Readiness of VIPs, other providers, and DMAS-contracted Managed Care Plans	▪ Assess readiness to move to a value-based payment strategy ▪ Define governance and accountability structure ▪ Establish risk-sharing responsibilities ▪ Manage the change ▪ Provide technical assistance and coaching ▪ Achieve readiness to accept value-based payments
Initial Payment Strategies	▪ Implement transition payments to enable providers to make the change to new payment strategies ▪ Establish boundaries for value-based reimbursement strategies
Partner with Medicare	▪ Partner with Medicare and Medicare-Medicaid Coordination Office to develop multi-payor value based reimbursement strategies and eliminate cost-shifting between payors

Virginia's DSRIP Waiver Submission Timeline

The two main deliverables for the DSRIP waiver are the concept paper and waiver application



Agenda

Introduction

Case for Change

Concept for Transformation

Opportunity for Public Comment

Topics for Public Comment

1. **Integrated Clinical and Social Data Exchange:** What is needed?
2. **VIPs:** If the state were to provide guidelines or parameters for participation, what should be included?
3. **Workforce Expansion:** What are recommended trainings for existing workforce, and what are biggest gaps in community workforce?
4. **Individuals in Crisis:** What are the biggest gaps for these individuals in current systems?
5. **Data:** If you have a robust data system, could it be leveraged for DSRIP?

*Until **October 13**, please submit additional questions and feedback to DSRIP@dmas.virginia.gov*

Delivery System Reform Incentive Payment Context and Update

September 2015

Transformation of Virginia's Medicaid Program

Virginia is building on the following key reforms:

1. Enrolled 75% of individuals into **capitated managed care**
2. Over 55% of long-term services and support (LTSS) expenditures are for **home and community-based services**
3. Contracted with a Behavioral Health Services Administrator **(BHSA)** to provide enhanced care coordination, 24 hour crisis support, and to manage a network of quality providers
4. Launched **Commonwealth Coordinated Care** – a Medicare-Medicaid enrollee demonstration to integrate medical, behavioral health, and LTSS

Lingering Limitations in the Payment and Delivery Systems

Transformation is constrained by limitations in:

Reimbursement and Incentives

Delivery System

Especially for individuals accessing behavioral health and long-term services and supports

Additional Transformations Underway

There are additional transformations underway that will improve how services and supports are delivered and reimbursed for Virginia Medicaid's most complex and vulnerable populations.

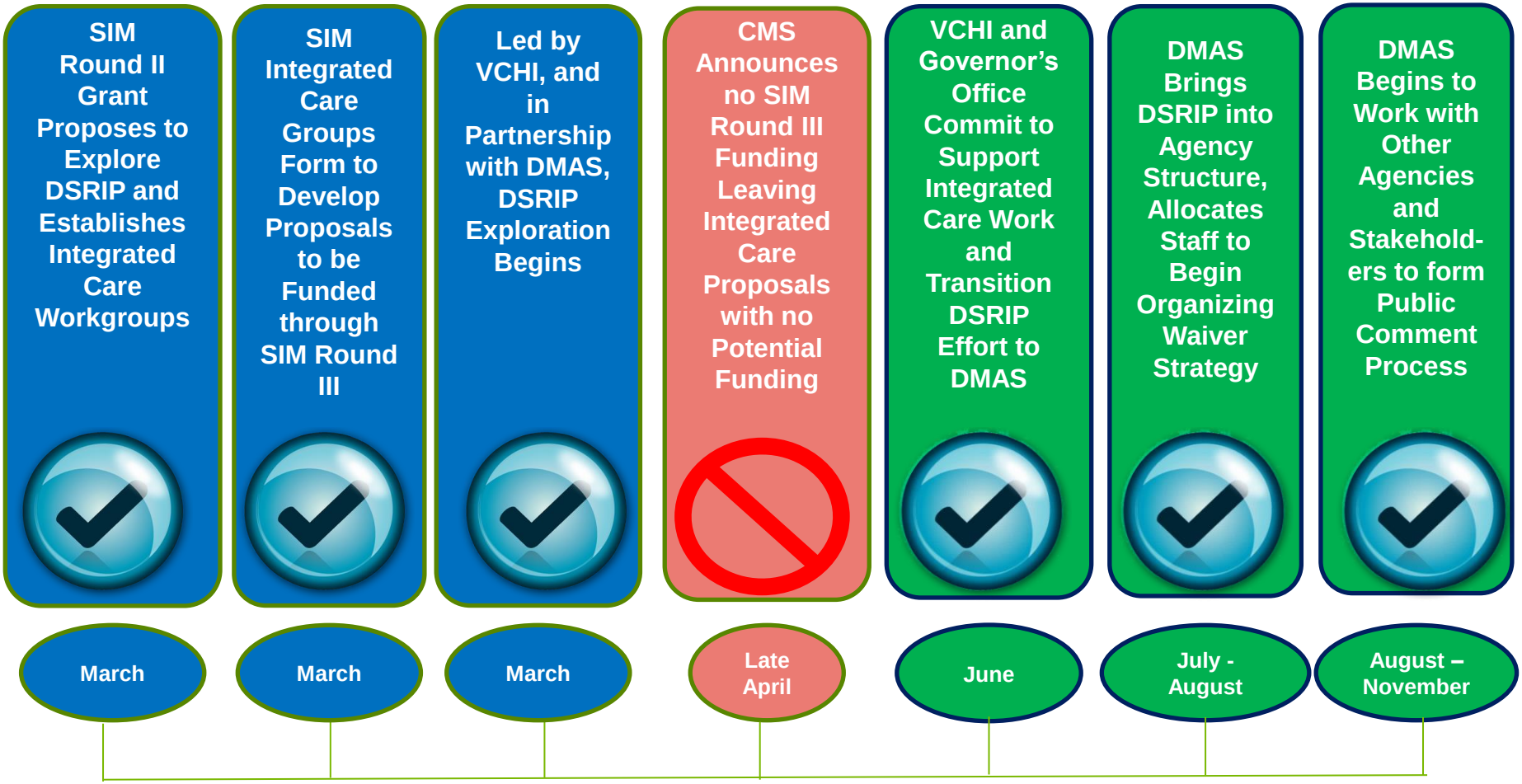
1. Managed Long-Term Services and Supports **(MLTSS)** – aligning with Medicare to transform care and enable individuals with the most complex and high-cost needs to thrive in the community

2. Comprehensive continuum of care that effectively treats the physical, behavioral, and mental dimensions of substance use disorder **(SUD)**

Also looking at how we can leverage the work of SIM

A Third Opportunity – Delivery System Reform Incentive Payment (DSRIP)

Where are we related to DSRIP?



Virginia's Plan for Comprehensive Federal Authority

How does this all fit together?

Virginia seeks 1115 waiver authority to implement three key reform initiatives:

1. Managed Long-Term Services and Supports **(MLTSS)**
2. Comprehensive continuum of care for treatment of substance use disorder **(SUD)**
3. Delivery System Reform Incentive Payment **(DSRIP)** to accelerate transformation of these and other initiatives

Delivery System Reform Incentive Payment Program: The Basics

What is DSRIP?

Medicaid wavier to access federal dollars to invest in transformation of the Medicaid delivery system

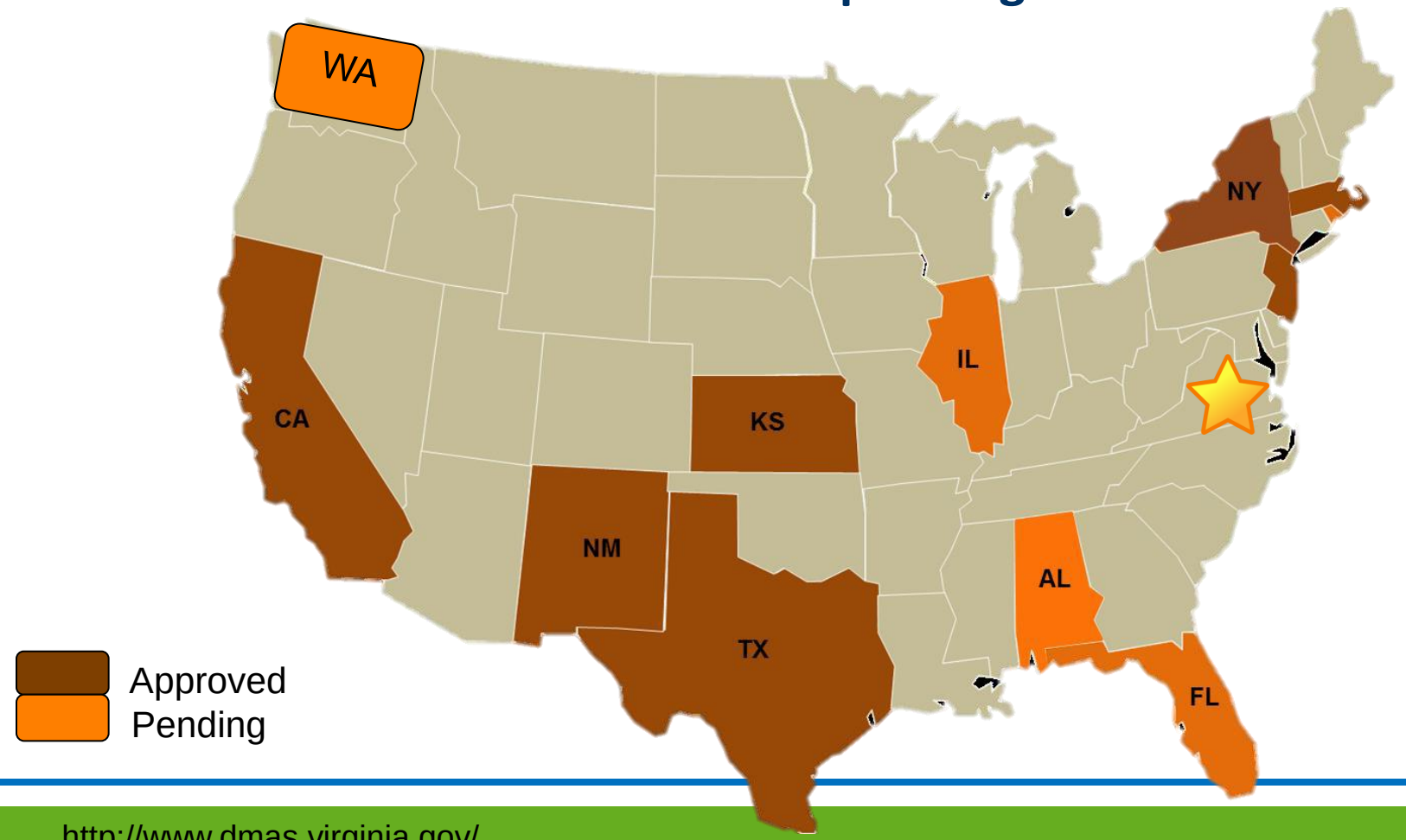
DSRIPs are NOT grant programs, they are performance-based incentive programs. There is no DSRIP "application" from the federal government

CMS has approved seven DSRIP programs to date (CA, NM, TX, KS, NJ, MA, NY)

Helping states move from Fee-for-Service to Value-Based Reimbursement

Approved or Pending DSRIP Programs

In addition to the seven states with approved DSRIP programs, there are five states in pending status



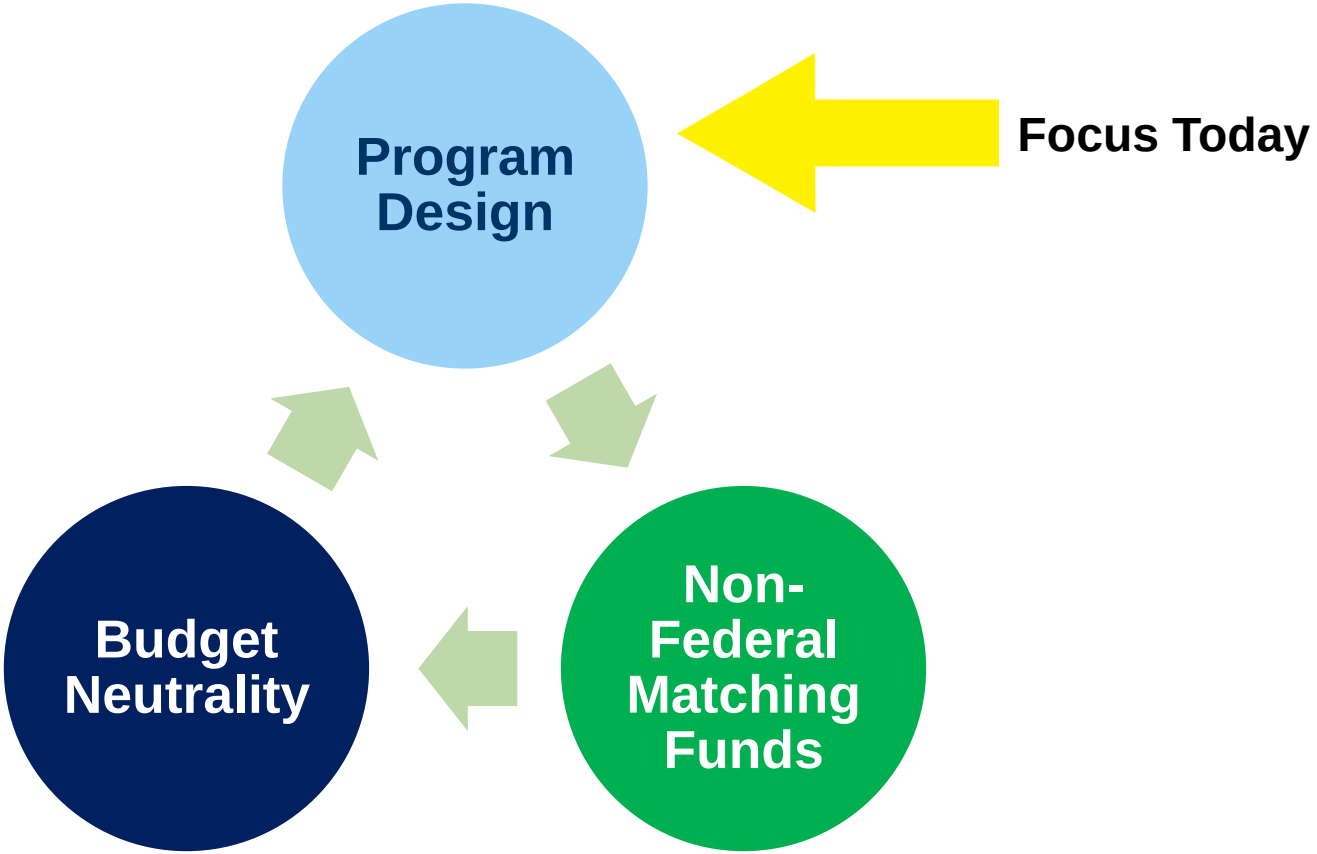
Emerging DSRIP Trends from CMS

Recent discussions with CMS regarding opportunities for Virginia have revealed:

1. Focus on provider readiness for Value-Based Payment
2. DSRIP program must be transformative within 5 years, demonstrate ability to become self-sustaining and eliminate the need for continued federal funding. Do NOT expect for this program to be renewed
3. As the program has grown and expanded, DSRIP programs have evolved across the nation
4. Expectations for the state to be a financial shareholder in the program

Main Components of DSRIP Program

There are three main components of a DSRIP Program



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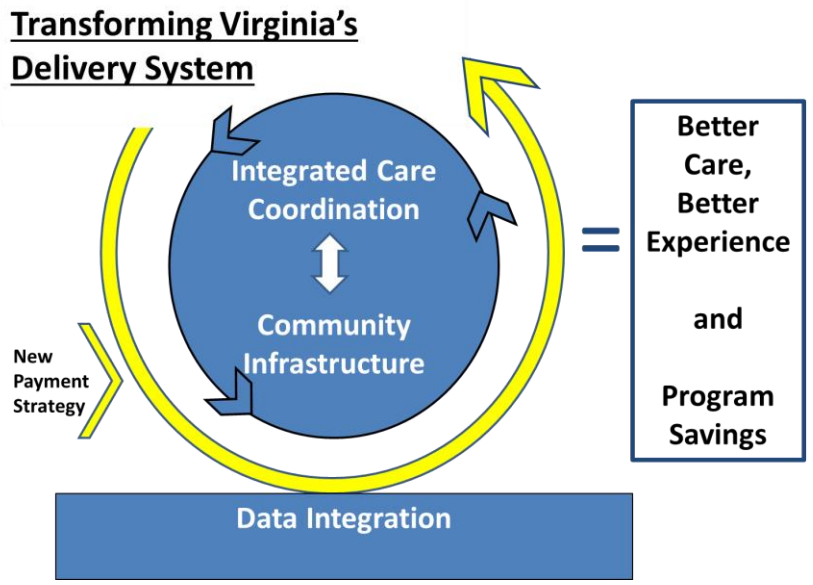


Additional Resources

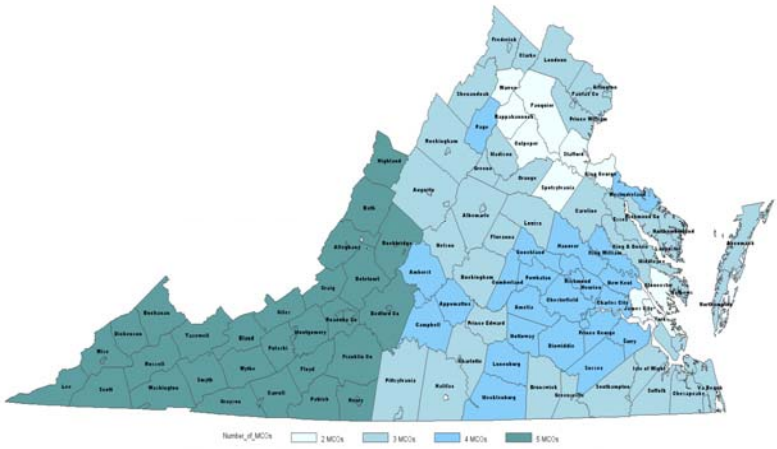
- DMAS Website (www.dmas.virginia.gov)
- TownHall (www.townhall.virginia.gov)
- Concept Paper
- Public Comment Period
- DSRIP@dmas.virginia.gov

A Quick Run through NCQA, Quality and the Medallion 3.0 program

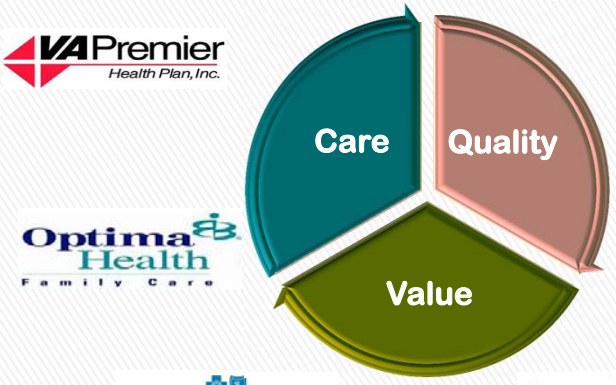
Cheryl Roberts, Deputy of Programs
Board of Medical Assistance Services
September 15, 2015

Let's Take a Quick Run ›

Statewide Medallion 3.0 Managed Care Coverage

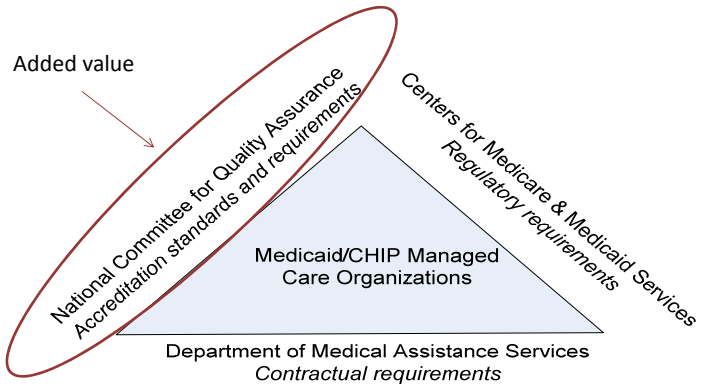


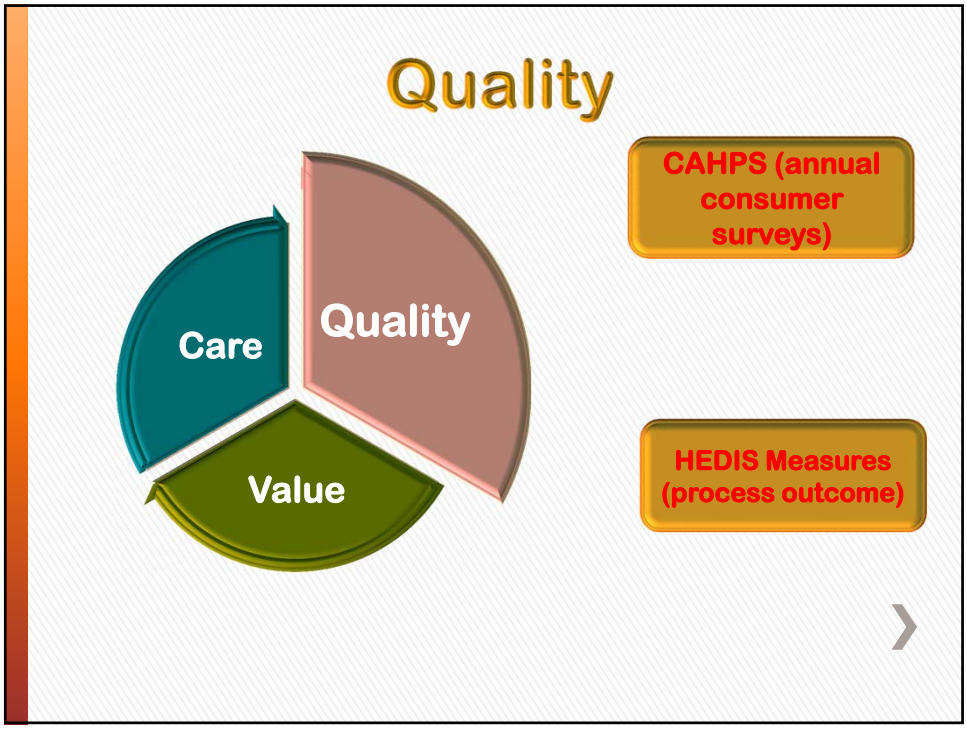
Virginia's Medallion 3.0 Managed Care Organizations



VA Premier Health Plan, Inc.
KAISER PERMANENTE
Optima Health Family Care
CoventryCares of Virginia
Anthem HealthKeepers Plus Offered by HealthKeepers, Inc.
INTotal Health Every Time. Every Touch.

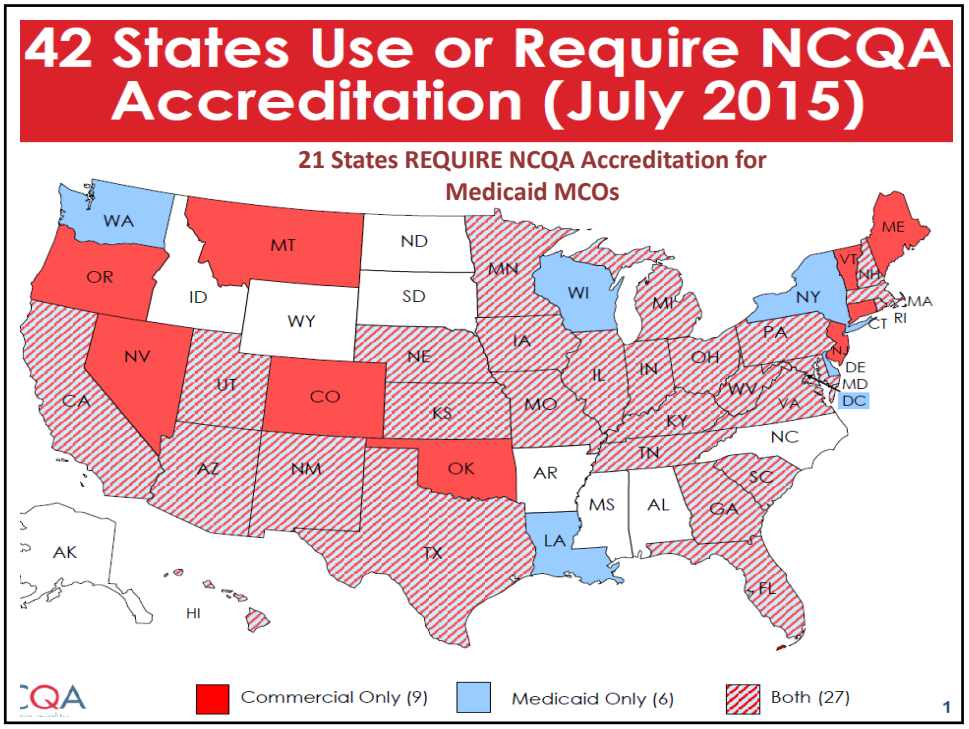
Virginia Medallion 3.0 Managed Care Quality Framework





NCQA - The National Committee for Quality Assurance

- **The National Committee for Quality Assurance** (NCQA) is an organization that:
- Strives to improve health care quality processes through the development of measure standards, analysis and
- Developed a nationally recognized methodology in the accreditation of health plans



Medallion 3.0 and NCQA

- Since 1997 , DMAS requires the Medallion 3.0 Health plans to have NCQA accreditation.
- It was part of our quality focus and mission
- The quality measures (HEDIS) are of high importance to DMAS and the MCOs
- The annual HEDIS scores and CAHPS surveys have a significant impact on the MCO accreditation level and our program evaluation.

Quick run through HEDIS

HEDIS Measures

- The **Healthcare Effectiveness Data and Information Set** (HEDIS) is one of the most widely used set of health care performance measures in the United States.
- The term "HEDIS" originated in the late 1980s as the product of a group of forward-thinking employers and quality experts, and was entrusted to NCQA in the early 1990s.
- See more at: http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures.aspx#sthash.Uq4ktkie.dpuf

HEDIS Measures :

- There are 80 plus measures in 5 domains
- Tested for validity and reliability prior to being adopted as a required HEDIS measure by NCQA
- Based on evidence based clinical guidelines
- Used industry-wide, enabling comparisons and identifying opportunities for improvement
- Rarely controversial
- Retired if clinical guidelines change or for other reasons that may deem a measure as no longer useful

HEDIS - FACTS

Did you know?

- There are more than 60 HEDIS measures that each Medicaid MCO has to calculate and report the scores for annually?!
- The "technical manual" for HEDIS includes detailed specifications on how to calculate each measure – it is nearly 1 inch thick?!
- Some of the HEDIS measures can be calculated through claims data, while others require abstraction of medical records (around 400 medical records per measure) in addition to claims data?!
- DMAS has a priority list of measures that are part of the Medallion 3.0 contract and reflects the population we serve.

Current set of High Priority HEDIS measures in Medallion 3.0 for children

- **Childhood immunization status – combo 3**
- Well child visits first 15 month of life
- Well child visits in 3rd,4th, 5th and 5th years of life
- Adolescent well care visits
- Follow-up care for children prescribe ADHD medication
- Use of first line psychosocial care for children and adolescence

Current set of High Priority HEDIS measures in Medallion 3.0

For Women

- **Timeliness of prenatal care**
- Postpartum visits
- Cervical cancer screening
- Breast cancer screening

For Behavioral Health

- Antidepressant medication management
- Follow-up after hospitalization for mental illness

Current set of High Priority HEDIS measures in Medallion 3.0 for Adults

- **Controlling high blood pressure**
- Medication management for Asthma
- Medical assistance with smoking and tobacco use cessation

- Comprehensive diabetes care
- Adult access to preventive and ambulatory services

- HEDIS measure in top 50% nationally
- **HEDIS** measures in Performance Incentive program

Higher Measures ?

Partnerships for Better Results

- Successful and high quality measures are obtained as partnership of care and documentation with the patients, physician community and the plans.
- DMAS sets the stage through its contractual provisions.
- DMAS is meeting with key provider groups to emphasize key measures.
- DMAS is changing member information to support programs.
- MCOs incentivize providers with shared savings.
- Plans affect patients behavior through specialized program , technology, education , outreach and care management.
- DMAS is implementing a performance based financial incentive program for the plans
- The priority HEDIS measures were selected in collaboration with the MCOs,
  - based on population health improvement needs, and
  - in alignment with other lines of business in managed care across the state.

"H" in CAHPS is for Happy

CAHPS -

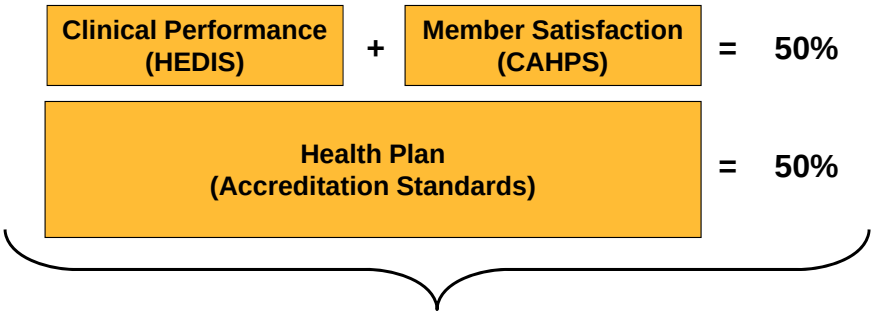
- **Consumer Assessment of Healthcare Providers and Systems** (CAHPS) surveys ask consumers and patients to report on and evaluate their experiences with health care.
- These surveys cover topics that are important to consumers and focus on aspects of quality that consumers are best qualified to assess, such as the communication skills of providers and ease of access to health care services

NCQA Plan Accreditation

NCQA Accreditation and Rankings

- NCQA accredits Medicaid commercial and Medicare Plans and ranks them .
- There are six accreditation levels
  - Excellent
  - Commendable
  - Accredited
  - Provisional
  - Interim
  - Denied

NCQA Health Plan Accreditation



Based on standards and clinical performance

NCQA Measuring quality. Improving health care.

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Medallion 3.0 Rankings

MCO Name	NCQA Accreditation Level	NCQA Rankings There are a total of 151 Accredited Medicaid MCOs	NCQA Accreditation Status
Anthem	Commendable	#79	NCQA renewal 04/2018
Coventry Cares	Commendable	#53	NCQA renewal 04/2018
INTotal	Accredited	#97	NCQA renewal 02/2017
Optima	Commendable	# 72	NCQA renewal 05/2018
VPHP	Commendable	#62	NCQA renewal 07/2016
Kaiser*	Commendable	N/A	NCQA renewal 07/2016

We have now completed our quick Run

Questions

To Infinity and Beyond!!! Performance Monitoring of Virginia's MLTSS and Behavioral Health Programs

Karen Kimsey
Deputy Director of Complex Care & Services
Virginia Department of Medical Assistance Services
September 15, 2015

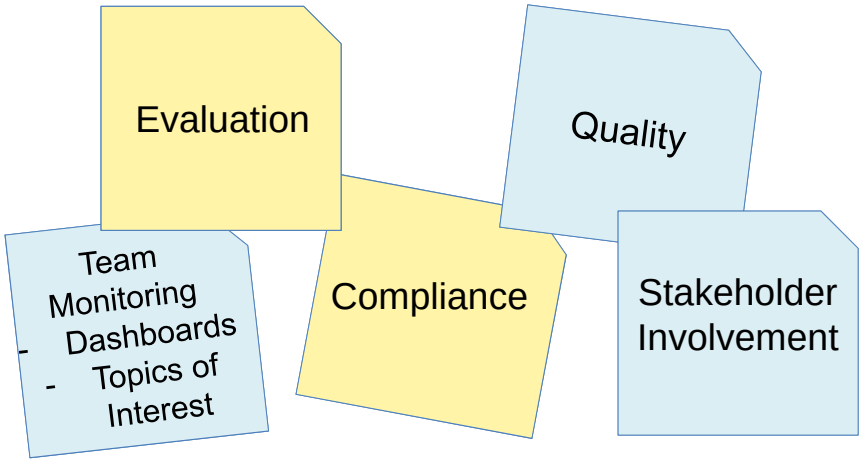
Overview

- Quality Overview – Both Programs
- CCC Specific Methods
- BHSA Specific Methods
- Questions

Magellan HEALTHCARE℠

Commonwealth Coordinated Care
Medicare & Medicaid working together for you

Methods for Assessing Performance and Program Improvement



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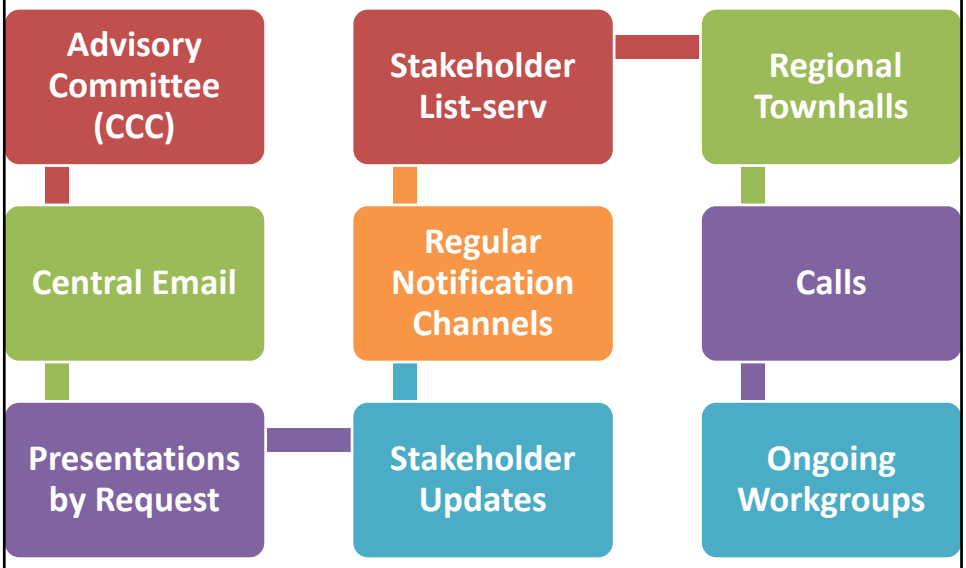
Multi-faceted Stakeholder Engagement



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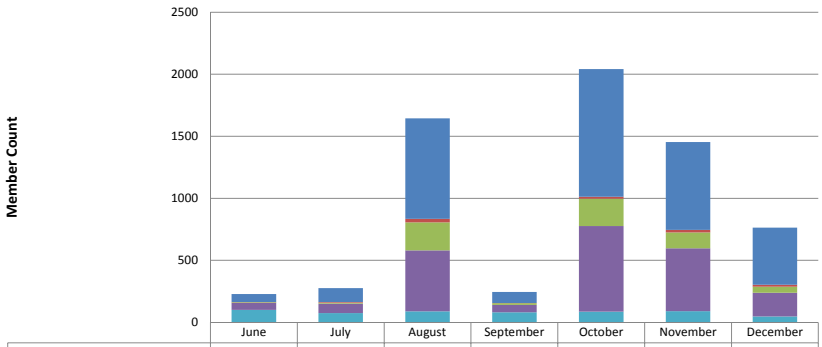
CCC Quality

1. Reporting metrics
2. State specific reporting methodology
3. PIPs and QIPs
4. Internal Committee
5. MMP Collaborative
6. Quality stakeholder workgroup

5

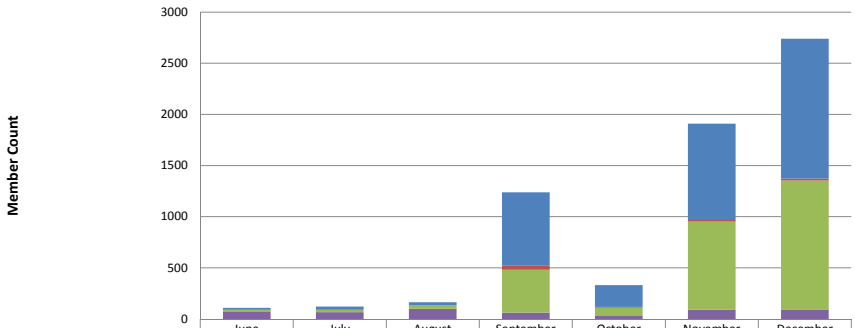
CCC Monitoring Dashboard
Health Risk Assessment Completion



	June	July	August	September	October	November	December
Total Due (A)	64	113	810	89	1030	708	461
Member Unwilling (B)	2	4	28	1	15	21	15
Unable to Locate (C)	4	8	226	14	220	127	49
Total Completed (D)	58	76	492	60	690	507	191
Completion Rate (%) = {D/(A-B-C)}	100	75.2	88.5	81.1	86.8	90.5	48.1

6

CCC Monitoring Dashboard
Nursing Facility Plan of Care
Completed within 90 days



	June	July	August	September	October	November	December
Total Due (A)	20	32	32	717	213	942	1367
Member Unwilling (B)	0	1	0	39	8	16	19
Total Completed (D)	15	21	32	420	75	859	1260
Completion Rate (%) = {D/(A-B)}	75	67.7	100	61.9	35.6	92.8	93.5

7

Other Performance Activities

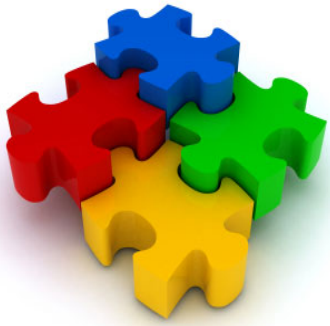
- Observations (HRAs, ICTs, POCs)
- Meetings/Trainings with MMPs
- Onsite reviews and technical assistance
- Regular reports from State LTC Ombudsman (Department of Aging and Rehabilitative Services)

Commonwealth Coordinated Care
Medicare & Medicaid working together for you

8

Care Coordination

- Heart of the program!
- Quarterly trainings based on observations and feedback
  - Pre/ post test, evaluation
  - Topics include MLTSS and contract requirements
- Currently holding monthly calls for the Care Coordinators for Q&A on various topics



Commonwealth Coordinated Care
Medicare & Medicaid working together for you

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Evaluation Activities

- National level activities
  - RTI (Virginia Evaluation Plan)
  - Kaiser Family Foundation Issue Brief: "Early Insights from Commonwealth Coordinated Care: Virginia's Demonstration to Integrate Care and Align Financing for Dual Eligible Beneficiaries: http://kff.org/medicaid/issue-brief/early-insights-from-commonwealth-coordinated-care-virginias-demonstration-to-integrate-care-and-align-financing-for-dual-eligible-beneficiaries/
- State level evaluation (partnership with George Mason University)
  - Focus groups
  - Evaluation Advisory Committee
  - Observations ("Notes From the Field")
  - Quarterly meetings with each MMP

Commonwealth Coordinated Care
Medicare & Medicaid working together for you

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BHSA (Fee for Service) Quality

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Magellan HEALTHCARE

Sample Portion of Report Card

Month/Year				Apr-15	May-15	Jun-15
FUNCTIONAL AREA	INDICATORS	DATA SOURCE	STANDARD			
GRIEVANCES						
Member	Member Grievances Received	Monthly Summary-CLN14	Trend	5	5	4
	Grievances Resolved	Monthly Summary-CLN14a+b	Trend	7	6	3
	Grievances Pending	Monthly Summary-CLN14c		4	3	4
	Percentage of Grievances Timely	Monthly Summary-CLN14e	Trend	100%	100%	100%
Provider	Provider Grievances Received	Monthly Summary-CLN15	Trend	10	5	4
	Grievances Resolved	Monthly Summary-CLN15a+b	Trend	6	10	5
	Grievances Pending	Monthly Summary-CLN15c		8	3	2
	Percentage of Grievances Timely	Monthly Summary-CLN15e	Trend	100%	100%	100%
RECONSIDERATIONS						
	Non-EPSDT	Monthly Summary-CLN17	Trend	22	28	29
	EPSDT	Monthly Summary-CLN18	Trend	1	0	35

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Magellan HEALTHCARE

BH Quality Improvement

- A comprehensive Quality Improvement (QI) Program is administered through Magellan of Virginia for FFS and non-traditional behavioral health services.
- A QI Committee is made up of Magellan leaders and stakeholder/member representation. DMAS monitors all activities.
- There are 4 subcommittees that focus on member services, utilization management, treatment record reviews and network.
- DMAS reviews, approves and monitors all QI activities.

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Magellan HEALTHCARE

Treatment Record Reviews (TRR)

Records may be requested as a result of a complaint or grievance, concerns reported from the clinical reviewers or as part of a sample review for adherence to clinical practice guidelines.

QI Plan involves reviewing records to ensure:

- Proper care coordination with PCP
- Appropriate discharge planning
- Compliance with Medicaid requirements

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Comprehensive Network Summary

Covered Services	Provider Count 3.25.15	Provider Count 4.10.15	Provider Count 5.10.15	Provider Count 6.10.15	7.10.15
23 Hour Observation Bed, Psych - General Hospital	2	2	2	2	2
Case Management, Foster Care Treatment	92	92	93	93	93
Case Management, MH	231	231	230	235	236
Case Management, SA	167	167	166	168	169
Closed Panel	0	0	5	38	49
Cmnty-Based Residential Group Home, Level A - MH	27	27	26	26	26
Cmnty-Based Residential Group Home, Level B - MH	49	49	49	49	49
Crisis Intervention, MH (per 15 min)	219	218	218	220	221
Crisis Intervention, SA (per 15 min)	121	121	121	123	124
Crisis Stabilization (per hour)	159	158	158	158	158
Day Treatment, SA	14	14	14	14	14
Day Treatment, SA (for pregnant or post-partum women)	3	3	3	3	3
Hospitalization, Psychiatric - Freestanding Psych Hospital	15	15	15	15	14
Hospitalization, Psychiatric - General Hospital	72	72	73	77	79
In-Home Bhvrl Therapies (ABA)	215	225	250	254	253
Intensive Community Treatment	36	36	36	36	36
Intensive In-Home Services	436	436	440	441	443
Intensive Outpatient, SA	78	78	79	79	79
Mental Health Skill-Building Services (MHSS)	595	594	595	600	601
Opioid Treatment	26	26	26	26	26
Partial Hospitalization, Psych--Day Treatment (Adults)	28	28	28	28	28
Psychosocial Rehabiliation	101	101	101	102	105
Residential Treatment Facility-Level C	31	33	34	34	34
Residential, SA (Pregnant & Post-partum Women)	4	4	4	4	4
Therapeutic Day Treatment (Children, Adol)	1,436	1,435	1,437	1,441	1,453
Traditional Outpatient Therapy-MH	5,840	5,903	5,993	6,405	6,490
Traditional Outpatient Therapy-SA	2,256	2,278	2,315	2,359	2,403
Total Distinct Providers/Service Address	**7,915**	**7,987**	**8,109**	**8,540**	**8,640**

Disclaimer: counts are base on distinct Provider and Service Location.

	3.25.15	4.10.15	5.10.15	6.10.15	7.10.15
*Providers can appear in multiple buckets					
Unique TIN Count:	1,601	1,613	1,621	1,631	1,639
Unique NPI Count:	4,545	4,580	4,653	4,863	4,919
Total Distinct Providers/Service Address:	7,915	7,987	8,109	8,540	8,640

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Magellan HEALTHCARE

BH Network

- All providers are assigned a Network Representative who is personally available to assist and support provider understanding and compliance with network participation requirements.
- QI Plan involves activities to ensure:
  - Provider Satisfaction
  - Network Adequacy

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Monthly Stakeholder Updates

- Magellan provides a monthly update which includes:
  - Utilization, Authorization and Claims Data
  - Trends and Patterns in Services
  - Readmission Rates
  - Committee Work
  - Call Center Productivity
    - Crisis Calls
  - Network Activity
  - Grievances and Appeals
  - Quality Improvement /Compliance Activities
  - Updates of Learning Collaboratives

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Special Investigations Unit - June Type of Allegation

Allegation Type – June 2015	Subtotal
Billing for Services Not Rendered	2
Misrepresentation of CPT Codes	1
Misrepresentation of Diagnosis	1
Misrepresentation of Provider	1
Grand Total	**5**

Allegation Type – 2013 to present	Subtotal
Altered Company Documents	3
Altered Medical Record	1
Billing for Services Not Rendered	16
Double Billing	1
Enrollment Fraud	2
Fabricated Records	1
Forgery	1
Law Enforcement RFI	1
Misrepresentation of CPT Codes	1
Misrepresentation of Diagnosis	2
Misrepresentation of Provider	1
No Allegation of FWA	1
Other	1
Quality of Care	2
Unnecessary Services	1
Grand Total	**35**

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Questions?

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Department of Medical Assistance Services
9/11/2015

Cost Estimate: Dental Coverage for Adults

- There are approximately 400,000 adults enrolled in Medicaid over the course of a year who do not currently receive dental coverage (beyond emergency procedures)

- Based on dental utilization rates of 19-20 year olds in Medicaid who have access to full dental coverage and other research, DMAS estimates that a **utilization rate of 27%,** that is 27% of the 400,000 enrolled adults (108,000) will receive dental services

- The estimated cost to provide **Full Dental Coverage** for Adults is **$76M** ($38M GF) **a year.** It is only $50M ($25M GF) the first year because of program implementation and billing and payment lags. Projected expenditures grow in future years with enrollment growth.

	Full Dental Benefit For Adults		
	GF	NGF	TF
SFY2017	$24,754,272	$24,754,272	$49,508,544
SFY2018	$37,806,525	$37,806,525	$75,613,049
SFY2019	$39,696,851	$39,696,851	$79,393,702

- Based on claims analysis of 19-20 year olds in Medicaid who have access to full dental coverage, approximately 20% have annual non-surgical (proxy for non-emergency dental) expenditures exceeding $500 and the spending over $500 accounts for 40% of the total non-emergency dental spend

- Based on the above analysis, the estimated cost to provide **Limited $500 Dental Benefit** for Adults is **$45M** ($22.7M GF) **a year.** It is only $38M ($19M GF) the first year because of program implementation and billing and payment lags. Projected expenditures grow in future years with enrollment growth.

	Limited $500 Dental Benefit for Adults		
	GF	NGF	TF
SFY2017	$18,813,247	$18,813,247	$37,626,494
SFY2018	$22,683,915	$22,683,915	$45,367,830
SFY2019	$23,818,111	$23,818,111	$47,636,221

- There would be additional administrative costs for claims processing and authorizations incurred with implementation of a dental benefit for adults. These have not been estimated at this time; however, these would be minimal compared to the service costs.

Department of Medical Assistance Services

Medicaid DSH and the Affordable Care Act

Presentation to the:

Board of Medical Assistance Services

September 15, 2015

http://dmas.virginia.gov

Department of Medical Assistance Services

Medicaid Hospital Payment Policy

- Unlike commercial payers, Medicaid (and Medicare) target payments to hospitals based on hospital characteristics (separate payments for operating, capital, medical education and disproportionate share)
- In many ways, DSH is just another payment
- What matters to a hospital is total reimbursement

Department of Medical Assistance Services

What is DSH?

- Federal requirement that states provide for "Disproportionate Share Hospital" (DSH) payments to hospitals that serve a "disproportionate" number of Medicaid and low income patients.
- Federal rules set:
  - Minimum criteria for which hospitals must qualify
  - A minimum payment adjustment for those hospitals
- As long as a state satisfies the federal minimum criteria, it has wide latitude to craft its own DSH payment policy
- DSH can be specifically used to pay for uninsured costs, not just Medicaid costs

Department of Medical Assistance Services

DSH Limitations

- Each state has an "allotment" of federal DSH funds
  - DSH spending is separately reported
  - Federal funds for DSH are not available beyond the allotment
  - State allotments were based on historical DSH expenditures in the early nineties
  - Virginia DSH allotment is low compared to other states (Virginia allotment per Medicaid member is 41st out of 50 states plus DC)
- Each hospital has a DSH limit
  - DSH payments to a hospital cannot exceed the Uncompensated Care Costs (UCC)
    - Medicaid losses for both FFS and MCO expenditures
    - Uninsured costs
  - States are required to audit UCC and determine that DSH does not exceed UCC

Department of Medical Assistance Services

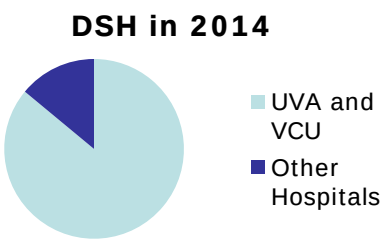
Virginia DSH Policy

- Partial financial relief to private hospitals that have a high proportion of Medicaid patients
- Pay up to the uncompensated care costs for Children's Hospital of the King's Daughters
- Maximize use of remaining federal funds to support indigent care at state teaching hospitals (UVA and VCU)
  - Gradually replaced GF-only funding for indigent care at UVA and VCU beginning in 1991
  - In FY14, DMAS estimates $207 million ($104 million in federal funds) in DSH payments to UVA and VCU

Department of Medical Assistance Services

Who Gets DSH and How Much

- Hospitals with >14% Medicaid utilization
  - 33 private hospitals (including 11 out-of-state hospitals)
  - CHKD
  - Catawba and Piedmont (DBHDS Geriatric Facilities)
  - UVA and VCU
- The majority of DSH goes to UVA and VCU



Department of Medical Assistance Services

ACA Reduction to DSH

- ACA reduced Medicaid DSH because the expansion of private insurance and Medicaid was expected to reduce the number of uninsured and hospital uncompensated care costs
- Not all states expanded Medicaid
- Congress directed Secretary to develop methodology that reflected reduction in uninsured
- DSH reductions initially were to start in FFY14
- Congress has twice delayed implementation of the DSH reductions but not reduced the total reduction through FY22
- Reductions now will be implemented in FFY17

Department of Medical Assistance Services

Federal Allotment and Reductions

FFY	Pre ACA DSH	ACA Reductions	Reduced DSH
2014	93,430,890	-	93,430,890
2015	95,766,662	-	95,766,662
2016	98,160,829	-	87,683,337
2017	100,614,850	15,716,238	84,898,612
2018	103,130,221	41,036,844	62,093,377
2019	105,708,476	41,036,844	64,671,632
2020	108,351,188	41,036,844	67,314,344
2021	111,059,968	41,909,968	69,150,000
2022	113,836,467	43,656,217	70,180,250
Total Reduction		224,392,954	

Federal DSH allotment is matched by state general funds

Department of Medical Assistance Services

Options to Address DSH Reductions

- Reduce total payments to hospitals
- Substitute other payments
  - Other payments may be less targeted
  - Other payments may also be limited
- Expand Medicaid

Department of Medical Assistance Services

Recent Virginia DSH Changes

Effective July 1, 2014

- DMAS worked with the VHHA and the Hospital Payment Policy Advisory Council to develop a sustainable DSH policy for private hospitals:
  - Designates $24 million in DSH funds for private non-children's hospitals beginning in FY15 based on historical DSH for private non-children's hospitals
  - Establishes an equitable distribution of those funds among private non-children's hospitals
  - Adjusts funding automatically consistent with changes in the allotment (including ACA reductions to DSH)
  - Authorizes non-DSH reimbursement increases to replace any ACA reductions to DSH for private hospitals
- Continues to use the remaining DSH to fund indigent care at UVA and VCU

Regulatory Activity Summary for September 15, 2015
(* Indicates recent activity)

2015 General Assembly

(01) Expand Alzheimer's Waiver: This regulatory action is required by 2015 budget language. This regulation will more broadly define eligible individuals that may be served by the Alzheimer's Assisted Living waiver program. The final exempt regulation is scheduled to be published in the Register on 8/10/15 and will become effective on 9/9/15.

(02) Pre-Admission Screening Changes: This regulatory action is required by 2015 budget language. The regulation will improve the preadmission screening process for individuals who will be eligible for long-term care services. These regulatory changes are currently being drafted.

***(03) Sterilization Compensation:** This regulation will allow DMAS to seek federal authority to exclude (for purposes of determining Medicaid eligibility) compensation provided to individuals who were involuntarily sterilized pursuant to the Virginia Eugenical Sterilization Act. A state plan amendment containing this change was approved by CMS on July 30, 2015 and VAC changes are being reviewed by the OAG.

***(04) FAMIS MOMS Eligibility for State Employees:** This regulatory action will permit low-income state employees and their dependents to obtain coverage through FAMIS MOMS. The NOIRA for this package is being printed in the Register on 9/7/2015, which will open a 30-day public comment period. After the comment period closes on 10/7/2015, the regulation will move to the proposed stage.

***(05) Technology Assisted Waiver Changes:** This regulatory action will change the use of private duty nursing; change the staff experience requirement to include a training program; and remove the reference to exhausting private insurance coverage. The NOIRA was submitted to the Governor for review on 7/17/15.

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(06) Standards for Home and Community-Based Settings: This regulatory action will require providers to comply with all of the relevant requirements of 42 CFR 441.530 et seq. with regard to the qualities required for community settings. These text changes are currently being drafted.

***(07) Non-Institutional Provider Reimbursement Changes:** This regulatory action combines three separate items required by 2015 budget language. First, this regulatory action will eliminate the requirement for pending, reviewing, and reducing fees for emergency room claims. Second, it will increase supplemental payments for physicians affiliated with freestanding children's hospitals with more than 50 percent Virginia Medicaid inpatient utilization effective July 1, 2015. Third, it will establish supplemental payment for state clinics operated by the Virginia Department of Health (VDH) effective July 1, 2015. A prior public notice was published and a state plan amendment (SPA) is currently being reviewed by DMAS staff prior to submission to CMS.

***(08) Institutional Provider Reimbursement Changes**: This action will eliminate inflation for inpatient hospital operating, graduate medical education, disproportionate share hospital, and indirect medical education payments in FY16. It will also implement the "hold harmless provision" for nursing facilities that meet the bed capacity and occupancy requirements, reimbursing with the price-based operating rate rather than the transition operating rate for those facilities. A prior public notice was published and a SPA is currently being reviewed by the Secretary of Health and Human Resources prior to submission to CMS.

(09) Supplemental Payments to Medical Schools in Eastern VA: This action will update the average commercial rate calculation of supplemental payments for physicians affiliated with a publicly funded medical school in Tidewater effective October 1, 2015. A prior public notice was published and a SPA is being drafted.

(10) MAGI: This action implements Modified Adjusted Gross Income (MAGI) thresholds in the Medicaid program and Children's Health Insurance Program (CHIP) in accordance with federally mandated eligibility determination requirements created under the Affordable Care Act. Multiple state plan amendments were submitted to CMS and approved in November and December, 2013. This final exempt regulation copies the state plan changes into state regulations. The final exempt regulations and Town Hall background document were submitted to the Office of the Attorney General (OAG) on 6/22/15.

***(11) CHIP Eligibility – Same Sex Marriage:** This action changes the Virginia state plan to recognize same-sex couples as spouses for purposes of determining CHIP eligibility. The CHIP state plan amendment was submitted to CMS on 6/25/15. Once the SPA is approved, regulatory changes will be drafted.

***(12) Medicaid Eligibility – Same Sex Marriage:** This action changes the Virginia state plan to recognize same-sex couples as spouses for purposes of determining Medicaid eligibility. The Medicaid state plan amendment was submitted to CMS on 7/30/15. Once the SPA is approved, regulatory changes will be drafted.

***(13) Treatment of Annuities:** This action complies with a federal Deficit Reduction Act, which requires DMAS to treat annuities and income from annuities according to certain rules, for purposes of determining Medicaid eligibility. Regulatory changes are being drafted.

***(14) Hospital Presumptive Eligibility:** In 2014, DMAS submitted a SPA to CMS to permit certain hospitals to make presumptive eligibility determinations for individuals seeking to be treated at those hospitals. The SPA was approved on July 28, 2015, and DMAS is reviewing related regulatory changes.

***(15) Supplemental Payments for Private Hospital Partners:** CMS approved SPAs permitting DMAS to make supplemental payments to private hospital partners, and DMAS has drafted related regulatory changes. These changes are being reviewed internally before being submitted to the OAG for certification.

***(16) Property Sales at Less Than Tax-Assessed Value:** This action complies with federal changes by changing the Medicaid eligibility rules that relate to property sales at less than tax-assessed value. Regulations are currently being drafted.

***(17) Reimbursement Changes for Fee-For-Service Providers and Services that Are Reimbursed on a Cost Basis:** CMS approved SPAs so that DMAS reimbursed fee-for service providers, and services based on a cost basis, according to certain requirements. DMAS drafted regulatory changes, which are being reviewed internally before being submitted to the OAG for certification.

2014 General Assembly

***(01) Discontinue Coverage for Barbiturates for Duals:** This SPA, effective January 1, 2014, enacts Section 2502 of the Affordable Care Act which amended section 1927(d)(2) of the *Social Security Act*. It excluded from Title XIX coverage for all conditions for barbiturates, by removing barbiturates and agents when used to promote smoking cessation from the list of drugs a state Medicaid program may exclude from coverage or otherwise restrict. The SPA was approved by CMS on 4/23/14. The Fast-Track regulatory package will be published in the Register on 9/7/15 and will become effective on 10/11/15.

(02) Supplemental Payments for County-Owned NFs: This action provides supplemental payments to locality-owned nursing facilities who agree to participate. The SPA was approved by CMS on 12/5/2014 and changes to parallel administrative code sections are awaiting approval by the Secretary.

(03) Hospital DSH Reduction: This action affects hospitals and was mandated by Chapter 2 of the *2014 Acts of the Assembly*, Item 301 WWW. The SPA was approved by CMS on 6/2/15 and a fast track regulatory action was submitted to the OAG for review on 7/16/15.

(04) NF Price Based Reimbursement Methodology: This action changes the cost-based methodology with the priced based method and was mandated by Chapter 2 of the *2014 Acts of the Assembly*, Item 301 KKK. The SPA was approved by CMS on 5/4/15. Fast Track changes to parallel administrative code sections are being reviewed by the Secretary.

(05) Hospital APR-DRG Methodology Change: This action changes the APR-DRG grouper for hospital reimbursement and was mandated by Chapter 2 of the *2014 Acts of the Assembly*, Item 301 VVV. The SPA was approved by CMS on 6/2/15 and changes to parallel administrative code sections are being reviewed by the Secretary.

(06) Type One Hospital Partners' Supplemental Payments: This action provides supplemental payments to Type One hospitals (state-owned teaching hospitals) qualifying partners and was mandated by Chapter 2 of the *2014 Acts of the Assembly*, Item 301 DDDD. The SPA was approved by CMS on 1/27/2015. The VAC action was certified by the OAG and moved to DPB for review on 7/31/15.

(07) GAP SMI Demonstration Waiver Program: The agency began work designing this new non-Medicaid program in early September in response to the Governor's directive. It provides a package of limited benefits to individuals who are 21 to 64 years old, uninsured, and residents of the Commonwealth. Some of the benefits are: physician, clinic, diagnostic outpatient procedures for both medical health conditions and behavioral health conditions related to diagnoses of serious mental illness. CMS approved the program in December, 2014. The emergency regulation action became effective 1/1/2015. The General Assembly proposed changes to this program in the 2015 budget and DMAS drafted a revised emergency regulation to incorporate these changes, which became final on 6/24/15. The proposed stage regulation, which will incorporate the changes from both emergency regulations, is circulating through the Agency for review.

***(08) HIV Premium Assistance Program**: The agency published a notice of periodic review for this small program and is initiating a rule making action. The changes to be made are: (i) individuals will no longer have to be unable to work; (ii) income considered during the eligibility determination process will be that of only the individual and spouse (rather than family), and; (iii) liquid countable assets is being expanded to include more types beyond the limited list in the regulations. The agency drafted a Fast Track action for the VAC changes, which will be published in the Register on 9/7/15; changes will become effective on 10/22/15. No SPA is required.

(09) GAP FAMIS Coverage of Children of State Employees: The agency began work developing this FAMIS expansion in early September in response to the Governor's directive. It provides FAMIS coverage for the children of state employees who have low incomes. The emergency regulation became effective 1/1/2015, and the permanent replacement regulation is awaiting the Governor's review. A companion Title XXI SPA was submitted to CMS.

(10) GAP Dental Services for Pregnant Women: The agency began work developing this Medicaid service expansion in early September in response to the Governor's directive. It provides complete, with the exception of orthodontia, dental service coverage to the 45,000 Medicaid-eligible pregnant women. The emergency regulation became effective on 3/1/2015 and the permanent replacement regulation is undergoing review by the Secretary. CMS approved the SPA on 5/18/15.

(11) MEDICAID WORKS: This action is tied to item (02) in the 2011 General Assembly section below. As a result of CMS approval of the agency's SPA for the 2011 action, the agency must modify the VAC to maintain the parallel contents between the Plan and VAC. A Fast Track action has been drafted and is awaiting approval by the Governor.

(12) Mandatory Managed Care (Medallion 3.0) Changes: This emergency regulation action requires individuals who receive personal care services via the Elderly or Disabled with Consumer Direction waiver to obtain their acute care services through managed care. It also shortens the time period for pregnant women to select their managed care organizations and complete the MCO assignment process. This emergency regulation became effective on 1/1/2015 and the permanent replacement regulation was submitted to the OAG on 4/2/15 for certification.

(13) MFP First Month's Rent: This Fast Track action permits the coverage of the first month's rent for individuals who qualify for assistance from Money Follows the Person assistance as they leave institutions and move into their communities. This is permitted by federal law and has been requested by community advocates. The VAC action is awaiting approval by the Governor.

2013 General Assembly

(01) Targeted Case Management for Baby Care, MH, ID, and DD: This SPA incorporates the reimbursement methodology for targeted case management for high risk pregnant women and infants up to age 2, for seriously mentally ill adults, emotional disturbed children or for youth at risk of serious emotional disturbance, for individuals with intellectual disability and for individuals with developmental disability. The SPA package was approved by CMS 12/19/13. The final-exempt VAC package is being drafted.

(02) Consumer Directed Services Facilitators: This Emergency/NOIRA complies with the *2012 Acts of the Assembly* Item 307 XXX that directed the DMAS to strengthen the qualifications and responsibilities of the Consumer Directed Service Facilitator to ensure the health, safety and welfare of Medicaid home-and-community-based waiver enrollees. This regulatory package is still pending OAG certification. No SPA action is required.

(03) Exceptional Rate for ID Waiver Individuals: This Emergency/NOIRA enables providers of congregate residential support services, currently covered in the Individual with Intellectual Disabilities Waiver (ID waiver), to render, in a more fiscally sound manner, services to individuals who have complex medical and behavioral care needs. Some of these individuals have long been institutionalized in the Commonwealth's training centers, and are being moved into community settings over the next several years in response to the settlement of the lawsuit brought against the Commonwealth by the Department of Justice. For providers to render services for such individuals, it is requiring substantially more staff time and skills. This regulatory action has been approved by the Governor and was submitted to the Registrar for publication on 11/13/14. The waiver change was approved by CMS on 4/23/2014. An emergency regulation is effective until 5/1/16. The proposed stage regulation is being reviewed by the Secretary.

(04) ICF/ID Ceiling: Cost Report Submission; Credit Balance Reporting: This Fast-Track modifies the Nursing Facility (NF) reimbursement methodology in three areas: (i) updates the calculation of per diem reimbursements for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) to account for state facilities' closures; (ii) makes a technical correction to an incorporation by reference included in NF cost reporting requirements, and; (iii) updates NF credit balance reporting requirements to reflect more current Medicaid policies. This regulatory package is currently at the Governor's office pending approval. A SPA of affected parallel State Plan sections will be required.

(05) Changes to Institutions for Mental Disease (IMD) Reimbursement: This Emergency/NOIRA is the result of the 2012 *Acts of the Assembly*, Chapter 3, Item 307 CCC, which directed DMAS to develop a prospective payment methodology to reimburse

institutions of mental disease (residential treatment centers and freestanding psychiatric hospitals) for services furnished by the facility and by others. The SPA was approved on 6/2/15. This Emergency regulation became effective 7/1/14. The permanent replacement regulation is awaiting OAG certification.

***(06) Medicare-Medicaid Alignment Demonstration (FAD)/Commonwealth Coordinated Care (CCC):** This SPA is being implemented by CMS to streamline service delivery, improve health outcomes, and enhance the quality of life for dual eligible individuals and their families. Under the Demonstration's capitated model, DMAS, CMS, and selected managed care organizations (MCOs) have entered into three-way contracts through which the MCOs receive blended capitated payments for the full continuum of covered Medicare and Medicaid benefits provided to dual eligible individuals, including Medicaid-covered long term services and supports and behavioral health care services. The participating MCOs will cover, at a minimum, all services currently covered by Medicare, Medicaid wrap-around services, nursing facility services, Medicaid-covered behavioral health services, home and community-based long-term services and supports provided under the Medicaid Elderly or Disabled with Consumer Direction (EDCD) Waiver. Robust care coordination, interdisciplinary care teams, and person-centered care plans are also mandatory services that must be provided through the participating MCOs. Virginia plans to offer the Demonstration from January 1, 2014, through December 31, 2016. This SPA was submitted to CMS 3/28/13 and was approved by CMS 6/12/13. The Emergency regulation took effect 12/10/2014 and the NOIRA will be published on 9/7/15 with a comment period running until 10/7/15.

***(07) Repeal Family Planning Waiver Regulations:** The Family Planning program is a benefit to qualified low income families by providing them with the means for obtaining medical family planning services to avoid unintended pregnancies and increase the spacing between births to help promote healthier mothers and infants. The purpose of this amended regulation is to implement the change of the program from a demonstration waiver to the state plan option to be in compliance with the state plan amendment approved by the Centers for Medicare and Medicaid Services (CMS) on September 22, 2011. This action was put on hold, but has been re-activated and the proposed stage is undergoing review by DMAS staff prior to being submitted to the OAG.

2012 General Assembly

(01) EPSDT Behavioral Therapy Services: The NOIRA action promoted an improved quality of Medicaid-covered behavioral therapy services provided to children and adolescents who may have autism spectrum disorders and similar developmental disorders. The proposed changes will differentiate Medicaid's coverage of behavioral therapy services, including applied behavior analysis, from coverage of community mental health and other developmental services and establish provider qualifications and clear criteria for Medicaid payment. This regulatory package was approved by DPB 11/27/12 and submitted to the Registrar's office 12/12/12 for publication in the *Virginia Register* 1/14/13 and the comment period ended 2/13/13. The proposed stage regulation is awaiting approval by the Governor's Office.

***(02) Mental Health Skill-Building Services:** The Emergency/NOIRA complied with the *2012 Acts of the Assembly*, Chapter 3, Item 307 LL that directed programmatic changes to Community Mental Health services to consider all available options including, but not limited to, prior authorization, utilization review and provider qualifications. The *2012 Acts of Assembly,* Chapter 3, Item 307 RR (f) directed DMAS to implement a mandatory care coordination model for Behavioral Health. The goals of Item 307 RR (e) include the achievement of cost savings and simplification of the administration of Community Mental Health Services. Emergency regulations became effective 10/10/13. DMAS received an extension, and the ER will last until 10/19/15. The proposed stage will be published in the Register on 8/24/15 and a 60-day public comment period will follow.

***(03) Appeals Regulations Update:** This Emergency/NOIRA regulatory action complied with the legislative mandate (Item 307, III of the *2012 Acts of Assembly*) and addressed recent case law and administrative decisions. These actions have created the need to clarify existing appeals processes and codify emerging processes made urgent by court and administrative case decisions and the increasing volume of appeals generated by provider audits and other utilization review mandates. The SPA was approved by CMS 12/12/12. DMAS received an extension of the emergency regulation, and it is in effect from 1/1/14-12/30/15. The proposed stage regulation awaits the Governor's approval.

2011 General Assembly

(01) Inpatient and Outpatient Rehabilitation Update: This Fast-Track action resulted from internal agency review. DMAS is updating its regulations for both inpatient and outpatient rehabilitation services, including services provided in Comprehensive Outpatient Rehabilitation Facilities (CORFs). In addition, several sections of regulations in Chapter 130 are being repealed and some of the retained requirements formerly located in that Chapter are being moved to Chapters 50 and 60. Outdated, duplicative, and unnecessary regulatory requirements in Chapter 130 are repealed. This regulatory package is currently at the Governor's Office pending approval.

(02) Client Medical Management (CMM): The Emergency/NOIRA action was designed to assist and educate beneficiaries in appropriately using medical and pharmacy services. Members who use these services excessively or inappropriately, as determined by DMAS, may be assigned to a single physician and/or pharmacy provider. DMAS received an extension of the emergency regulation, which is effective 12/16/13 to 12/15/2015. The fast-track stage is awaiting the Governor’s signature.

(03) 2011 Exceptions to Personal Care Limit: This action complied with the legislative mandate to develop and implement exception criteria for those individuals who require more than 56 hours per week of personal care services (which includes supervision time). The final stage documents were sent to the Governor on 5/19/2015.

2010 General Assembly

(01) Mental Health Services Program Changes to Ensure Appropriate Utilization and Provider Qualifications: This Emergency/NOIRA action complied with the 2010 Appropriations Act that required DMAS to make programmatic changes in the provision of Intensive In-Home services and Community Mental Health services in order to ensure appropriate utilization and cost efficiency. The final regulations became effective 1/30/2015. A SPA was submitted to CMS on 3/25/15. CMS sent a Request for Additional Information on 6/10/2015 and DMAS is preparing a response.

2009 General Assembly

(01) Social Security Number Data Match for Citizenship and Identity: This Fast-Track change conforms to CHIPRA of 2009 which offers states a new option to assist Medicaid applicants and recipients in the verification process. Section 211 of CHIPRA gives states the ability to enter into a data match with the Social Security Administration to verify the citizenship and identity of Medicaid applicants and recipients who claim to be United States citizens. Because provision of a Social Security number is already a condition of eligibility for Medicaid, adoption of this option will remove a barrier to enrollment and will result in a more seamless application process for most Medicaid applicants and recipients. This regulatory package is currently at the Governor's office pending approval.

Items that have completed both their state regulatory process and their federal approval process, if a federal approval process was necessary, have been dropped off of this report.