
**Medicaid Updates:
Care Coordination Activities
&
Budget Forecast**

Briefing to
**Senate Finance Committee
Health and Human Resources Subcommittee**

Presentation Outline

■ *Care Coordination Initiatives*

Regional Expansions of the MCO Program

Foster Children in the MCO Program

Elderly or Disabled with Consumer Direction

HCBC Waiver Recipients' Medical Care

Behavioral Health

Dual Eligibles

Chronic Kidney Health Home

□ 2011 Consensus Forecast

Overview of Care Coordination Initiatives in Virginia Medicaid

- **Item 297 MMMM of the 2011 Appropriation Act directed the Department of Medical Assistance Services (DMAS):**
 - “to expand principles of care coordination to all geographic areas, populations, and services under programs administered by the department...based on the principles of shared financial risk...and improving the value of care delivered”
- **Item 297 MMMM went on to delineate specific potential initiatives to fulfill this stated intent**
- **The initiatives underway at DMAS under this Item are congruent with Governor McDonnell’s efforts to reform the Virginia Medicaid Program as recommended by the Virginia Health Reform Initiative Advisory Council (VHRI)**

Regional Expansions of the MCO Program

- **Item 297 MMMM (a) directs DMAS to geographically expand the current full-risk, capitated Managed Care Organization (MCO) program which provides covered services to Medicaid and FAMIS recipients**

- **As of November 2011:**
 - **The MCO program operates in 114 localities**
 - **Provides services to 585,300 Medicaid/FAMIS recipients, representing 62% of the total recipient population**
 - **Partners with five NCQA-accredited managed care organizations**
 - **Optima Family Care (151,683 lives) – NCQA status = Excellent**
 - **Virginia Premier Health Plan (142,945 lives) – NCQA status = Excellent**
 - **Anthem HealthKeepers Plus (225,669 lives) – NCQA status = Excellent**
 - **CareNet/Southern Health (24,540 lives) – NCQA status = Excellent**
 - **Amerigroup Community Care (40,463 lives) – NCQA status = Commendable**

Regional Expansions of the MCO Program

(continued)

- **Current Exclusions from the MCO program:**
 - **Individuals with Medicare and Other Primary Insurance**
 - **Individuals in Home & Community Based Waivers (majority)**
 - **Individuals in Nursing Homes/ICFs/MR/Long-Stay Hospitals**
 - **Individuals in Hospice**
 - **Foster care/subsidized adoption children**
 - **Individuals in a PACE program (a different managed care model)**
 - **Birth Injury Fund enrollees**

- **Plus individuals in certain geographic areas...**

Population Expansion in the MCO Program: Foster Care Children

- **Item 297 MMMM (b) directs DMAS to add, on a pilot basis with the City of Richmond, foster care children under the MCO delivery system**
 - **The MCO program is the primary service delivery model for otherwise healthy children and will be the exclusive model once statewide coverage is attained in 2012**
 - **As indicated previously, foster children have heretofore been excluded from the MCO program for various reasons**
 - **Now that the MCO program is present in large contiguous portions of the state (and statewide by July 1, 2012), continuity of care coordination for a somewhat more transient population may be achievable**
 - **DMAS is piloting this initiative with Richmond (approximately 230 children) as of December 1, with possible expansion to the surrounding counties and other regions under the MCO program in 2012, eventually applying it statewide**

Population Expansion in the MCO Program: Foster Care Children

(continued)

- **Since January 2011, staff from DMAS have been working collaboratively with the Richmond Department of Social Services (RDSS) and four of the Medicaid MCOs to implement the pilot project**

- **Challenges involving systems and training had to be overcome prior to the pilot's implementation**
 - **As a result, implementation was moved to December 1, 2011 (from the July 1, 2011 date in the Appropriation Act)**

- **We are optimistic that the lessons learned in this implementation effort will ease the expansion of foster care coverage to other localities/regions**
 - **Statewide expansion, if pursued, will need to be accomplished in phases due to the complexities involved**

Population Expansion to Care Coordination: Long-Term Care Related

- **Item 297 MMMM (c), (d), and (g) direct DMAS to implement a care coordination program for various populations receiving Medicaid Long-Term Care services.**
 - **MMMM (c): care coordination for participants in the Elderly & Disabled with Consumer Direction (EDCD) waiver**
 - **MMMM (d): MCO coverage for *medical care* needs of participants already in Home and Community Based Care (HCBC) waivers (the MCO coverage does not include the waiver services)**
 - **MMMM (g): care coordination for individuals dually eligible for services under Medicare and Medicaid**
- **There is significant overlap between these three sub-items in terms of population, and in terms of services coordinated, primarily in that (g) subsumes much of (c) and (d).**

Population Expansion to Care Coordination: Long-Term Care Related

(continued)

- **Item 297 MMMM (c) granted authority to DMAS to implement a care coordination program for recipients in the Elderly or Disabled with Consumer Direction (EDCD) waiver**
 - **Approximately 63% of EDCD recipients are dually eligible for Medicare and Medicaid**
 - **a region-based dual-eligible care coordination model is currently in development under authority in Item 297 MMMM (g), which would be anticipated to eventually expand statewide (to be discussed below)**
 - **The remaining EDCD recipients would be included in the MCO program for their medical needs under authority in Item MMMM (d) (also to be discussed below)**
- **For these reasons, DMAS is not currently developing a separate care coordination program targeted specifically to individuals in the EDCD waiver**

Population Expansion to Care Coordination: Long-Term Care Related

(continued)

- **Item 297 MMMM (d) granted authority to DMAS to modify the MCO program to include individuals enrolled in home and community-based care (HCBC) waivers for coverage of medical care**
 - **Currently, HCBC recipients are categorically excluded from the MCO program unless they were already enrolled in MCOs prior to accessing the waiver (the latter allowed since September 2007)**

- **Effective September 1, 2012, DMAS intends to enroll existing waiver recipients into MCOs for coverage of medical care**
 - **HCBC waiver services will remain “carved out” of the MCO-covered services (reimbursed on a fee-for-service basis through DMAS)**
 - **DMAS will exclude Technology-Assisted waiver recipients**
 - **The implementation of this item could not occur prior to full statewide coverage of the MCO program (the original date, January 2012, was not attainable)**

Population Expansion to Care Coordination: Long-Term Care Related

(continued)

- **Item 297 MMMM (g) granted authority to DMAS to develop and implement a care coordination model for individuals dually eligible for services under both Medicare and Medicaid**
 - **The original implementation date was specified as April 2012**
 - **Subsequent to the Appropriations Act (July 2011), CMS announced an initiative to develop a care coordination model for dual eligible individuals utilizing a three-way contract with managed care entities**
 - **The details are still emerging, but generally speaking, the model will allow for integration of acute, behavioral, and long-term care services and combined funding of Medicare and Medicaid under one capitated payment to the managed care entity(ies)**
 - **DMAS submitted a Letter of Intent to CMS to participate in the initiative and is currently writing the full proposal for consideration by CMS**
 - **Under the current schedule articulated by CMS, the model would be implemented by the end of CY 2012**

Service Expansion to Care Coordination: Behavioral Health Services

- **Item 297 MMMM (e) and (f) direct DMAS to develop and implement, respectively, a care coordination model for individuals in need of behavioral health services not currently provided through a MCO**
 - **Language in (e) directing the “blueprint” of such a system articulates 18 “principles” to which the care coordination model must adhere**
 - **The language in (e) also specifies that the model must continue to recognize that Targeted Case Management is the responsibility of the Community Services Boards – the entity coordinating care cannot replace that function**
 - **The language in (f) then allows DMAS to implement the model on a mandatory basis**

Service Expansion to Care Coordination: Behavioral Health Services

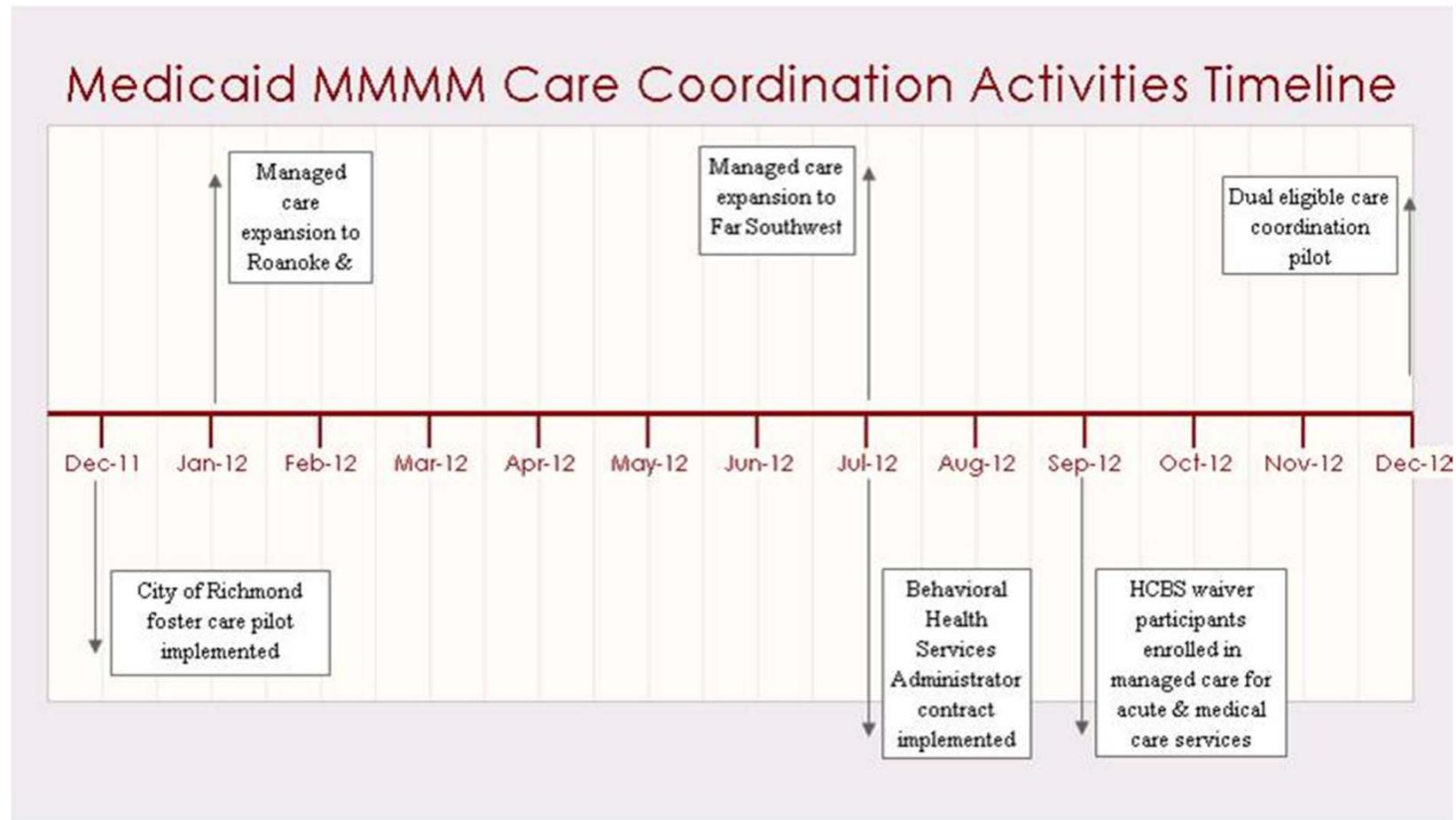
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- **Because of many recent changes in the administration of Medicaid community mental health services and the uncertainty of their affect on utilization, among other concerns, DMAS is currently developing an RFP for an Administrative Services Organization (ASO) to coordinate these services**
 - **It is fully intended that the principles articulated in the Appropriation Act will be applied under the ASO (i.e. the RFP will serve as the “blueprint”)**
 - **It is fully intended that the ASO contract will be replaced by a risk-based capitation model in the near future (likely after three years of the ASO model)**
 - **Beginning coordination of these services as an ASO model will allow DMAS to analyze utilization based on recent changes prior to memorializing existing utilization in the development of capitation rates**
 - **The ASO RFP should be released before the end of the calendar year, with implementation on July 1, 2012**

Additional Care Coordination Model: Health Home for Chronic Kidney Disease

- **Item 297 MMMM (h) granted authority to DMAS to develop and implement a care coordination model for individuals with chronic kidney disease (CKD) under a chronic care health home model**
 - **DMAS has researched the feasibility of this approach and determined not to pursue this model for various reasons:**
 - **Despite the advantageous federal match rate for two years, this would still require new General Funds, especially when the enhanced rate expires**
 - **Because a significant amount of Medicaid recipients with CKD are or become dual eligible, the majority of savings achieved, if any, would accrue to Medicare, not Medicaid**
 - **The other care coordination activities outlined in Item 297 MMMM (discussed above) will eventually cover these individuals; separating out those with CKD would serve to fragment service delivery**
- **Currently, DMAS is encouraging the development of Medical or Health Homes within the existing MCO program or the new care coordination programs in development**

Summary Timeline for Care Coordination Initiatives Under Virginia Medicaid



Budget Assumptions for Care Coordination Initiatives Under Virginia Medicaid

General Fund Savings Estimated for Item 297 MMMM

	<u>Item</u>	2011 Approp. Act <u>2012</u>	State Fiscal Year 2011 Consensus Forecast		
			<u>2012</u>	<u>2013</u>	<u>2014</u>
MMMM (a)	Regional Expansion	\$0	\$784,840	\$5,524,491	\$6,219,282
MMMM (b)	Foster Care	\$0	\$0	\$0	\$0
MMMM (c)	EDCD	\$890,844	\$0	\$0	\$0
MMMM (d)	HCBC Medical	\$422,003	\$0	\$886,207	\$930,517
MMMM (e/f)	Behavioral Health	\$2,412,870	\$0	\$14,290,970	\$16,893,967
MMMM (g)	Dual Eligibles	\$0	\$0	\$0	\$0
MMMM (h)	Kidney Disease	\$0	\$0	\$0	\$0
	TOTAL:	\$3,725,717	\$784,840	\$20,701,668	\$24,043,766

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■ *2011 Consensus Forecast*

Forecasting Process

- Section 32.1-323.1 of the *Code of Virginia* mandates:

“By November 15 of each year, the Department of Planning and Budget, in cooperation with the Department of Medical Assistance Services, shall prepare and submit an estimate of Medicaid expenditures for the current year and a forecast of such expenditures for the next two years to the House Committees on Appropriations and Health, Welfare and Institutions and to the Senate Committees on Finance and Education and Health, and to the Joint Legislative Audit and Review Commission.”

Forecasting Process

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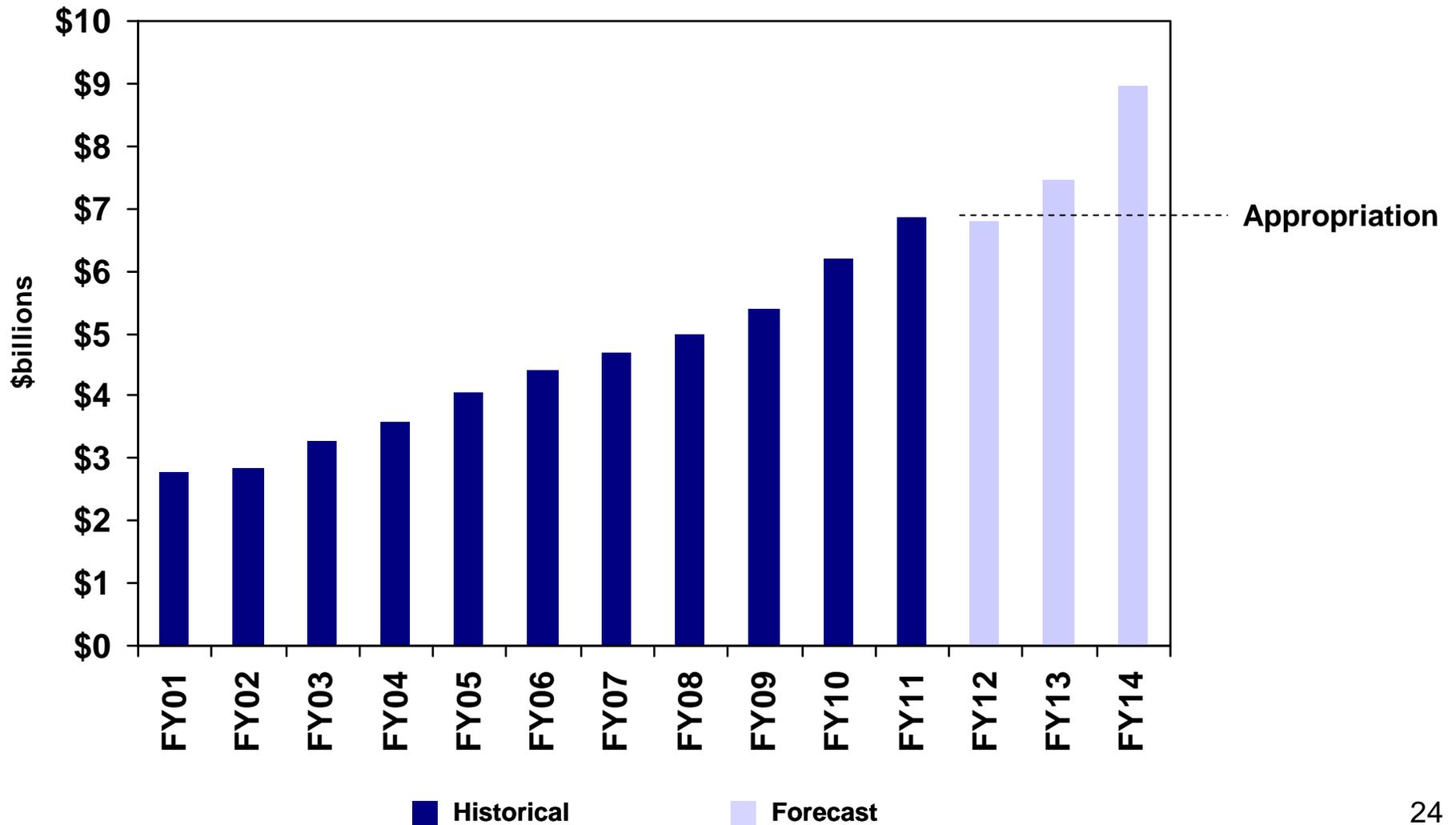
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- Due November 15 to Governor and General Assembly
 - Projects spending in current and subsequent two years
 - Assumes existing program (existing law and regulations)
 - Changes are due to:
 - Change in enrollment, utilization, and inflation
 - Application of existing state laws and regulations
 - Application of existing federal laws and regulations

Forecasting Process

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- Each year, DMAS and DPB prepare independent forecasts using monthly level expenditure and utilization data
 - The forecast is comprised of over 70 different models that project utilization and cost per unit for each benefit category
 - The two agencies meet to compare and evaluate the individual forecasts and an official “Consensus” forecast is adopted

Official Consensus Medicaid Forecast

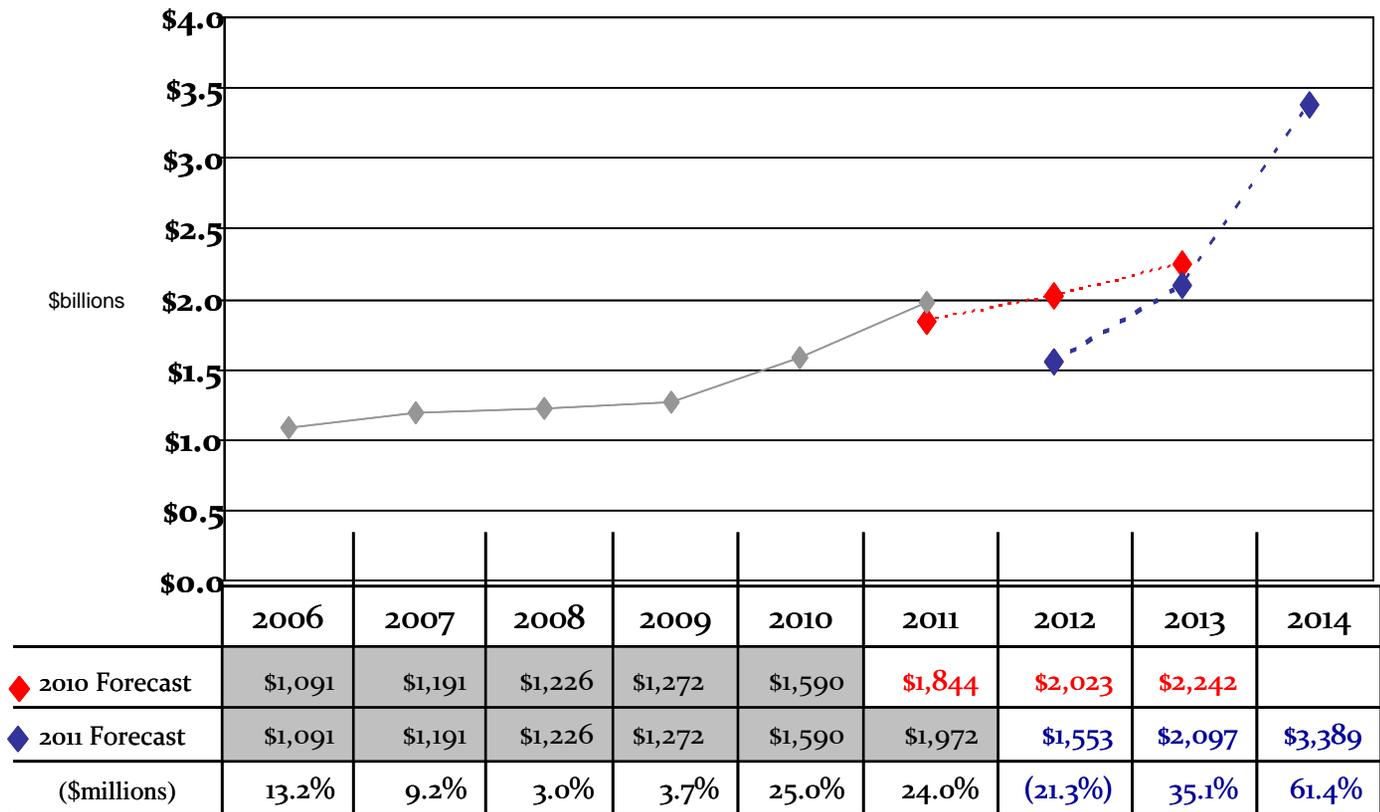


Funding Surplus/(Need) based on Official Consensus Medicaid Forecast

		Appropriation (\$millions)	Consensus Forecast (\$millions)	Surplus/(Need) (\$millions)
FY 2012	Total Medicaid	\$6,877	\$6,726	\$150.1
	State Funds	\$3,513	\$3,427	\$85.4
	Federal Funds	\$3,364	\$3,299	\$65.8
FY 2013	Total Medicaid	\$7,138	\$7,430	(\$292.4)
	State Funds	\$3,643	\$3,816	(\$173.0)
	Federal Funds	\$3,495	\$3,614	(\$119.4)
FY 2014	Total Medicaid	\$7,138	\$9,170	(\$2,032)
	State Funds	\$3,643	\$4,121	(\$477)
	Federal Funds	\$3,495	\$5,049	(\$1,555)

MCO Capitation Payments

Historical and Projected Expenditures for Managed Care Services

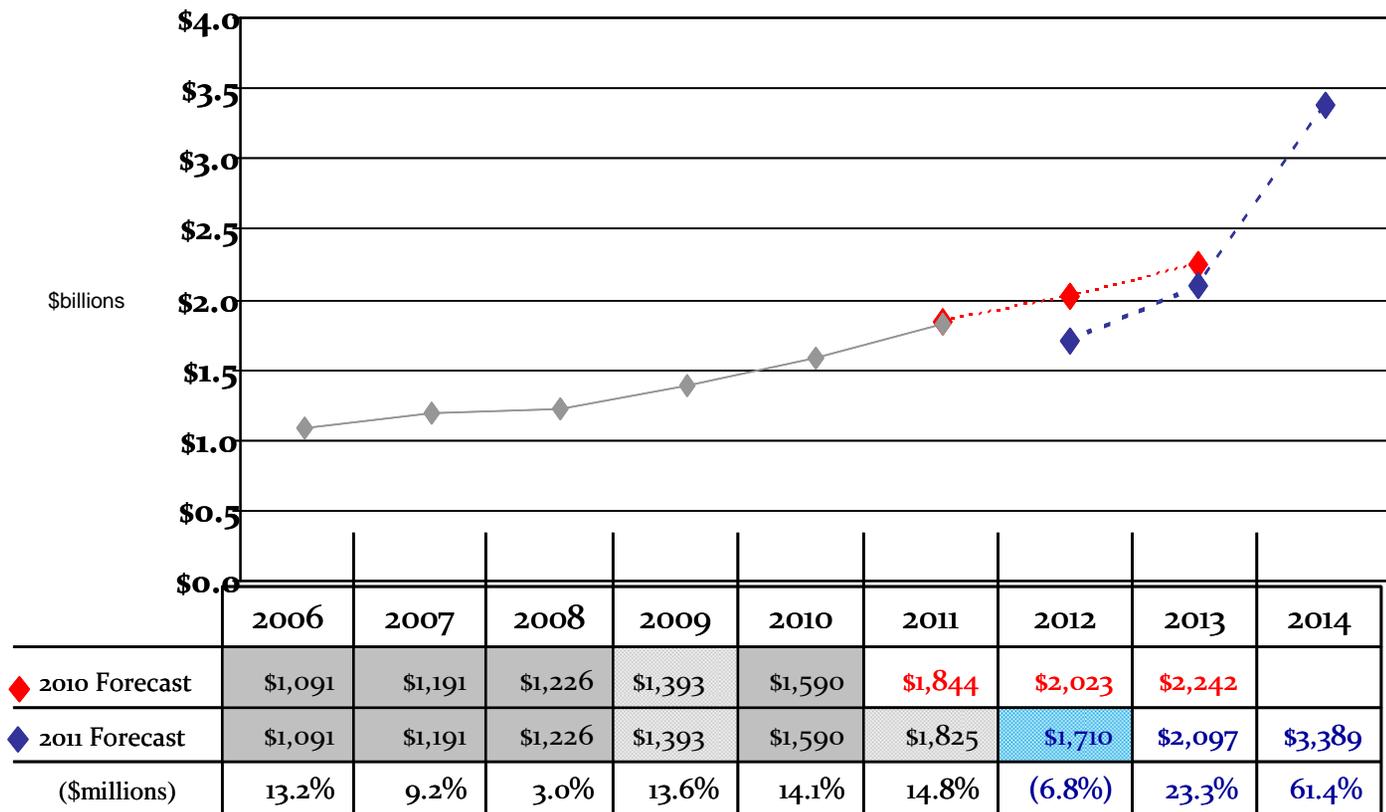


- Variation in the number of annual MCO capitation payments due to payment timing cost savings initiatives and federal match rate maximization efforts

MCO Capitation Payments

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Historical and Projected Expenditures for Managed Care Services

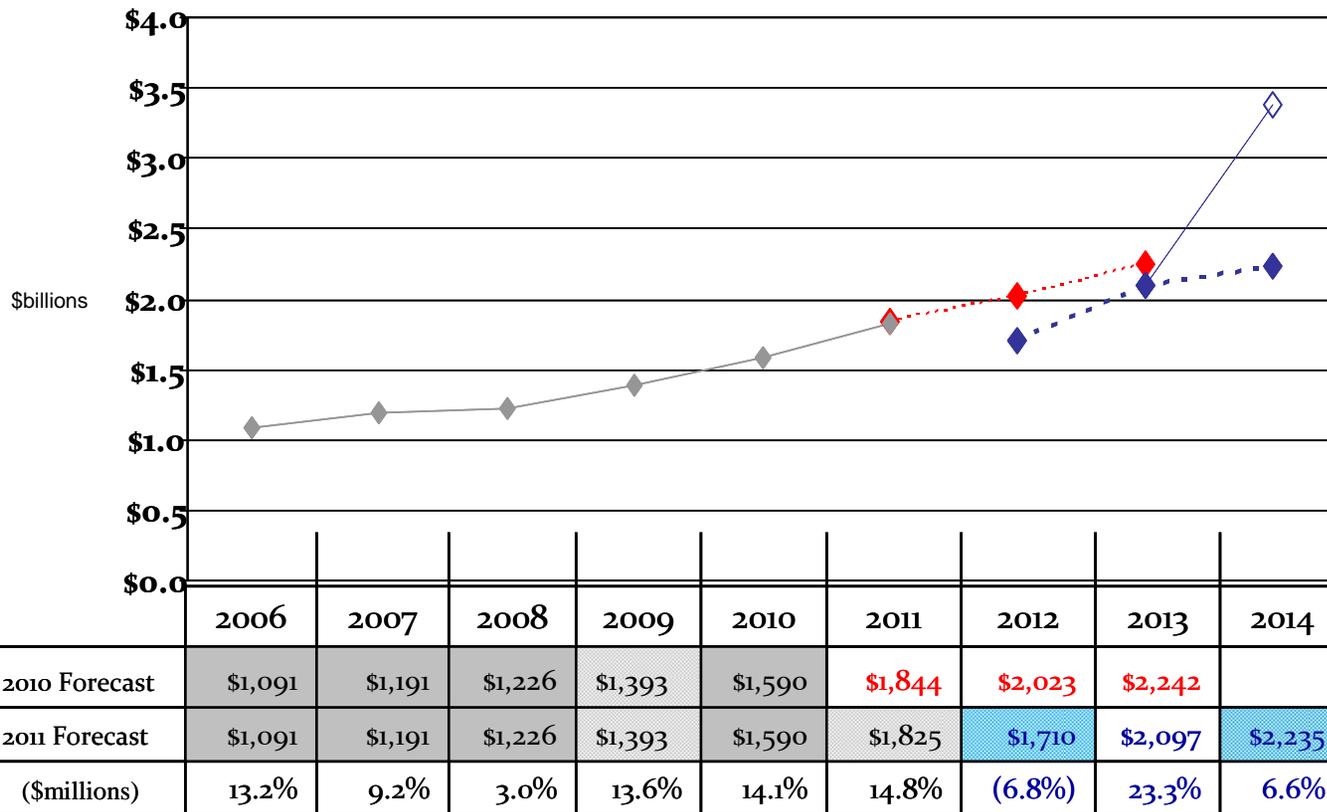


- Adjusting for the variation in the number of annual MCO capitation payments shows true annual growth rates
- Reduction in FY12 reflects decrease in average PMPM rates
- Increase in FY13 reflects projected 5.4% increase in rates as well as the expansion into Southwest Virginia

MCO Capitation Payments

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Historical and Projected Expenditures for Managed Care Services



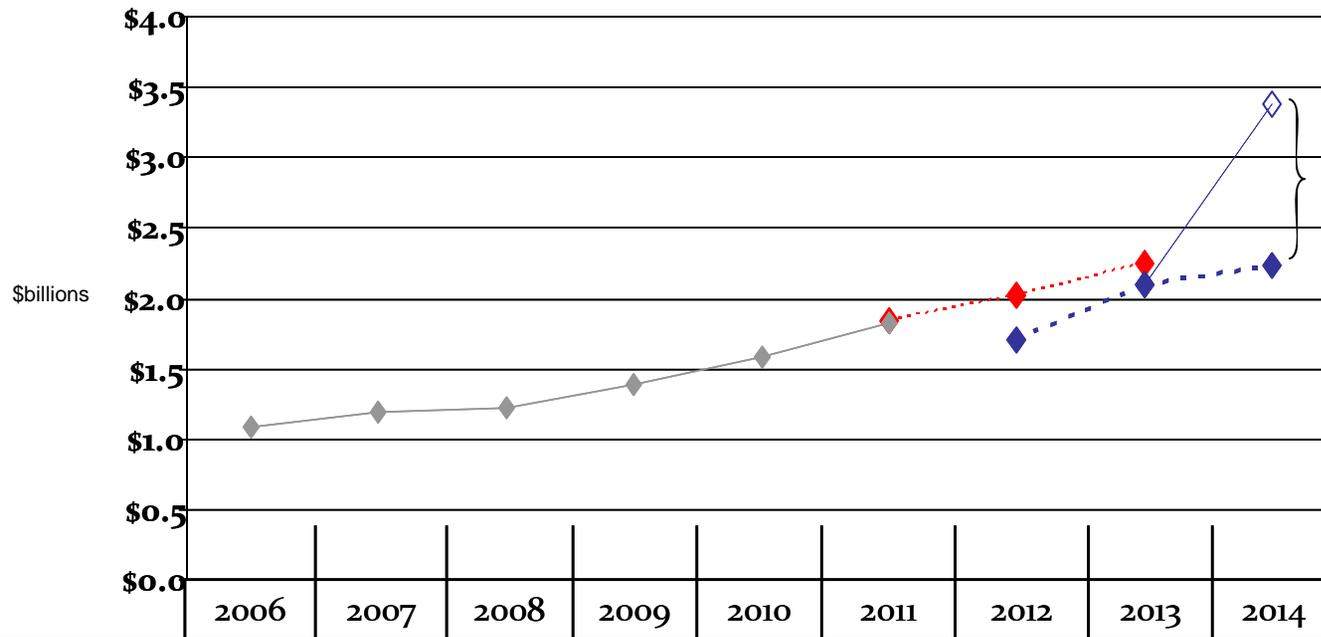
- Increase in FY14 reflects payments for individuals enrolled under Federal health care reform coverage effective January 1, 2014.

- Projected expenditures include payments for new coverage categories (100% federal funds) and for additional enrollees in existing categories (“woodwork” – current federal match rate)

MCO Capitation Payments

(continued)

Historical and Projected Expenditures for Managed Care Services



Impact of PPACA

\$1.15 billion – MCO Payments

\$970 million New Populations 100% Federal Funds

\$179 million “Woodwork” 50% Federal Funds/50% GF

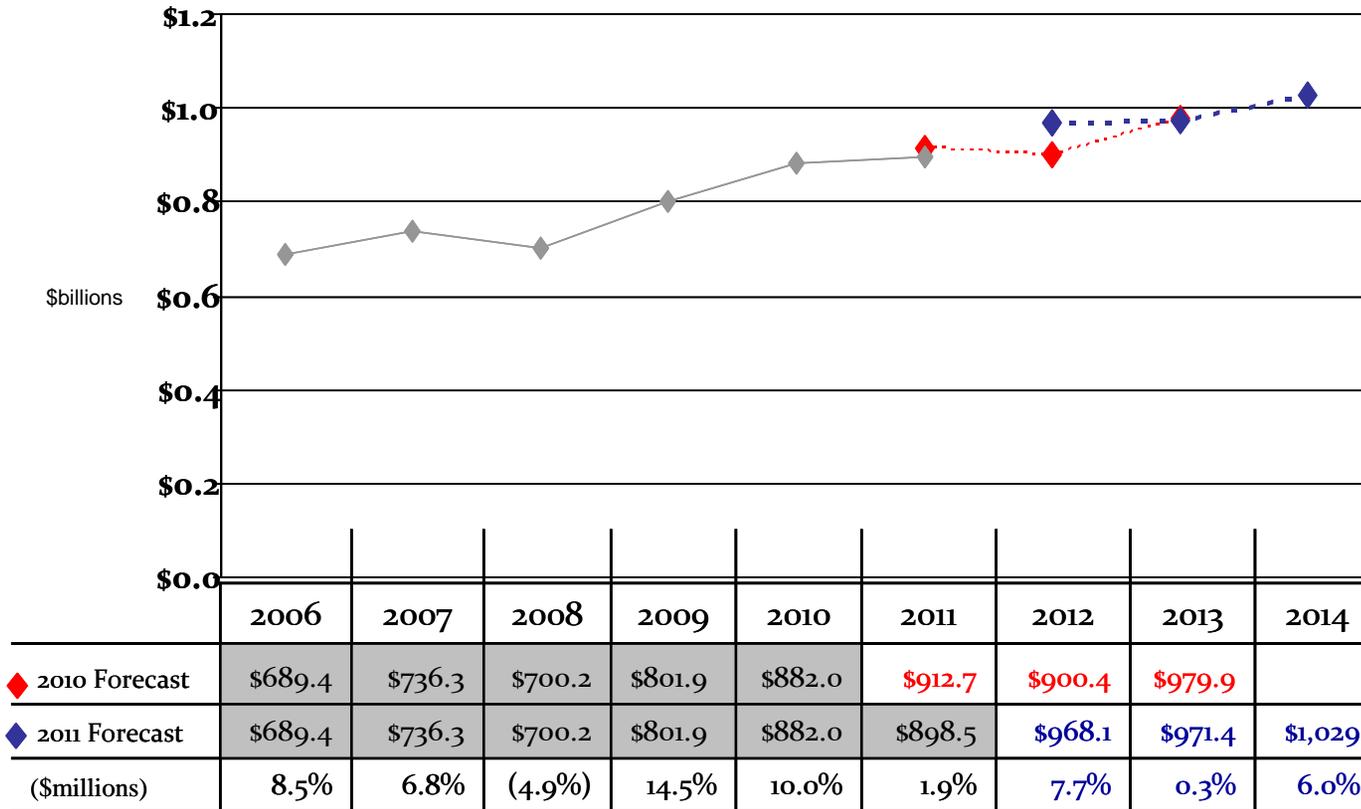
\$10 million – Dental

\$170 million – Behavioral Health

\$1.3 billion – TOTAL

Inpatient Hospital Expenditures

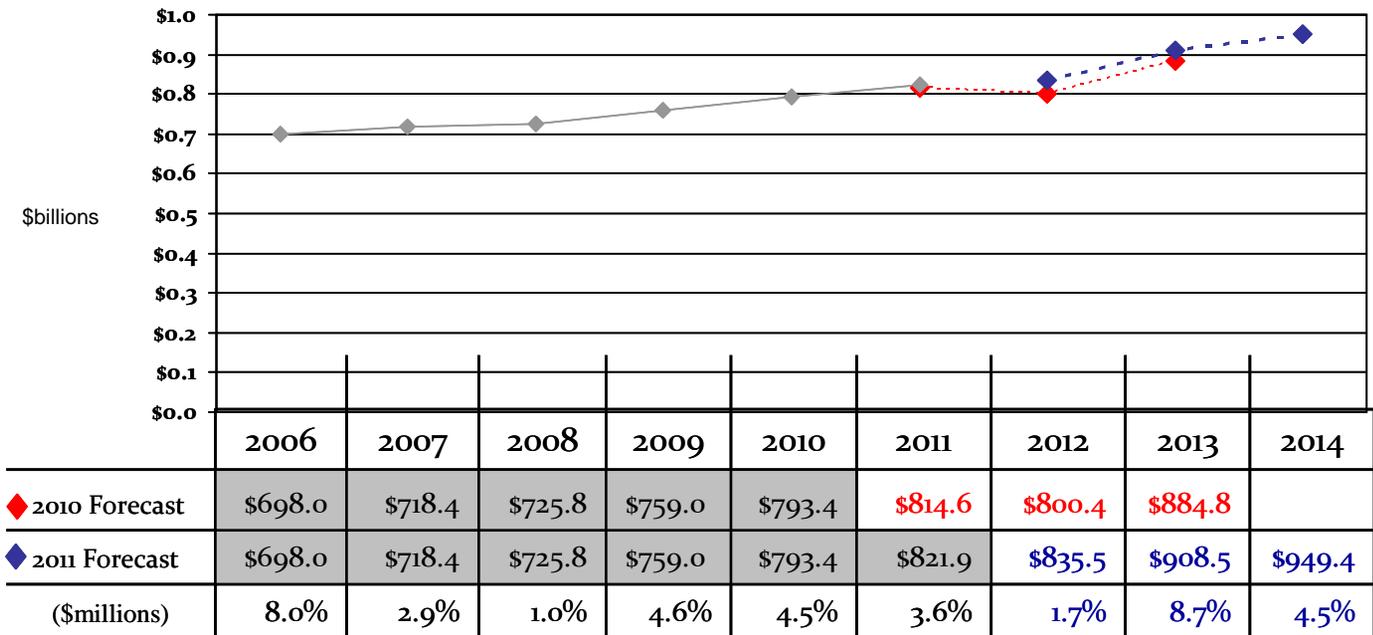
Historical and Projected Expenditures for FFS Inpatient Hospital Services



- Again, payment timing issues related to cost savings initiatives, year-end cash management and federal match rate maximization efforts mask the true annual growth trends; *however shifts are not as straightforward to adjust*
- Since the authorizing language to withhold inflation increase from inpatient hospital rates expires at the end of FY12, FY13 reflects restoration of inflation which costs approx \$195 million

Nursing Facility Expenditures

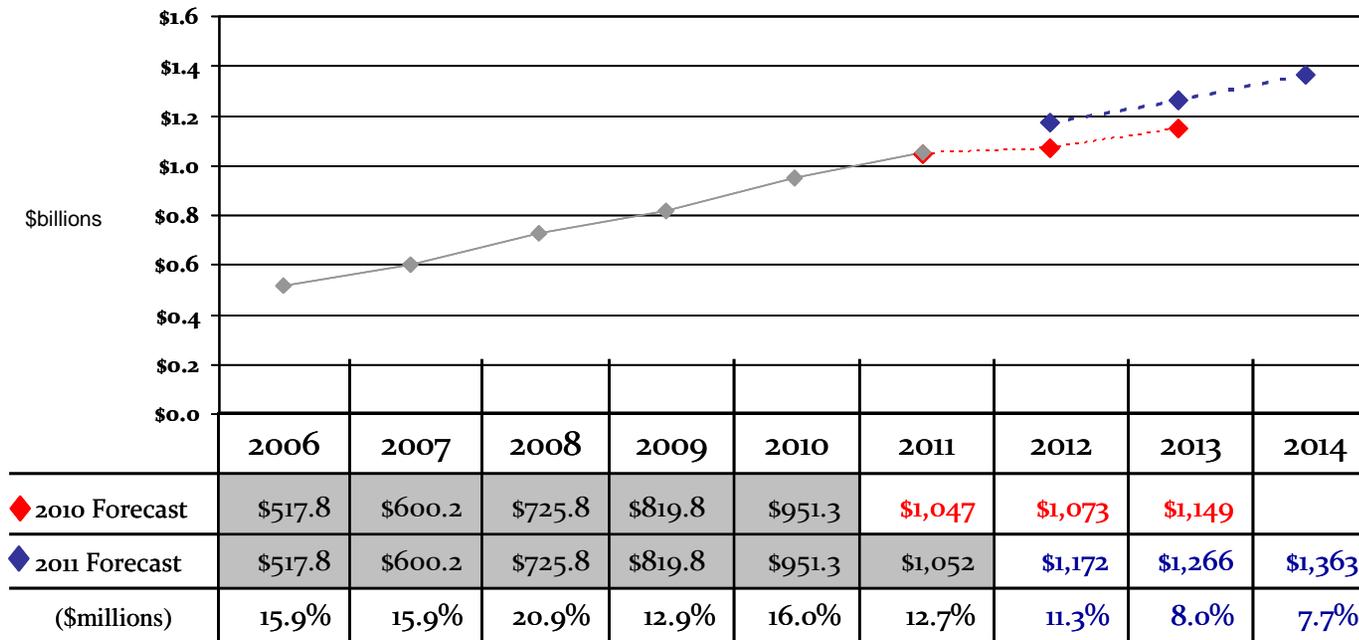
Historical and Projected Expenditures for Nursing Facility Services



- Since the authorizing language to withhold inflation increase from nursing facility rates expires at the end of FY12, FY13 reflects restoration of inflation which costs approx \$62million

Home & Community-Based Care Waiver Expenditures

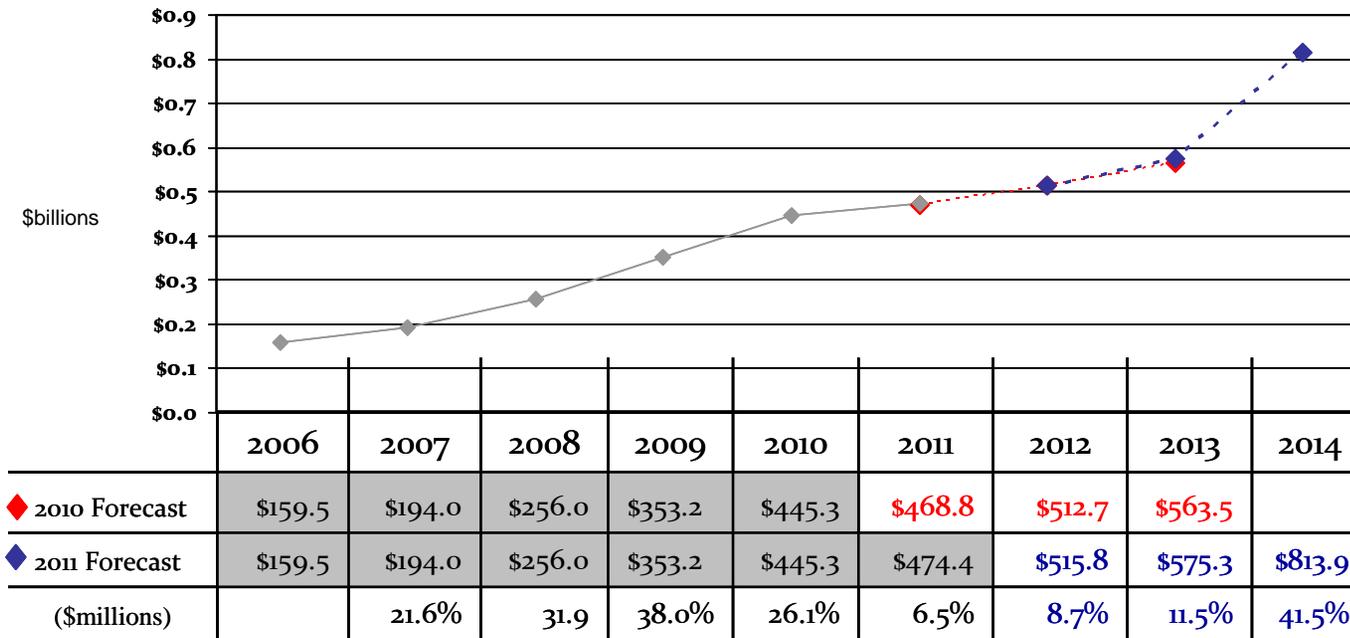
Historical and Projected Expenditures for Home & Community-Based Care Waiver Services



- Utilization of personal care and respite services has been increasing significantly; initiatives were implemented in FY12 to cap personal care hours and reduce the number of allowed respite hours per year

Behavioral Health Expenditures

Historical and Projected Expenditures for Behavioral Health Services



- Utilization of behavioral health services has been experiencing high growth rates over the past several years, however several initiatives implemented have curbed the growth
- The FY14 increase reflects expenditures associated with the enrollment of new populations under Federal health care reform