DMAS UPDATE
Joint Subcommittee for Health and Human Resources Oversight
August 21, 2017
Agenda

- DMAS Mission
- Medicaid Reforms
- CCC Plus
- Medallion 4.0
- Implementing JLARC Recommendations
- Other Program Updates
Virginians Covered by Medicaid/CHIP

1 in 8 Virginians rely on Medicaid

Medicaid is the primary payer for behavioral health services

Medicaid covers 1 in 3 births in Virginia

33% of children in Virginia are covered by Medicaid & CHIP

2 in 3 nursing facility residents are supported by Medicaid

62% of long-term services and supports spending is in the community

Medicaid plays a critical role in the lives of over 1.3 million Virginians
Benefits: Covered Groups and Services

Medicaid coverage is primarily available to Virginians who meet specific income thresholds and other eligibility criteria, including:

- children
- pregnant women
- Parents, caregivers
- Seniors, blind, and individuals with disabilities

Eligibility is complex and not all Virginians with low income are covered
Funding Medicaid Coverage

- State Appropriates General Funds
- State Receives Federal Match (50% Match Rate)
- DMAS Pays for Enrollee Health Care Services
- DMAS Pays for Enrollee Health Care Services
- 25% of Medicaid Enrollees
- 75% of Medicaid Enrollees
- Fee-For-Service (FFS) Providers Paid Directly
- Managed Care: MCO Coordinates Care and Contracts with Providers to Deliver Services

Enrollment vs. Expenditure SFY 2016

- 1.3 million enrolled
- $8.41 billion expenditures
- 28% Parents, Caregivers & Pregnant Women
- 12% Children in Low Income Families
- 49% Individuals with Disabilities
- 17% Older Adults
- 6% 23% of the Medicaid population
- 0% 68% of total expenditures

Drives
MEDICAID REFORMS
Three phases of Medicaid reform outlined in the 2013 *Virginia Acts of Assembly* focused on:

**Phase One**: Advancing reforms in progress  
**Phase Two**: Implementing innovations in service delivery, administration and beneficiary engagement  
**Phase Three**: Including long-term care in a coordinated system

<table>
<thead>
<tr>
<th>Results</th>
<th>Medicaid Reforms</th>
<th>Accomplishment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dual Eligible Demonstration Pilot</td>
<td>Implemented Medicare-Medicaid Enrollee Financial Alignment demonstration (Commonwealth Coordinated Care)</td>
<td></td>
</tr>
<tr>
<td>Foster Care</td>
<td>Implemented inclusion of children enrolled in foster care in managed care</td>
<td></td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>Expedited the tightening of regulatory standards, services limits, provider qualification, and licensure requirements for community behavioral health services</td>
<td></td>
</tr>
<tr>
<td>Commercial-like Benefit Package</td>
<td>Changed services and benefits to be the types of services and benefits provided by commercial insurers in managed care where feasible</td>
<td></td>
</tr>
<tr>
<td>Limited Provider Networks and Medical Homes</td>
<td>Implemented changes to support beneficiaries receipt of higher quality coordinated care through a limited network arrangement in Northern Virginia</td>
<td></td>
</tr>
<tr>
<td>ID/DD Waiver Design</td>
<td>Implementing the redesign of the ID/DD waiver to provide more comprehensive and targeted service options</td>
<td></td>
</tr>
</tbody>
</table>
| All Non-Medicare EDCD Waiver Enrollees in Managed Care for Medical Needs | Phase 1: Implemented changes and EDCD waiver enrollees are covered by health plans for medical needs (HAP)  
Phase 3: Implementing Commonwealth Coordinated Care Plus (CCC Plus) |  |
| All Inclusive Coordinated Care for Long Term Care Beneficiaries | Phase 1: Implemented Commonwealth Coordinated Care and Initiated transition of all non-dual waiver recipients into managed care  
Phase 3: Implementing Commonwealth Coordinated Care Plus (CCC Plus) |  |
# Medicaid Innovation and Reform Commission

## Results

<table>
<thead>
<tr>
<th>Medicaid Reforms</th>
<th>Accomplishment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Efficient Administration</strong></td>
<td></td>
</tr>
<tr>
<td>Enhanced Program Integrity and Fraud Prevention</td>
<td>Enhanced Recovery Audit Contracting (RAC), data mining, service authorization, coordination with Medicaid Fraud Control Unit (MFCU), and Payment Error Rate Measure (PERM)</td>
</tr>
<tr>
<td>eHHR</td>
<td>Implemented new eligibility and enrollment information system for Medicaid and other social services</td>
</tr>
<tr>
<td>Coordinate Behavioral Health Services</td>
<td>Aligned and coordinated behavioral health services through the behavioral health services administrator (BHSA); implemented behavioral health homes</td>
</tr>
<tr>
<td>Quality Payment Incentives</td>
<td>Implemented financial incentives and high quality outcomes through the Medallion Care System Partnership and alternative payment methods to encourage accountability within the Medicaid provider and MCO program</td>
</tr>
<tr>
<td>Parameters to Test Innovative Models</td>
<td>Implemented over 100 quality measures to evaluate pilot innovations such as behavioral health homes and streamlined care transitions. Payment withhold based on attainment of quality indicators</td>
</tr>
<tr>
<td><strong>Beneficiary Engagement</strong></td>
<td></td>
</tr>
<tr>
<td>Cost Sharing and Wellness</td>
<td>Developed programs to incent enrollee participation in health and wellness activities to improve health and control costs in managed care; increased patient responsibility by reinstating copayments for FAMIS</td>
</tr>
</tbody>
</table>

All reform initiatives were successfully completed.
Major Initiatives of Virginia Medicaid

1. Launched Commonwealth Coordinated Care Plus in August 2017
2. Procure Managed Care for pregnant women and children (Medallion 4.0) in 2017
3. Procure many technology changes (Medicaid Enterprise System) 2017-18
4. Implement Addiction and Recovery Treatment Services (ARTS) in 2017
5. Advance Delivery System Reforms

90% of Virginia Medicaid enrollees will soon be in managed care (currently 75%)
DMAS is working on a number of initiatives in the following categories:

- Evolve Managed Care
- Improve Care
- Transform Delivery System
- Increase Program Efficiency and Controls
- Implement Mandatory Federal Changes
- Modernize Technology
- Enhance Internal Operational Effectiveness
Strategic Transition to Managed Care

## Two managed care programs

<table>
<thead>
<tr>
<th>CCC Plus</th>
<th>Medallion 4.0</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Serving older adults and disabled</td>
<td>▪ Serving infants, children, pregnant women, parents</td>
</tr>
<tr>
<td>▪ Includes Medicaid-Medicare eligible</td>
<td>▪ 760,000 individuals</td>
</tr>
<tr>
<td>▪ 216,000 individuals</td>
<td></td>
</tr>
<tr>
<td>▪ Long-term services and supports in the community and facility-based,</td>
<td>▪ Births, vaccinations, well visits, sick visits,</td>
</tr>
<tr>
<td>acute care, pharmacy</td>
<td>acute care, pharmacy</td>
</tr>
<tr>
<td>▪ Incorporating community mental health</td>
<td>▪ Incorporating community mental health</td>
</tr>
<tr>
<td>▪ Implementation started Aug 2017</td>
<td>▪ New procurement 2017</td>
</tr>
<tr>
<td>▪ Implement statewide by Jan 2018</td>
<td>▪ Building on two decades of managed care experience</td>
</tr>
<tr>
<td>▪ Approximately $30B over 5 years</td>
<td>▪ Implement statewide 2018</td>
</tr>
<tr>
<td>▪ Estimated $10B - $15B over 5 years</td>
<td></td>
</tr>
</tbody>
</table>
Managed Care Alignment

CCC Plus and Medallion 4.0 managed care programs are aligned in many ways

- Regions
- Services (where possible)
- Integrated behavioral health models
- Common core formulary
- Care management
- Provider and member engagement
- Innovation in managed care practices including VBP
- Quality, data and outcomes
- Strong compliance and reporting
- Streamlined processes and shared services
Commonwealth Coordinated Care Plus (CCC Plus)

- New statewide Medicaid managed care program beginning August 2017 for over 216,000 individuals
- Participation is required for qualifying populations
- Integrated delivery model that includes medical services, behavioral health services and long term services and supports (LTSS)
- Care coordination and person centered care with an interdisciplinary team approach
Six Health Plans Contracted Statewide

- Aetna Better Health of Virginia
- Anthem HealthKeepers Plus
- Magellan Complete Care of Virginia
- Optima Health
- United Healthcare
- Virginia Premier Health Plan

A list of CCC Plus regions by locality is available at: [http://www.dmas.virginia.gov/Content_pgs/mltss-proinfo.aspx](http://www.dmas.virginia.gov/Content_pgs/mltss-proinfo.aspx)
## CCC Plus Regional Launch

**CCC Plus has a phased in approach**

### August 2017 – January 2018

<table>
<thead>
<tr>
<th>August</th>
<th>September</th>
<th>October</th>
<th>November</th>
<th>December</th>
<th>January</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tidewater</strong></td>
<td><strong>Central</strong></td>
<td><strong>Charlottesville</strong></td>
<td><strong>Roanoke Alleghany &amp; Southwest</strong></td>
<td><strong>Northern &amp; Winchester</strong></td>
<td><strong>CCC and remaining ABD</strong></td>
</tr>
<tr>
<td>Effective 8/1/17</td>
<td>Effective 9/1/17</td>
<td>Effective 10/1/17</td>
<td>Effective 11/1/17</td>
<td>Effective 12/1/17</td>
<td>Effective 1/1/18</td>
</tr>
</tbody>
</table>

CCC Plus has a phased in approach.
Medallion 4.0

- Medallion 4.0 will cover 760,000 Virginians

- Medicaid enrollees have a choice of 3 or more plans in each of the six regions

- New carved-in populations and services:
  - Early Intervention Services
  - Third Party Liability (TPL)
  - Community Mental Health and Rehabilitation Services (CMHRS)
Medallion 4.0 presents optional carved-out services, such as:

- School-based services
- Early Intervention
- Dental Care
- Plan First

DMAS will not consider optional services before 2019
# Medallion 4.0 Timeline

Medallion 4.0 has a phased in approach

## 2017–2018

<table>
<thead>
<tr>
<th>August 2018</th>
<th>September 2018</th>
<th>October 2018</th>
<th>November 2018</th>
<th>December 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tidewater Region</td>
<td>Central Region</td>
<td>Northern /</td>
<td>Charlottesville/</td>
<td>Roanoke / Alleghany /</td>
</tr>
<tr>
<td>Effective 8/1/18</td>
<td>Effective 9/1/18</td>
<td>Winchester</td>
<td>Western Region</td>
<td>Southwest Region</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Effective 10/1/18</td>
<td>Effective 11/1/18</td>
<td>Effective 12/1/18</td>
</tr>
</tbody>
</table>
IMPLEMENTING JLARC RECOMMENDATIONS
## JLARC Project Functional Categories

Projects fit into one of more of the following categories:

<table>
<thead>
<tr>
<th>Uniform Assessment Instrument (UAI)</th>
<th>Recommended efforts to improve UAI reliability for children; UAI training and screening; ensure timely screening; and strengthen oversight of UAI process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rates</td>
<td>Adjust rates to: account for expected savings; allow negative historical trends to carry forward; rebase administrative rates for enrollment changes and deduct unallowable administrative expenses from rate setting</td>
</tr>
<tr>
<td>Financial Oversight</td>
<td>Strengthen oversight by requiring: detailed MCO financial and utilization reporting; control of related party spending; excessive related party spending is not included in capitation; and underwriting gain returns above three percent</td>
</tr>
<tr>
<td>Programs</td>
<td>Administer compliance review and sanctions, report on MCO performance and incentivize MCO performance improvement. Additionally, strengthen oversight of behavioral health and LTSS service delivery</td>
</tr>
<tr>
<td>Trend Impact</td>
<td>Monitor MCO spending and utilization trends and analyze what is driving those trends. To include: identifying inefficiencies and adjusting rates accordingly, and monitoring MCO utilization control methods and evaluating their impact</td>
</tr>
<tr>
<td>Policy</td>
<td>Submit for CMS review, a proposal requiring cost-sharing based on family income for LTSS eligible individuals eligible through the optional 300 percent of SSI</td>
</tr>
</tbody>
</table>

12 FTES and $3,046,792 appropriated to DMAS over the next two years
JLARC Project Implementation Work to Date

- Issued and reviewed responses from MCO Trend Analysis RFI
- Organized projects across different areas of DMAS
- Began process of hiring contractors and staff, including a Chief Health Economist, to complete JLARC projects
OTHER PROGRAM UPDATES
Addiction and Recovery Treatment Services (ARTS) Transformation

Magellan will continue to cover community-based substance use disorder treatment services for fee-for-service members.

Effective April 1, 2017
Addiction and Recovery Treatment Services (ARTS)
Peer Recovery Supports effective July 1, 2017

All Community-Based SUD Services will be Covered by Managed Care Plans
A fully integrated Physical and Behavioral Health Continuum of Care
# Preliminary Increases in Addiction Providers Due to ARTS

<table>
<thead>
<tr>
<th>Addiction Provider Type</th>
<th># of Providers before ARTS</th>
<th># of Providers after ARTS</th>
<th>% Increase in Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Detox (ASAM 4.0)</td>
<td>Unknown</td>
<td>103</td>
<td>NEW</td>
</tr>
<tr>
<td>Residential Treatment (ASAM 3.1, 3.3, 3.5, 3.7)</td>
<td>4</td>
<td>78</td>
<td>↑ 1875%</td>
</tr>
<tr>
<td>Partial Hospitalization Program (ASAM 2.5)</td>
<td>0</td>
<td>13</td>
<td>NEW</td>
</tr>
<tr>
<td>Intensive Outpatient Program (ASAM 2.1)</td>
<td>49</td>
<td>72</td>
<td>↑ 47%</td>
</tr>
<tr>
<td>Opioid Treatment Program</td>
<td>6</td>
<td>29</td>
<td>↑ 400%</td>
</tr>
<tr>
<td>Office-Based Opioid Treatment Provider</td>
<td>0</td>
<td>55</td>
<td>NEW</td>
</tr>
</tbody>
</table>
## Total Expenditures on Community-Based Behavioral Health Services

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Intensive In-Home</td>
<td>$55.4</td>
<td>$75.2</td>
<td>$112.1</td>
<td>$148.0</td>
<td>$176.5</td>
<td>$129.3</td>
<td>$94.4</td>
<td>$87.1</td>
<td>$99.3</td>
<td>$108.3</td>
<td>$108.3</td>
<td>$127.6</td>
</tr>
<tr>
<td>Therapeutic Day Treatment</td>
<td>$30.8</td>
<td>$45.0</td>
<td>$66.8</td>
<td>$112.7</td>
<td>$144.9</td>
<td>$166.1</td>
<td>$139.2</td>
<td>$144.9</td>
<td>$151.6</td>
<td>$171.8</td>
<td>$176.5</td>
<td>$186.0</td>
</tr>
<tr>
<td>Mental Health Skill Building</td>
<td>$23.4</td>
<td>$30.7</td>
<td>$46.4</td>
<td>$65.8</td>
<td>$92.6</td>
<td>$138.2</td>
<td>$185.3</td>
<td>$224.5</td>
<td>$239.1</td>
<td>$191.4</td>
<td>$204.6</td>
<td>$251.0</td>
</tr>
<tr>
<td>Other Behavioral Health Services</td>
<td>$33.9</td>
<td>$36.2</td>
<td>$42.8</td>
<td>$46.5</td>
<td>$47.4</td>
<td>$52.4</td>
<td>$57.3</td>
<td>$59.6</td>
<td>$59.9</td>
<td>$58.1</td>
<td>$60.0</td>
<td>$71.5</td>
</tr>
</tbody>
</table>

**Graph:** The graph shows the trend of expenditures for various services from 2006 to 2017. The expenditures for Intensive In-Home and Therapeutic Day Treatment services show a significant increase, particularly in the later years. Mental Health Skill Building and Other Behavioral Health Services also show an upward trend, with Mental Health Skill Building having a more gradual increase compared to Other Behavioral Health Services.
Transformation of Medicaid Community-Based Mental Health Delivery System

- Partnering with Dr. Ben Miller funded by RWJF to analyze Medicaid behavioral health spending at provider level and city/county level

- Dr. Miller is working with stakeholders to create a plan for DMAS to transform its existing delivery system into a comprehensive, evidence-based continuum of community-based mental health services with uniform standards and quality measures
Partnering with VDH to Improve Population Health Outcomes

✔ ED Care Coordination and Prescription Monitoring Program Integration
  - DMAS secured $3.9 million in 90/10 HITECH funding
  - Implement statewide technology solution to connect EDs, PCPs, and MCOs in real-time

✔ Virginia Neonatal Perinatal Collaborative
  - Drawing down federal Medicaid funds to improve infant and maternal health outcomes statewide
  - Collaboration of VDH, DMAS, ACOG, AAP, and March of Dimes and led by physicians
Common Core Formulary

- Common list of drugs that all CCC Plus and Medallion 4.0 health plans must cover
- Includes all drugs in 90 common drug classes on DMAS’ Preferred Drug List (PDL)
- Plans can add drugs but cannot remove
- Plans cannot require additional prior authorizations or added restrictions

Advantages
- Provides continuity of care for patients
- Decreases administrative burdens for prescribers

Expected to be budget neutral
✓ 47% of physicians who do not accept Medicaid cite prescription Prior Authorizations (PAs) as the primary reason.
  ▪ Respondents also cited services PAs, the time involved in PAs, reimbursement, and inconsistent administrative requirement.

✓ 52% of physicians who accept Medicaid cited PAs as the biggest problem they face in treating Medicaid patients.
  ▪ 40% identified inconsistent requirements for medications.
DMAS Pharmacy Benefit Manager (PBM)

- All inclusive contract for all pharmacy services including claims processing, Drug Utilization Review, Preferred Drug List (PDL) and Service Authorization activities
- Awarded to Magellan - October 1, 2017 implementation
- Benefits of PBM
  - Centralizes all pharmacy services
  - One call center to assist members & providers
- Innovations with new PBM
  - Specialty Drug Management
  - Integration of Laboratory Values
  - Electronic Prior Authorizations
  - ePrescribing
2017 Acts of Assembly Item 310V
MCO Reporting on Medicaid Pharmacy Claims

• Requires MCOs to report payments to pharmacies and PBMs in claims submissions

• Implementation Timeline
  ▪ **March 20, 2017** - Medallion 3.0 MCOs notified of contractual requirement
  ▪ **April 21, 2017** – DMAS provides new reporting requirements to MCOs
  ▪ **April – May, 2017** – DMAS develops a secure process to protect and maintain confidentiality of proprietary information submitted by MCOs
  ▪ **July, 2017** – 5 of 6 Medallion 3.0 MCOs submitted required data to DMAS
  ▪ **December 1, 2017** – Report due to the Chairmen of the House Appropriations and Senate Finance Committees
# Implementation of CDC Opioid Guidelines by Virginia Medicaid Health Plans

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>7/1/16</td>
<td>Fee-for-Service implements Opioid Rx Quantity Limits (QL) and Prior Authorizations (PAs). Non-opioid pain relievers &amp; naloxone available without PA.</td>
</tr>
<tr>
<td>12/1/16</td>
<td>Medicaid plans implement PAs and QLs for “new” opioid starts. Non-opioid pain relievers &amp; naloxone available without PA. Letters to educate providers and patients.</td>
</tr>
<tr>
<td>4/1/17</td>
<td>Addiction Recovery &amp; Treatment Services (ARTS) available to all Medicaid members. VA Board of Medicine implements regulations for opioid and buprenorphine prescribing.</td>
</tr>
<tr>
<td>7/1/17</td>
<td>PAs and QLs for all members in Medicaid plans. Work with commercial plans to replicate Medicaid opioid prescribing efforts.</td>
</tr>
<tr>
<td>9/1/17</td>
<td>Recommendations for coverage of evidence-based, non-pharmacologic pain treatment modalities and integrated behavioral health and chronic pain treatment.</td>
</tr>
</tbody>
</table>
Our Mission Remains Unchanged

Ensure Virginia’s Medicaid Enrollees Receive Quality Health Care

Superior Care  
Cost Effective  
Continuous Improvement

As DMAS drives improvement and innovation, our mission remains the same