DMAS UPDATE
HEALTH AND HUMAN RESOURCES
OVERSIGHT COMMITTEE
OCTOBER 21, 2019

KAREN KIMSEY
DIRECTOR,
Department of Medical Assistance Services
Agenda

- Managed Care Update
- Behavioral Health Redesign Update
- DMAS Organizational Update
**Who Does Medicaid Serve?**

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children</td>
<td>703,000</td>
</tr>
<tr>
<td>Pregnant Women and Parents</td>
<td>135,000</td>
</tr>
<tr>
<td>Older Adults</td>
<td>78,000</td>
</tr>
<tr>
<td>Individuals with Disabilities</td>
<td>151,000</td>
</tr>
<tr>
<td>Expansion Adults</td>
<td>325,000</td>
</tr>
</tbody>
</table>

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

*DMAS data as of October 2019*
Medicaid covers a wide variety of services, which may include:

- Long Term Services & Supports
- Behavioral Health
- Addiction and Recovery Treatment Services
- Dental Care (limited)
- Primary Care
- Acute Care
Medicaid Expenditures by Population

Medicaid Enrollees and Expenditures, SFY 2019

- **Children**: 50% Enrollment, 21% Expenditures
- **Pregnant Women and Parents**: 10% Enrollment, 9% Expenditures
- **Older Adults**: 6% Enrollment, 42% Expenditures
- **Individuals with Disabilities**: 11% Enrollment, 19% Expenditures
- **Expansion Adults**: 23% Enrollment, 8% Expenditures

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

Majority of Medicaid expenditures go to care for older adults and individuals with disabilities.
Managed Care Expansion Timeline to Date

**2016 – 2018**
- Successfully procured the CCC Plus program
- Regional implementation - Aug 2017 – Jan 2018
- Community mental health services phased in Jan 1, 2018

**2017-2018**
- 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)

**January 2019 - Present**
- 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**
- 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)

*Expanded managed care to remaining fee-for-service populations per requirements in the Appropriations Act*
## Managed Care Programs

90% of Medicaid members are now in managed care

<table>
<thead>
<tr>
<th>Commonwealth Coordinated Care Plus (CCC Plus)</th>
<th>Medallion 4.0</th>
</tr>
</thead>
<tbody>
<tr>
<td>243,400 Members</td>
<td>1,049,300 Members</td>
</tr>
</tbody>
</table>

### 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.
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
VBP is a Powerful Tool to Promote Quality and Efficiency

**Program**

**Clinical Efficiencies**
- Evaluate levels of preventable utilization (i.e., ED visits, hospital admissions, hospital readmissions)
- Develop performance measures to track MCO- & hospital-specific performance

**Performance Withholds**
- Performance targets for key process and outcome metrics
- Focus on behavioral health, chronic conditions, maternity care, and prevention

**Incentive**

**Medallion 4.0** → 1% capitation withhold beginning in SFY 2021

**CCC+** → 1% capitation withhold beginning in 2019

**2020** → Adjust capitation rates

**2021 and Beyond** → MCOs have two-sided risk based on measure performance

**Outcome**
As a whole, these policies align to provide material, financial incentives for MCOs to improve quality and efficiency in key program areas.
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

<table>
<thead>
<tr>
<th></th>
<th>Forecast</th>
<th>Actual</th>
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<tbody>
<tr>
<td>Medallion Base Medicaid</td>
<td>$300.16</td>
<td>$298.17</td>
</tr>
<tr>
<td>Medallion Expansion Medicaid</td>
<td>$556.54</td>
<td>$528.89</td>
</tr>
<tr>
<td>CCC Plus Base Medicaid</td>
<td>$1,828.94</td>
<td>$1,823.31</td>
</tr>
<tr>
<td>CCC Plus Expansion Medicaid</td>
<td>$1,774.72</td>
<td>$1,768.45</td>
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</table>

Actuals do not include GA changes

### Fiscal Impact of FY20 Rates Compared to Forecast

<table>
<thead>
<tr>
<th></th>
<th>Base Medicaid</th>
<th>Expansion Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total Funds</td>
<td>GF</td>
</tr>
<tr>
<td>Medallion 4.0</td>
<td>($14,953,572)</td>
<td>($7,476,786)</td>
</tr>
<tr>
<td>CCC Plus</td>
<td>($14,492,748)</td>
<td>($7,246,374)</td>
</tr>
</tbody>
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For More Information

✓ Managed Care Contracts
  ▪ 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
  ▪ 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
  ▪ Medallion 4.0 - http://www.dmas.virginia.gov/#/med4reports


✓ 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
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**
- **Evidence-Based**
- **Aligned**

More equitable distribution of services – from prevention to acute

Proven practices with measurable effectiveness and quality

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
Trends in CMHRS

Annual Cost of Community Mental Health and Rehabilitation Services
(State Fiscal Year)
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
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

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**What are our top priorities at this time?**

- 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

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**Why BH Redesign for Virginia?**

- 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)
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

- Stakeholder Implementation Workgroups
  - 20+ meetings
  - 100+ stakeholders
  - 5 workgroups (4 service specific)

- Mercer Rate Study & Fiscal Impact Analysis
  - Assumptions for rate development
  - Assumptions for fiscal impact
  - Input from stakeholder workgroups

- Interagency Prioritization and Alignment Efforts
  - Workforce needs analysis
  - Alignment with other key initiatives
## Fiscal Impact Summary

<table>
<thead>
<tr>
<th></th>
<th>FY2021</th>
<th>FY2022</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Fund</td>
<td>$8,130,868</td>
<td>$16,708,460</td>
</tr>
<tr>
<td>Non-General Funds</td>
<td>$11,082,810</td>
<td>$22,814,805</td>
</tr>
<tr>
<td>Subtotal</td>
<td>$19,213,678</td>
<td>$39,523,265</td>
</tr>
<tr>
<td>MEL (2 FTEs)</td>
<td>$352,361</td>
<td>$352,361</td>
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<tr>
<td>TOTAL FUNDS REQUESTED</td>
<td>$19,566,039</td>
<td>$39,875,626</td>
</tr>
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## Comparison of Proposed Services

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

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.
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.”