



DMAS UPDATE

HEALTH AND HUMAN RESOURCES OVERSIGHT COMMITTEE

OCTOBER 21, 2019

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Department of Medical Assistance Services

Agenda

- Managed Care Update
- Behavioral Health Redesign Update
- DMAS Organizational Update

MANAGED CARE UPDATE

October 21, 2019

Who Does Medicaid Serve?

Children — 703,000

Pregnant Women and Parents — 135,000

Older Adults — 78,000

Individuals with Disabilities — 151,000

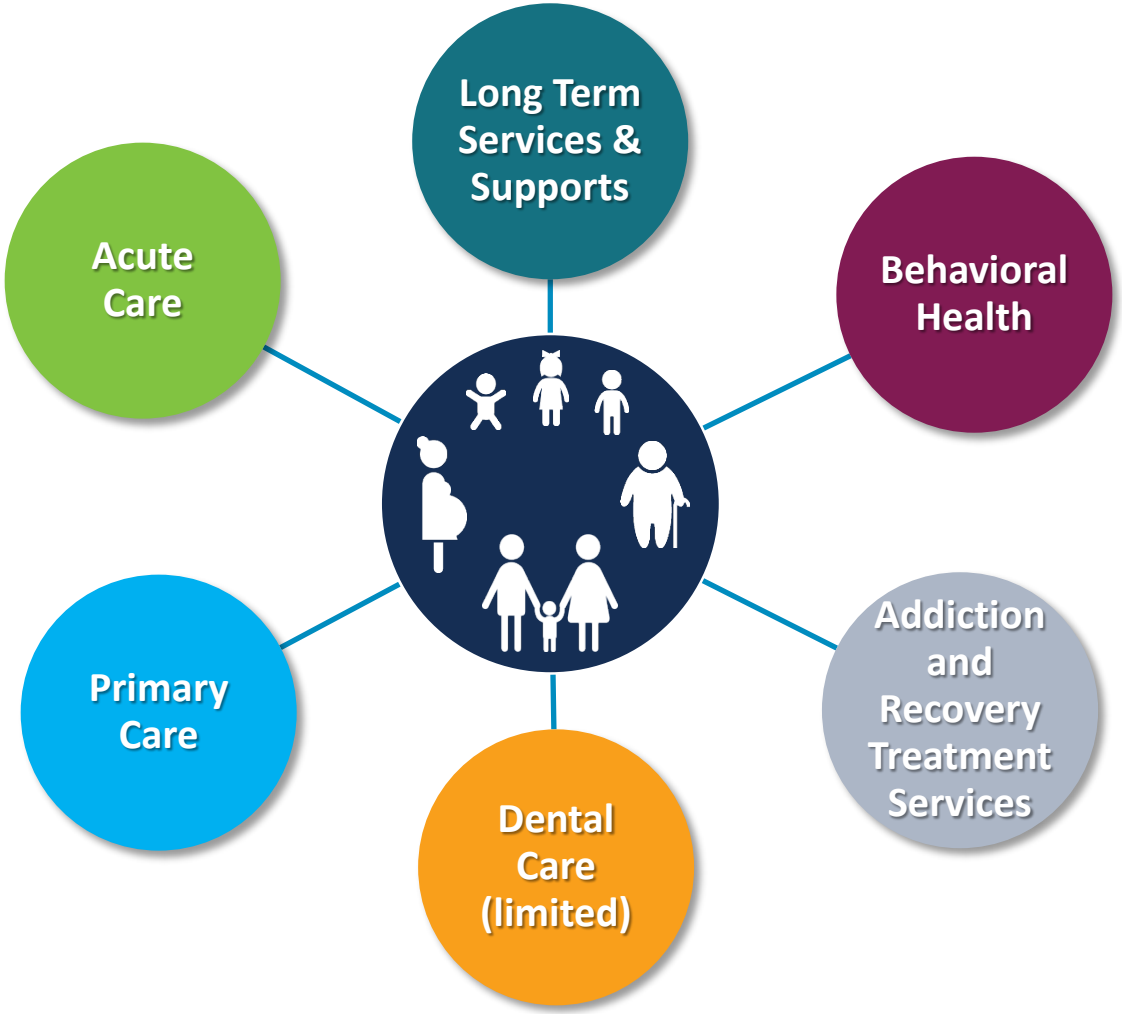
Expansion Adults — 325,000

Medicaid plays a critical role in the lives of over 1.4 million Virginians*

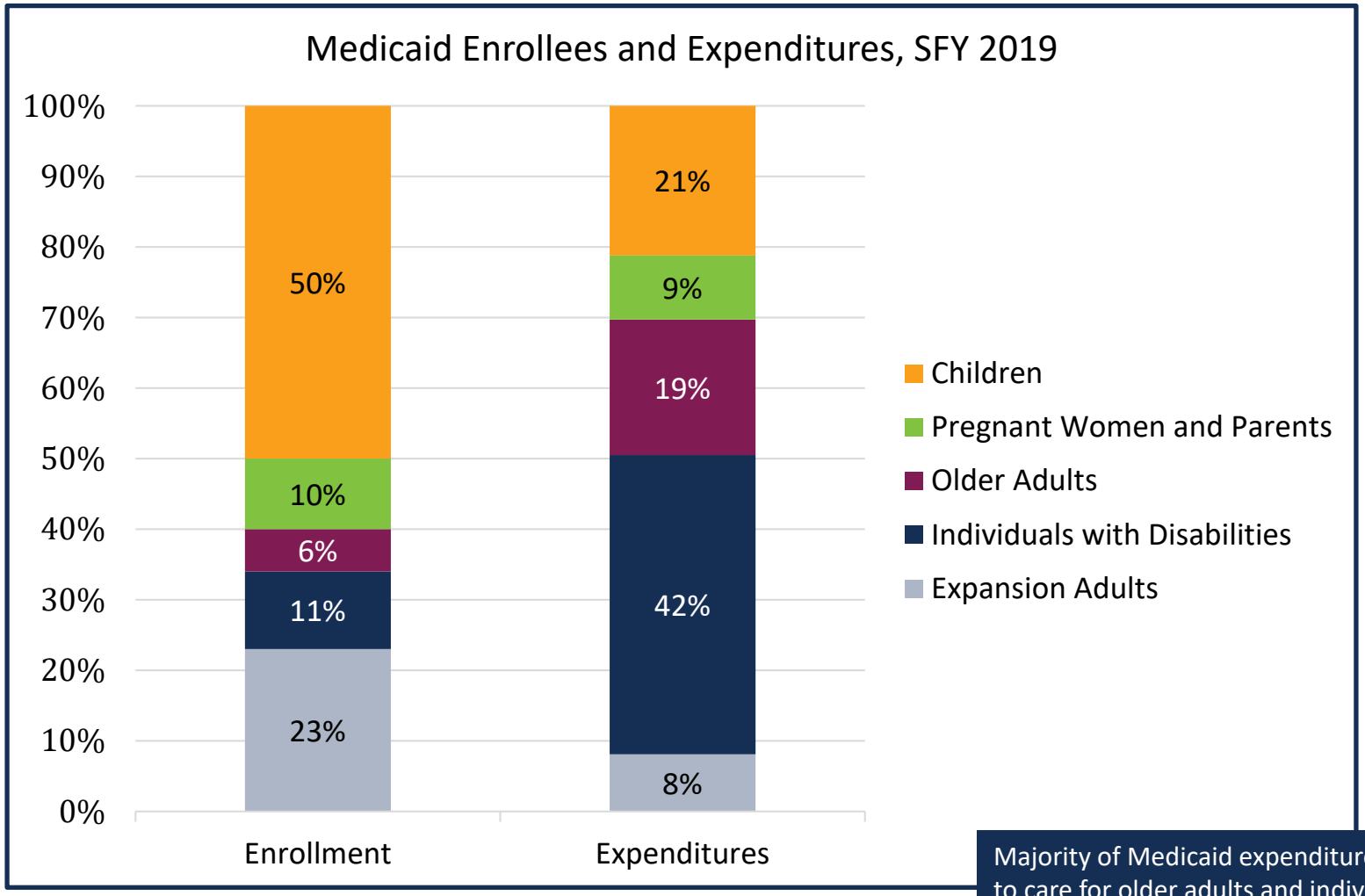
*DMAS data as of October 2019

Medicaid Benefits and Covered Services

Medicaid covers a wide variety of services, which may include:



Medicaid Expenditures by Population



Majority of Medicaid expenditures go to care for older adults and individuals with disabilities.

Expenditures for Expansion adults are from January 1, – June 30, 2019

Managed Care Expansion Timeline to Date

2016 – 2018

CCC Plus Statewide Implementation

- Successfully procured the CCC Plus program
- Regional implementation - Aug 2017 – Jan 2018
- Community mental health services phased in Jan 1, 2018

2017-2018

Medallion 4.0 Statewide Implementation

- Successfully procured Medallion 4.0 program
- Regional Implementation – Aug 2018 - Dec 2018
- Community mental health services phased in, beginning Aug 2018 – Dec 2018, (during the regional launch)

Expanded managed care to remaining fee-for-service populations per requirements in the Appropriations Act

January 2019 - Present

Implement Managed Care Expansion; Continue Corrections/Refinement

- During the first full year post- CCC Plus and Medallion 4.0 implementation, plans continue to refine program and correct start-up issues, including with community mental health services
- January 1, 2019 - Successfully phased in the Medicaid expansion population

2019 - Ongoing

Increase Monitoring, Oversight; and Transparency

- **Focus on quality, accountability, and greater transparency**
- **Contract monitoring**
- **Corrective action plans (CAPs)**
- **Future Initiatives**
  - **Value based purchasing**
  - **Alignment of MCO Contracts**
  - **MES Connectivity**
  - **COMPASS**
  - **Behavioral Health Redesign (proposed)**

Managed Care Programs

90% of Medicaid members are now in managed care

	Commonwealth Coordinated Care Plus (CCC Plus) 243,400 Members	Medallion 4.0 1,049,300 Members
Covered Groups 	▪ Serving older adults, disabled children, disabled adults, medically complex newly eligible adults; includes individuals with Medicare and Medicaid (full-benefit duals)	▪ Serving infants, children, pregnant women, caretaker adults, and newly eligible adults
Covered Benefits 	▪ Full continuum of services (same as Medallion), but also includes long-term services and supports (LTSS) in the community and in nursing facilities and hospice	▪ Births, vaccinations, well child visits, sick visits, acute care, pharmacy, ARTS, behavioral health services, including community mental health rehabilitation services; excludes LTSS

DMAS Monthly Enrollment as of October 1, 2019

Oversight of Managed Care Operations & Performance

Five main oversight functions; goal is continuous quality improvement:

Contract Development and Monitoring ensures MCO operations are consistent with the contract requirements, includes working with members and providers to resolve any identified service and care management concerns

Systems and Reporting manages data submissions from the MCOs in accordance with the DMAS Managed Care Technical Manual

Compliance Monitoring Process oversees, develops and monitors MCO corrective action plans (CAPS) and sanctions

Quality Performance and Improvement measures MCO performance against standard criteria, such as HEDIS, PIP, PVM and facilitates focused quality projects to improve care for all members, including with the DMAS external quality review (EQR) contractor

Financial Oversight monitored in several ways. Plans are licensed by the Bureau of Insurance (meet solvency criteria). MCO rates are determined by our actuary, are certified as actuarially sound, and approved by CMS

Contract Development and Monitoring Activities

Ensure health plans are providing high quality health care through contract monitoring

Contract Development and Monitoring Activities

- Ensure contract fully supports federal and state requirements and aligns with program needs and expectations
- Provide close oversight and on-going technical assistance to health plans, including care coordinators
- Work with members and providers to resolve any identified service and care management concerns
- Conduct on site/desk reviews of identified agency priority areas and to address any health plan specific concerns

DMAS MCO Contract Requirements

- DMAS Contract Standards
  - ✓ legally binding; comprehensive
- Federal Managed Care Regulations
- Federal 1915(b) and 1915(c) Waiver compliance
- Licensure and Certifications:
  - ✓ Virginia Department of Health - Managed Care Health Insurance Plan (MCHIP) Quality Certificate, approves geographical coverage areas based on network adequacy
  - ✓ Bureau of Insurance (Financial Solvency)
  - ✓ NCQA Accreditation (HEDIS, CAHPS, and more)

Systems and Reporting and Compliance Monitoring

Continual emphasis on health plan quality, accountability and transparency

MCOs are responsible for robust and transparent reporting on critical elements
MCOs submit deliverables as specified in the contract and in the current the Managed Care Technical Manual

DMAS collects, reviews, and validates contract deliverables based on Technical Manual specifications
Generation of monthly metrics to review MCO performance in several areas

Implemented encounter process system (EPS) which is used for reporting, analysis and (soon) rate setting

Analyze encounter data to determine timeliness, completeness, accuracy and reasonableness
Provide technical assistance to health plans on identified problem areas

Take compliance action, such as issuing Corrective Action Plans and financial penalties when needed a health plan is not conforming to one, or more, contract requirements

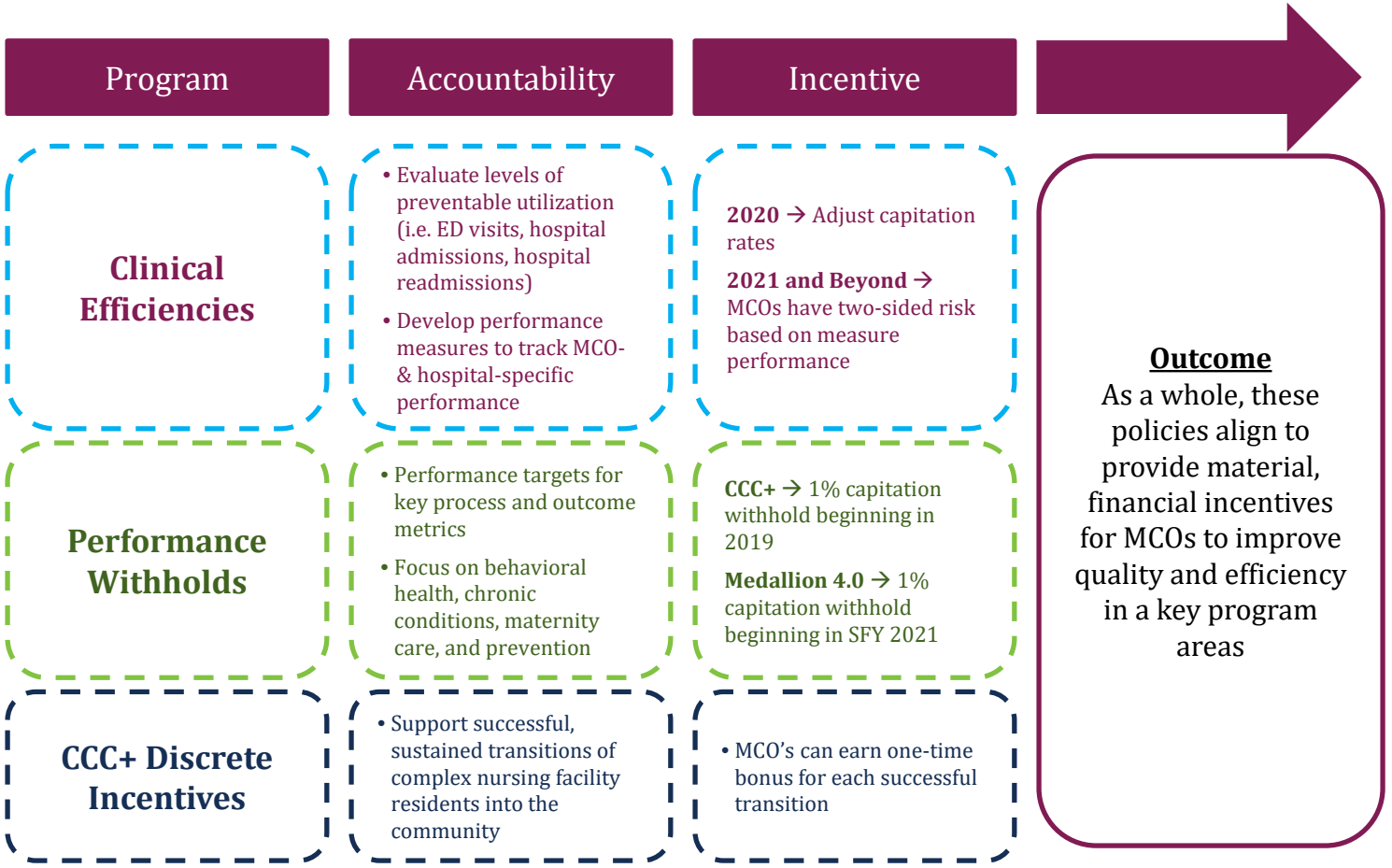
Quality Improvement Activities

MCOs complete federal, state and DMAS established quality improvement activities, including:

- NCQA Accreditation; includes reporting of Healthcare Effectiveness Data and Information Set (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) data
- Annual health plan quality rating system (QRS), “score card” tool designed to increase health plan transparency and accountability. Consumers use this information to help make an informed MCO selection
- Participation in performance improvement projects (PIPS) and Performance Measurement Validation Activities (with the DMAS external quality review contractor)
- Participating in either a performance incentive award program (Medallion 4.0) or quality withhold program (CCC Plus)
- Value based payment strategies

Current VBP Efforts Through MCO Contracts

VBP is a Powerful Tool to Promote Quality and Efficiency



Performance Improvement Projects (PIP)

Annually, the health plans must perform at least one clinical and one non-clinical PIP

Clinical PIPs include projects focusing on:

- prevention and care of acute and chronic conditions,
- behavioral health,
- long term services and supports,
- high-volume services,
- high risk services, and/or high cost services

Non-clinical PIPs include projects focusing on:

- availability, accessibility,
- cultural competency of services,
- interpersonal aspects of care,
- appeals, grievances, complaints,
- care transitions and continuity,
- coordination of care and care management,
- member satisfaction

2019 CCC Plus Performance Improvement Projects

Ambulatory Care Emergency Department Visits (Clinical)

Follow Up After Hospital Discharge (Nonclinical)

2019 Medallion 4.0 Performance Improvement Projects

Timeliness of Prenatal Care-Subpopulation race, ethnicity, geographic area (Clinical)

Tobacco Cessation in Pregnant Women (Nonclinical)

Financial Oversight with Provider Reimbursement

- Plans are required to be licensed by the Bureau of Insurance (BOI), a Division of the Virginia State Corporation Commission, and meet solvency requirements
- DMAS reviews the MCO quarterly and annual filings to BOI and annual audits
- DMAS monitors net profit and medical loss ratios and administrative expense ratios
- Rates are determined by our actuary, certified as actuarially sound, and approved by CMS
- Program staff participate with provider reimbursement in rate setting process and waiver cost effectiveness development process
- On-going fiscal monitoring and trending
- 2018 JLARC Report to the General Assembly was submitted reviewing financial and utilization planning for managed care operations, including future plans regarding the need for a baseline data collection year given the changing managed care populations

Current MCO Rates Compared to Forecast

- Current rates are slightly below forecast
- DMAS notified Money Committee Chairmen and Department of Planning and Budget Director in May 31, 2019 letter, as required by the Budget

FY20 PMPM Compared to Forecast

	Forecast	Actual
Medallion Base Medicaid	$300.16	$298.17
Medallion Expansion Medicaid	$556.54	$528.89
CCC Plus Base Medicaid	$1,828.94	$1,823.31
CCC Plus Expansion Medicaid	$1,774.72	$1,768.45
Actuals do not include GA changes		

Fiscal Impact of FY20 Rates Compared to Forecast

	Base Medicaid		Expansion Medicaid
	Total Funds	GF	Total Funds
Medallion 4.0	($14,953,572)	($7,476,786)	($88,884,551)
CCC Plus	($14,492,748)	($7,246,374)	($5,909,280)

For More Information

- ✓ Managed Care Contracts
  - CCC Plus - http://www.dmas.virginia.gov/#/cccplusinformation
  - Medallion 4.0 - http://www.dmas.virginia.gov/#/med4
- ✓ Technical Reporting Manuals
  - CCC Plus - http://www.dmas.virginia.gov/#/cccplushealthplans
  - Medallion 4.0 - http://www.dmas.virginia.gov/#/managedcares
- ✓ External Quality Review Annual Reports
  - CCC Plus - http://www.dmas.virginia.gov/files/links/3243/VA2018_CCC_EQR_TechRpt_F1.pdf
  - Medallion 4.0 - http://www.dmas.virginia.gov/#/med4reports
- ✓ Virginia Managed Care Annual Report - http://www.dmas.virginia.gov/#/cccplusinformation
- ✓ MCO Compliance Reports - http://www.dmas.virginia.gov/#/med4reports
- ✓ Managed Care Corrective Action Plans
  - CCC Plus - http://www.dmas.virginia.gov/#/cccplusinformation
  - Medallion 4.0 - http://www.dmas.virginia.gov/#/med4reports
- ✓ DMAS Quality Strategy - http://www.dmas.virginia.gov/files/links/416/DMAS%202017-2019%20Quality%20Strategy.pdf
- ✓ Performance Incentive Awards - http://www.dmas.virginia.gov/#/incentiveawards
- ✓ NCQA Health Plan Ratings for Virginia Medicaid (ratings for other states are also available for comparison) - http://healthinsuranceratings.ncqa.org/2019/search/Medicaid/VA

PROPOSED BEHAVIORAL HEALTH REDESIGN UPDATE

Advancing Proactive, Evidence-Based Solutions

October 21, 2019

VIRGINIA'S MEDICAID PROGRAM
DMAS
INNOVATION • QUALITY • VALUE

Proposed

Advancing Behavioral Health Care in Virginia

From Band-Aids to proactive, evidence-based solutions

Current Medicaid-Funded Behavioral Health Services

High Acuity

Outdated

Imbalanced

Behavioral Health Redesign Care Continuum

Full Continuum

More equitable distribution of services – from prevention to acute

Evidence-Based

Proven practices with measurable effectiveness and quality

Aligned

Enhances other BH transformation efforts (STEP-VA, FFPSA) and coordinates systems among state agencies

Behavioral Health Redesign for Virginia

Vision

Implement fully integrated behavioral health services that provide a full continuum of care to Medicaid members. This comprehensive system will focus on access to services that are:

High Quality

Quality care from quality providers in community settings such as home, schools and primary care

Evidence-Based

Proven practices that are preventive and offered in the least restrictive environment

Trauma-Informed

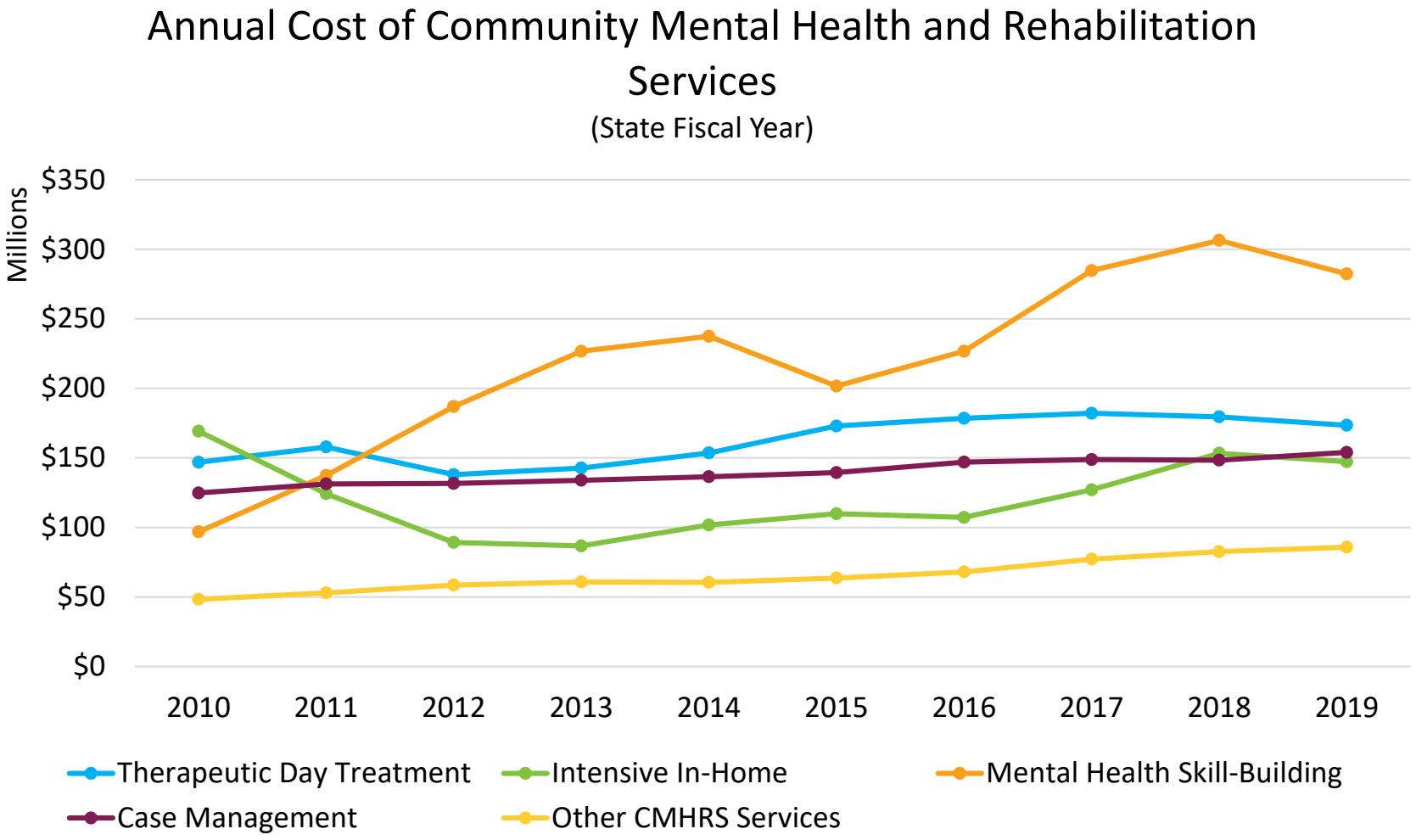
Better outcomes from best-practice services that acknowledge and address the impact of trauma for individuals

Cost-Effective

Encourages use of services and delivery mechanisms that have been shown to reduce cost of care for system

20

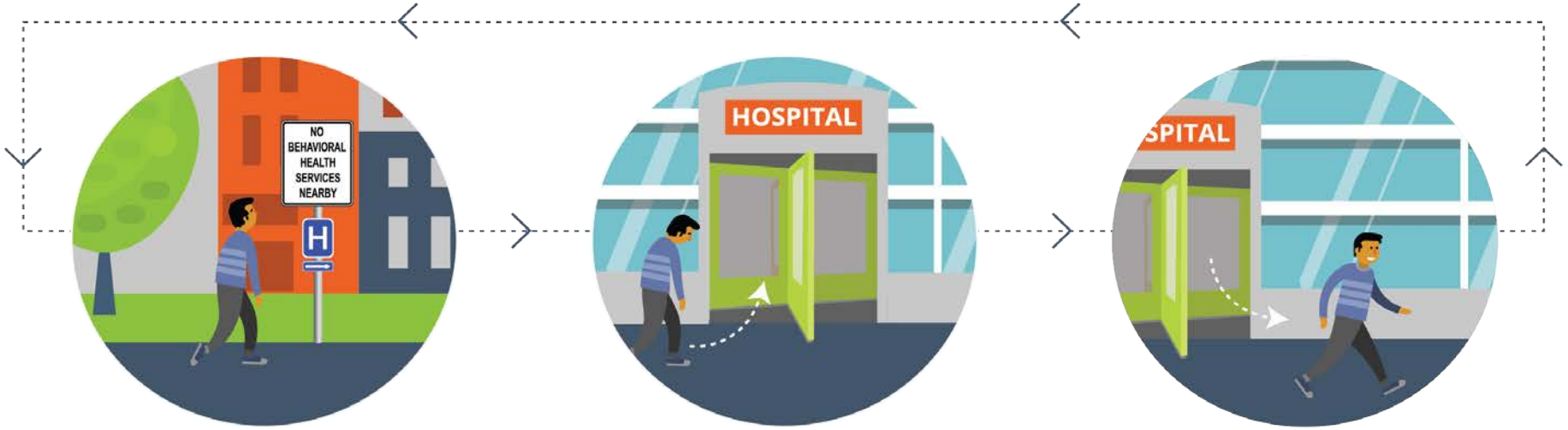
Trends in CMHRS



Proposed

BH Redesign and Psychiatric Inpatient Admissions

Lack of alternative crisis services has contributed to the increasing number of temporary detention orders



- There are approximately 300,000 crisis calls statewide each year, out of which, 90,000 calls resulted in face-to-face evaluation; only 15-25% were billed to Medicaid
- Based on our current system - ~25,000 individuals are hospitalized due to crisis calls

BH Redesign provides solutions instead of Band-Aids to permanently decrease capacity and reliance on state psychiatric beds

Behavioral Health Redesign Current Priorities Explained

What are our top priorities at this time?

Implementation of ***SIX*** high-quality, high-intensity, and evidence-based services that have demonstrated impact and value to patients

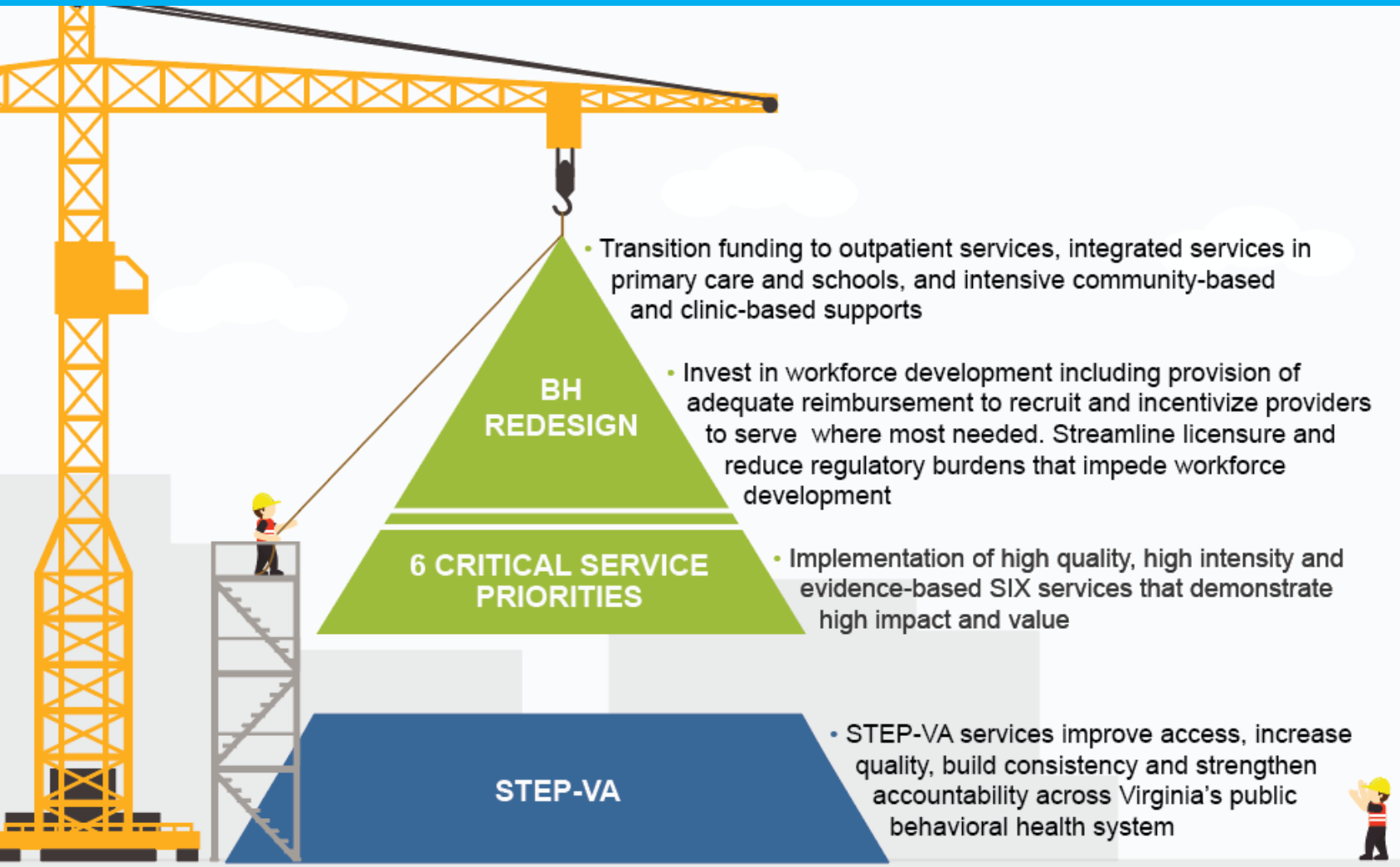
Services that currently exist and are licensed in Virginia ***BUT*** **are not covered by Medicaid** or the service is not adequately funded through Medicaid

- Partial Hospitalization Program (PHP)
- Program of Assertive Community Treatment (PACT)
- Multi-Systemic Therapy (MST)
- Intensive Outpatient Program (IOP)
- Comprehensive Crisis Services (Mobile Crisis, Intervention, Residential, 23Hr Observation)
- Functional Family Therapy (FFT)

Why BH Redesign for Virginia?

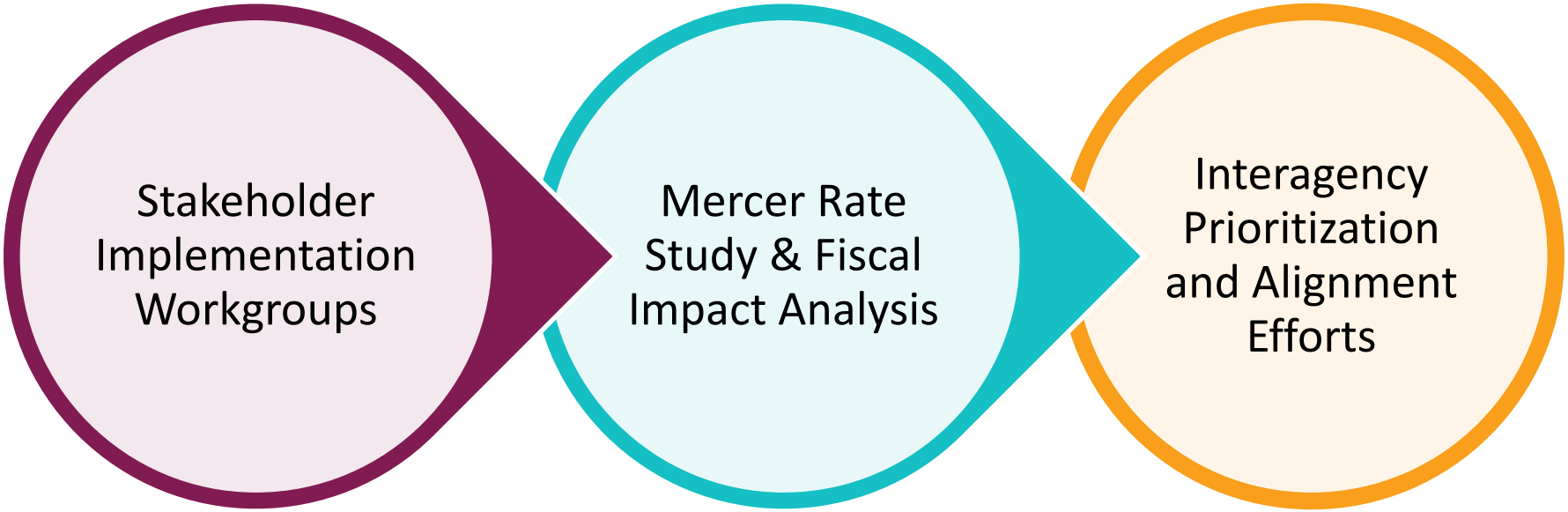
- ✓ Provides alternatives to state psychiatric admissions and offers step-down resources not currently available in the continuum of care, which will assist with the psychiatric bed crisis
- ✓ Demonstrated cost-efficiency and value in other states

Redesign Supports & Enhances: STEP-VA



- Transition funding to outpatient services, integrated services in primary care and schools, and intensive community-based and clinic-based supports
- Invest in workforce development including provision of adequate reimbursement to recruit and incentivize providers to serve where most needed. Streamline licensure and reduce regulatory burdens that impede workforce development
- Implementation of high quality, high intensity and evidence-based SIX services that demonstrate high impact and value
- STEP-VA services improve access, increase quality, build consistency and strengthen accountability across Virginia's public behavioral health system

BH Redesign Efforts since May 2019



20+ meetings
100+ stakeholders
5 workgroups
(4 service specific)

- Assumptions for rate development
- Assumptions for fiscal impact
- Input from stakeholder workgroups

- Workforce needs analysis
- Alignment with other key initiatives

Fiscal Impact Summary

	FY2021	FY2022
General Fund	$8,130,868	$16,708,460
Non-General Funds	$11,082,810	$22,814,805
Subtotal	$19,213,678	$39,523,265
MEL (2 FTEs)	$352,361	$352,361
TOTAL FUNDS REQUESTED	$19,566,039	$39,875,626

Comparison of Proposed Services

Services	Current Costs	FY2021	FY 2022
Assertive Community Treatment	$14,819,250	$24,927,362	$29,552,449
Multi-Systemic Therapy		$2,836,385	$3,178,836
Functional Family Therapy		$1,366,334	$1,528,993
Intensive Outpatient		$229,507	$8,040,373
Partial Hospitalization	$429,230	$908,412	$1,518,984
Crisis Intervention	$4,761,084	$1,131,528	$7,355,437
Community-Based Crisis Stabilization	$21,312,912	$21,833,399	$21,833,399
23-Hour Observation		$355,756	$889,799
Crisis Stabilization Unit		$6,947,472	$6,947,472
Grand Total	**$41,322,476**	**$60,536,154**	**$80,845,741**
Net Increase In Costs		**$19,213,678**	**$39,523,265**

Note: Prior impact summary slide displays total costs (medical and administrative costs); this slide shows only medical costs associated with the services

Redesign Brings Alignment Across BH Efforts

BH Redesign Leverages Medicaid Dollars to Support Cross-Secretariat Priorities

Redesign & Family First Prevention Act

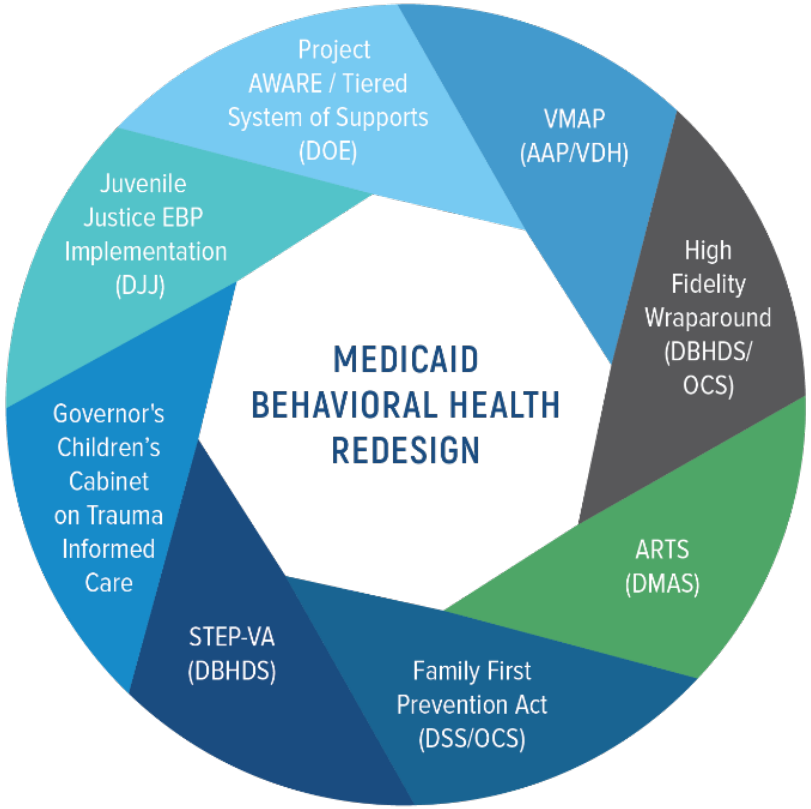
Focused on workforce development, evidence-based programs, prevention-focused investment, improving outcomes, and trauma-informed principles

Redesign & Juvenile Justice Transformation

Supports sustainability of these services for the provider community, particularly in rural settings who have struggled with maintaining caseloads and business models when dependent on DJJ or CSA

Redesign & Governor's Children's Cabinet on Trauma-Informed Care

BH Redesign continuum is built on trauma-informed principles of prevention and early intervention to address adverse childhood experiences



§1115 Serious Mental Illness Waiver Opportunity

- DMAS already has §1115 ARTS waiver which allows Substance Use Disorder (SUD) residential and inpatient treatment and also required implementation of an ASAM Continuum of Care.
- A new CMS SMI 1115 Waiver is available that would *infuse new federal dollars replacing GF funds currently used to pay for some TDO's. The 1115 waiver would allow federal funds to pay for adult inpatient psychiatric hospitalizations and psychiatric residential treatment benefit creating new capacity and alternatives to TDOs*
- *The SMI 1115 is different from ARTS because DMAS must first implement Redesign to demonstrate availability of a comprehensive continuum of evidence-based community mental health services prior to an 1115 waiver application.*
- Could result in GF savings - **state psychiatric hospitals could bill Medicaid (at 90% federal match/10% provider assessment for expansion and 50/50 for traditional) instead of using 100% GF dollars**

https://www.medicaid.gov/federal-policy guidance/downloads/smd18011.pdf

Proposed

Redesign Implementation Steps

If Authority is Granted to Proceed

Reconvene regular stakeholder workgroups for installation planning

INSTALLATION PLANNING

- Systems changes
- SPA, Regulations and Manual Updates
- Launch statewide workforce training

ACCOUNTABILITY

Develop metrics and dashboards with stakeholder input to report out on implementation progress and outcomes

1115 SMI WAIVER

Once installation plan is clear, engage Federal Government for 1115 SMI Waiver application

Throughout this process, we commit to continued interagency partnership with DBHDS as well as continued alignment efforts with DSS-DOE-DJJ-DOC

DMAS ORGANIZATIONAL UPDATE

October 21, 2019

Overview of Organizational Changes at DMAS: Evolution of Several Divisions to Serve Key Cross-Agency Functions

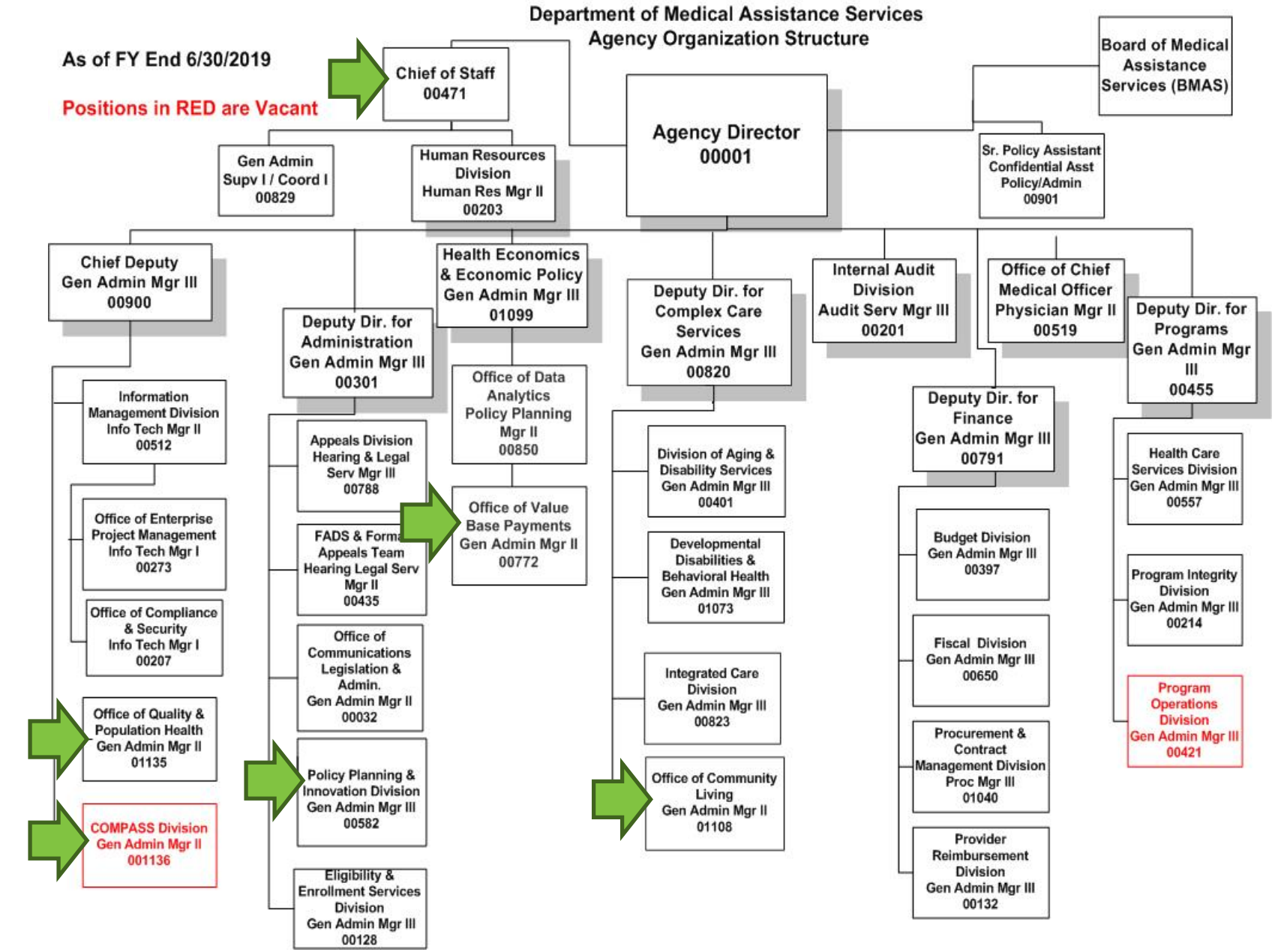
Office of the Chief of Staff was created to provide coordinated oversight of all operations and projects within the agency, with a particular focus on human resources and workforce development

The Office of Quality & Population Health and the Office of Value Based Purchasing were created to execute cross-divisional initiatives to ensure high-quality, high-value care across delivery systems

The COMPASS Division was created to lead the implementation and monitoring of the 1115 COMPASS demonstration waiver

Reorganization of several divisions resulted in the creation of Health Economics & Economic Policy; Policy, Planning and Innovation Division; the Division of Federal Reporting; and the Office of Community Living to ensure strong oversight over the agency's data analytics; policy development; federal reporting; and home- and community-based waivers, respectively

DMAS Organizational Chart: As of End of FY19



Focus on Improving Efficiency, Transparency and Oversight

- Restructuring and alignment of managed care divisions to ensure appropriate oversight of managed care contracts and a coordinated delivery system
- Changes to Finance business processes to ensure external and internal oversight and transparency
- Focus on HR to improve efficiency and ensure positions are filled timely
  - Between 7/1/2018 – 6/30/2019 DMAS filled 119 Classified Positions (with 58 Classified Position Departures) and filled 78 Wage Positions (with 57 Wage Position Departures)

Preliminary Centers for Healthcare Strategies (CHCS) Findings on DMAS Organizational Structure:

CHCS has found that ***"based on its understanding of Medicaid programs across the country and interactions with DMAS leadership and staff, the current structure of DMAS is consistent with other state Medicaid agencies."***

"DMAS is very capable of advancing specific strategic priorities with speed and intensity, as demonstrated by the successful implementation of Medicaid expansion. The agency is also successful in the ongoing management of a large volume of competing priorities created by the day-to-day demands involved in administering a state Medicaid program."