REPORT OF THE
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Medicaid Reform in Virginia: Report of the Medicaid Revitalization Committee

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

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EXECUTIVE SUMMARY

House Bill 758, passed by the 2006 General Assembly and signed by Governor Kaine on April 5, 2006, set into motion a self-examination of Virginia's primary healthcare delivery mechanism for the State's most vulnerable citizens – the Medicaid program. The legislation creates a group consisting of patient advocates, healthcare providers, health insurers, program administrators, and other stakeholders – the Medicaid Revitalization Committee – to examine alternative and innovative approaches to healthcare delivery under Medicaid, with a focus on client-centered planning, individual budgeting, and self-directed quality assurance and improvement.

House Bill 758 directed this Medicaid Revitalization Committee to consider several potential reforms to the Medicaid program, including the creation of an incentive structure utilizing enhanced benefit accounts, to promote increased personal responsibility in the healthcare decisions of Medicaid recipients. The legislation further envisioned increased enrollment from "un-managed" delivery models to care-coordination programs such as managed care and disease management. Additionally, House Bill 758 directed the MRC to consider revising the Medicaid program to allow additional mechanisms for purchase of employer-sponsored health insurance through health benefits accounts funded at the actuarially defined risk-based premium cost that would otherwise be borne by the Medicaid program as a direct insurer. Finally, the legislation focused on the expanded use of electronic access mechanisms for both providers, through electronic funds transfer and claims submittal, and recipients, through direct debit-like access to the enhanced benefit accounts.

The Department of Medical Assistance Services convened the Medicaid Revitalization Committee on July 14, 2006. The Committee met five times over the course of the summer to discuss and debate potential Medicaid reform ideas intended to fulfill the mandate of House Bill 758. The Department employed a professional facilitator to lead the discussion, as the Department did not want to inappropriately guide or limit the reform discussions. Meeting materials, recommended readings, and public comments were all made available to anyone interested in following the Committee's deliberations through the Department's internet site.

At the outset Committee members wish to express our appreciation to the Legislature for directing this important study of the Commonwealth's critically important Medicaid programs, as well as our compliments to DMAS staff for the serious, thoughtful and open-minded way in which they undertook the charge. Our facilitator, Barbara Hulburt was also instrumental in keeping the group moving forward together.

We learned much about other state Medicaid reform efforts, but also how each state's approach is driven by their history, the relative size and scope of their program and the unique characteristics of their health care system. Some experiences and policies are potentially applicable to Virginia (e.g., beneficiary incentives for disease management) and other elements are not - either because Virginia is already applying the concept (e.g., managed care) or the relatively lean nature of our program makes it impractical (e.g., higher cost-sharing levels are more applicable in states with higher eligibility levels).

Our recommendations are designed to strengthen the value and improve the financial sustainability of the Commonwealth's Medicaid programs. The major themes of our findings are to: 1) build on our program's strengths in managed care; 2) expand disease management programs; and 3) provide tools and incentives for providers and recipients to achieve optimum health outcomes.

It is important to note from the perspective of a Committee made up primarily from representatives of healthcare service providers and patient advocates, that this report is intended to focus solely on Medicaid reform concepts and opportunities expressed in House Bill 758. The Committee has self-regulated itself in regards to the exclusion of reform concepts such as expanded eligibility for Medicaid and payment enhancements for service providers. While the Committee would likely have clear consensus that such reforms would be welcome enhancements to the Virginia program, these goals have been well-established and articulated by Committee members and their organizations already. In proposing reforms solely related to the provisions of House Bill 758, the Committee is not diminishing the perceived need for these other types of reforms, merely separating those reforms from this discussion.

It is also important to note, from the Committee's perspective, that a major area of reform for the Virginia Medicaid program is the integration of long-term and acute care through care-coordination model(s). As will be discussed in the Committee's report, the elderly and disabled population served through Medicaid represent a minority of total recipients (approximately 30%), but account for a majority (approximately 70%) of healthcare expenditures in the program. This long-term care services reform initiative, however, is being conducted relative to separate authority in the 2006 Appropriation Act (Item 302 – ZZ), and was not considered within the scope of this Committee.

The Committee also spent considerable time discussing possible initiatives in support of more efficient administrative and claims data exchange for both providers and the agency. The Committee's deliberations in this area must be considered as part of a broader set of health care information technology initiatives underway in the Commonwealth. It is important to note that DMAS is participating in the work of the Commonwealth's new Health Information Technology (IT) Council created in August by Governor Kaine, which, with available federal funds, is moving forward on a parallel path to support electronic medical and health record tools. One probable focus of the Health IT Council's effort, and a topic on which Committee members offered support, is offering providers easier access to recipient medication histories for better management of treatments.

To fulfill its mandate in House Bill 758, the Committee proposes the following consensus recommendations in the order that they appear in the report:

Recommendation #1: The Department of Medical Assistance Services should seek funding and approval (both state and federal) to expand population-based disease management programs to target high cost and/or high prevalence disease states for which nationally accepted evidence-based care guidelines exist. The Department should develop a list of such disease states and estimate the costs associated with program administration for each disease. This expanded program should also include aspects of provider-centric models where the healthcare provider plays a

more direct and active role in the care management. The Department shall determine the scope of the expanded disease management program, including the possibility of one or more pilot programs, based on funding made available for this purpose.

Recommendation #2: The Department of Medical Assistance Services should seek funding and approval (both state and federal) to provide access to enhanced benefit accounts, or a similar mechanism, in which recipients are rewarded for compliance with aspects of their care plan through financial incentives that can be used to purchase healthcare related goods and services not otherwise covered by the Medicaid program (including patient cost sharing responsibilities). These accounts would be accessed through an electronic debit card or similar electronic mechanism. The Department shall determine the scope of the program based on funding made available for this purpose and should include provisions for recipient education regarding these accounts and their use.

Recommendation #3: The Department of Medical Assistance Services should require electronic funds transfer for payment of healthcare services to all enrolled Medicaid providers. This requirement should also be enforced though participating managed care organizations and other contractors facilitating or directly providing healthcare services in the Medicaid program. This would include consumer directed services within long-term care where feasible.

Recommendation #4: The Department of Medical Assistance Services should seek funding (both state and federal) to implement a web-based claims submission system available free of charge to all healthcare providers for use in the submission of Virginia Medicaid claims and for the receipt of electronic remittance advices. The Department should require participating managed care organizations and other contractors facilitating or directly providing healthcare services in the Medicaid program to offer such electronic capabilities as well. This would exclude consumer directed care services within long-term care services. The Department and its contractors should encourage provider usage of this web-based system and any currently approved electronic claims submission mechanisms for Virginia Medicaid. The Department should monitor the usage of electronic claims submission relative to paper claims submission and make further recommendations to achieve a virtually paperless claims process.

Recommendation #5: The Department of Medical Assistance Services should continue working toward the goal of expanding managed care into new regions and across additional eligibility categories where feasible. Expansions should only take place if the program can ensure no diminished access to quality care for recipients. The Department should take great care to assure that if included within a managed care program, recipients with disabilities and special needs have access to needed services. The Department should not be limited in its program design utilized for expansions to the current model, but should explore other potential models of care coordination and delivery, including greater use of local health agencies, telemedicine and defined-contribution models, to fulfill the unique needs of recipients in the new regions and eligibility categories. The Department should not

impose monetary benefit caps or benefit restrictions (relative to current policy) under existing or expanded managed care programs without a provision for catastrophic coverage maintained within the Medicaid program.

Recommendation #6: The Department of Medical Assistance Services should study the potential impact of modifications to existing programs for public subsidy of employer-sponsored or other private health insurance coverage for Medicaid-eligible individuals, including the impact of switching from mandatory to voluntary enrollment in these subsidy programs. To the extent the public subsidy is cost effective / cost neutral relative to the cost of direct Medicaid coverage, and based on the Department's analysis and input from stakeholders, the Department should consider modifications to these subsidy programs to further encourage the use of available private insurance coverage options. Any modifications to or expansions of these programs should include consumer protection mechanisms.

Recommendation #7: The Department of Medical Assistance Services should seek federal approval to expand, where feasible, "buy in" programs to allow expanded participation in the Medicaid and FAMIS programs, including the program authorized as the Family Opportunity Act, to the extent such expanded participation can be shown to be cost effective / cost neutral to the Commonwealth.

We are pleased to submit this report of the Committee's findings and recommendations to the Governor, the House Committees on Appropriations and Health, Welfare and Institutions, and the Senate Committees on Finance and Education and Health. While staff from the Department of Medical Assistance Services (DMAS) provided technical assistance in drafting this report, it is important to emphasize that the discussion and recommendations herein are those of the Medicaid Revitalization Committee.

INTRODUCTION

House Bill (HB) 758 (see Appendix A), passed by the 2006 General Assembly and signed into law by Governor Kaine on April 5, 2006, set into motion a self-examination of Virginia's primary healthcare delivery mechanism for the State's most vulnerable citizens – the Medicaid program. The legislation creates a group consisting of patient advocates, healthcare providers, health insurers, program administrators, and other stakeholders – the Medicaid Revitalization Committee – to examine alternative and innovative approaches to healthcare delivery under Medicaid, with a focus on client-centered planning, individual budgeting, and self-directed quality assurance and improvement (Committee members and their affiliation are listed in Appendix B to this report). This state-initiated Medicaid reform effort is particularly timely in that reform efforts on the federal level have been articulated and codified recently with the Deficit Reduction Act of 2005 (DRA).

This report of the Committee's findings and recommendations to the Governor, the House Committees on Appropriations and Health, Welfare and Institutions, and the Senate Committees on Finance and Education and Health is intended to fulfill the mandate of HB 758. While staff from the Department of Medical Assistance Services (DMAS) provided technical assistance in drafting this report, it is important to emphasize that the discussion and recommendations herein are those of the Medicaid Revitalization Committee. It should also be noted that public comments for consideration by the Committee during its deliberations have been summarized and are presented in full in Appendix C to this report.

Fundamental Elements of House Bill 758

HB 758 directed the Medicaid Revitalization Committee (hereafter, the MRC) to consider several potential reforms to the Medicaid program, including the creation of an incentive structure to promote increased personal responsibility in the healthcare decisions of Medicaid recipients. While the legislation envisioned increased enrollment from "un-managed" delivery models to care-coordination programs – Medicaid managed care, primary care case management, and disease management – a key issue to be considered by the MRC was the creation of voluntary enhanced benefit accounts, or health opportunity accounts, to facilitate healthy behavior and training in effective and appropriate self-care. Under this model, financial incentives could be deposited into the benefit accounts to reward adherence to the plan of care. The legislation emphasized personal responsibility that would be facilitated through a recipient's ability to purchase, from this enhanced benefits account, qualifying services or items outside the scope of basic coverage, such as a health club membership, for example, thereby further promoting the well-being of the Medicaid recipient and potentially diminishing future utilization of acute care services.

Additionally, HB 758 directed the MRC to consider revising the Medicaid program to allow additional mechanisms for purchase of employer-sponsored health insurance through health benefits accounts funded at the actuarially defined risk-based premium cost that would otherwise be borne by the Medicaid program as a direct insurer. HB 758 envisions that voluntary participation in private insurance programs under a public subsidy to the enrollee could allow flexibility in benefit design and the potential ability to actively manage the benefit structure, including direct purchase of non-covered, but qualifying services and items.

Finally, HB 758 directed the MRC to consider the phased implementation of direct electronic access to the enhanced benefit accounts for recipients and fully implemented electronic funds transfer technology for providers and participating managed care organizations (MCOs). Specifically, the legislation envisioned a system where direct payment from the health opportunity accounts for certain items and services could be made by the recipient, via an electronic benefits card acting like a debit card, at the point of purchase, rather than through a claims submission system to a third party like the Medicaid program or the participating MCOs.

Mission of the Medicaid Revitalization Committee

The mission of the MRC was to consider potential revisions to the program as identified in HB 758, and to make recommendations regarding the future structure of Virginia's Medicaid program. As directed by HB 758, the MRC's recommendations focus on emphasizing the state's role in purchasing healthcare services, leveraging the forces of the marketplace to customize services to meet the diverse needs of Virginia's Medicaid population, enhancing personal responsibility and empowering individuals who desire to manage their healthcare, bridging public and private coverage, maximizing access, and containing the growth of Medicaid expenditures in the Commonwealth.

Brief Summary of MRC Meetings

To fulfill this mission, the MRC held a series of public meetings from July through October 2006. DMAS staff provided much of the meeting materials for the MRC's consideration. However, to assure full participation of all Committee members and provide an efficient and inclusive process for considering issues and making recommendations, DMAS engaged the services of a professional facilitator to lead the meetings. The following is a summary of the topics covered at each of the meetings. Meeting materials (including minutes and presentations) are available to the public on the DMAS internet site.

July 14, 2006. The first meeting was held on July 14, 2006 during which DMAS staff provided an overview of HB 758 and the MRC's charge. Additionally, DMAS staff discussed the current state of the Virginia Medicaid program and compared Virginia Medicaid to the Florida Medicaid reform plan (major aspects of which HB 758 appeared to incorporate). Finally, the MRC facilitator discussed the rules of engagement, so-to-speak, for the Committee deliberations and facilitated the Committee's discussion of the materials presented by DMAS staff.

August 2, 2006. The second MRC meeting was held on August 2, 2006 during which a public comment period was held to allow non-MRC members access to impacting the deliberations of the Committee. Additionally, DMAS staff addressed the MRC's desire for more information on Florida and other state Medicaid reform efforts. DMAS staff also provided information about disease management and electronic access in the Medicaid program.

August 9, 2006. The third meeting addressed the desire of the MRC to hear additional information regarding disease management and electronic access in Virginia Medicaid. DMAS staff provided additional information on both topics, and a panel made up

of representatives from the Virginia Medicaid fee-for-service disease management program (*Healthy Returns*) and a Managed Care Organization (MCO) representative from the Virginia Medicaid managed care program discussed in more detail their respective disease management programs in Virginia's Medicaid program, and participated in the Committee's deliberations on the topic.

August 29, 2006. The fourth meeting of the MRC was an all-day meeting during which DMAS staff presented an overview of Medicaid managed care programs, with significant detail on the Virginia MCO program. Additionally, DMAS staff presented information on existing employer-sponsored health insurance premium subsidy programs, as well as public insurance Buy-In programs in Virginia and those contemplated in other state reform efforts. Finally, DMAS staff discussed optional Deficit Reduction Act (DRA) provisions for benchmarked benefit design and enhanced recipient cost-sharing.

September 21, 2006. Prior to the fifth meeting of the MRC, DMAS staff provided MRC members and the general public (through the internet site) a draft report of the MRC deliberations. The draft report was released to allow public comment on the report at the fifth meeting, so that the MRC could consider the public's input prior to finalizing the report to the Governor and General Assembly. DMAS staff presented the consensus recommendations at the meeting and the public comment period was held, followed by the Committee's deliberations on the draft report.

Organization of the Report

This report is organized to mirror the order of discussions held during the five MRC meetings. MRC recommendations will be presented by topic area as the topic is discussed. For contextual purposes, the report will begin with an overview of the current Virginia Medicaid program, followed by a discussion of selected other state Medicaid reform efforts underway. This will be followed by the findings and recommendations of the MRC in relation to the main components of HB 758, which are expanded use of disease management programs, enhanced electronic access, expanded use of managed care, and expanded use of employer-sponsored insurance subsidies and Buy-In programs.

VIRGINIA'S MEDICAID PROGRAM & OTHER STATE REFORM EFFORTS

In order to propose reforms to the Medicaid program, it is first important to understand how the Virginia program works, who the program serves, and how the program is financed. This discussion will also facilitate the understanding of the scope of reform efforts underway in other states and their relevance or application to the Virginia program.

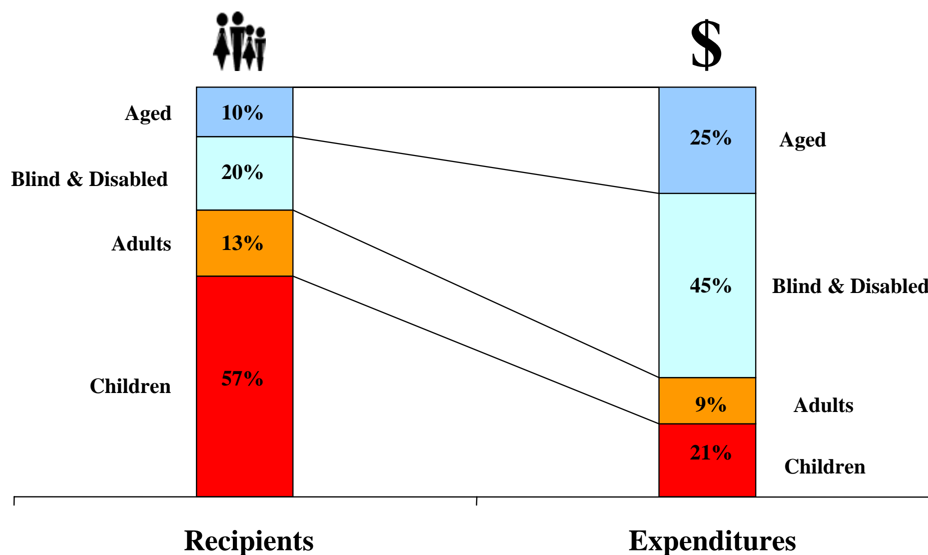
Background on Virginia Medicaid

Medicaid is an entitlement program authorized under Title XIX of the Social Security Act that provides coverage of medical services for certain disabled and low income individuals. Medicaid is financed jointly by the state and federal governments and administered by the states, within guidelines established and approved at the federal level. Federal financial assistance is provided to states and the federal match rate is based on the state's per capita income. The federal match rate for Virginia is currently 50 percent, meaning that for every dollar expended in the Medicaid program, 50 cents is from the federal government and 50 cents is from the state's general fund.

While Medicaid was created to assist individuals with low incomes, coverage is dependent upon other criteria as well. Eligibility is primarily for people who fall into particular groups such as low-income children, pregnant women, the elderly, individuals with disabilities, and parents or caretaker relatives of dependent children. Within federal guidelines, states set their own income and asset eligibility criteria for Medicaid. This results in a great variation of eligibility criteria among the states.

In state fiscal year (FY) 2005, the Medicaid program served an average of nearly 691,000 recipients per month with annual expenditures of $4.4 billion (approximately one-half from federal funding). Children and adult caretakers make up about 70 percent of the Medicaid beneficiaries, but they account for only 30 percent of Medicaid spending. The elderly and persons with disabilities, while a minority in terms of recipients served (30 percent), account for the majority (70 percent) of Medicaid spending because of their intensive use of acute and long-term care services (Figure 1).

Figure 1
2005 Recipients/Expenditures



The Virginia Medicaid program covers a broad range of services with nominal cost sharing for some of the beneficiaries as permitted under federal law. The Virginia Medicaid program covers all federally mandated services:

- Inpatient and outpatient hospital care
- Physician, nurse midwife, and pediatric and family nurse practitioner services
- Federally qualified health centers and rural health clinic services
- Laboratories and x-ray services
- Prenatal care
- Family planning services
- Transportation services
- Skilled nursing facility and home health care services for persons over age 21
- Early screening, diagnosis, and treatment program for children ("EPSDT")

Additionally, Virginia Medicaid also provides some services at the state's option, including but not limited to:

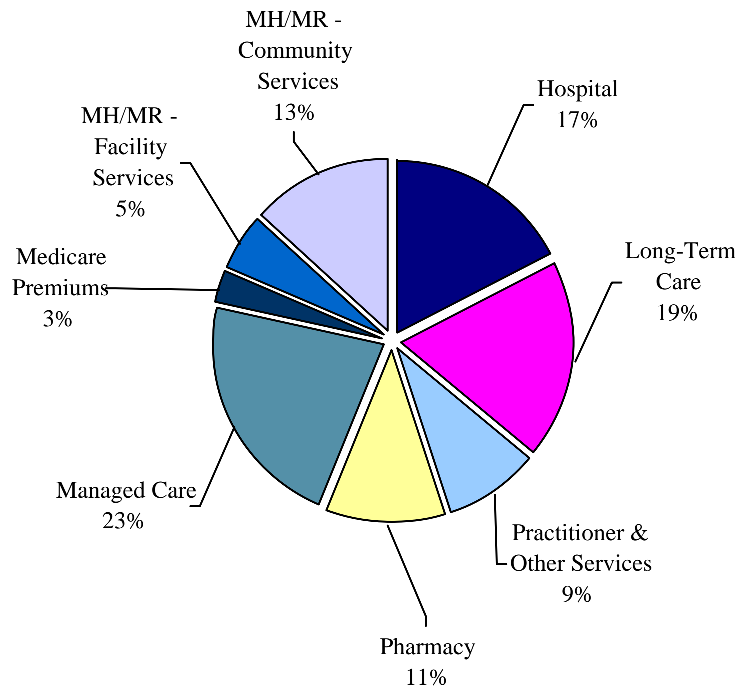
- Dental services for persons under 21
- Prescribed drugs
- Rehabilitation services such as occupational, physical, and speech therapy
- Intermediate care facilities for persons with mental retardation (MR) and related conditions
- Mental health services
- Home and Community-Based Services as an alternative to institutionalization

Health care services are provided to Medicaid recipients through two general models: fee-for-service (FFS) - the standard Medicaid program where providers are reimbursed directly from DMAS for services rendered; and managed care - utilizing contracted managed care organizations which pay providers directly (Virginia pays private MCOs a "per member per month" fee through a full risk contract to manage the majority of the recipients' care). Certain recipients (most notably those in long-term care programs) are currently excluded from participation in the MCO program. Additionally, Medicaid managed care is not yet available statewide due to market conditions (this will be discussed later in the report). Recipients who would otherwise be eligible for managed care if plan coverage existed in their region are enrolled in a primary care case management program, but services remain reimbursed under the FFS methodology.

As of August 2006, nearly 55 percent of Medicaid/FAMIS recipients were enrolled in the MCO program, with approximately 45 percent of recipients in the FFS program. Figure 2 (next page) presents the proportion of healthcare expenditures by the major service area in FY 2005. It is important to note that the "Managed Care" expenditure total represents the expenditure to the participating health plans, with plans paying providers for services to their participants.

Despite Virginia's relative affluence (7th in the nation in per capital income), Virginia remains ranked near the bottom among states in terms of the number of Medicaid recipients as a percentage of the population (47th in the nation) and the Medicaid expenditure per capita (49th in the nation). Based on these and other statistics, Virginia's Medicaid program has long been described as a very lean program with very strict eligibility criteria and modest payment rates for services. Administrative costs of the Virginia Medicaid program represented only 1.8 percent of total Medicaid expenditures in 2005.

Figure 2
FY 2005 Expenditures, by Service Category



Recent Medicaid Reform Efforts in Other States

HB 758 employed reform terminology that is also used in the recent reform efforts of several other states. The state reform efforts that most appeared to mirror the language and concepts found in HB 758 are the following: Florida, South Carolina, West Virginia, Kentucky, and Idaho. West Virginia, Kentucky and Idaho were the first States to attempt reforms under the new authority granted under the Deficit Reduction Act of 2005 (DRA), thus they have pursued their reforms through State Plan amendments. Because the DRA provides states with additional flexibility to make Medicaid program changes which formerly could only be done through a waiver, the Centers for Medicare and Medicaid Services (CMS) is encouraging states to first try the State Plan Amendment route before considering a waiver. Florida's reform is being implemented through a waiver, but information on Florida's program is provided because so many of the terms and concepts used in HB 758 appear in Florida's waiver. South Carolina submitted a waiver application to CMS in November 2005, but this application is currently on hold while the State explores ways to achieve their goals through a State Plan Amendment under the DRA.

When reading HB 758 and other state reform proposals, it is useful to keep in mind that reform terminology has broad and often different meaning depending on the state. The DRA also has its own reform terminology. For example, Enhanced Benefit Accounts (EBAs) and Health Opportunity Accounts (HOAs) are used almost interchangeably in HB 758. However, EBAs as used in the Florida waiver address the broad concept of wellness incentives (providing incentives to recipients so they will engage in wellness activities). Various states offer wellness incentives, but have different terms for them. HOAs on the

other hand, is a term from the DRA which refers to what are also known as Health Savings Accounts (HSAs) in the private sector—funds set aside through savings or employer contributions which are used to pay for routine health care services until a high deductible is met. The high deductible health plan covers catastrophic costs.

Another example of a term which has different meanings in different states is "Personal Health Accounts" (PHAs). In South Carolina, PHAs refer to risk-adjusted premiums which Medicaid recipients would use to shop around for a health plan which best meets their needs. They could use it to buy a health plan offered by a Managed Care Organization (MCO) or to purchase health insurance offered by their employer. However, in Idaho, PHAs refer to wellness incentive accounts. Recipients will receive credits deposited in their PHA for activities such as losing weight or keeping well child appointments. These credits can then be used to purchase items such as fitness center memberships, bicycle helmets or nicotine patches.

One of the major factors driving the current round of state-initiated Medicaid reforms is the growth in Medicaid expenditures. Although not all states listed cost savings explicitly in their goals, it appears that the ability to control future expenditures is an important part of these reform efforts. For example, even in Florida where officials indicated the reform effort was not designed to cut the Medicaid budget, one of their objectives was to better predict expenditures in the future and to gain better control over those expenditures. In addition to cost containment, these recent reform efforts have other common goals which include increasing recipient choice, encouraging personal responsibility, providing additional benefit flexibility, and increasing care coordination and preventive health. Table 1 below lists some reform goals that these states have in common:

Table 1
Stated Goals of Other States' Reform Efforts

	FL	SC	WV	KY	ID
Increase/Enhance Recipient Choice	✓	✓		✓	
Encourage/Promote Personal Responsibility	✓		✓	✓	✓
Benefit Package Flexibility	✓	✓	✓		
Increased Care Coordination/ Preventive Care/ Health Improvement	✓	✓	✓	✓	✓
Cost Savings		✓			✓
Other		Introduce more competition	Streamline administration	Stretch resources	

Because these states have many of the same goals, they have also proposed to achieve these goals through the same or similar means. Table 2 (next page) provides an overview

which represents our understanding of the latest information available on each of these state reform efforts and shows elements which various states have in common:

Table 2
Other State Reform: Overview

	FL	**SC**	**WV**	**KY**	**ID**
Authority	Waiver	Waiver*	DRA/SPA	DRA/SPA	DRA/SPA
Start	7/06	TBD	11/06	5/06	10/06
Region	2 counties (initially)	Statewide	3 counties (initially)	Statewide (except Louisville area)	Statewide (Medicare/caid in certain areas)
Consumer Choice/ Customized benefits	Yes	Yes	Limited	Limited	Limited
Wellness Incentives	Yes	Yes	Yes	Yes	Yes
Disease management	Yes	No	No	Yes	Yes
Employer Sponsored Insurance	Yes	Yes	No	Yes	Yes
Electronic enhancements	Yes	Yes	Yes	No	No
Cost sharing changes	No	Yes	Yes	Yes	Yes

* Although South Carolina submitted a waiver application, the State is currently pursuing reform efforts through the DRA and a State Plan Amendment.

Further information on each state is provided below. It is important to understand that many of these reforms represent an outline of a desired approach, with details still very much in development. This section of the report is merely intended to provide background on certain state reform efforts that have been highlighted in recent articles and press releases; the applicability of these reform ideas, many of which are articulated in HB 758, to the Virginia Medicaid program will be discussed in more detail in subsequent sections of this report.

Florida

The DRA was not in effect when Florida started its reform effort. Thus, their reform proposals are being implemented through a waiver which was approved by CMS on October 19, 2005 for a five year period from July 2006 through June 2011. This reform effort is starting on a relatively small scale, with implementation occurring initially in only two counties, Broward County in the Fort Lauderdale area, and Duval County in the Jacksonville area. The plan is to expand the reform program to other counties after Florida has had a chance to evaluate the results in Broward and Duval counties.

Florida's stated goals are to promote patient responsibility, to facilitate marketplace decisions, to provide a bridge between public and private health insurance coverage, and to achieve a sustainable growth rate. Much like the expressed intent of HB 758, Florida's reform effort is designed to increase recipient choice, empower recipients to participate in

health care, encourage benefits that better meet recipient needs, allow access to services not traditionally covered by Medicaid, and reward recipient healthy behavior and choices. Health care services will be delivered through coordinated systems of care which include Provider Service Networks and Health Maintenance Organizations. Recipients can also choose to enroll in their employer's health insurance plan and Medicaid will pay the employee share of the premium.

Under Florida's reform initiative, reform plans have new flexibility to alter the amount, scope, and duration of certain Medicaid services. There is flexibility to tailor benefits to certain populations by reducing or enhancing current service levels as long as certain benefits continue to be offered at current levels, and plans can demonstrate that the overall benefit package is actuarially equivalent to the pre-reform Medicaid benefit package. It also appears that the Florida reform will include a monetary benefit cap mechanism where health plan liability, and Medicaid liability generally, will be capped at some monetary threshold. However, indications from Florida are that this cap will be set at a level high enough to mitigate its practical effect.

The Enhanced Benefit Account component establishes a pool of funds to encourage recipients to engage in "healthy behaviors". Individual Medicaid recipients earn access to "credit" dollars from the pool by completing defined healthy practices and/or behaviors such as attending scheduled preventive health appointments or active participation in an alcohol/drug treatment program. Once credits are earned, they may be used to purchase health-related services and products such as over-the-counter medications, vitamins or orthopedic aids. Earned credits may be used during or within three years following cessation of Medicaid eligibility (a fact sheet on Florida's reform is provided in Appendix D).

South Carolina

The information on South Carolina's reform effort was obtained from a waiver application that was submitted to CMS in November 2005. This waiver application is currently on hold while the State explores ways to achieve their goals through a State Plan Amendment. For this reason, it is uncertain how many of their reform proposals will actually be implemented or how they will be implemented.

South Carolina proposed developing Risk Adjusted Premiums (which were referred to as Personal Health Accounts or PHAs) allowing recipients to shop around for a health plan with benefits tailored to their needs. If a plan's premium was less than the State's contribution, the recipient could use any residual to pay for cost sharing or services not covered by the plan.

South Carolina appears to have been the only State thus far to propose using Health Savings Accounts for Medicaid recipients. Referred to as Self-Directed Plans, the proposal would include catastrophic coverage plus selected screenings and preventive care, but would allow recipients wide discretion to choose how to spend the rest of their Personal Health Account on other medical services that they would purchase directly from providers at Medicaid FFS rates. As with other South Carolina initiatives, this proposal is still in the concept phase and the State recognized that only recipients with demonstrated capacity to manage their own care would be allowed to enroll in this plan.

Under the South Carolina proposal, enrollees also would have the option of enrolling in employer-sponsored health insurance (a fact sheet on South Carolina's reform is provided in Appendix E).

West Virginia

In April 2006, West Virginia submitted a State Plan Amendment (SPA) to the Centers for Medicare and Medicaid Services (CMS) requesting approval to reform its Medicaid program by revising its benefit package. The federal government approved West Virginia's SPA on May 3, 2006, granting the state authority to proceed with its reform initiative. West Virginia is currently scheduled to begin implementing its reform plan in three counties (Clay, Upshur, and Lincoln) in November 2006, with statewide implementation scheduled to occur over the following four years. The redesign program (known as Mountain Health Choices) will only apply to healthy children and adults. Children in foster care, seniors, adults, and children with disabilities, and pregnant women are not subject to the state's reform plan.

The West Virginia SPA has four key components. The first component allows West Virginia to group its current 29 eligibility categories down into four general categories: healthy children, healthy parents, special needs individuals, and individuals over the age of 65. The second component allows the state to offer healthy adults and children a choice between a basic benefit plan and an enhanced benefit plan. The basic plan offers recipients fewer benefits than are currently available through the West Virginia Medicaid program. For instance, the basic plan imposes limits on home health, durable medical equipment (DME), non-emergency transportation, and prescription drug benefits. The basic plan also eliminates coverage for some services that beneficiaries are currently receiving through the state's traditional Medicaid program such as nutrition education, diabetes care, skilled nursing care, and smoking cessation. The enhanced plan provides members with a richer array of benefits because it does not place limits on the dental, hearing, vision, prescription drug, DME, home health, or medically necessary transportation benefits. This plan also includes many of the same standard Medicaid benefits that the state eliminated for the basic plan. Both the basic and enhanced plans include wrap-around coverage to ensure that enrollees under the age of 19 receive Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services when medically necessary.

The third SPA component is a member agreement that recipients must sign and comply with in order to receive benefits through the enhanced plan. The agreement outlines recipients' responsibilities and rights and is intended to get members to assume more responsibility in managing their health. By signing the document, recipients agree to several conditions such as going to a "medical home" (i.e. a primary care provider) for regular examinations, arriving on time for all medical appointments, and using the hospital emergency room for emergencies only. As part of this requirement, health care providers must monitor and report on their patients' compliance with the member agreements. For example, providers will be required to monitor whether their patients receive health screening exams, adhere to health improvement programs, take their medication as directed, and show up for scheduled appointments. Recipients who fail to meet these requirements will be removed from the enhanced benefit plan and placed back into the basic plan for at

least 12 months after which they will be given the option of signing a new agreement during eligibility redetermination.

The healthy reward accounts represent the fourth component of the West Virginia SPA. These accounts are only available to recipients who sign the member agreement and are enrolled in the enhanced benefit plan. The state will use the accounts to reward recipients for making healthy decisions by providing them with "credits" that they can use to pay for non-covered health care services such as provider co-payments or non-emergency visits to hospital emergency rooms. Additional bonus credits will also be available to recipients who meet their health goals.

The enhanced benefit plan will be furnished through either a primary care case management system (fee-for-service) or a managed care entity. Enrollment into either the basic or enhanced plans will occur when individuals go through their initial Medicaid eligibility determination or at a scheduled redetermination. When fully implemented, the West Virginia reform program will cover approximately 180,000 children and 60,000 adults, representing about half of the state's Medicaid population (a fact sheet on West Virginia's reform is provided in Appendix F).

Kentucky

Kentucky submitted an §1115 waiver application to the Centers for Medicare and Medicaid Services (CMS) in January 2006 to reform its Medicaid program by revising its members' benefit packages and implementing other ancillary changes. During the CMS review process, the waiver application was revised into a State Plan Amendment (SPA) under the DRA. The program (known as KyHealth Choices) was approved by the federal government on May 3 with an implementation date of June 1, 2006.

Prior to implementing the SPA, Kentucky sent all Medicaid recipients letters informing them that they were being assigned to one of the following four benefit plans: Family Options, Optimum Choices, Comprehensive Choices, or Global Choices. The Family Choices Plan covers most children who are enrolled in Medicaid, including those enrolled in the Kentucky Children's Health Insurance Program (KCHIP). The Optimum Choices Plan covers individuals with mental retardation and developmental disabilities who require long-term care assistance. The Comprehensive Services Plan applies to Medicaid recipients who are elderly or have brain injuries and require a nursing facility level of care. Finally, the Global Choices Plan applies to the general Medicaid population. All of the plans cover basic medical services, including mental health services, in both inpatient and outpatient settings.

Under the Kentucky reform program, most Medicaid recipients are required to pay for a portion of their covered services through co-payments that typically range from one to ten dollars. However, because Kentucky wants to encourage Medicaid members "to make wise health decisions," it does not require them to pay co-payments for preventive health care services such as annual physical examinations or vaccinations. The maximum amount that any recipient will have to pay annually in co-payments under the state's reform plan is $225 for health care services and $225 for prescription drugs. Recipients who reach the annual co-payment limit are not required to share additional costs for their covered services.

In addition, recipients who are under the age of 18, pregnant, or receiving hospice care are exempt from the co-payment requirement.

Additional key components of the SPA include an employer-sponsored health insurance requirement and the "get healthy accounts." The employer-sponsored insurance requirement was included in the SPA as an additional means of reducing costs for Kentucky by requiring Medicaid members who have access to employer sponsored insurance (ESI) to purchase it if it is determined by the state to be more cost-effective than traditional Medicaid coverage. To facilitate this, Kentucky will pay private insurance premiums for these beneficiaries and wrap around the commercial coverage with Medicaid services.

The state included the "get healthy accounts" in its reform plan in order to entice recipients with pulmonary disease, cardiac disease, or diabetes to become more responsible for managing their own health conditions by financially rewarding them for engaging in healthy behaviors. For example, Kentucky will place funds into accounts for these recipients anytime they fill prescriptions or keep appointments with their health care providers. Individuals with the accounts will have access to additional vision and dental benefits as well as nutritional and smoking cessation services. Recipients with other disease conditions may be allowed to receive the accounts as the program matures.

The KyHealth Choices program currently applies to approximately 700,000 Medicaid recipients throughout Kentucky with the exception of recipients residing in one of the 16 counties in the Louisville region. This region is currently operating under an §1115 waiver that is administered by a managed care organization. Approved Kentucky Medicaid providers are required to provide all of the services that are included on the recipients' benefit plans. Providers will be reimbursed on a fee-for-service basis using state approved fee schedules. Kentucky plans to evaluate the KyHealth Choices program during the summer of 2007 to assess its effect. Program changes may be made based on the results of the evaluation (a fact sheet on Kentucky's reform is provided in Appendix G).

Idaho

Idaho is also implementing its Medicaid reform effort through a State Plan Amendment under the new flexibility granted by the DRA. The State Plan Amendment was approved by CMS on May 25, 2006, and Idaho expects to implement its reform program statewide, beginning in October 2006.

Through its reform proposals, Idaho hopes to encourage wellness and early prevention services to improve people's health, promote responsible use of the healthcare system to reduce unnecessary services that are often expensive, and use limited resources wisely and invest carefully in targeted services to achieve long-term savings.

The centerpiece of the Idaho reform effort is the grouping of all Medicaid recipients into three general categories and the development of separate health benefit packages tailored to each of these three groups. The three eligibility groups are: healthy adults and children, beneficiaries with disabilities, and elderly beneficiaries. Idaho will use a health risk assessment during the eligibility process to place beneficiaries in one of three plans: a basic

plan, an enhanced plan and a Medicare/Medicaid plan. Enrollment in the enhanced and Medicare/Medicaid plans is voluntary.

The Basic Plan, for children and adults of average health, emphasizes preventive care and promotes wellness for children through non-clinical settings such as schools. Within the basic plan, Idaho is proposing to implement enforceable cost sharing to increase the responsibility of beneficiaries and to encourage cost-effective care in the most appropriate setting (the cost sharing details have yet to be worked out). Individuals can be switched from the Basic Plan to the Enhanced Plan if an assessment or medical review shows that their health needs have changed.

The Enhanced Plan is for children and adults with disabilities or special needs from birth to 64 years of age. This plan will mirror pre-reform Medicaid benefits. The goal is to deliver cost-effective individualized care by providing more individual choice and control. Idaho will provide community supports modeled after the National Cash and Counseling Demonstration and will provide increased opportunities for employment for persons with disabilities. Idaho also plans to include pay-for-performance incentives for providers for preventive care, key outcomes and chronic disease management.

The Medicare/Medicaid Plan will provide Medicaid benefits for adults over age 65 who are covered under Medicare. Individuals selecting the Medicare/Medicaid Plan must also select and enroll in a Medicare Advantage Plan. The plan will be implemented in selected counties and will be expanded to additional counties as Medicare Advantage Plans become available in those counties. The goal is to deliver more cost-effective care integrated with Medicare coverage.

In all three plans, Personal Health Accounts (PHAs) will provide rewards for healthy behaviors. Credits will be deposited in their PHA for losing weight or keeping well child appointments. Credits can be used for items such as fitness center memberships, bicycle helmets or nicotine patches.

Idaho also plans to control costs by managing the delivery of services more efficiently. Changes include provider pay-for-performance, selective contracting with vendors to obtain better prices for services, goods and equipment, and greater use of health information technology.

Finally, Idaho plans to strengthen the employer-based health insurance system by expanding the option of premium assistance to all children and working-age adults who would prefer to enroll in an available commercial insurance product rather than Medicaid - currently this option is available only in their State Child Health Insurance Program (a fact sheet on Idaho's reform is provided in Appendix H).

FINDINGS AND RECOMMENDATIONS RELATED TO THE PROVISIONS OF HOUSE BILL 758

House Bill 758 directs the MRC to consider several potential reforms for the Virginia Medicaid program. Generally speaking, the bill articulates the desire to move more of the

Medicaid population into a managed environment, which not only includes managed care, but also includes care coordination and disease management. Within these programs, HB 758 specifically mentions the use of enhanced benefit accounts in which incentive funds are deposited to reward healthy behavior. These funds would be available for use to purchase non-covered health-related goods and services. Additionally, the bill contemplates the use of managed care premium values allowed for use by recipients, through these enhanced benefit accounts, to purchase employer-sponsored insurance that may be available. Finally, the bill discusses enhancement to electronic funds transfer and other electronic access.

This section of the report will provide discussion of these general topics. For each of these, the report will discuss the concept itself, what Virginia Medicaid currently does in each regard, other state approaches to the concept, and conclusions and any recommendations endorsed by the MRC for the future direction of the Medicaid program in Virginia. While there is clearly room for reform in the Virginia Medicaid program, the Committee discovered during the meeting process that Virginia Medicaid has many aspects of the reform initiatives underway in other states already in place here. For this reason, much of what the MRC recommends is the continuation and expansion of existing programs administered within DMAS. However, the MRC is unanimous in its statement that the recommendations provided are for enhancements to the Virginia Medicaid program, many of which will have start-up costs. Many of the potential cost savings are based on future cost avoidance, which is not easily identified in a two-year budgeting process. The MRC does not wish to see these enhancements implemented through budget reductions for other aspects of Medicaid, such as reduced provider payment, service contractions, or eligibility contractions. Indeed, sentiments expressed by committee members and the public would support increases in provider reimbursement and broader Medicaid eligibility.

Disease Management

A major focus of HB 758 is the expanded use of disease management programs for the chronically ill. Specifically, HB758 directs the MRC to consider "disease management programs or other behavior modification activities…to make healthy decisions and to engage in self-management of their healthcare." Additionally the bill contemplates a "transitioning of all recipients remaining in the fee-for-service program to a disease management program, care coordination program, or enrollment in MCOs."

What is Disease Management?

Health insurers and companies are developing and implementing disease management (DM) programs in an effort to reduce, for both individuals and society, the physical, psychological, social, and economic pressures associated with chronic conditions and diseases. DM programs attempt to both improve the quality of patient care and slow the growth of health care costs. DM programs were once considered experimental in the early 1990s, but their success in helping to improve quality of care has led to unprecedented growth in this industry. Many health insurance plans and most Medicaid programs now offer some form of DM services. DM programs are operated by managed care plans, provider groups, state agencies, and specialized DM companies.

DM programs offer a range of activities to address the shortcomings of the current health care system. Well-designed DM programs typically include the following activities: the targeting of high-risk patient populations; the promotion of evidence-based treatment plans with primary care physicians; patient self-management and education programs; patient monitoring and provider feedback; and a rigorous system of evaluation.

Programs can be patient-centric, provider-centric, or a hybrid of both designs. Patient-centric programs typically utilize a nurse care manager to conduct assessments, monitor treatment, and support patients, often from a remote location (usually telephonically). The main goals of patient-centric programs are to educate patients about their condition and promote self-care. In the patient-centric design, provider participation is ideal, but not essential.

Conversely, for provider-centric programs, provider participation is essential to the program's success. In a provider-centric program, the primary care provider (e.g. physician, nurse practitioner, physician assistant) conducts an assessment and develops a treatment plan in accordance with national evidence-based standards. Provider-centric programs operate a team approach to health care, where the primary care provider acts as the coordinator of the participant's health care. An additional incentive or compensation structure (often referred to as "pay-for-performance") is often essential for the success of a provider-centric program. Recently, DM programs began to offer blended or hybrid program designs that focus efforts on both the patient and the provider.

Virginia's Current Disease Management Initiatives

In 2004, Health Management Corporation proposed a pilot of the *Healthy Returns* disease management (DM) program to DMAS. *Healthy Returns* ran from June 2004 through June 2005 and offered DM services for Virginia Medicaid fee-for-service participants with congestive heart failure and/or coronary artery disease at no cost to the Commonwealth. The *Healthy Returns* pilot produced successful, yet preliminary, results.

In 2005, pursuant to the Appropriations Act, DMAS developed and released a request for proposals (RFP) to expand and outsource the DM and chronic care management program for beneficiaries in the fee-for-service program. After an extensive procurement process, DMAS awarded the contract to Health Management Corporation. The expanded *Healthy Returns* DM program was implemented on January 13, 2006.

Healthy Returns focuses on preventative care, promotion of self-management, and appropriate use of medical services in the fee-for-service system. *Healthy Returns* provides DM services to Medicaid and FAMIS fee-for-service recipients with asthma (adults and children), congestive heart failure (adults), coronary artery disease (adults), and diabetes (adults and children).

Healthy Returns is a patient centric DM program that uses national, evidence-based guidelines for the relevant disease states to focus on participant care management. The care management is facilitated through various program initiated interventions:

- Baseline health status assessment,

- Routine monitoring,
- Education on health needs and self-management,
- Monitoring of participant compliance with self-management protocols, and
- Facilitation of contact with providers and community agencies.

In addition to program initiated contacts, *Healthy Returns* participants also have the benefit of a nurse line available to participants 24 hours per day seven days per week through a centralized toll-free number that provides clinical support to answer questions and assist participants with referrals.

Healthy Returns' is currently an "opt-in" program where recipients identified with one of the four chronic conditions voluntarily choose to participate in the program (Table 3 presents program statistics for the first six months). Eligible participants are identified through claims analysis or provider referral, and eligible participants are invited to participate through initial outreach by the program administrator. DMAS is pursuing the transition from "opt-in" to "opt-out" status with the Centers for Medicare and Medicaid Services (CMS). Under an "opt-out" program, individuals with an eligible chronic condition are automatically enrolled and receive program materials. Individuals who are automatically enrolled, however, may disenroll from the program at any time.

Table 3:
***Healthy Returns* Participation (January – June 2006)**

Condition	Medicaid	FAMIS
Asthma	8,540	402
Coronary Artery Disease	958	0
Congestive Heart Failure	753	0
Diabetes	4,065	38
TOTAL	**14,316**	**440**

Virginia is the first state to offer DM to recipients (non-dual eligible recipients) receiving long-term care services though one of seven home and community-based waivers. Virginia's home and community-based waivers (HCBS waivers) provide specialized services that allow participants to receive services in a community setting of their choice as an alternative to an institution. DMAS currently offers the following HCBS waivers: Elderly and Disabled with Consumer Direction, HIV/AIDS, Mental Retardation (MR), Day Support, Developmental Disabilities, Technology Assisted, and Alzheimer's. Special protocols were developed with key stakeholder input to optimize DM resources for HCBS waiver participants – particularly for the MR waiver participants.

In addition, Virginia was one of eight states selected to participate in the national Agency for Healthcare Research and Quality (AHRQ) Medicaid Case Management Learning Network. Virginia's *Healthy Returns* program is being evaluated by AHRQ for best practices in design, implementation, satisfaction, and outcomes. AHRQ Learning Network

also provides Virginia the opportunity to learn about initiatives and innovations in other states and to obtain technical assistance from experts in the field.

In addition to the *Healthy Returns* program for the Medicaid Fee-for-Service (FFS) population, Virginia also offers DM to participants enrolled in any of Virginia's five Medicaid Managed Care Organizations (MCOs) participating in the Medicaid managed care program. In 2005, 431,529 Medicaid recipients received services through Medicaid MCOs. Table 4 presents information on the disease states that are currently managed through DM programs in Medicaid managed care.

Table 4: Disease Management Programs Offered to Medicaid MCO Participants (July 2006)

Health Plan	Programs
Health Plan I	Asthma, Congestive Heart Failure (CHF), Diabetes, Depression, High-risk Pregnancy, Lower Back Pain; Adding Coronary Artery Disease (CAD) in 2007
Health Plan II	Asthma, CHF, Diabetes, Depression, High-risk Pregnancy, Lower Back Pain; Adding CAD in 2007
Health Plan III	Asthma, Diabetes, Prenatal; Adding CAD and CHF in 2007
Health Plan IV	Asthma, CAD, CHF, Diabetes, Prenatal
Health Plan V	Asthma, CAD, Chronic Obstructive Pulmonary Disorder, CHF, Depression, Diabetes, HIV/AIDS, Schizophrenia

Disease Management Initiatives Nationwide

In 2004, the Georgetown University Center on an Aging Society estimated that 97 percent of all health plans were pursuing some type of DM program. CMS indicates that as of March 2004, over 30 states (including Virginia) have Medicaid DM programs for their fee-for-service clients. Table 5 (next page) presents summary information DMAS was able to obtain on some of the other state DM programs.

Medicaid Revitalization Committee Discussions and Recommendations for Disease Management

The MRC discussed the current status of disease management in the Virginia Medicaid program and believes that Virginia is certainly moving in the correct direction with its new expanded DM offering for the FFS program and its desire to connect with more potential participants through its pursuit of the "opt-out" program design with CMS at the federal level. However, HB 758 specifically directs the MRC to consider the expansion of DM programs, as well as the incorporation of incentive structures to reward adherence to the plan of care in the DM programs.

Virginia is currently offering disease management services for four disease states for children and adults on the FFS side of Medicaid, and requires that MCOs participating in Medicaid managed care program also provide services for these diseases (as shown on Table 4 previously, many provide coordination for many more disease states). While the MRC

Table 5: Summary of Other State DM Programs	
Arkansas	High Risk obstetrics and neonatology
Colorado	Asthma, Diabetes
Illinois	Asthma, High emergency room (ER) utilizers, adults with disabilities
Indiana	Asthma, Diabetes, CHF, Hypertension
Iowa	Asthma, Co-morbidities, high-utilizers
Kansas	Asthma, Diabetes, CHF, high-utilizers
Kentucky	Asthma, Diabetes
Montana	Asthma, Diabetes, Hypertension
New Hampshire	Asthma, Diabetes, CAD, CHF, Chronic Obstructive Pulmonary Disease (COPD), End-Stage Renal Disease(ESRD)
North Carolina	Asthma, Diabetes, CHF
Oklahoma	High Cost/Risk, ER utilizers
Oregon	Asthma, Diabetes, CHF, COPD, CAD
Pennsylvania	Asthma, Diabetes, COPD
Rhode Island	High-risk
South Carolina	Asthma, Diabetes, Hypertension
Texas	Asthma, Diabetes, CHF, COPD, CAD
Vermont	Asthma, Diabetes
Virginia	Asthma, Diabetes, CHF, CAD
Washington	Asthma, Diabetes, COPD, ESRD
Wyoming	Asthma, Diabetes, CHF, CAD, COPD, Depression, and High Risk Maternity

believes the currently targeted chronic diseases should continue to be targeted, the MRC would like to see the expansion of the current program to more disease states, including a program for high-risk pregnancies, and would like to see the program shift from a purely patient-centric model, to one that also incorporates direct and active care coordination by the provider.

It is clear to the MRC that while the patient-centric model is a significant first step that can have very positive outcomes for the participating population, the ideal situation would be one in which the physician (in most cases) is interacting with both the patient and the DM program administrator to encourage the participant and to modify the plan of care to meet the changing needs of the patient. This provider interaction, however, also highlights the need to focus the program on disease states for which national, evidence-based care guidelines exist upon which to base the plan of care so that the participant is not receiving mixed messages from the healthcare provider and the DM administrator. Further, the MRC recognizes that diseases for which there is high utilization/high cost of care should be prioritized for disease management expansions.

It is important to understand that an expansion of the disease management program, especially one which incorporates aspects of provider-centric models, will have administrative costs, and these costs will accrue upon implementation. Until the Department identifies which diseases meet the requirements outlined above, the Committee cannot offer estimates of those administrative costs. Based on those costs, it may also be prudent for the

Department to pursue expansions of the disease management program, as described above, through a pilot approach.

While there will be immediate administrative costs, potential cost savings are only realized through cost avoidance generated by participants adhering to care plans and improving their health status, or by keeping these chronic diseases in check so that acute episodes are avoided to the extent possible. It is through the avoided acute care services that the Medicaid program will experience the financial benefits of effective disease management. This cost avoidance is particularly difficult to quantify, and certainly does not fit into a two-year budgeting process as utilized by the Commonwealth.

Based on this discussion, the Medicaid Revitalization Committee presents the following recommendation for consideration by the Governor and General Assembly:

Recommendation #1: The Department of Medical Assistance Services should seek funding and approval (both state and federal) to expand population-based disease management programs to target high cost and/or high prevalence disease states for which nationally accepted evidence-based care guidelines exist. The Department should develop a list of such disease states and estimate the costs associated with program administration for each disease. This expanded program should also include aspects of provider-centric models where the healthcare provider plays a more direct and active role in the care management. The Department shall determine the scope of the expanded disease management program, including the possibility of one or more pilot programs, based on funding made available for this purpose.

Enhanced Benefit Accounts

In addition to the scope and design of the disease management program, the MRC was asked to consider the notion of incentives for healthy behavior in the Medicaid program. Specifically, HB 758 directs the MRC to consider the use of voluntary enhanced benefit accounts (or health opportunity accounts) for:

- individuals with chronic diseases or who are at risk of having or developing one or more chronic diseases;
- individuals for whom healthcare costs are or may become high;
- individuals whose current or future health may be improved through a disease management program focused on identification of chronic illnesses, incentives for healthy behavior, and training in effective and appropriate self care; or
- individuals wishing to exercise the option to purchase private health insurance through their employer (to be discussed later in this report)

HB 758 further asks the MRC to consider the development of a system of monetary incentives for Medicaid recipients to make healthy decisions and to engage in self-

management of their health care. As can be seen by the extensive level of detail specific to enhanced benefit accounts in the mandate, incentive programs for healthy behavior represents a major component of the MRC's deliberations.

What are Enhanced Benefit Accounts?

As mentioned earlier in the discussion of state Medicaid reform efforts, enhanced benefit accounts (EBAs) can be defined as incentive based health care programs designed to reward clients for healthy behaviors. Incentives are earned based on behaviors that promote good health. Examples of these behaviors include receiving all scheduled immunizations, receiving all scheduled well-child screenings, and following treatment protocols for chronic health conditions, such as diabetes and heart disease.

Patient behaviors can be tracked using claims data, self reporting mechanisms, or provider generated reports. EBA type programs have other names as well, such as "Health Opportunity Accounts" or "Health Rewards Accounts". These programs can reward both the healthcare provider or the client for healthy behaviors or following or fully implementing an evidence-based health care program.

Virginia's Current Enhanced Benefit Account Initiatives

Virginia Medicaid does not currently have any enhanced benefit accounts or other healthy behavior-type reward programs in either fee-for-service or the managed care environment. While it can certainly be argued that the disease management programs already offer a potential for improved quality of life as a significant reward for participating recipients, it is likely that this intangible reward is insufficient to entice a recipient to make the correct health choices in his/her everyday life. The Medicaid program only benefits from disease management if the recipient's quality of life actually improves; beyond the altruistic importance of that success, any long-term cost avoidance for the program is entirely dependent upon the recipient allowing the program to work for him or her.

EBAs are a relatively new concept for Medicaid programs in general. The Deficit Reduction Act of 2005 (DRA) allows greater flexibility in the ability of states to provide certain healthy incentive programs, and many states are considering some form of an incentive program. EBA programs tend to focus on a "carrot" approach, whereby participants are rewarded for healthy behavior. Some states, however, appear to be utilizing a "stick" approach in limiting benefits as a result of "unhealthy" behavior. The following provides some detail on these approaches.

Enhanced Benefit Accounts Nationwide

Florida is a prime example of the "carrot" approach to enhancement of benefits to reward healthy behavior. In Florida's Medicaid reform waiver, EBAs are designed to be used to purchase health care related goods and services, such as over the counter medications, health club memberships and healthcare related home modifications. Florida's plan is to use claims data, provider reporting and other methods to determine healthy behaviors. The EBA will be a swipe card type debit account which will be capitalized by credits earned from recipient healthy behavior. Monitored behaviors will include

participation in Disease Management programs, receiving immunizations, and attending well-child visits. Florida plans to allow access to the awarded healthy behavior credits for a specified period up to three years even after Medicaid eligibility ends.

Florida's EBA program will require a significant amount of collaboration with clients, providers, managed care organizations and third party vendors and retailers. Florida will manage the policies and procedures, but will create an "Enhanced Benefit Panel" with seven members from provider and recipient advocacy groups to provide guidance on the development and evaluation of the program. Florida may contract with a third party administrator to administer the EBA program.

While West Virginia's Medicaid reform initiative includes a similar EBA provision to that of Florida, a cornerstone of the plan could be described as the "stick" approach to enhanced benefits. In West Virginia, the plan is for a two-tiered Medicaid benefit that will apply primarily to healthy adults and children. All applicable clients will receive a basic benefit plan depending on their eligibility category. This benefit package will include all federally-mandated services and some limited state-option services, but is clearly a lower benefit than was previously available to these clients pre-reform. Clients will have the option of enrolling in an enhanced benefit program through a "member agreement" that the client must sign. In the member agreement, the client agrees to:

- utilize a medical home (generally a Primary Care Physician or PCP),
- comply with scheduled appointments,
- use the emergency room only in an emergency, and
- comply with plans of care, including prescriptions.

In order to be effective, West Virginia will track compliance with the member agreement. Tracked responsibilities in the member agreement include:

- screenings as directed by the healthcare provider,
- adherence to health improvement programs as directed by the healthcare provider,
- missed appointments, and
- compliance with medications.

As indicated previously, it appears that many of the enhanced benefits in West Virginia's program were more broadly made available under West Virginia's pre-reform program. The list of enhanced benefits includes the following:

- Orthotics/Prosthetics (children),
- Preventive Diabetes Care (adults and children),
- Skilled Nursing Care (children),
- Substance Abuse/Mental Health Services (adults and children),
- Tobacco Cessation (adults and children),
- Nutritional Education (adults and children),
- Cardiac Rehabilitation (adults),
- Chiropractic Services (adults),

- Emergent Dental Services (adults), and
- Higher benefit allowances for basic plan services (i.e. removal of prescription limitations).

From what could be ascertained from a review of West Virginia's submission to CMS, it appears that the "medical home" provider will assess compliance. It has not been determined as of the date of this report whether or not financial compensation will be made for this compliance monitoring by providers and how this compliance monitoring will be carried out. However, it is clear that if a client does not comply with the member agreement, the client will be put back into the basic benefit plan for at least 12 months, after which the client can sign a new agreement at the next scheduled eligibility determination.

Like Florida's EBA program, recipients with member agreements also will have access to "Healthy Rewards Accounts", in which "credits" will be deposited into member accounts for healthy behaviors. These credits can be used for co-payments, non-covered services or other health related goods and services.

Regardless of participation in the basic or enhanced benefit plans, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services will still be required for children under 19. EPSDT requires all states with a federally-funded Medicaid program to provide all medically necessary services to children under the age of 19 regardless of whether or not the service is covered under the Medicaid state plan. This requirement appears to mitigate the incentive effect if the two-tiered approach for children in West Virginia's plan. The West Virginia plan is expected to be implemented in November of 2006.

Medicaid Revitalization Committee Discussions and Recommendations for Enhanced Benefit Accounts

Much like other states, as shown through the previous discussion of their reform efforts, the MRC believes that the notion of a financial incentive to reward adherence to the plan of care has the potential to be an effective incentive for the Medicaid population due to the low incomes of the recipients themselves. Structured to allow for the purchase of limited health-related goods and services, the creation of an enhanced benefit account in which reward credits are deposited and can be accessed by the recipient directly as he/she purchases a qualifying item or service could provide a powerful incentive for these recipients to be more cognizant of their health. These are citizens who are clearly struggling to make ends meet on a daily basis for whom any financial help would be welcome, even if the goods/services were limited to certain health-related items.

Implementation of these accounts will be dependent upon funding for this enhancement to the disease management program. Significant thought should be given to the determination of eligible goods and services, the mechanism by which recipients access accounts, determining which populations should be eligible for these accounts, and the reward structure itself. Additionally, significant attention should be paid to educating recipients regarding these accounts and their use.

The MRC does not believe that it is prudent for the Virginia Medicaid program to reform the program to include tiered benefits based on compliance with behavior measures (the West Virginia approach). Virginia's Medicaid program, as previously discussed, is a very lean program. While it is a valuable benefit for the recipients who access healthcare through the program, the notion of eliminating benefits for those who are struggling to maintain their health does not seem sensible for the Commonwealth to pursue.

The MRC offers the following recommendation regarding enhanced benefit accounts:

Recommendation #2: The Department of Medical Assistance Services should seek funding and approval (both state and federal) to provide access to enhanced benefit accounts, or a similar mechanism, in which recipients are rewarded for compliance with aspects of their care plan through financial incentives that can be used to purchase healthcare related goods and services not otherwise covered by the Medicaid program (including patient cost sharing responsibilities). These accounts would be accessed through an electronic debit card or similar electronic mechanism. The Department shall determine the scope of the program based on funding made available for this purpose and should include provisions for recipient education regarding these accounts and their use.

Electronic Access to Virginia Medicaid

In addition to the discussion of enhanced benefit accounts discussed above, HB 758 also discusses the use of enhanced electronic access, specifically electronic funds transfer, within the Medicaid program. The MRC's specified responsibilities in HB 758 include a directive to consider requiring all Medicaid Managed Care Organizations (MCOs) to phase in implementation of electronic funds transfer technology to add efficiencies to administrative procedures, reduce costs, and avoid mistakes and abuse. While it appears that the primary intent in this section of HB 758 was geared towards electronic access to enhanced benefit or health opportunity accounts, which have previously been discussed in this document, the mandate is clear that the MRC was to consider other electronic access to Medicaid.

What is Enhanced Electronic Access?

In addition to access to debit-type enhanced benefit accounts discussed previously, the MRC considered electronic access to mean electronic funds transfer (EFT) and electronic claims submissions. These terms are defined as:

- EFT - the capability to electronically transfer funds from a claims account to an individual or group provider bank account for money owed for approved healthcare services

- Electronic Claims Submission – the capability to submit Health Insurance Portability and Accountability Act (HIPAA) compliant claims transactions electronically to the insurer (or Medicaid program).

Virginia's Current Electronic Access to Medicaid

Virginia Medicaid's fee-for-service program implemented EFT as an option for all Medicaid providers in 2000. Approximately 32% of Virginia Medicaid providers participate in EFT, however it should be noted that this represents 71% of the claims dollars spent. As indicated, EFT is an optional service offered to Medicaid enrolled providers. It is, however, strongly encouraged during the enrollment and re-enrollment process and through periodic provider mailings. Providers can still receive "paper checks" and paper remittance advices. All of Virginia Medicaid's contracted MCOs provide EFT to their providers as an optional service as well, with the exception of the newest contracted MCO, AmeriGroup, which plans to do so in early 2007. The utilization percentage of EFT by MCO-contracted providers ranges from 0% to 50%.

In Medicaid fee-for-service, approximately 84% of claims submitted to the DMAS fiscal agent, First Health Services (FHS) are electronic transactions (excluding encounter data and cross-over claims). This rate drops to approximately 69% when pharmacy claims are excluded (virtually all pharmacy claims are submitted electronically). Medicaid MCOs, which also receive and process paper claims, report an electronic claims submission from a low of 41 percent to a high of 83%. The MCO with the highest rate of electronic claims submissions by their providers has implemented a free web-based claims submission technology that is currently being considered by DMAS (this functionality will allow providers with an internet connection to submit claims transactions at no additional cost and without using a third party vendor).

Electronic Access to Medicaid Nationwide

The MRC was unaware of any state reform efforts in which EFT or electronic claims submission were being required of providers for participation in the Medicaid program.

Medicaid Revitalization Committee Discussions and Recommendations for Enhanced Electronic Access

The MRC believes that the use of electronic funds transfer and electronic claims submission has the potential to enhance the efficiency of payment for services rendered by providers to the Medicaid recipient population and reduce the potential for fraud. While the MRC understands that there has been some resistance to these electronic access options by certain providers, the Committee believes that the time has come to begin requiring providers to accept payment electronically through EFT. This stance is based on the fact that all providers already have bank accounts, and EFT does not usually cause any additional costs to be borne by the providers. In fact, EFT will enhance cash flow for these providers as payments are received more rapidly for services.

Regarding electronic claims submission, providers must currently utilize a third party clearinghouse in order to submit HIPAA-compliant claims electronically. This service does present costs to providers, some of which do not experience the volume of cases to make this third party contract viable financially. However, DMAS is currently pursuing the acquisition of web-based claims submission software that would allow any provider with an internet connection to submit HIPAA compliant claims (DMAS is pursuing a federal grant

opportunity to finance all or some portion of this initiative). This service would be free for the provider (beyond the cost of the existing internet connection), although there would still likely be some start-up costs in terms of education and training on the new interface. However, the efficiency that would be obtained for both DMAS and the provider in terms of claim completeness and processing time reductions would likely offset any start-up costs for even very small volume providers.

The MRC discussed in some detail the possibility of providing financial incentives, beyond the inherent efficiencies, for participating in electronic claims submittal and electronic funds transfer. However, the conclusion that the efficiencies inherent in these electronic access approaches were adequate incentive for providers was reached by the Committee. As such, the MRC offers the Governor and General Assembly the following recommendations regarding electronic access to the Medicaid program:

Recommendation #3: The Department of Medical Assistance Services should require electronic funds transfer for payment of healthcare services to all enrolled Medicaid providers. This requirement should also be enforced though participating managed care organizations and other contractors facilitating or directly providing healthcare services in the Medicaid program. This would include consumer directed services within long-term care where feasible.

Recommendation #4: The Department of Medical Assistance Services should seek funding (both state and federal) to implement a web-based claims submission system available free of charge to all healthcare providers for use in the submission of Virginia Medicaid claims and for the receipt of electronic remittance advices. The Department should require participating managed care organizations and other contractors facilitating or directly providing healthcare services in the Medicaid program to offer such electronic capabilities as well. This would exclude consumer directed care services within long-term care services. The Department and its contractors should encourage provider usage of this web-based system and any currently approved electronic claims submission mechanisms for Virginia Medicaid. The Department should monitor the usage of electronic claims submission relative to paper claims submission and make further recommendations to achieve a virtually paperless claims process.

Medicaid Managed Care

HB 758 includes significant references to an expansion of managed care for Medicaid recipients and directs the Medicaid Revitalization Committee to consider various reforms related to managed care. Specifically, the MRC is directed to consider:

- calculating risk-adjusted premiums for Medicaid recipients enrolled in Medicaid managed care organizations,
- a transitioning of all recipients remaining in the fee-for-service program to a disease management program, care coordination program, or enrollment in MCOs, and
- a requirement that all Medicaid MCOs take steps to phase in implementation of electronic funds transfer technology to add efficiencies to administrative procedures, reduce costs, and avoid mistakes or abuse (discussed previously).

What is Managed Care?

The managed care delivery system represents a care delivery model where the goal is a system that delivers quality, cost effective healthcare through monitoring and recommending the utilization of services. These models became popular in the late 1980's primarily in the commercial insurance population. The system promised to contain costs and focus on preventive care, prior authorization and network development. While this traditional model floundered somewhat in the commercial market due to many factors, such as the consumers' desire for provider choice, the model succeeded in the Medicaid market and grew stronger in the 1990's. This model proved it worked better than the fee-for-service model in urban areas; states that implemented managed care experienced improved recipient health outcomes, stronger provider networks and reduced utilization trends.

Virginia's Current Medicaid Managed Care Program

In the mid 1990s, DMAS initiated a full-risk, Medicaid managed care program utilizing managed care organizations (MCOs) for the delivery of health care to Medicaid recipients. The MCO program was created to improve Medicaid recipient access to medical care, promote disease prevention, ensure quality care, and affect savings. On January 1, 1996, the MCO program began in Tidewater as a pilot project that included four MCOs servicing seven localities in the Tidewater region. Since then, the program has experienced multiple regional and plan expansions and is currently serving more than 420,000 Medicaid/FAMIS recipients in 110 Virginia localities (see Figure 3, below, and Figure 4, next page).

Figure 3

Medicaid Managed Care Expansions, 1997-2006

Year	Locality	Lives Added
1997	Tidewater	80,000
1999	Central Virginia	70,000
2000	Areas Adjacent to Central Virginia	10,000
2001	Northern Virginia, Danville and Roanoke (Includes implementation of FAMIS into new areas and areas currently served by MCOs)	103,000
2005	Northern Virginia and Winchester	40,600
2006*	Culpeper, Danville	4,000

*In addition, the ABD 80% group was added July 1, 2006 (≈1,400 lives)

Figure 4

MCO Geographic Coverage

Map Key

- Two or more Managed Care Organizations
- One Managed Care Organization/Fee For Service
- MEDALLION PCCM (Fee for Service) Only

The program has also provided the Commonwealth with value and high quality healthcare via an integrated and comprehensive delivery system to Medicaid and FAMIS recipients. This includes disease and case management programs, enrollee outreach, and ongoing quality improvement. The Commonwealth also requires its MCOs to have national quality accreditation. This accreditation measures access to care, overall member satisfaction, prevention, and treatment. Five MCOs are currently National Committee for Quality Assurance (NCQA) accredited and have an "Excellent" rating while two MCOs are currently pursuing NCQA accreditation. Those two MCOs have existing quality accreditation through other quality organizations.

Virginia Medicaid's expenditures to the MCOs are pre-set at a monthly per member per month (PMPM) capitation fee. It is important to note that while HB 758 directs the MRC to consider the use of risk-adjusted premiums for Medicaid recipients enrolled in Medicaid managed care organizations, the MCO capitation rates already employ such a methodology. Using the Chronic Illness and Disability Payment System (CDPS), Virginia's Medicaid program is already utilizing the methodology that the Florida reform plan hopes to achieve over the next few years. Florida's managed care program does not currently collect the detailed data necessary for CDPS; Virginia, on the other hand, has already been collecting the needed encounter data and using CDPS for the last four capitation rate developments (since FY 2004 rates were developed).

The MCO program is a full-risk managed care model in which the MCOs accept the PMPM as payment-in-full regardless of the cost of services actually incurred by the individual recipients. There are no monetary caps where once reached, services would be denied, nor are there risk-corridors or other re-insurance options in which the state would assume the cost of services beyond a certain monetary threshold. Thus, to the Managed care participant, the program remains a defined-benefit approach, but the utilization is managed through typical MCO processes of prior authorization and utilization review.

DMAS operates its mandatory managed care program through a CMS waiver and through state regulations. Certain Medicaid and all FAMIS recipients are required to access services through the MCO program if a choice of MCOs is available in the region. Benefits are mandated by DMAS in its MCO contracts. A few services like dental and community based mental health services are carved-out and remain the responsibility of the Medicaid FFS program. All other service and authorization requirements, claims, appeals, and marketing practices are handled by the MCOs in accordance with their operating requirements. Enrollment into managed care and program information dissemination is handled by DMAS through contracted enrollment brokers.

DMAS regulates the managed care program through: monthly MCO meetings; network reviews; on-site visits; pattern of care studies; ongoing assessment and approval of member documents such as MCO identification cards and member handbooks; annual revision of the MCO contracts; review of MCO enrollee communications; and significant complaint and report monitoring. DMAS contracts with an external quality review (EQR) organization to examine each MCO's policies, procedures, and services with respect to enrollee rights and protections, quality assessment and performance improvement, and grievance systems. The Bureau of Insurance regulates the licensure and solvency of the

MCOs in Virginia. This oversight has resulted in DMAS having MCOs that are fiscally strong and administratively efficient.

MCOs are successful in enhancing access and availability of care by requiring physician, hospitals, ancillary, transportation, and specialty provider networks that are better than what was historically available in regular Medicaid. The program promotes preventive care services, continuity and appropriateness of care, extensive member services including 24-hour nurse advice lines, enhanced services and benefits (such as adult vision services, enhanced pre-natal programs, case management services, and group and individualized enrollee health education and outreach). MCOs actively recruit providers, build networks, and credential providers to assure well-qualified providers are giving care to their enrollees.

The MCO program serves a significant number of children due to the eligibility categories targeted for coverage in the program (discussed below). Because of this predominance of children, the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program represents a vital component of the preventive services included within the MCO program benefits. In areas with no managed care, the fee-for-service program provides EPSDT services. As access to these preventive services are vital, marketing of the availability of EPSDT services has been a major focus of the Department both for the fee-for-service population and through the MCOs for the managed care population.

In FY 2005, Medicaid managed care served 55% of Medicaid/FAMIS enrollees while the fee-for-service program served the remaining 44%. The program targets FAMIS recipients, families and children, some of the disabled and medically indigent populations in regions for which plan coverage exists. Certain recipient populations are excluded from MCO coverage even when plans are otherwise available in the region. Specifically, the FFS system, by design, still serves the Long Term Care population (both those institutionalized and those in the various home and community based waiver programs), Foster Care children, and those with third party insurance (the largest group being the dually eligible Medicare/Medicaid population). Additionally, at any given point in time, a significant number of MCO-eligible new recipients will be in FFS for a month or two awaiting plan assignment to one of the MCOs in their region.

Managed Care in Medicaid Nationwide

Based on DMAS research, 36 states currently operate managed care programs within their Medicaid and S-CHIP programs. The 36 state programs range from full risk programs similar to Virginia's, to non-risk payment models. State managed care programs contain varying components (flexible benefits, cost sharing, enhanced services, behavioral health and pharmacy carve outs). In some states (like Virginia), enrollment for certain populations is mandatory when plan choice exists, whereas other states utilize voluntary enrollment for certain populations (a summary of other state managed care programs was provided to Committee members and is available on the DMAS web-site).

Managed care has played a prominent role in the reform efforts underway at the various state Medicaid programs across the nation. As previously discussed, Florida's reform plan foundation is the creation of market-driven managed care plans to accommodate certain mandatory and voluntary recipient populations. Within this reform effort, Florida

will eventually utilize the same risk adjustment methodology (CDPS) as currently used by DMAS in setting MCO capitation rates. South Carolina's reform concept, though not yet approved, also envisions the use of risk-based premium development for use in contracting with managed care plans either through the Medicaid program, employer-sponsored offerings, or in the private market.

Medicaid Revitalization Committee Discussions and Recommendations for Medicaid Managed Care

Based on information provided by DMAS during the discussions of managed care in the Virginia Medicaid program, the Committee was struck with the realization that reform efforts pertaining to managed care coverage in the Florida plan, and to some extent, the South Carolina plan, appear to be striving toward design and functionality already inherent in Virginia's MCO program. The Committee found it particularly interesting that these reform efforts were focusing on the notion of "risk-based premium calculations" while Virginia had been employing such a methodology for the past four iterations of rate development in MCOs.

The Committee was also impressed by the Department's stated expansion goals for both geographic and eligibility category coverage. DMAS refers to these expansion goals as both "wide" and "deep", respectively. The largest group of Medicaid recipients categorically excluded from managed care are the long-term care recipients in institutions or in home and community based waiver programs. Many of these individuals are also dually eligible for both Medicare and Medicaid. DMAS is already creating a blue-print of managed care coverage for these populations through both the Program for All-inclusive Care for the Elderly (PACE) model and the Special Needs Plan (SNP) model incorporating Medicare's managed care program (Medicare Advantage) with state Medicaid managed care programs. This blueprint will be presented to the Governor and General Assembly by December 15, 2006.

DMAS is currently reviewing the efficacy of including other categorically excluded groups within a managed care model. The Aged, Blind and Disabled 80% group (incomes at 80% of the federal poverty limit) was just added to the managed care roles in July 2006. Currently, a multi-disciplinary team is reviewing the potential inclusion of foster care children under the current MCO program. As the Department moves forward with eligibility category expansions to managed care, the Committee is concerned that the special needs of previously excluded populations be addressed in the program/benefit design, including a focus on concerns or complaints from these groups specifically as the managed care program evolves.

From a geographic perspective, DMAS is currently targeting expansion of the MCO program in areas that are now being served by only one contracted MCO. In those localities, managed care participation remains a voluntary choice by managed care eligible recipients. The Department wants to consider expansion of the MCO programs in these localities as a way to strengthen and stabilize the program.

Additionally, the Department is considering options for geographic expansion into areas where no Medicaid/FAMIS contracted MCOs currently operate. The future expansion

of Virginia's managed care program into these areas may be very difficult for a variety of reasons. Most of the remaining areas currently without Medicaid managed care coverage are extremely rural, and it remains to be seen if the same model implemented in urban areas will work for rural areas, especially when there is a general lack of providers (not just Medicaid) and a lack of managed care experience (both commercial and Medicaid) in the region. There is also an increased cost to providing outreach in rural areas. Additionally, the Department is experiencing some difficulty in expanding and in maintaining coverage in certain areas due to network development issues related primarily to reimbursement rates.

Recognizing that the Department's stated goals for expanding managed care are consistent with the directives in HB 758 and the conclusions of the MRC, the Committee's recommendation regarding Medicaid managed care is, in part, an endorsement of DMAS' current direction. However, the Committee also believes that the Department should consider the development of alternative managed care models in the areas that may be difficult to penetrate under the current MCO model. Specifically, the Committee recommends that alternatives to care delivery, such as telemedicine, may mitigate some provider shortages (particularly among specialists) that could inhibit the network development efforts of the MCOs attempting to move into these areas of the state.

Further, the MRC believes that the Department should not only consider the existing "defined-benefit" approach and may wish to explore other managed care models, such as a "defined-contribution" approach where the financial liability of a MCO is limited to a predetermined monetary level, and thereby make coverage in these areas more feasible from a business perspective. The Committee is unanimous, however, that benefits under these alternatives or any other Virginia Medicaid care models should not be capped at a monetary threshold that once exceeded, eliminates Medicaid coverage. Even under a defined-contribution approach where the plans' liability may cease, the Department needs to incorporate reinsurance or catastrophic coverage provisions such that the recipients' needs will continue to be met and healthcare providers will continue to be paid for their services rendered to these vulnerable citizens. As such, the MRC offers the following recommendation (next page) regarding managed care in Virginia's Medicaid program for consideration by the Governor and General Assembly.

Employer-Sponsored Insurance Subsidies and Buy-In Programs

HB 758 also includes multiple references to employer-sponsored health coverage in delineating the options for consideration by the Revitalization committee. Specifically, the bill directs the MRC to consider voluntary enhanced benefit accounts for "individuals wishing to exercise the option to purchase private health insurance through their employer…" It further states that the Committee should consider "employer-sponsored insurance options, for recipients who have access to such insurance, that provides such individuals with enhanced benefit accounts having deposits of the actuarially prescribed amount … that may be used to purchase private health insurance through their employer…"

Recommendation #5: The Department of Medical Assistance Services should continue working toward the goal of expanding managed care into new regions and across additional eligibility categories where feasible. Expansions should only take place if the program can ensure no diminished access to quality care for recipients. The Department should take great care to assure that if included within a managed care program, recipients with disabilities and special needs have access to needed services. The Department should not be limited in its program design utilized for expansions to the current model, but should explore other potential models of care coordination and delivery, including greater use of local health agencies, telemedicine and defined-contribution models, to fulfill the unique needs of recipients in the new regions and eligibility categories. The Department should not impose monetary benefit caps or benefit restrictions (relative to current policy) under existing or expanded managed care programs without a provision for catastrophic coverage maintained within the Medicaid program.

What are Employer-Sponsored Insurance Subsidy and Buy-In Programs?

Employer-sponsored or other private insurance subsidy programs allow individuals who are eligible for Medicaid, but who have access to employer-sponsored or other insurance, to subsidize the premium costs of that private insurance with direct premium assistance from the public insurance program. Typically, the public program (Medicaid) determines if subsidizing participation in the private insurance would be cost effective. In other words, if Medicaid can pay the premium costs of the eligible recipient at a lower cost than would be expected for Medicaid-funded services if the eligible individual remained within Medicaid, the subsidy would be cost effective for the program.

Buy-In programs allow otherwise ineligible individuals to pay a premium to a public program, such as Medicaid, to become eligible for coverage through that public program. Buy-in programs can provide certain individuals with access to group coverage that may be more economical than can be obtained in the private insurance market. Whether these programs are cost effective for states depends on benefit and premium structures.

Virginia's Current Premium Assistance and Buy-In Programs

Virginia Medicaid currently administers three premium assistance programs that allow Medicaid eligible individuals to enroll in non-Medicaid insurance programs through direct premium assistance from the Medicaid program. These programs are the Health Insurance Premium Payment (HIPP) program, the FAMIS *Select* program, and the Medicare Premium Assistance program. All three programs utilize a cost effectiveness test to determine if premium assistance is economical to the Medicaid program relative to full coverage under Medicaid.

Health Insurance Premium Payment (HIPP): In 1991, the Social Security Act was amended to require State Medicaid programs to pay premiums for employer group health insurance for Medicaid eligible individuals when such premium assistance was determined to be cost effective. This mandate was subsequently made optional to states under the Balanced Budget Act of 1997, but Virginia Medicaid has continued this program as a mandatory enrollment requirement.

When DMAS is advised of the availability of employer insurance to a client, HIPP staff contact the employer to obtain information about the cost and coverage of the health insurance policy. That cost is compared to the estimated baseline costs to the Commonwealth to provide coverage to an individual of similar age and gender under the MCO program (previously discussed). If it is determined that the premium is equal to or less than the MCO program cost, DMAS advises the client that the agency will pay for the coverage and the client enrolls in the employer-sponsored plan. Because the program is mandatory when cost effective, Virginia Medicaid is required to provide wrap-around services to HIPP participants. These wrap-around services essentially ensure that the participant can access any Medicaid-covered services not covered by the employer-sponsored plan. Wrap around also includes a provision to account for patient cost sharing obligation differences between the Medicaid program and the private insurance plan.

Generally, the HIPP program reimburses the client/policy holder directly each month upon presenting evidence of the premium withholding or payment (in rare instances, reimbursement may be sent to the employer). Each month, HIPP analysts review their active cases to determine that the client still has Medicaid eligibility; the client is still employed; the health insurance policy is still in effect; and the premium amount is still correct and being deducted from the employee's check. As of August 2006, the HIPP program had an active caseload of 1,338 cases.

FAMIS Select: FAMIS *Select* is a fairly new program to subsidize the purchase of private or employer-sponsored health insurance for families with access to such coverage. Previously, the FAMIS program utilized the HIPP model as an option for the children's healthcare program. Under the old HIPP-like program, however, there was very low participation and considerable administrative costs. Thus, the FAMIS program migrated to an optional program which allowed much greater flexibility in program design.

In order to participate in FAMIS *Select*, a child must be eligible for the FAMIS program. Under this voluntary program, Virginia's FAMIS program will contribute $100 per month per child to the family to purchase the private insurance. The subsidy is capped at the total cost of the family premium for the insurance purchased, but it is important to note that this family premium cap allows for the possibility that FAMIS *Select* could actually subsidize the adult(s) covered under the family plan in addition to the child(ren), depending on the premium cost and the amount of assistance provided.

Unlike the HIPP program, if enrolled in FAMIS *Select*, only the private plan's benefits are available; the child is not enrolled in the FAMIS plan and is not entitled to any FAMIS benefits not provided under the private plan (except for any child immunizations that the private/employer-sponsored plan does not cover). Also, unlike HIPP, the purchased

plan's cost sharing applies without an obligation to the FAMIS program to compensate the recipient for any cost sharing differences.

Because of the lack of wrap-around coverage, FAMIS recipients have the option to end participation in FAMIS *Select* at any time, and revert back to the regular FAMIS program. Eligibility for FAMIS (and therefore, subsidy under FAMIS *Select*) is still subject to an annual 12 month review. In order to remain in FAMIS *Select*, recipients must show monthly proof of coverage and premium payment.

FAMIS *Select* was implemented on August 1, 2005. As of the beginning of August 2006, there were 284 children actively enrolled. Over 200 additional adults and other non-FAMIS eligible children are also covered by the families' insurance policies. A total of 353 children received services through FAMIS Select during the first year of operation.

Medicare Premium Assistance: Medicaid has subsidized Medicare cost sharing for certain low-income, dually eligible Medicare beneficiaries since the two programs were enacted as part of the Social Security Act amendments of 1965. Virginia Medicaid provides premium assistance for both Medicare Part A (hospitalization) and Medicare Part B (primarily physician coverage) in certain circumstances.

Because Part A is more or less an entitlement program for elderly and disabled people who receive Social Security benefits, there are very few individuals for whom Medicaid needs to purchase this Medicare coverage. However, a minority of elderly persons have insufficient work history and do not qualify for Social Security. They can obtain Medicare Part A by paying a premium ($393 per month in 2006). If they qualify for Medicaid, States may use the premium assistance program to enroll them and to pay this amount on their behalf. Part B is not an entitlement, and requires the payment of a premium in order to participate in the insurance program. In 2006, this premium amount was set at $88.50 per month.

State Medicaid agencies are required to assist low-income Medicare beneficiaries to pay Medicare cost sharing, defined as premiums, deductibles, and coinsurance, as follows:

- All cost sharing for those below the Federal Poverty Level (FPL) and otherwise qualifying,
- Part B premiums for persons with incomes 100-120 percent of FPL,
- Part B premiums for persons 120-135 percent of FPL, limited by funding availability, and
- Part A premiums for persons with disabilities who have worked their way off Social Security and whose incomes are below 200 percent of FPL.

Table 6 (next page) presents summary information on recipients for whom Virginia Medicaid subsidizes the Medicare premium costs.

Medicaid Buy-In: In addition to programs to assist in the premium costs of non-Medicaid insurance programs, DMAS is also implementing a Medicaid Buy-In program. During the 2006 Session, the Governor and General Assembly authorized and funded DMAS

Table 6:
Medicare Premium Assistance Recipients

- Qualified Medicare Beneficiary (QMB): must be eligible for Medicare Part A. Income must be at or below 100% of the Federal Poverty Income Guidelines and resources must be not more than $4,000 for a single person and $6,000 for a couple. Medicaid pays the Medicare Part A (if applicable) and Part B premiums and the coinsurance and deductibles that Medicare does not pay [August 1 – 20,383 recipients]
- Special Low-Income Medicare Beneficiary (SLMB): must be eligible for Medicare Part A. Income must be between 100% and 120% of the Federal Poverty Income Guidelines and resources must not be more than $4,000 for a single individual and $6,000 for a couple. Medicaid pays the Medicare Part B premiums [August 1 – 14,525 recipients]
- Qualified Individual (QI): must be eligible for Medicare Part A. Income must equal or exceed 120% but be less than 135% of the Federal Poverty Income Guidelines. Resources must be at or below $4,000 for a single person and $6,000 for a couple. Medicaid pays the Medicare Part B premiums [August 1 – 5,154 recipients]
- Qualified Disabled and Working Individual (QDWI): Medicaid can pay Medicare Part A premiums for certain disabled individuals who lose Medicare coverage because of work. Individuals must have income below 200% of the Federal Poverty Income Guidelines and resources of no more than twice the standard allowed under SSI [August 1 – 20 recipients]

to establish a Medicaid Buy-In program through a State Plan amendment. Prior attempts at a similar program through a Medicaid demonstration waiver had not received federal approval.

The Medicaid Buy-In program will allow certain working people with disabilities to pay a premium to participate in the Medicaid program. The potential loss of Medicaid eligibility due to an ability to work and earn income has been a major disincentive for certain disabled individuals to seek employment. The program will be targeted to recipients or applicants that meet the income, asset and eligibility requirements for the Medicaid-covered group of individuals who are blind or disabled and have incomes that do not exceed 80% of the Federal Poverty Level ($654/mo. in 2006). The Appropriation Act requires the new Medicaid Buy-In program to be implemented by January 1, 2007.

S-CHIP Buy-In: Additionally, the 2006 Appropriation Act directed DMAS to "review and evaluate State Children's Health Insurance Program (SCHIP) Buy-In programs for children that are operating in other states…" The language further requires DMAS to present the findings of this review to the Chairmen of the House Appropriations and the Senate Finance Committees, and the Joint Commission on Health Care by October 1, 2006. The presentation to Joint Commission on Health Care was completed on September 14, 2006, and the report was submitted within the required deadline. It is unclear at this time what action will be taken to implement an S-CHIP Buy-In program in the Commonwealth.

Family Opportunity Act: In addition to the Medicaid Buy-In and research into the SCHIP Buy-In programs, DMAS is considering a Deficit Reduction Act (DRA) optional provision, called the Family Opportunity Act, for a Buy-In program established within the Medicaid program. The DRA creates a new optional Medicaid eligibility group for children with disabilities under age 19 who meet the Supplemental Security Income (SSI) disability requirements and whose family income does not exceed 300 percent Federal Poverty Level (FPL).

Under this program, families would be charged premiums for participation. According to the DRA, premiums for children with family income up to 200 percent FPL may not exceed 5% of the family income. Premiums for children with family income that is between 200% and 300% of the FPL may not exceed 7.5% of family income. States may require families to participate in employer-sponsored family health coverage (if the employer pays at least 50% of the total annual cost of the premium for family coverage). States must reduce premiums by an amount that reasonably reflects the premium contribution of the family for employer-sponsored family health coverage. According to the DRA, states can begin to phase in coverage starting in January 2007.

Private Insurance Subsidy in Medicaid Reform Nationwide

As mentioned previously, many states are including premium assistance for the purchase of private insurance as major components of their Medicaid reform efforts. In Florida, for example, Employer-Sponsored Health Insurance (ESI) is listed as one of the four fundamental elements of the reform. Florida sees ESI as a way to bridge public and private coverage and a way to foster independence among recipients by providing individuals with a subsidy to move to private health insurance. Under the reform program, Medicaid recipients can voluntarily opt out of Medicaid coverage and enroll in their employer's health insurance plan (with the State contributing toward the cost of that plan up to the Medicaid premium amount). Because this will be a voluntary program, Florida Medicaid is not required to provide any wrap-around for cost sharing or benefits.

South Carolina's draft approach (not approved) has two "Option-Out" programs (ESI and a Self-Directed Plan) where beneficiaries choose to receive medical care outside the Medicaid program and Medicaid only provides a defined amount of financial support. Like Florida, the program looks to be voluntary, meaning that recipients who opt for ESI or self-directed plans would agree to accept whatever services are covered by the private plan, with whatever cost sharing the plan imposes. The State would pay up to the amount it would have paid to cover the recipient under Medicaid (if the optional plan's premium is higher, the recipient would pay the difference).

The Kentucky Medicaid program currently has a HIPP program, but only has 14 recipients enrolled statewide. The State plans to educate eligibility workers about the existence of the HIPP program and to strengthen the current HIPP program. This will include a requirement for beneficiaries to enroll in employer-sponsored private health insurance if it is available and if it is cost-effective to the Medicaid program (much like Virginia's HIPP program currently).

Currently, Idaho Medicaid is limited in its ability to offer premium assistance as an option to children and adults in mandatory eligibility categories. The reform proposes to expand premium assistance to all children and working age adults who would prefer to enroll in commercial insurance. Idaho also indicates it plans to change its rules to allow children of families who currently have health insurance to qualify for premium assistance (this component appears to still be in the preliminary planning stages and no details are available yet).

Medicaid Revitalization Committee Discussions and Recommendations for Private Insurance Subsidies and Public Insurance Buy-In Programs

Not all members of the MRC were aware of the existing premium subsidy programs administered by the Department within the Medicaid and FAMIS programs. As such, it appears that DMAS is already making a concerted effort to encourage employer-sponsored insurance use through public subsidy programs. However, it is also clear to the MRC that opportunities may exist to modify and/or expand these existing programs to further encourage the cost effective use of Medicaid funding through the promotion of private insurance coverage.

Specifically, DMAS indicated that it is currently examining the potential costs and benefits of moving from a mandatory HIPP program to a voluntary program for Medicaid modeled after the FAMIS *Select* approach. While this may seem counter intuitive, the theorized benefits include the potential for greater marketing of the option to recipients who could choose to participate even if it required additional out-of-pocket expenses. Under the mandatory program, the employer coverage would not have been deemed cost effective and the enrollee would have been denied for HIPP participation. Under a voluntary program, the Medicaid subsidy could be capped at a premium amount (at worst, a cost neutral impact on the Medicaid program) and the recipient could choose to shoulder the additional costs. While most Medicaid recipients would be unable to choose such an option, some may, and the potential for more customized benefits under the employer plan and a desire to remove any perceived stigma that may be attached to participation in a public insurance program like Medicaid may be the incentive to do so. The Commonwealth may benefit from more personal responsibility for healthcare shouldered by the recipients and potential reductions in the administrative costs associated with the mandatory program.

As part of an optional program, it could also be possible to expand the subsidy program from employer-sponsored insurance options only to include other private insurance plans. While it is unlikely that such comprehensive coverage would be available at a similar cost as found in the Medicaid program, the possibility would exist for creative benefit designs to meet the basic needs of a population with a desire to achieve health coverage in the private insurance market, albeit with financial help from the Medicaid program.

It is also possible that this type of approach could be used in market-developed alternative Medicaid managed care plans. In South Carolina, discussed earlier, the state is contemplating the capitalization of Personal Health Accounts (PHAs) with a risk-based premium amount. The recipient would then shop among alternative Medicaid plans and utilize the PHA to directly pay for the plan. Depending on how the market responds to this demand, the recipient could have the option to purchase a more cost-effective benefit plan tailored to his or her needs (or perceived needs). Any additional funds left in the PHA could then be used for additional healthcare services or cost sharing, for example. This is still a very much unproven approach even in the private market through health savings accounts, but it may be a viable option for Virginia Medicaid to consider as the program evolves.

In addition to the subsidy programs, DMAS is currently implementing the Medicaid Buy-In, and exploring options for additional buy-in programs in both the Medicaid and FAMIS programs. While the MRC has been asked to consider Medicaid reform, the larger

issue for the Commonwealth may very well be affordable insurance coverage for the currently uninsured. Absent eligibility expansions within the Medicaid and/or FAMIS programs, a potentially cost effective opportunity for additional coverage of the uninsured could be through a buy-in to the public programs. If these programs can provide group coverage at premium rates well-enough below private insurance premiums that are affordable to the population in need of coverage, the participants will benefit from the insurance coverage, and the Commonwealth could benefit from the reduction in indigent care and other uncompensated healthcare costs borne by the state and the providers.

Much like the subsidy programs, it remains to be seen if the buy-in programs can provide affordable group coverage for these otherwise uninsured individuals. Depending on the premium amounts, the buy-in may not be a realistic option unless additional public subsidy is provided to reduce those costs. Because the Virginia Medicaid program has very tight eligibility policies, many very low income individuals remain ineligible for Medicaid. At the same time, they likely do not have the disposable income necessary to pay even a modest premium to buy-in to the program. Thus, while the buy-in may be a realistic option for some of the relatively higher income levels among the uninsured, there may be a gap in coverage remaining for the very poor Medicaid-ineligible population unless premium subsidies are included for this group. This will be an on-going policy decision facing the Commonwealth as it struggles with the provision of health insurance to the currently uninsured population.

The MRC is not in a position to make a specific recommendation regarding the modification and/or expansion of the premium assistance and buy-in programs due to the research and analysis that is still on-going. As such, the MRC recommends that the Department continue its analysis of options that could promote the cost effective use of Medicaid funds for subsidy and buy-in programs. The following recommendations are presented to the Governor and General Assembly:

Recommendation #6: The Department of Medical Assistance Services should study the potential impact of modifications to existing programs for public subsidy of employer-sponsored or other private health insurance coverage for Medicaid-eligible individuals, including the impact of switching from mandatory to voluntary enrollment in these subsidy programs. To the extent the public subsidy is cost effective / cost neutral relative to the cost of direct Medicaid coverage, and based on the Department's analysis and input from stakeholders, the Department should consider modifications to these subsidy programs to further encourage the use of available private insurance coverage options. Any modifications to or expansions of these programs should include consumer protection mechanisms.

Recommendation #7: The Department of Medical Assistance Services should seek federal approval to expand, where feasible, "buy in" programs to allow expanded participation in the Medicaid and FAMIS programs, including the program authorized as the Family Opportunity Act, to the extent such expanded participation can be shown to be cost effective / cost neutral to the Commonwealth.

CONCLUSION

In conclusion, the Medicaid Revitalization Committee is pleased to submit this report and seven recommendations for potential enhancements to the Virginia Medicaid program. In many respects, these recommendations could be described as modest reforms. Perhaps more accurately, many of the recommendations could be described as endorsements for the Department's current direction toward reforming and enhancing aspects of the Medicaid program. However, the effect of these consensus reforms could be significant for the recipients in the program, and the sustainability of healthcare coverage for the poor and disabled.

As the MRC has discovered over the course of the five meetings held this summer, the Virginia Medicaid program is already implementing many aspects of the reform initiatives being incorporated into other state Medicaid programs. While other states have appeared to be out front in reforming their programs, Virginia Medicaid has already been expanding managed care and disease management, utilizing risk based premiums for its managed care, offering employer-sponsored insurance subsidy programs, developing a web-based claims submittal system, and encouraging other electronic access to the Medicaid and FAMIS programs.

The MRC is also concerned that other measures, such as a reduction in benefits if members fail to meet behavioral benchmarks, monetary caps on covered expenditures, or increased cost sharing, are at best unproven in regards to their effect on the health and well-being of the Medicaid population. At worst, such policy could result in the exclusion of coverage for those most in need of healthcare services. If the Virginia Medicaid and FAMIS programs had broader eligibility, benefit design flexibility and cost sharing modifications could have the potential to modify behavior and promote more efficient use of Medicaid services, and thereby contain the growth in costs. But Virginia's Medicaid program is very strict in terms of eligibility and scope of services. Provisions for cost sharing flexibility in the DRA, for example, are focused on recipient income levels that are almost entirely unrepresented in the Virginia Medicaid program.

The reforms proposed in this report have the potential to significantly enhance the Medicaid program along the lines intended by HB 758. As stated earlier in this report, the mission of the MRC as articulated in HB 758 was the development of recommendations focused on emphasizing the state's role in purchasing healthcare services, leveraging the forces of the marketplace to customize services to meet the diverse needs of Virginia's Medicaid population, enhancing personal responsibility and empowering individuals who

desire to manage their healthcare, bridging public and private coverage, maximizing access, and containing the growth of Medicaid expenditures in the Commonwealth.

The MRC believes that implementation of the recommendations herein represent a significant step toward this stated mission. Members of the Committee look forward to working with the Governor and General Assembly, as well as the Department of Medical Assistance Services, to make these reforms a reality for the Virginia Medicaid program.

Appendices

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Appendix A

VIRGINIA ACTS OF ASSEMBLY -- 2006 SESSION

CHAPTER 655

An Act relating to medical assistance services; State Plan amendment or application for certain waiver.

[H 758]

Approved April 5, 2006

Be it enacted by the General Assembly of Virginia:

1. *§ 1. Medical assistance services; State Plan amendment or application for waiver.*

A. By July 1, 2006, the Department of Medical Assistance Services (DMAS) shall convene a Medicaid Revitalization Committee (the Committee) to prepare recommendations for any State Plan amendments or waiver authority, including but not limited to a research and demonstration project waiver pursuant to Section 1115 of Title XIX of the Social Security Act, as amended, necessary to reform and revitalize Virginia's Medicaid program. The Committee shall consist of no less than eight and no more than 15 members and shall include representatives from the affected state agencies and from stakeholder and advocacy groups and from providers that serve Medicaid enrollees.

Recommendations shall be developed that shall include fundamental elements to move toward emphasizing the state's role in purchasing healthcare services, leveraging the forces of the marketplace to customize services to meet the diverse needs of Virginia's Medicaid population, enhancing personal responsibility and empowering individuals who desire to manage their healthcare, bridging public and private coverage, maximizing access, and containing the growth of Medicaid expenditures in the Commonwealth.

By December 1, 2006, these recommendations developed by the Committee must be submitted by the Director of the Department of Medical Assistance Services to the House Committees on Appropriations and Health, Welfare and Institutions and the Senate Committees on Education and Health and Finance and include estimates of the costs and cost savings for implementation of the waiver or amendments to the State Plan.

B. Prior to convening the Committee, the Director of the Department of Medical Assistance Services shall:

1. Prepare a concise and precise statement of the concept of fundamental elements listed in subsection A that is focused on bridging public and private coverage through client-centered planning, individual budgeting, and self-directed quality assurance and improvement. He shall distribute the statement to all interested parties.

2. Consult with the Centers for Medicare and Medicaid Services concerning the concepts and options of any waiver application.

C. To address these fundamental elements, the options that the Committee must consider in developing its recommendations shall include:

1. Voluntary enhanced benefits accounts (which may be named health opportunity accounts) for (i) individuals with chronic diseases or at risk of having or developing one or more chronic diseases; (ii) individuals for whom healthcare costs are or may become high; and (iii) individuals whose current or future health may be improved through a disease management program focused on identification of chronic illnesses, incentives for healthy behavior, and training in effective and appropriate self-care; or (iv) individuals wishing to exercise the option to purchase private health insurance through their employer as described in subdivision 4.

2. Disease management programs or other behavior modification activities, including behavioral health, a system of monetary incentives for Medicaid recipients to make healthy decisions and to engage in self-management of their healthcare, and the deposit of incentive funds in enhanced benefits accounts to be accessed by enrollees to purchase healthcare services or items that are not covered under Virginia Medicaid and will assist enrollees in being personally responsible for their own healthcare.

3. Risk-adjusted premiums for Medicaid recipients enrolled in Medicaid managed care organizations (MCOs), calculated to be actuarially comparable to currently covered services under the Virginia State

Plan for Medical Assistance. The actuarially developed risk-adjusted premiums shall be designed to reduce adverse selection and provide incentives for cost containment through identification of chronic illness before the recipient becomes seriously ill because of lack of treatment.

4. Employer-sponsored insurance options, for recipients who have access to such insurance, that provides such individuals with enhanced benefits accounts having deposits of the actuarially prescribed amount referenced in subdivision 3 that may be used to purchase private health insurance through their employer, and requires these individuals to assume any costs of private health insurance that are not covered by the Medicaid premium.

5. A transitioning of all recipients remaining in the fee-for-service program to a disease management program, care coordination program, or enrollment in MCOs.

6. A requirement that all Medicaid MCOs take steps to phase in implementation of electronic funds transfer technology to add efficiencies to administrative procedures, reduce costs, and avoid mistakes and abuse.

7. The phased implementation of electronic benefits cards for enrollees to access voluntary enhanced benefits and services.

8. Criteria for determining eligibility for the various options being considered including enrollment in the waiver.

9. A process, amounts, and specific criteria for the award of incentive funds that can be earned by or awarded to enrollees.

10. A process for establishing voluntary enhanced benefits accounts into which the incentive funds may be deposited and from which enrollees may access the funds.

11. A determination of the services or items and insurance plans, where possible, for which the funds in the enhanced benefits accounts may be used by enrollees.

12. A mechanism by which (i) enrollees who lose Medicaid eligibility while enrolled in the voluntary program as identified in subdivision C 1 may retain access to the money in their enhanced benefits accounts but will only be eligible for the voluntary program for the purpose of depleting the funds in the enhanced benefits account and will not receive any other Medicaid services, and (ii) enrollees could access services in the event of a depletion of the voluntary program funding.

13. The contractor criteria (i) for the establishment and management of the voluntary enhanced benefits accounts; (ii) for the development of disease management plans, including training of enrollees; and (iii) for implementation of the electronic benefits funds transfer technology.

D. By May 15, 2007, the Department of Medical Assistance Services (DMAS) shall prepare, submit, and seek approval of any required State Plan amendments or waiver authority, including, but not limited to, a research and demonstration project waiver pursuant to Section 1115 of Title XIX of the Social Security Act, as amended, to reform Virginia's Medicaid program that shall include fundamental elements to move toward greater emphasis on the state's role in purchasing healthcare services, leveraging the forces of the marketplace to customize services to meet the needs of Virginia's various Medicaid populations, enhancing personal responsibility and empowering individuals to manage their healthcare, bridging public and private coverage, and containing the growth of Medicaid expenditures in the Commonwealth.

E. Neither this act nor any new or revised project that may be, but is not required to be, implemented pursuant to this act shall be construed as creating any legally enforceable right or entitlement to enrollment in an enhanced benefit account program, the Virginia Plan for Medical Assistance Services, or Title XIX of the Social Security Act, as amended, on the part of any person or to create any legally enforceable right or entitlement to participation in any program by any person.

2. That, upon the approval by the Centers for Medicare and Medicaid Services of any State Plan amendments or waiver authority pursuant to this act, expeditious implementation of the program modifications shall be deemed to be an emergency situation in accordance with § 2.2-4002 of the Administrative Process Act of the Code of Virginia; therefore, to meet this emergency situation, the Board of Medical Assistance Services or the Director, acting on the Board's behalf, shall promulgate emergency regulations to implement the waiver.

3. That, in order to avoid costs as much as possible during the regulatory process, the Board of Medical Assistance Services shall, when in compliance with the Administrative Process Act (§ 2.2-4000 et seq.) of the Code of Virginia, notify, distribute, and provide public access and opportunity for comment via electronic media, including but not limited to, posting documents to and receiving comments via the Department's website, by e-mail, and fax. The Board shall, however, continue to

provide public notice and participation to those persons who do not have access to the Internet or other forms of electronic media.
4. That the provisions of this act shall not become effective unless an appropriation of general funds effectuating the purposes of this act is included in the general appropriations act passed by the 2006 Session of the General Assembly, which becomes law.

Appendix B

MEDICAID REVITALIZATION COMMITTEE

Representing	Committee Member
Virginia Hospital & Healthcare Association	Christopher Bailey
Children's Health Insurance Program Advisory Committee	Judith Cash
Medical Society of Virginia/Virginia Academy of Pediatrics	Leslie C. Ellwood, M.D.
Virginia Pharmacists Association	Becky Snead
Virginia Health Care Association	Hobart Harvey
Virginia Poverty Law Center	Jill Hanken
Persons with Disabilities	Maureen Hollowell
Board of Medical Assistance Services	Rose Chu
Medicaid MCO Representative	Doug Gray
Virginia Association of Community Services Boards	Mary Ann Bergeron
Old Dominion Medical Society	Theopolis Gilliam, Jr., M.D.
Virginia Commonwealth University Health System	Sheryl Garland
Virginia Association of Home Care	Marcia Tetterton
National Alliance on Mental Illness	Alexander Macaulay
Virginia Association of Area Agencies on Aging	Diana Wallace

Appendix C

Summary of Public Comments

The MRC provided opportunity for public comment at the August 2, 2006 meeting to allow non-MRC members to impact the deliberations of the Committee. Public Comment was again accommodated at the September 21, 2006 meeting to hear comments on the draft report. The Department also established a website providing information on the Committee's deliberations and invited the public to submit comments through that site as well. Eight individuals presented public comments at the August 2, 2006 meeting and two individuals submitted their comments to the Department through the web address. Three individuals presented comments at the September 21, 2006 meeting. All electronic comments were posted to the MCR web site. The organizations and individuals submitting comments represented providers, patient advocates and another legislatively mandated committee and are listed below.

<u>Organizations/Individuals Submitting Public Comments:</u>

- The Virginia Chapter of the American College of Nurse Midwives and The Commonwealth Midwives Alliance - August 2, 2006
- Bonnie Matheson, The Greenhouse (Midwife) - August 2, 2006
- Child and Family Behavioral Health Policy and Planning Committee - August 2, 2006
- Virginia Network of Private Providers - August 2, 2006 & September 21, 2006
- Voices for Virginia's Children - August 2, 2006
- ValueOptions, Inc. - August 2, 2006
- Virginia Primary Care Association - August 2, 2006
- Virginia Chapter of the March of Dimes - August 2, 2006
- National Association of Chain Drug Stores - August 2, 2006
- REACH (Richmond Enhancing Access to Community Healthcare) - August 2, 2006
- CHIP of Virginia - September 21, 2006
- Medco - September 21, 2006 (no electronic comment provided – Committee received a PowerPoint presentation)

Generally, six of the commenters focused on coverage of pregnant women, children and low income families; three commenters focused on coverage of mental health services; one spoke about primary care coverage; one addressed medication therapy management.

A few common elements emerged from these public comments. Three commenters called for increases in provider reimbursement for various services. Four commenters advocated coverage of additional specific services. Three commenters requested that the eligibility level for the FAMIS Moms program be increased. Finally, two commenters called for and increase in coverage for low income parents.

<u>Excerpts from Some Commenters (Items the MRC Should Consider)</u>

- Reimbursing services provided by Certified Professional Midwives and facility reimbursement for nurse midwives in birthing centers.
- Covering additional intermediate level behavioral health services for children.
- Funding adolescent substance abuse services and services for youth with co-occurring mental health and substance abuse problems.
- Expanding coverage for pregnant women by increasing eligibility under the FAMIS Moms program to 200% of the federal poverty level (FPL).
- Covering FAMIS Moms up to three months prior to the date of application and automatic eligibility for all newborns of women enrolled in FAMIS Moms.
- Expanding coverage for low-income parents to at least 50% of the FPL.

- Implementing a buy-in program for families of children with disabilities, as allowed by the federal Family Opportunity Act.
- Developing a comprehensive system with effective, evidence based treatment that focuses on building resiliency in families, supporting recovery, and reintegration into the community for the mental health population.
- Expanding the use of medication therapy management and collaborative pharmacy-assisted disease management in Medicaid programs.
- Studying provider rates for mental health services.
- Conducting a rate study of Medicaid behavioral services.
- Working with community health centers in the area of disease management and considering the financial stability of Federally Qualified Health Centers (FQHCs).
- Taking into account that some of the provisions of House Bill 758 would create challenges for the population with mental illness/mental retardation.
- Expanding the use of EPSDT services

The full public comments submitted to the MRC are included in this Appendix on the following pages.

Public Comments
Medicaid Revitalization Committee, August 2, 2006
Virginia Chapter, American College of Nurse Midwives and the Commonwealth Midwives Alliance

On behalf of the Virginia Chapter of the American College of Nurse Midwives and the Commonwealth Midwives Alliance, I am writing to ask the Medicaid Revitalization Committee to consider expanding access to midwifery care for Medicaid recipients. The Commonwealth licenses two types of midwives: Certified Nurse Midwives, who are licensed jointly by the Boards of Medicine and Nursing, and who practice in collaboration and consultation with physicians, and Certified Professional Midwives, licensed under the Board of Medicine, who practice independently and provide prenatal care and home birth deliveries. Both groups of midwives adhere to the Midwives Model of Care that has been found to be safe and cost-effective for low-risk women.

The Virginia Chapter of the American College of Nurse Midwives and the Commonwealth Midwives Alliance believe that the mission of the Medicaid Revitalization Committee—"enhancing personal responsibility and empowering individuals who desire to manage their healthcare, bridging public and private coverage, maximizing access, and containing the growth of Medicaid expenditures in the Commonwealth"—is entirely consistent with the midwives' model of care. . The components of the Midwives Model of Care are:

- To monitor the physical, psychological and social well-being of the mother and baby throughout the childbearing cycle;
- To provide the mother with individualized education, counseling, and prenatal care, continuous hands-on assistance during labor and delivery, and postpartum support;
- To minimize technological interventions; and
- To Identify and refer women who require obstetrical attention.

At the present time, nurse midwives may seek Medicaid reimbursement for their services if they attend births in hospitals. A small number of nurse midwives practice in a birthing center in Alexandria, and these midwives cannot bill Medicaid for facility fees because birthing centers are not licensed by the Department of Health. Birthing centers are facilities designed for low-risk mothers and babies. They are places where women come throughout their entire pregnancies so that nurse-midwives and other providers can monitor their physical, psychological and social well-being during prenatal care, provide them with individualized and group education, continuous hands-on assistance during labor and delivery, and postpartum support. At the same time the providers minimize technological interventions and identify and refer high risk women who require medical attention.

Midwives' care is safe. Nurse midwives practicing in birth centers maintain very low hospital transfer rates, and their cesarean section rates average 4.5% in comparison with national rates that are over 30% (source: Dr. Juliana Fehr, Nurse Midwifery Program Director, Shenandoah University). In addition, according to a 2005 British Medical Journal study reviewing the practice of Certified Professional Midwives in North America, the transfer rate from home to hospital for laboring women was 12%, and 3.7% of these women had cesarean sections (Johnson & Daviss, *BMJ* 2005;330;1416). These excellent outcomes are attributed to the time-intensive care that is offered within the Midwives Model which increases the likelihood that women stay low risk. Also, if women develop risks, they will be spotted early and the referral can be facilitated in a timely manner prenatally and early in labor.

Certified Professional Midwives have only recently been licensed to practice midwifery in Virginia, and they are not eligible to seek reimbursement as Medicaid providers. However, Certified Professional Midwives have attained Medicaid reimbursement in other states, and we hope that Virginia will follow their lead. While the number of clients served will continue to be small, home births are less expensive than hospital births; therefore, there would be savings to the Commonwealth in reimbursing Certified Professional Midwives.

Not only can midwives provide less expensive pregnancy care with very low non-invasive patient outcomes, the Midwives Model of Care requires that clients be fully informed participants in their care. The Midwives Model of Care is truly client-centered and consistent with the mission of the Medicaid Revitalization Committee. In fact, client-centeredness is written into the Code of Virginia for licensure of Certified Professional Midwives (*§ 54.1-2957.11)*.

As the Committee deliberates its charge, Virginia's midwives remain hopeful that the Committee will consider reimbursement of services by Certified Professional Midwives and facility reimbursement for nurse midwives in birthing centers. Thank you so much for your time and consideration.

Comments from Bonnie B. Matheson.

Bonnie B Matheson
The Greenhouse
540-364-9023 office

I hope you will consider reimbursing people whom you insure when they use a Birthing Center instead of a hospital. After all many women feel strongly that the safest way to have a baby is as far away from a hospital as possible.

If someone will look into it they will discover that it is cost effective to have women going to a non-hospital environment to birth their babies with Midwives in attendance.

Only high risk mothers should need an O.B. or a hospital. In fact home is probably the safest place to have a baby. In Great Britain women are being encouraged to stay home and give birth because they will have fewer problems there.

Women should be rewarded for using Non-Nurse Midwives as well. Certified Professional Midwives believe in and use the Midwives Model of Care. This is non-invasive and tends to produce fewer side effects and complications down the road.

Doulas should also be reinbursable. Doulas make births go a lot more smoothly for mother and baby. They greatly reduce the number of C-sections and even of pain medication. The doula is a real money saver for the state. The state ought to encourage their use and pay women back for most or all of their cost.

Please take these things seriously. Birth is changing both for the better (Midwives and home birth or Birth Center birth) and for the worse (huge numbers of unnecessary C-sections which are expensive and cause more problems later).

Support those who are trying their hardest to let women have a good safe natural experience with fewer interventions and way less cost.

Best regards,

Bonnie B. Matheson

Comments to the Medicaid Revitalization Committee
August 2, 2006
Brian L. Meyer, Ph.D.

Thank you for the opportunity to present these comments. I am Dr. Brian Meyer, the Executive Director of the Virginia Treatment Center for Children at the VCU Medical Center. I am also the Chair of the Child and Family Behavioral Health Policy and Planning Committee, a legislatively-mandated workgroup that provides an annual report to the Governor and the Legislature regarding the state of children's behavioral health services in the Commonwealth. The Committee's reports include recommendations for changes to state law, policy, and the annual budget. The recommendations I make today come from the Committee's just-released 2006 report.

Children's behavioral health services in Virginia are in crisis. In every area of the state, urban and rural, we hear complaints that mental health and substance abuse services for children are either unavailable or that the waiting lists are so long – four months for an outpatient visit, six months to see a child psychiatrist – that families cannot obtain services when they need them. The lack of treatment capacity is caused by inadequate funding for these services. We also have a serious imbalance in the system which is represented in Medicaid in which low end services like outpatient therapy and medication management, and high end services like acute inpatient care and residential treatment, are funded, but the intermediate services that children and adolescents need to prevent placement are neither funded nor available. Thus the Commonwealth spends hundreds of millions of dollars annually on restrictive high end services that remove children from their families and communities.

In making the following recommendations, we keep in mind three facts. First, treating behavioral health problems when children are young decreases later costs of behavioral health services. Second, treating behavioral health problems lowers the cost of treating other health care problems. Third, treating behavioral health problems lowers later costs to larger systems that are also funded by the state, including education and juvenile and criminal justice, such that every $1 spent saves $4 later.

Our Committee makes the following recommendations regarding Medicaid:

1. DMAS should conduct a study of intermediate level behavioral health services for children to determine which services, if funded by Medicaid, would significantly reduce utilization of restrictive residential placements in favor of home- and community-based services. In particular, we recommend studying such services as crisis intervention programs, mobile crisis teams, in-home family therapy and intensive in-home family therapy, respite care, wraparound services, intensive case management, afterschool behavioral health programs, intensive outpatient programs, and services for youth with co-occurring mental health and substance abuse problems. We believe it is far better to spend the funds keeping children with their families in the least restrictive possible environment.

2. DMAS should fund adolescent substance abuse services and services for youth with co-occurring mental health and substance abuse problems. We know that the adult outcomes of poor health, lowered productivity, DUI fatalities, and broken families, to name a few, could be significantly decreased if teens with substance abuse problems were treated. Half of all youth with mental health problems have co-occurring substance abuse problems, yet Medicaid pays only for mental health services, which does not address half of the problem. A study conducted several years ago by DMAS concluded that providing adolescent substance abuse treatment services would cost only $5.5 million per year.

3. We recommend that DMAS study suspending rather than ending Medicaid benefits when youth are incarcerated. Many youth are required to obtain appointments for mental health services before they can be released, but they cannot because their benefits have been ended.

4. EPSDT continues to be underutilized throughout Virginia. We recommend that DMAS provide regional trainings to pediatricians, family practitioners, case managers, DSS social workers, and service providers to expand the use of EPSDT screenings.

5. Any reshaping of Medicaid funding must address the real cost of providing services. Behavioral health service reimbursement rates have not been studied by DMAS since 1994. Our committee has found that the major reason there is a shortage of acute psychiatric inpatient beds for children, and that hospitals continue to close beds, is inadequate reimbursement rates. In particular, we recommend that Medicaid rates for outpatient psychiatric appointments, acute inpatient hospitalizations, day treatment, intensive in-home services, and behavioral health care provided by primary care physicians be studied.

We believe that taking these five simple steps would go a long way toward increasing the mental health of today's youth and tomorrow's adults. Thank you.

Comments to the Medicaid Revitalization Committee
August 2, 2006

Jennifer Fidura
Virginia Network of Private Providers

First, do no harm!

- We want to emphasize that our focus is on the welfare of the consumers and their ability to access services and supports which meet their needs
- The population we serve is a unique population with mental illness, mental retardation or dual diagnosis, including individuals supported by both the Community Services Boards and the network of private providers. This population are individuals with varying degrees of disability who benefit from (and virtually survive because of) supports received from their Case Managers and their service providers
- The challenge of enrolling the dual eligibles in an appropriate Medicare Part D prescription plan that would continue to meet their needs over time is a perfect example of the work done by the Case Managers and the residential service providers – the transition went relatively well for most, but only because of the effort expended by the Case Managers and the service providers
- We recognize that our population falls into that slice of your pie chart which is low in number and high in cost – please be cautious about thinking that there may be quick fixes with changes in services or access to services with this population most of whom, without the supports they have now, would be in state facilities at a far greater cost to Virginia.

Many of the "considerations" on your list would create challenges for our consumers –

- Creation of an incentive structure to promote increased personal responsibility may be less than successful with consumers who find basic living skills a challenge
- Effective utilization of enhanced benefit accounts or utilization of direct electronic access to those accounts would be difficult for consumers who are mentally challenged and lack internet access or transportation to acquire access
- This is also a population that find it very difficult to anticipate service needs – remember the earlier comment about Medicare Part D

One of the DRA optional "considerations" also gives us great concern for our population – Alternative Premiums and Cost Sharing

- While many of our consumers fall below 100% of the Federal Poverty Level (currently $817 per month for a family of one) a few might be subject to cost sharing as described in the DRA as a state option
- For those who have just achieved a "victory" by having the PMA raised to 165% of base SSI rate (in 2006 from $603 to $995) it would be a shame to lose what they had gained by being given the opportunity to "share" the cost!

Another DRA option was not on the list presented at the last meeting for "consideration" –

- The option of covering HCBS under the State Plan is one we would like to see discussed to assess the benefits or risks to consumers.
- It may be worth considering for those individuals with mental illness and currently do not have Medicaid funded access to many services
- While it does have a more stringent eligibility criteria than a HCBS Waiver (150% vs 300% FPL) it would add services, partially funded by the Federal government, that do not exist today

Again, do no harm – we support a fragile population in an even more fragile system

- The CSBs and network of private providers are the strength of the system and are frequently all that stand between the consumers living in the community and institutionalization (at a far greater cost to Virginia)
- We support the efforts of this committee and of DMAS and will actively assist in any way possible, but please, do no harm!

Comments to the Medicaid Revitalization Committee
September 21, 2006

Jennifer Fidura
Virginia Network of Private Providers

I want to commend the Committee for their efforts, and commend the staff of DMAS for their ability to pull the many different elements and ideas together in a surprisingly coherent and cohesive fashion.

The draft report seems to capture the elements required and the recommendations, as written, appear to "do no harm." We will continue to monitor closely the further development of the recommendations and the implementation as follows:

- Enhanced benefit accounts – be cautious about the potential for misuse or exploitation of debit cards if assigned to persons who are seriously mentally ill or severely cognitively impaired;

- Web-based claims – make the exclusion "staff wage payments in consumer-directed models within long-term care services" instead of the wording used which could include agency functions which support the consumer-directed services.

- Buy-in opportunities – While it is stated in other places, a specific reference to the Family Opportunity Act in the recommendation would place an important emphasis on this option.

Thank you for the opportunity to comment and to participate in this process.

Testimony to Medicaid Revitalization Committee
John Morgan, Ph.D.
Voices for Virginia's Children

Members of the Medicaid Revitalization Committee: Good morning. My name is John Morgan, Senior Policy Analyst with Voices for Virginia's Children. Thank you for the opportunity to comment regarding potential revisions to the Medicaid program.

Voices recommends your consideration of three changes that will benefit Virginia's children.

First: Expand Coverage for Pregnant Women

In 2005 the Virginia General Assembly created and funded the FAMIS Moms program to provide coverage to pregnant women with income up to 150% FPL. In 2006 the eligibility level was increased to 166% FPL. We commend the General Assembly for creating this program and for the increase in eligibility this past session.

Voices advocates an expansion of FAMIS Moms eligibility to 200% of the FPL. Currently FAMIS covers infants up to 200% of the FPL, but pregnant women only to 166% FPL. Therefore, some babies covered by FAMIS are born to mothers who could not access prenatal care through Medicaid or FAMIS Moms. Aligning eligibility for both programs at 200% of FPL would ensure that the mothers of all babies covered by FAMIS have had access to adequate pre-natal care. This would potentially save money by reducing any indigent care costs associated with those uninsured mothers, and also by improving pregnancy outcomes and infant health in this group of FAMIS babies. Note that money invested in FAMIS Moms does bring in a federal match - every $1 that Virginia spends will bring in an additional $2 from the federal government.

Another important yet politically sensitive issue is the provision of prenatal care to pregnant women who are not citizens. While most non-citizens are not eligible for Medicaid or FAMIS Moms coverage until the time of delivery, many of their babies will be covered under FAMIS Plus or FAMIS. Again, because these women have limited access to prenatal care, the state could end up paying higher costs associated with infant health problems that could have been prevented through regular prenatal care. Voices advocates improving the health status of these infants covered by FAMIS by expanding eligibility to non-citizen pregnant woman who otherwise would be eligible.

Second: Expand Coverage for Low-Income Parents

Virginia's Medicaid income eligibility limits for parents, relative to most other states, are extremely restrictive. Depending on locality, eligibility ranges from just 22-30% of the FPL. The 2006 FPL for a family of 4 is $20,000, so in Virginia only those parents making less than approximately $5,000 per year are eligible. Expanding coverage will reduce the number of uninsured parents and support their participation in the workforce. But here's the important connection to children's health: Research indicates that when states expand coverage to parents, those parents are then more likely to enroll their eligible children in coverage. So one indirect benefit of expanding coverage to low income parents is an increase in the number of covered children, which of course improves their health status. Therefore, to improve the health status of low-income children, Voices supports an increase in Medicaid elibility for parents to at least 50% of FPL.

Third: Create Medicaid and SCHIP Buy-in Programs

Voices strongly recommends a buy-in program, as allowed by the federal Family Opportunity Act, for families of children with disabilities whose family income is below 300% of the FPL. Enacting a buy-in program will support currently uninsured families who are forced into poverty to pay for expensive medical care out-of-pocket.

Finally, while this Committee's focus is not on reimbursement rates, Voices requests that you recommend a rate study for Medicaid behavioral health services, particularly for outpatient psychiatric care, behavioral

health care services provided by primary care physicians, acute inpatient hospitalization, day treatment services, and intensive in-home family services.

We recommend these enhancements as sensible steps to improve the health status of Virginia’s children.

Thank you.

Comments for the Medicaid Revitalization Committee
August 2, 2006

Dr. Lawrence Goldman
ValueOptions
VP, Strategic Planning & Development
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Good morning, Commissioner Finnerty and members of the committee. I am Larry Goldman, Vice President of Strategic Planning and Development for ValueOptions, Inc. ValueOptions, headquartered in Norfolk, Virginia, is the not only the largest privately owned behavioral health managed care organization in the nation, but is the largest manager of Medicaid Mental Health Programs. In addition, we provide managed behavioral healthcare programs to large employers health plans, and the Federal Government throughout the country, covering over 24, 000,000 Americans. We are proud to collaborate with the Commonwealth in managing employee assistance, mental health, and substance abuse treatment for the Virginia Commonwealth Employees, as part of the COVA Care plan.

We manage Medicaid and public assistance program for states and counties across the nation in large urban, suburban, as well as rural and frontier areas. Through innovation and the use of ValueOptions' state-of-the-art technology, our government partners have integrated services more effectively across agencies and programs. Our programs have achieved:

- Increased access to services,
- Expanded involvement and satisfaction of consumers and advocates, and
- Savings that have been reinvested into the behavioral healthcare system.

I would like to discuss several items that may be important for to the committee to consider as it examines innovative approaches to Medicaid healthcare delivery in the Commonwealth of Virginia:
They are:

- That it is important for the Commonwealth to define a strategic vision, and to clearly communicate it to all stakeholders, from consumers to families to providers, etc.
- That behavioral health care become an integral part of Medicaid revitalization, meeting the goals of transformation and recovery as addressed by the President's New Freedom Commission on Mental Health Care
- That the Commonwealth look carefully at the current behavioral health delivery model, with some consideration that although an insurance model can be effective for some sector of the Medicaid population, the use of a specialized mental health vendor for adults with serious mental illness and children who have serious emotional disturbances can be more effective, both from an outcomes and cost perspective.
- That the movement towards consumer-directed care is a key step in the revitalization of the system, but this model needs to be specially crafted to meet the needs of this population of consumers, creating the right incentives that truly do influence compliance and outcomes.
- That the development of a comprehensive system would provide an integration of services across all life domains, helping to blend the systems, agencies, and dollars that allow effective, evidence based treatment, performed in a cost effective manner that focuses on building resiliency in families, supporting recovery, and reintegration into the community
- I would like to conclude by quoting the Former Speaker of the House, Newt Gingrich, who stated in his recent testimony to the Medicaid Commission on July 12, 2006:
  - "…[we] must not be bound by the status quo, as successful and potentially successful initiatives may look radically different that what we've seen in the last forty years…"
- We at ValueOptions support the efforts of this Committee and the Commonwealth as we look for ways to enhance and revitalize the Medicaid system; the key is to look ahead, prepare for the future, while learning from the past.

ValueOptions and I thank you for allowing me to bring these key issues to you.

Rick Shinn
Director of Public Affairs
Virginia Primary Care Association
(800) 966-8272 x: 19

Date: August 2, 2006

Virginia Primary Care Association Comments on the Impact of Medicaid Revitalization Efforts in Virginia on Community Health Centers / Federally Qualified Health Centers

Good morning. My name is Rick Shinn. I am the Director of Public Affairs for the Virginia Primary Care Association, representing Federally Qualified Health Centers (FQHCs), commonly called Community Health Centers (CHCs), that provide primary health care services in medically underserved areas of the Commonwealth. Our members operate 73 health care sites across Virginia, with the mission of helping those persons and communities most in need. As non-profit community based safety net providers, twenty percent of our patients, eighteen percent of total revenues, and thirty-two percent of revenues derived from services comes from Medicaid. Change to Medicaid is obviously an issue that is significant to our patients and our centers.

Florida has often been mentioned during discussions on Medicaid Revitalization. To let you know, in Florida, the community health centers were invited to be actively involved at the state level during their discussions, and the state embraced several of the concepts of their community health centers. Even the Governor of Florida has embraced FQHCs as a partner in their reform. The Florida Section 1115 waiver incorporated several items related to FQHCs – our request is that this committee and DMAS look to community health centers as a partner in this effort, since we provide primary care to a large portion of the Medicaid population in Virginia.

Critical to the financial stability of our Federally Qualified Health Centers and look-alike programs is the special consideration in federal regulations on reimbursement for Medicaid to FQHCs. With Medicaid reform, there is a grave concern that reform efforts may either intentionally, or more likely by oversight, harm the financial stability of FQHCs, a critical part of the health care safety net in Virginia. The “wrap-around” system that Virginia uses to work with FQHCs needs to be protected.

FQHCs by definition only work in medically underserved areas or with medically underserved populations. Hence, all Medicaid managed care networks should be required to contract with FQHCs and their sites in those areas. This is another feature of the Florida plan.

Once interesting feature in Florida is that they were able to obtain a Section 1115 waiver that established a Low Income Pool. Not limited to hospitals only, this pool was designed so that providers with certain high levels of uninsured would also be able to use those funds for provider services. Virginia should seriously consider this as a viable option for handling the ever pressing issue of how to provide services to those lacking health insurance. With the data available from FQHCs, distribution of these funds could be managed equitably to ensure that areas with high rates of uninsured would be targeted. I believe the amount that Florida allocated was capped at one billion dollars per year for the next five years.

On enhanced benefits plans, Florida has given special status to FQHCs and included FQHC visits as a credit towards their Enhanced Benefits Accounts. The rationale for this is that FQHCs provide a true medical home, a continuity of care, and a range of services designed to reduce the costs of health care. As an example, one of these programs is our Health Disparities Collaboratives, designed to target specific high cost high incidence disease. Currently, we operate health disparities collaboratives for diabetes, cardiovascular, asthma and prevention. Over half of our health centers offer these programs, with two additional organizations planning to offer these programs this fall. We would urge Virginia to consider the benefits of working with our community health centers in the area of disease management.

In addition, Florida has actually decided to contract with their community health centers for their disease management model and some of the HMOs in Florida will be contracting to use that model through their systems as well.

The quality of care and disease management programs implemented by Community Health Centers have been noted in various studies and articles. Our health centers can be an instrumental asset in helping the Commonwealth as it seeks to contain costs and to improve service delivery, particularly for those who are considered medically underserved. At least one study has noted that community health centers lower the cost of provider services to Medicaid recipients by 30%. CHCs have been recognized nationally for their ability…"to ensure quality care at lower costs by providing a regular source of primary & preventive care services, thus, reducing ER use and avoidable hospitalizations…" as noted by the Kaiser Commission on Medicaid & the Uninsured (March 2006.)

Since so many of our patients are Medicaid recipients, an area of concern for FQHCs is the potential impact on reimbursement and the potential impact on the financial stability of community health centers. A portion of the funding for our centers comes from federal Section 330 grants, designed to help bring health care services to the uninsured and poor in Medically Underserved Areas. In order to safeguard those funds from subsidizing other federal programs, Congress has passed regulations that govern reimbursement for FQHCs. This reimbursement system is critical to insure the financial stability of our health centers, and in continuing the mission of serving those in need.

We ask that special consideration be given to this issue, and that protections for FQHC and FQHC look-alike programs be covered in any bills, statutes, waivers, state plan amendments and regulations that may guide Medicaid reform in Virginia. We are willing to work closely with this committee, with DMAS and with the General Assembly on this effort.

One of the goals of revitalization is to look at ways to contain the growth of Medicaid expenditures. As a way to help providers manage costs, an area that needs to be fully discussed is the implementation and utilization of electronic health records. Our centers are currently exploring this issue, and estimate that the cost will be approximately two million dollars for state-wide implementation in community health centers, not including any special modifications or other needs to meet potential standards that may be developed for handling Medicaid records. This represents an enormous cost to non-profit safety net providers.

Our Community Health Centers/FQHCs are not opposed to reform. We simply ask that our Community Health Centers/FQHCs be a partner with the state in guiding this reform, and that community health centers also be asked for input on reform efforts. We need further, detailed discussion with this committee and DMAS on these critical issues for Community Health Centers/FQHCs. Please call upon us for any additional information we can provide as we work together to meet the needs of the Commonwealth and her citizens.

Kindest regards,

Rick Shinn
Director of Public Affairs
Virginia Primary Care Association
(800) 966-8272 x: 19

Comments from the March of Dimes

8.2.06

Sara Long, Director of Program Services
March of Dimes, Virginia Chapter
804-968-4120

DMAS revitalization committee re: Prenatal Care Coverage

- I am Sara Long, Director of Program Services for the Virginia Chapter of the March of Dimes. I want to discuss prenatal care coverage for pregnant women in Virginia.

- The March of Dimes believes that prenatal, delivery and postpartum services should be provided to every pregnant woman. Because women who receive prenatal care generally have better birth outcomes, prenatal care is extremely cost effective.

- Appropriate maternity care is critical to ensuring that every new baby is born as healthy as possible. Women who receive prenatal care are more likely to have access to services that identify problems early and may help improve the health of both mothers and babies.

- The March of Dimes estimates that 15% of women of childbearing age in Virginia are uninsured.

- The March of Dimes hopes the committee will recommend expanding access to prenatal care for low-income women by increasing eligibility for FAMIS Moms to 200% of the federal poverty level, which is currently at 166% of FPL.

- In addition, the March of Dimes proposes that two provisions be added: to provide FAMIS Moms coverage up to three months prior to the date of application and to provide automatic eligibility for all newborns of women enrolled in FAMIS Moms. An alternative to the second provision would be retroactive coverage for newborns that apply for FAMIS a few months after birth.

- Thank you for this opportunity to comment.

Alternative and Innovative Approaches to Prescription Drug Health Care Delivery under Virginia Medical Assistance

August 2006

Medicaid Revitalization Committee
Department of Medical Assistance Services
600 East Broad Street
Seventh Floor Conference Room
Richmond, Virginia 23219

National Association of Chain Drug Stores (NACDS)
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www.nacds.org

Members of the Medicaid Revitalization Committee:

Thank you for allowing the National Association of Chain Drug Stores (NACDS) to suggest alternative and innovative approaches to prescription drug health care delivery under the Virginia Medical Assistance Program.

NACDS represents the nation's leading retail chain pharmacies and suppliers, helping them better meet the changing needs of their patients and customers. Our members operate more than 35,000 pharmacies, employ 108,000 pharmacists, fill more than 2.3 billion prescriptions yearly, and have annual sales of over $700 billion. In Virginia, NACDS represents 19 chain pharmacy companies with almost 1,000 retail pharmacies, employing almost 101,500 employees, including more than 2,800 pharmacists. NACDS companies pay over $957 million in total taxes to the state of Virginia annually.

Real Medicaid Reform Requires Targeted Solutions

For Medicaid Reform to produce greater efficiency, quality of care, and lasting savings in the delivery of prescription drugs, it must employ targeted solutions. Medicaid must adopt new incentives for providers to implement more flexible and more effective disease management and chronic care programs, particularly for these aged beneficiaries and beneficiaries with disabilities and chronic illnesses. Efforts to better coordinate care should be supplemented with technologies that allow for more efficient methods of collecting and sharing information. New technologies can improve safety and quality in patient care by helping to coordinate care and avoiding duplication of services.

By federal law, all state Medicaid programs are required to have drug utilization review (DUR) programs. These include prospective programs that screen for such issues as drug-drug interaction and drug allergies, as well as retrospective programs that review claims data to identify fraud, abuse, or physician prescribing patterns that reveal inappropriate or medically unnecessary treatments. States should strengthen their Medicaid drug utilization review (DUR) programs by requiring interventions intended to encourage appropriate, safe, and cost-effective prescription drug use. Generally, DUR programs should observe patterns of drug use and costs, compare the results to peer-reviewed standards, and provide information to physicians, pharmacists, or health plan sponsors with the goals of correcting drug utilization problems and minimizing the likelihood of adverse patient health outcomes.

Many Medicaid beneficiaries take five or more drugs each month. When multiple drugs therapies are prescribed, the risks of adverse drug reactions and interactions increase exponentially. DUR programs can help to identify high-end users of prescription drugs, providing opportunities for intervention with the prescribing physicians or the patients themselves. A focus on high-cost users, especially those prescribed

many different drugs (poly-pharmacy), has the potential for producing both cost savings and quality improvement.

In particular, physician profiling programs identify doctors whose prescribing practices vary dramatically from their peers or show drug-specific variations, such as when a physician regularly prescribes a brand name version of an off-patent drug where the off-patent drug is more often prescribed by other physicians. Physician profiles also may identify how well individual physicians adhere to treatment guidelines and preferred drug lists.

Finally, it is important to build upon existing state initiatives in addressing Medicaid reform. The solutions that we recommend to the Department of Medical Assistance Services – medication therapy management, pharmacy-assisted collaborative disease management, and the use of e-technologies – are well-tested in Medicaid and other public and private drug benefit programs and have been shown to produce significant savings. Successful adoption of these initiatives will ensure that Virginia Medicaid beneficiaries receive high-quality, safe, and effective drug benefits at lower costs, a wining combination for reform.

Proposal 1: Expand Use of Medication Therapy Management and Collaborative Pharmacy-Assisted Disease Management in Medicaid Programs

Better management of care – including pharmacy benefits –improves quality of care and patient safety and presents the potential for considerable savings.

Medication therapy management and face-to-face disease management programs focus interventions on helping patients with complex, chronic, and costly medical conditions (such as diabetes, asthma, and smoking cessation) to better understand how to manage their drug therapies and diseases or conditions. Those patients most at risk for medication errors and adverse reactions can be identified and their therapy managed by a pharmacist working with the primary care provider.

Disease management programs typically focus interventions on patients with complex chronic medical conditions, especially those with a high risk of complications and co-morbidities such as diabetes and asthma. There are at least 30 states, including Virginia, with existing Medicaid disease management programs. In addition, over half of private employers with employee health plans report that they offer disease management to their employees.

These programs, such as Virginia's, tend to be broader in scope, focusing on management of the full range of treatments for these patients. Disease management programs may employ or contract with physicians or specialists, nurses or nurse practitioners, or pharmacists in guiding patients to manage their diseases. However, these providers may be located in other states, and disease management services may be provided by phone, rather than face-to-face.

Medication therapy management (MTM), on the other hand, is more targeted, and is primarily intended to optimize health outcomes by helping patients better understand their drug therapies and improve adherence to prescribed regimens using existing pharmacy providers. MTM gained widespread public attention when Congress mandated that it be offered as a service by plans participating in the new Medicare Part D benefit.

Over the last decade, several states have implemented MTM programs and pharmacy-assisted disease management programs for Medicaid beneficiaries. These programs typically focus interventions on patients with complex chronic medical conditions, especially those with a high risk of complications and co-morbidities, such as diabetes, kidney disease, asthma and other chronic pulmonary diseases, or chronic heart disease. They also take a collaborative approach, with the pharmacist and primary care provider working closely and meeting face-to-face with the patient to ensure that medications prescribed are appropriate to the disease or conditions being treated, and do not create additional health issues via adverse reactions or drug interactions. These programs manage not only the patient's disease or condition, but also

the medications used to treat the disease or condition. They have a notable track record for achieving significant savings.

Given that Part D requires MTM for high-use, high-cost Medicare beneficiaries using multiple medications – including many dual eligibles that will still be covered by Medicaid for other services such as long-term care – a logical extension would be to apply the same MTM requirements to high-use, high-cost beneficiaries on multiple medications who remain in Medicaid. One could even argue that the anti-discrimination provisions of the Medicaid law imply that non-dual Medicaid beneficiaries should be able to access the same MTM or pharmacy-assisted disease management services available to duals.

Virginia Healthy Returns: In June 2004, the Virginia Medicaid program implemented a pharmacy-assisted disease management program using pharmacists and nurse consultants as program advisors for beneficiaries with just two disease states – coronary artery disease and congestive heart failure. A 10-month review published in September 2005[1] reported improved results in 9 of 12 clinical outcomes, including reduced LDL and blood pressure levels. The report indicated that self-care practices – including blood pressure control, weight monitoring, and adherence to a sodium-restricted diet – had improved and, as a result, the rates of use of ACE inhibitors and beta blockers had declined. There was also a decline in rate of use observed for quinolones, non-sedative barbiturates, analgesics, and antihistamines. The number of inpatient hospital admissions among participants was down 5 percent, as was the duration of admissions.

Overall expense per beneficiary per month had dropped by $23, which led to a two percent gross savings for the Healthy Returns program. This savings was driven primarily by the $17 per beneficiary per month decline in overall pharmacy expenses.

Clearly, the state's positive experience with the Healthy Returns program would justify the expansion of that program to address additional disease states and conditions.

Other Examples of State Medicaid MTM Programs

Medicaid MTM and pharmacy-assisted disease management programs in Mississippi, Iowa, and Missouri also have proved successful in managing costs. These programs pay pharmacy providers on a per-encounter basis for the additional services provided to enrollees. A third program was implemented in Minnesota in April of this year. A fourth program, implemented in North Carolina in June, is reimbursing participating pharmacies on a monthly basis.[2]

Mississippi Medicaid: Mississippi was the first state in the nation in 1998 to receive federal approval to provide reimbursements for pharmacists for MTM encounters. Under the Mississippi program, pharmacists evaluate patients, review drug therapies with doctors, and educate patients about managing the disease and adhering to the drug regimen. Pharmacists are authorized to make up to 12 visits per patient per year, offering counseling and drug therapy management relating to asthma, diabetes, anticoagulation, and hyperlipidemia.

Iowa Medicaid Pharmaceutical Case Management Program: The Institute for the Advancement of Community Pharmacy worked with the Iowa Medicaid program in 2000 in implementing the Iowa Medicaid Pharmaceutical Case Management (PCM) Program, after funds were appropriated by the state legislature. Services under the Iowa program are provided by pharmacist-physician collaborative teams.

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[1] *Healthy Returns Care Management Program: Annual Report*, Commonwealth of Virginia Department of Medical Assistance Services, September 2005,

[2] Under the Mississippi waiver program, Medicaid pays a flat $20 fee for 15- to 30-minute patient encounters. Under the Iowa and Missouri programs, pharmacists are paid $75 for the patient's initial and annual assessment and $40 for problem follow-up assessments, as well as $25 for preventative assessments. The Minnesota program is paying Minnesota $54 for the first patient encounter and $32 for a limited number of follow-up encounters. The North Carolina program will reimburse those pharmacies that agree to accept locked-in beneficiaries for MTM services at $10 per month per beneficiary.

Medicaid enrollees are eligible to participate if they take four or more regularly scheduled non-topical medications, are not nursing home residents, and have at least one of twelve select disease states (congestive heart failure, ischemic heart disease, diabetes mellitus, hypertension, hyperlipidemia, asthma, depression, atrial fibrillation, osteoarthritis, gastroesophageal reflux disease, peptic ulcer disease, and chronic obstructive pulmonary disease.) Participating providers receive lists of eligible patients being treated in their practices. Pharmacists also may contact patients to urge them to participate, or may contact patients' physicians to discuss pharmaceutical case management.

In its first year, 117 pharmacies from all areas of the state participated, meeting with 943 (31 percent) of the 3,037 patients deemed eligible for the program. Pharmacists detected an average of 2.6 medication-related problems per patient, recommending a new medication 52% of the time and discontinuation of a medication 33% of the time. Patients receiving PCM services had a 12.5% improvement in the Medication Appropriateness Index (MAI)[3], with a 24% decrease in the inappropriate use of medications among beneficiaries 60 years of age or older.[4]

Missouri Medicaid Pharmacy-Assisted Collaborative Disease Management Program: In July 2003**, t**he state of Missouri undertook a pharmacy-led disease management program for Medicaid beneficiaries with asthma, depression, diabetes, and a history of congestive heart failure, choosing those beneficiaries for participation who were most at risk. Medicaid enrollees with at least one of those diagnoses can be voluntarily enrolled. Once an enrollee candidate is identified, the Department of Medicaid Services recruits the beneficiary's primary care provider and the pharmacist normally used to fill the beneficiary's prescriptions, asking those providers to work in a collaborative mode. After the physician and pharmacist conduct their own assessments, the providers are encouraged to have at least one initial face-to-face meeting. Following that initial provider meeting, disease management is provided through patient face-to-face meetings with one or both providers, depending on the issues to be discussed.

The Missouri program in its first year utilized the services of 318 physicians and 290 pharmacists, focusing on 1,203 high-risk patients with asthma, diabetes, heart failure, depression, and related co-morbidities. At the end of that year, state Medicaid officials estimated that per capita annual program expenditures had been reduced by $6,804 and they projected annualized program savings of $2.4 million.[5] The patients showed a 7.6 percent reduction in health care utilization, including fewer hospitalizations, fewer emergency room visits, lower prescription drug utilization, fewer office visits, and lower per-month expenditures.

Minnesota Medicaid Medication Therapy Management Program: As noted above, the Minnesota legislature in its First Special Session of 2005 enacted legislation requiring the establishment of a Medicaid medication therapy management program. The Minnesota Department of Human Services (DHS) implemented MTM guidelines in April of this year, utilizing the *Core Elements of an MTM Service* model developed jointly and published in April 2005 by NACDS and the American Pharmacists Association (APhA). That model describes the MTM services that can be provided by community pharmacies, and is designed to improve care, enhance communication among patients and providers, improve collaboration among providers, and optimize medication use for improved patient outcomes.

Minnesota Medicaid beneficiaries are eligible for the program if they:

- Are taking four or more prescriptions to treat or prevent two or more chronic medical conditions; or

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[3] The MAI employs implicit criteria to judge the appropriateness of medication prescribing. It measures the following key areas of desirable medication use: 1) medication indication, 2) effectiveness, 3) dosage, 4) correct directions, 5) drug-drug interactions, 6) drug-disease interactions, 7) expense, 8) practical directions, 9) therapeutic duplication, and 10) duration. The MAI does not measure adverse indications or patient medication compliance.

[4] *Iowa Medicaid Pharmaceutical Case Management Program, Report of the Program Evaluation,* University of Iowa Colleges of Public Health, Pharmacy, and Medicine, December 2002.

[5] *2006 Disease Management Directory & Guidebook*, "Pharmacist-Led DM Delivers Clinical, Financial Dividends, pp. 7-10, and Missouri Medicaid DM Program Shows Positive First-Year Outcomes, pp. 583-84.

- Have drug therapy issues identified by DHS that have resulted in, or will likely result in, significant non-drug Medicaid costs.

Maryland P3 Diabetes Disease Management Program: In February 2006, the University of Maryland School of Pharmacy, the Maryland Pharmacists Association, and Maryland Medical Assistance unveiled P3, a disease management program for diabetics living in Maryland's Allegany County. Under the program, trained pharmacists teach diabetic Medicaid beneficiaries and employees of private employers how to use blood glucose monitors correctly, and they provide counseling aimed at helping the diabetic patients better control their disease. The pharmacists meet with participants regularly to review blood sugar readings and discuss the participant's condition, setting goals in collaboration with physicians. The monitor, other diabetes supplies, and diabetes-related medications are free to participants. The employer or the Medicaid program pay for the pharmacy visits and any prescription drug co-pays. The Maryland Pharmacy School provides supplemental training to the participating pharmacists.

North Carolina Lock-In Program: The North Carolina Medicaid program implemented, in June 2006, a pharmacy lock-in program for beneficiaries taking more than 11 medications per month. This program reimburses those pharmacies that voluntarily agree to participate in the program for providing MTM services to beneficiaries designated for lock-in. Beneficiaries are locked in to receiving their medications and MTM services from the pharmacy from which they normally receive pharmacy services. The participating pharmacies are to be reimbursed on a per-patient per-month basis. (This program differs from the Virginia Client Medical Management Program which locks-in beneficiaries to primary care physicians or primary pharmacies when there are indications of beneficiary fraud and abuse.)

Pharmacy Coalitions Have Been Working to Create an MTM Model

NACDS is part of a coalition known as the Pharmacy Quality Alliance (PQA) that also includes the Centers for Medicare and Medicaid Services (CMS), the National Community Pharmacists Association (NCPA), and America's Health Insurance Plans (AHIP) and others. One purpose of that alliance is to develop strategies for optimizing patient health outcomes using pharmacy services, for example by helping Medicare Part D enrollees with multiple illnesses understand how to use their medications, thereby improving their compliance with medication treatment regimens and reducing overall health care costs for Medicare enrollees. The strategies produced are likely to build on the *Core Elements of an MTM Service* model.

MTM is most effective when conducted face-to-face in interactions that provide the pharmacist with the optimal opportunity to observe signs of and visual cues to the patient's health problems, including adverse reactions to medications and problematic interactions between medications. The pharmacist's observations produce early detection of medication-related problems that can reduce emergency room visits, hospitalizations, and abuse of medications.

Proposal 2: Expand Use of E-Prescribing and Related Technologies

As the federal Medicaid Commission has correctly observed, health information technology can be used to (1) monitor and improve safety and quality, (2) control costs, (3) simplify program administration, (4) improve data collection, and (5) improve patient coordination among multiple providers. In summary recommendations now under consideration, the Commission has suggested that federal incentives should be provided to encourage the states to implement e-prescribing and other e-technologies.

E-prescribing is the use of electronic systems to generate prescriptions and transmit prescription information between prescribers, pharmacists, and payors such as Medicaid programs (or their designated fiscal intermediaries). The Medicare Modernization Act and the regulations adopted under that act require that prescribers and dispensing pharmacies comply with federal e-prescribing standards for drugs covered under Medicare Part D that are prescribed to Part D-eligible individuals. Because these mandated e-standards already apply to the prescriptions dispensed to dual eligibles under Part D, considerations of administrative efficiency would seem to dictate that they be extended to apply equally to non-dual Medicaid beneficiaries.

E-technology is a term sometimes used to describe systems that offer additional tools to make prescribing safer and more efficient. Basic e-prescribing systems typically provide physicians with a drug database for prescribing, check prescriptions against a formulary, and screen for drug-drug interactions with other drugs prescribed using the system. More extensive e-technology may include patient profiles that associate diagnoses with prescriptions, screen for drug allergies or drug-disease warnings, and offer additional drug reference capabilities.

These automated systems can provide several benefits to Medicaid programs:

- Increased accuracy and patient safety due to computer generation of legible, consistently formatted prescriptions, and screening for potential interactions;
- More efficient methods for monitoring patient history, and the reduction or elimination of poly pharmacy, fraud, and abuse;
- Better formulary compliance, with checks performed at the point of prescribing;
- More efficient communication with pharmacies, with a reduced need for calls to physicians to clarify information from handwritten or telephoned prescriptions; and
- Improved patient satisfaction due to the rapid filling of prescriptions, with fewer errors.

In 2004, Florida Medicaid contracted with a private company to provide handheld, wireless devices to 1,000 high-volume prescribers. The devices provide the Medicaid PDL, 60-day patient-specific prescription histories, and drug utilization reports (interaction reports, etc.). An expansion of the program that began in January 2005 eventually provided devices to a total of 3,000 prescribers and expanded the patient prescription histories to 100 days. In the program's first year, Florida Medicaid observed an absolute reduction of four percent in significant drug interactions, with cost savings of about $700 per month for each physician enrolled in the program (about $8.4 million in savings annually). By March 2006, the Florida Agency for Health Care Administration was reporting savings of $825 per physician per month.

There are over 19,700 non-federal practicing physicians in Virginia. If just 10 percent of those physicians were to utilize e-prescribing technology similar to that used in Florida, Virginia could see savings of $19.5 million to $35.5 million.

Conclusion

NACDS believes that the adoption of these specific approaches to Medicaid revitalization – greater use of medication therapy management and an expansion of pharmacy-assisted collaborative disease management, and e-prescribing technology and related e-technology systems – would mean better patient outcomes for Virginia's Medical Assistance population and significant savings for the Commonwealth's Medicaid program. We strongly encourage the Medicaid Revitalization Committee to include these measures in any Medicaid reform package.

Thank you for the opportunity to comment.

August 1, 2006

TO: Medicaid Revitalization Committee

FROM: Jacqueline D. Hale

SUBJECT: Public Comment

Hello. My name is Jacqueline Hale, and I am a Program Coordinator at REACH, a Richmond-area non-profit dedicated to increasing access to affordable healthcare for uninsured and underinsured persons in our community. REACH is a partnership of safety net providers and others working together to develop a more coordinated model of caring for uninsured persons in metro Richmond. Thank you for the opportunity to share my thoughts.

The rates of uninsured Virginians range from 6.3% for people who were uninsured all year, to 11.5% for those that were uninsured at some point during the year (VDH, 2005). These uninsured Virginians live in our neighborhoods, and they work in our communities. They raise families, and their children attend our schools. They live sicker, and die younger than people that do have health insurance. This is a crisis that has reached national proportions, and in Virginia it affects just over 1 million people.

More than half of uninsured, adult Virginians work more than 35 hours a week and most Virginians without health insurance are 19 – 44 years old (VDH, 2005). Why are they uninsured? In Virginia, private, employer-based insurance accounts for the majority of coverage (VDH, 2005). Unfortunately, increasing healthcare costs and insurance premiums are forcing more businesses to decrease or drop their coverage for employees altogether, adding a substantial burden to the healthcare "safety net" that exists to provide care for the uninsured.

Virginia's safety net is comprised of free clinics and community health centers, Virginia Commonwealth University and University of Virginia Medical Centers, and others with a mission to care for underserved persons. The majority of these vital organizations are privately funded – supported by grants from the federal government, local foundations, and other generous donors. The "safety net" began as a temporary solution to care for the growing numbers of uninsured in Virginia, but has since evolved into a permanent fixture in our healthcare landscape.

The typical uninsured resident, for whom employer-based coverage is not an option, relies on this "safety net", or hospital emergency rooms, to provide care when they absolutely need it – they are less likely to seek out and receive preventive care. They are more likely to be diagnosed at more advanced disease stages**,** and less likely to receive needed therapeutic care, including medicine and surgery. The economic vitality of our community is compromised by the poorer health, premature death, and long-term disability of uninsured residents.

In other states, there are alternatives for these uninsured residents, specifically for parents whose children are already enrolled in Medicaid or a children's health insurance program. But in Virginia, very few low-income adults have the option for coverage through a public program.

Virginia's publicly supported infrastructure to care for the uninsured is very different from many states. Virginia only offers public health insurance programs (i.e., Medicaid) to children and pregnant women in low-income families, or to adults who are *very* poor, aged, blind or disabled.

Virginia's Medicaid coverage for low-income adults is only available to extremely low-income adults who are parents of children on FAMIS Plus, or caretakers of older residents who are also on Medicaid. Hardly any low-income parents/caretakers qualify, as the income guidelines are so low that it is unbelievable for a family to exist on the allotted income. For instance, a family of three living in a rural area can only have income amounting to a meager $307/month, $337/month for a family in an urban area, or $410/month in Northern Virginia.

In comparison, the Federal Poverty Level, or FPL, for a family of three is $1,383/month. Thus, in Virginia, parents/caretakers must earn less than 30% of the Federal Poverty Level to meet the eligibility requirements for Medicaid coverage. These eligibility requirements – for the median range – are the 10th lowest in the United States.

Medicaid in Virginia is not a readily available coverage option for low-income adults. While Virginia has expanded coverage to pregnant women and made FAMIS/FAMIS Plus more accessible for families with children, advocates have not succeeded in their tireless efforts on behalf of low-income, uninsured adults. Many of these adults are parents of children enrolled in FAMIS/FAMIS Plus. These parents are employed, and while their income falls within the more flexible guidelines for FAMIS/FAMIS Plus, there is no public insurance program in Virginia to support them. The parents are caught between a rock and a hard place – they make too much for public coverage, and too little to afford private health insurance.

Parents who have health insurance are less likely to miss work due to illness, and are more productive on the job. Insured parents won't worry about going to the doctor, dentist or filling a prescription. Most importantly, parents that have insurance can set a good example for their children by regularly seeking preventive care, and making healthier decisions for the entire family. This will reinforce other messages from the Commonwealth – like the Department of Health and Medical Assistance Services – about the importance of accessing healthcare when needed, and will ensure that more residents understand the value of preventive care and healthy living.

Other states have tackled this issue, expanding Medicaid or children's health insurance programs to parents of children enrolled in state-sponsored coverage programs. A report by the Commonwealth Fund finds that inclusion of low-income parents in these coverage programs not only reduces the number of uninsured adults, but can also increase the number of covered children (*Health Insurance: A Family Affair*, *2001*). Expanding FAMIS/FAMIS Plus to cover low-income parents of enrolled children is an effective way to increase covered lives in Virginia, and ultimately improve the health status of families throughout the Commonwealth.

Expanding coverage to low-income parents is not only effective, it is more cost efficient, as well. As it stands today, the cost of caring for the uninsured is borne by all Virginia residents. Public support from Federal, state and local governments (i.e., Virginia taxpayers) accounts for 75 - 85% of the total value of uncompensated care provided to persons without health insurance each year. In addition, Virginia's insured residents directly subsidize the cost of caring for the uninsured through increases in their health insurance premiums in their employer-based coverage. Families USA estimates that $734 of a family policy premium for an employee at a corporation in Virginia goes towards the cost of caring for the uninsured (Families USA, 2005).

It is not fiscally responsible for Virginia and its residents to continue funding care for the uninsured in this manner; it is not working. Uninsurance weighs heavily on the minds of the vast majority of Virginians. In 2004, about 8 in 10 of the state's insured population said they were fearful about not being able to continue to afford health insurance (VDH, 2005). It is time for change, it is time for this committee to effect that change.

REACH urges this committee to take expansion of public coverage to low-income parents into serious consideration. The effect of more covered lives in Virginia will be seen in all sectors: lower uncompensated care costs for taxpayers and health systems, smaller increases in premiums for employer-based coverage, additional coverage of children of low-income parents, and improved access to healthcare for the uninsured. All this results in a Virginia with happier, healthier families, a more productive workforce, and energized communities.

Sincerely,
Jacqueline D. Hale
Program Coordinator
REACH

Testimony to Medicaid Revitalization Committee
Lisa Specter-Dunaway
CHIP of Virginia

Members of the Medicaid Revitalization Committee: Good morning. My name is Lisa Specter-Dunaway, President of CHIP of Virginia. Thank you for the opportunity to comment on your draft report.

In reviewing the report, I would like to provide the following recommendations to improve health outcomes for Virginia's children.

1. Expand Disease Management Requirements for Medicaid MCOs

   CHIP programs have partnered with Medicaid MCOs to address premature births and asthma. In both cases we have been able to show favorable outcomes for the families as well as significant cost savings.

   With our Partners in Pregnancy initiative, Sentara claims records indicated a dramatic reduction in NICU Paid Amounts per Admission and NICU Average Length of Stay (ALOS). Based on a cost avoidance model, NICU costs were reduced by $2.3 million while more than 1,600 NICU days were avoided.

   The program is currently in the final stages of a Center for Health Care Strategies Best Clinical and Administrative Practices comprehensive evaluation. Preliminary data appear to support that the investment in additional services (such as CHIP provides) for high risk moms results in reductions in the health care costs for the child in the first year of life.

   This has also been the case with a Virginia Premier Asthma project where after disease management education through CHIP nurses and community health workers, ER visits dropped dramatically.

   These strategies work.

2. Expand Coverage for Pregnant Women

   Since the FAMIS MOMS program was created by the General Assembly, income eligibility has increased from 150% to 166% FPL. We applaud the General Assembly for creating this program and for the increase in eligibility this past session. The program works in supporting low-income women's access to prenatal care, but the income eligibility level should increase to 200% of the FPL. This would align the coverage with that for infants and should further improve pregnancy outcomes and infant health resulting in fewer long-term health care costs for the babies.

   CHIP programs have seen a significant increase in pregnant women who are not citizens. The majority of these women are not eligible for FAMIS MOMS or Medicaid until delivery when most of their babies will be covered. Regardless of their citizenship status, it makes fiscal sense to provide prenatal coverage that can improve the health of our youngest citizens. Prenatal care is a significantly less expensive service than the NICU, early intervention services, or other preventable treatments and could result in significant long term financial costs for the Commonwealth.

3. Automatically enroll babies born to FAMIS Moms.

   When a FAMIS Mom delivers her baby, the infant is not automatically enrolled into the FAMIS, FAMIS Plus or Medicaid program. A signed application must be received within the month in which the baby is born to ensure that birth-related expenses will be covered if the baby is found eligible. The job of a new mother is one of the most difficult. The Commonwealth should use the existing technology to automatically enroll these children, especially given the challenges presented by the DRA.

4. Increase the use of EPSDT

EPSDT is a critical, but underused service in Virginia. DMAS has done an exceptional job increasing access to dental care through Smiles for Children. Although the rate increase for services was a critical part of their success, it is a good example of what can be done. I urge you to examine what can be done to further educate pediatricians, family practitioners, outreach workers and other health professionals about the value of EPSDT.

Again, thank you for the time you've invested in this process. Improving access to preventive health care services will not only save the Commonwealth money in the long term, it is the right thing to do.

Submitted by:
Lisa Specter
President and CEO
CHIP of Virginia
701 E. Franklin St.
Suite 502
Richmond, VA 23219

Appendix D:

Florida Medicaid Reform

Component	FLORIDA - Description
Reform Authority	Section 1115(a)(1) Research and Demonstration Waiver
Reform Name	Florida Medicaid Reform
Time Frame	• Approved by CMS October 19, 2005. • 5-year period: July 1, 2006 – June 30 2011 • Phase I—July 1, 2006 Implementation in 2 Counties: Broward and Duvall. Within 1 year, expansion to 3 additional counties: Baker, Clay, and Nassau. • Phase II—If legislature approves, based on experience in Phase I, expansion to additional geographic areas. • Phase III—Expansion statewide by June 2010.
Goals	• Patient Responsibility and Empowerment • Marketplace Decisions • Bridging Public and Private Coverage • Sustainable Growth Rate
Main Program Elements	• Risk-Adjusted Premiums • Enhanced Benefit Accounts (EBA) • Employer-Sponsored Insurance (ESI) • Low-Income Pool (LIP)
Quick Summary	• The State will develop risk-adjusted premiums for Medicaid enrollees. This caps the amount the state will spend on a beneficiary for any given year. • Health Plans will offer all mandated benefits, but can tailor their scope to meet the needs of specific Medicaid groups. • Beneficiaries can choose the plan that best meets their needs. By participating in activities that promote healthy behavior, beneficiaries earn credits which can be used to purchase additional services, such as over-the-counter drugs. • Beneficiaries can also choose to enroll in their employers' plan with the State contributing toward the cost of that plan up to the Medicaid premium amount.
Populations Covered (Initially)	Mandatory Participants: • TANF and TANF-related group--1931 Eligibles o Families under 23% of FPL o Poverty-related children with income above TANF limit: ▪ Up to age 1, up to 200% FPL ▪ Up to age 6, up to 133% FPL ▪ Up to age 21, up to 100% FPL (All are mandatory Medicaid eligibles except poverty level children up to age 1 with income between 185% and 200% of FPL) • Aged and Disabled—SSI cash assistance (75% of FPL) and children eligible under SSI.

Component	FLORIDA - Description
	Voluntary Participants: (Mandatory enrollment of these groups will be phased in) • Foster children • Individuals with developmental disabilities • Children with special health care needs • Individuals residing in institutions • Individuals in hospice-related group • Pregnant women above 1931 poverty level • Dual eligible individuals Enhanced Benefit Account • Individuals under 200% of FPL can continue to access EBA benefits after losing Medicaid eligibility.
Enrollment	• Newly Medicaid eligible will be enrolled upon becoming eligible • Current enrollees will enroll in reform plan at the time of eligibility re-determination or open enrollment period.
Service Providers	• The Health Plans can be Managed Care Organizations, Provider Service Networks, or Employer-Sponsored Plans.
Benefit Packages	• Benefits received determined by the group an individual is in, and by the Plan chosen. • Health Plans must cover all mandatory State Plan services. • For children under 21, pregnant women, and emergency services, service limits cannot be more restrictive than State Plan limits. • For other populations and services, plans can change the amount, duration and scope of State Plan services to tailor it to particular population, but revised benefit package must be actuarially equivalent to the current State Plan package and State must certify that it meets a benefit sufficiency standard. • Benefits divided into comprehensive and catastrophic benefit packages Comprehensive Benefits • Services which most people need. Represents dollar amount equivalent to 90% of historical Medicaid expenditures. • The premium covers 100% of the cost of care up to established comprehensive care threshold, and then the catastrophic benefit premium covers additional care. Catastrophic Benefits • For unusually high costs incurred by an enrollee during a given year. Expected to represent less than 10% of the aggregate premium. • Catastrophic benefit threshold is triggered by either a pre-determined dollar threshold or an inpatient day threshold. • If MCO accepts financial risk, it receives catastrophic premium and pays for catastrophic care up to annual limit. If MCO does not accept risk, State becomes a re-insurer and pays MCO Medicaid fees for catastrophic level care. Enhanced Benefits Account (EBA) • For clients that participate in State-defined activities that promote healthy behavior, State deposits funds into an EBA account which can be used for additional services such as over the counter drugs or vitamins. Employee Sponsored Insurance • Medicaid clients can voluntarily opt out of Medicaid coverage and enroll in their

Component	FLORIDA - Description
	employer's health insurance plan. • State pays up to the amount it would have paid to cover recipient under Medicaid. (If ESI premium is higher, client pays the difference.) • State does not provide any wrap-around. (State does not pay difference between ESI cost sharing and nominal Medicaid cost sharing, nor does it cover services not covered under the ESI plan.)
Premiums	• State develops aggregate, risk-adjusted premiums based on individuals' age, sex health status. The Aggregate premium is divided into Comprehensive and Catastrophic Care components, based on pre-determined dollar amounts. The annual maximum benefit limit will be applied to all recipients with the exception of children under 21 and pregnant women. (Recipients are responsible for making arrangements for care which exceeds the annual benefit limit.)
Payment to Plans	• Risk-adjusted premiums are divided into comprehensive and catastrophic components. • All plans are at risk for comprehensive component and receive a premium for comprehensive care. Plans can choose whether to cover (be at risk for) catastrophic component. If plan chooses not to cover catastrophic component, the State becomes the re-insurer and plan remits claims to the State for services rendered under this component. • State has built-in safeguards to minimize cost shifting and maximize enrollee care.
Cost Sharing	• ESI participants will have to pay any cost sharing imposed by their employers' plans. All other enrollees will be subject to the same cost sharing restrictions and protections provided for all Medicaid recipients under federal law.
Other	• A Low Income Pool was established to ensure continued government support for provision of health care services to Medicaid, underinsured and uninsured populations. The Pool is a capped annual allotment of $1 billion per year for five years. •
Waivers Requested	• Statewide-ness/Uniformity—(Different delivery systems in certain areas) • Amount, Duration, and Scope and Comparability—(Different intensity of services for mandatory services, and different benefits for those in ESI or EBA groups) • Income and Resource Test—(Greater income/resource limits for EBA group) • Cost Sharing—(Greater cost sharing limits for ESI group) • Freedom of Choice—(Of providers) • Provider Agreements—(Allows non-enrolled providers to provide benefits to EBA group) • Retroactive Eligibility—(Waives 3-month retroactive eligibility) • Eligibility—(Provide only emergency are and nursing home care for up to 30 days from eligibility date until enrollment into MCO. Also allows for ESI group to receive less than State Plan benefits). • Payment Review—(To extent that prepayment review may not be available by individual beneficiaries to their providers.)

Appendix E:

South Carolina Medicaid Reform

Component	SOUTH CAROLINA - Description
Reform Authority	Section 1115(a)(1) Research and Demonstration Waiver (CMS has not yet approved this waiver.)
Reform Name	• South Carolina Healthy Connections •
Time Frame	• Submitted to CMS November 16, 2005. • While waiting for approval, SC hopes to enroll more Medicaid recipients in managed care.
Goals	• Provide more individual choice for Medicaid recipients. • Introduce more competition and choice in the Medicaid system. (Have plans compete by offering array of benefit packages and prices for different groups.) • Produce cost savings and better care for Medicaid recipients.
Main Program Elements	• Personal Health Accounts (PHA) • Self-Directed Plans • Employer-Sponsored Insurance (ESI) • Cost Sharing
Quick Summary	• The State will develop risk-adjusted premiums or Personal Health Accounts (PHAs) that recipients can use to shop around for a variety of providers. State will still pay for services if a recipient exceeds his PHA. • Medicaid beneficiaries will have a choice of enrolling in several different types of health plans including pre-paid plans (MCOs), PCCMs, Employer-Sponsored Insurance, and Self-Directed Plans similar to Health Savings Accounts. Benefits offered will vary by health plan. • The Self-Directed Plans will offer recipients the greatest choice of options and the State indicates that this component will only be offered to individuals who demonstrate that they are capable of managing their own care.
Populations Covered	• All full Medicaid beneficiaries are covered by the waiver except for: dual eligibles, foster care children, and family planning waiver recipients. • Long Term Care Services are excluded from the waiver. • Expansion population: uninsured family members who get coverage when a Medicaid-eligible individual enrolls in their employer’s plan, and individuals that lose eligibility but still have a balance in their PHA and can use that balance for medical services for 12 months or until the balance is exhausted.
Enrollment	• Newly Medicaid eligible will be enrolled in the reform waiver upon becoming eligible. • Current beneficiaries will be enrolled in the reform waiver at the time of their eligibility redetermination.

<table>
<tr><th>Component</th><th>SOUTH CAROLINA - Description</th></tr>
<tr><td>Service Providers</td><td>
<u>Pre-Paid Plans</u>-- Choice of MCO or PPO
<u>Medical Homes Network--</u>PCCM networks with Family Physicians as gatekeepers administered by a formal administrative services organization (ASO). PCP must sign agreement with the State.
<u>FFS--</u>will be maintained for eligibility categories excluded from reform program, while State transitions to reform program, and as an option for disabled children.
<u>Employer/Group Insurance Assistance</u>—Employer-provided plans
<u>Self-Directed Care Pilot Program</u>—Similar to a Health Savings Account. Part of the PHA would pay for a major medical insurance plan (essentially, inpatient services and related care). State will contract with a vendor to provide administrative framework for this component. Hospitals will bill Medicaid on FFS basis as done currently for Medicaid-eligible recipients.
</td></tr>
<tr><td>Benefit Packages</td><td>
Benefits determined by eligibility group and by the health plan chosen.
Services for all children (under 19), regardless of plan, cannot be more restrictive than current Medicaid State Plan services.

<u>Pre-Paid Plans</u>

For adults, package must include, at a minimum: all mandatory services, plus pharmacy and DME. Package must meet the federal requirement for amount, duration and scope. Package may be more limited in scope than the current State Plan for one or more individual services. Thus, the premium charged by the plan may be lower than the PHA for that beneficiary. Beneficiaries may use any residual in PHA for services not covered, or to cover cost sharing.
Children will receive all mandatory and optional services, including EPSDT.

<u>Medical Home Network</u>

Must include all Mandatory and Optional services. Premium is actuarially equivalent to current FFS experience (and requires full PHA).

<u>Employer/Group Insurance Assistance</u>

Whatever services are covered by employer’s plan, with whatever cost sharing employer’s plan has. (No wrap-around provided by the State.)

<u>Self-Directed Care Pilot Program</u>

Catastrophic coverage plus selected screenings and preventive care. Insurance limited to major medical coverage that includes only inpatient hospital coverage and related costs plus preventive services.

<u>Other</u>

Non-emergency medical transportation will be addressed outside of the reform waiver through a regional transportation broker.
Medicaid Services Excluded from the waiver:

Nursing Home Services greater than 28 days
Home and Community Based Services Applicable to the Following Waivers: Elderly/Disabled, HIV/AIDS, Assisted Living, Vent, MR, Head and Spinal Cord Injury.
Non-Emergency Transportation Services
Services Funded by State Agencies
Integrated Personal Care Services
Behavioral Health Services
Residential care Facility Services
SMI Premiums

</td></tr>
</table>

Component	SOUTH CAROLINA - Description
	o PACE Program o Family Planning Waiver Expenditures o Medicaid Disproportionate Share Program o Medicaid Cost Settlements o Transplant Services
Personal Health Accounts (PHAs)	• PHA based on risk adjusted current FFS expenses. • Initially PHAs are for individuals; the goal is to offer family PHAs later. • The value of a beneficiary's PHA is based on the current Medicaid benefit package. • A prepaid plan's premium cannot exceed the value of the benefit package they offer. If the benefit package offered by a plan is not as great in overall scope or value as the current Medicaid program, the plan cannot charge a premium that is equal to the PHA. If the package is less than the current Medicaid package, the beneficiary can use residual in PHA to pay for cost sharing or services not covered by plan. • In the two "Option-Out" programs (ESI and Self-Directed Plan), beneficiaries choose to receive medical care outside the Medicaid program and Medicaid only provides a defined amount of financial support. • For recipients in a pre-paid health plan, the plans are only at risk up to a certain level. After that, the State assumes most of the risk, acting as a reinsurer. If a self-directed participant exhausts his PHA and needs health services, he will be moved into a full service plan. His liability is limited to a defined "gap" amount (out-of-pocket maximum).
Payment to Plans	• Pre-Paid Plans—MCOs or PPOs set the level of benefits and adjust their premium accordingly. State pays the plan up to the PHA amount. State will provide reinsurance: Plan will be at risk for full cost of care up to a determined amount; above that amount the plan will pay a small percentage of the cost and the State will pay the rest. • Medical Homes Network—PCPs sign agreements with the State and are paid on a FFS basis plus a PMPM case management fee. ASOs must contract with state and are in charge of helping provider networks with case management, and disease management. State determines expected costs for MHN beneficiaries and ASOs share any difference (loss or savings) with the State. ASOs paid administrative fee and claims processed on a FFS basis. State hopes to convert ASOs into Prepaid Ambulatory Healthcare Programs (PAHPs) which assume more risk and process claims. • Employer/Group Insurance Assistance (ESI)—The State pays up to the amount it would have paid to cover recipient under Medicaid. (If ESI premium is higher, recipient pays the difference.) • Self-Directed Care Pilot Program—Similar to a Health Savings Account. Part of the PHA would pay for a major medical insurance plan. Providers of major medical services will be reimbursed under FFS system. State will contract with a vendor to provide administrative framework for this component. Beneficiaries would choose how to spend the rest on other medical services that they would purchase directly from providers at Medicaid FFS rates. The State plans to contract with a vendor to administer this component.
Cost Sharing	• Reform plan keeps co-payments for primary and preventive care at current nominal levels or even decreases them in some cases. Other forms of care would

Component	SOUTH CAROLINA - Description
	have somewhat higher co-payments. Health plans are provided with maximum co-payments for State Plan services. For services not covered currently under the State Plan, health plans are free to determine the co-pay. • The following beneficiaries not subject to co-pays: children, pregnant women, institutionalized individuals and those in home and community based waivers. Family Planning Services not subject to co-pays. • Maximum out-of-pocket limits: $250/individual, $400/family. • Providers can withhold non-emergency services until payment plan for co-payments is established and can terminate services if payment plan is not followed.

Appendix F:

West Virginia Medicaid Reform

Component	WEST VIRGINIA - Description
Reform Authority	• State Plan Amendment (SPA)
Reform Name	• NA
Time Frame	• Approved by CMS on May 3, 2006 • Implementation: November, 2006 • Initially, the SPA will be implemented in three counties (Clay, Upshur, and Lincoln) and will be implemented statewide over four years.
Goals	• Streamline administration • Tailor benefits to population needs • Coordinate care, especially for members with chronic conditions • Provide members with the opportunity and incentives to maintain and improve their health
Main Program Elements	• Simplify Eligibility Categories • Basic and Enhanced Benefit Packages • Member Agreements • Healthy Rewards Accounts
Quick Summary	• Reduces 29 eligibility categories to 4 (children, adults 65 and over, adults with children, special needs groups) • Offer enrollees a choice between a Basic Medicaid benefit package and an Enhanced Medicaid package for those who sign member agreements indicating that they will comply with all prescribed mental treatments and wellness behaviors. • The Basic Medicaid Plan decreases some of benefits currently offered under the Medicaid State Plan. The enhanced plan provides current Medicaid benefits with some additional services. • Uses medical homes (PCPs) to provide enrollees with health care and care management services. Medical homes maintain centralized comprehensive records. • Healthy Rewards Accounts that provide enrollees with incentives to make healthy decisions and use health care services appropriately. Allot enrollees credits quarterly that they can use for co-pays and non-covered services. • Uses electronic health information to gather health information on enrollees needed to provide quality health outcomes. • Will use four indicators to monitor enrollees' compliance with the member agreement: receiving recommended screenings, adherence to health improvement programs, attending scheduled appointments, and taking medication as directed. Enrollees who fail to comply will be moved to the Basic package.
Populations Covered	• Healthy children and parents on Medicaid. • When implemented statewide, program will apply to about 180,000 children and 60,000 adults (about half the States' Medicaid population).

Component	WEST VIRGINIA - Description
Enrollment	• Enrollment will occur when individuals sign member agreements during their Medicaid enrollment or re-determination processes.
Service Providers	• Enhanced benefit package will be furnished through either a primary care case management system (fee-for-service basis) or a managed care entity.
Benefit Packages	Children – Basic Plan • Will have fewer benefits than current Medicaid plan. • Limited to four prescriptions per month; new limits on dental, hearing, vision. No coverage of skilled nursing, orthotics, prosthetics, tobacco cessation programs, nutrition education, diabetes care, or chemical dependency and mental health services. Children – Enhanced Plan • No limits on dental, hearing, vision services; prescription drugs; or medically necessary transportation. • Includes skilled nursing care, orthotics/prosthetics, tobacco cessation, nutritional education, diabetes care, chemical dependency/mental health services Adults – Basic Plan • Will have fewer benefits than current Medicaid plan. • Limits on home health, DME, non-emergency transportation, and 4 prescriptions per month. Emergency dental services, diabetes care, physical and occupational therapy, and mental health services are not covered. Adults – Enhanced Plan • No limits on medically necessary prescription drugs, home health, DME, or transportation. • Also includes Cardiac Rehabilitation, Chiropractic Services, Emergency Dental Services, Tobacco Cessation, Chemical Dependency/Mental Health Services, Diabetes Care, and Nutritional Education.
Cost Sharing	• Higher co-pays for non-emergency use of the emergency room. Other measures may be taken, but details are still being worked out.

Appendix G:

Kentucky Medicaid Reform

Component	KENTUCKY - Description
Reform Authority	• State Plan Amendment
Reform name	• *KyHealth Choices*
Time Frame	• The *KyHealth Choices* Waiver was approved by CMS on January 18, 2006. • Kentucky began implementing the waiver in May 15, 2006. • On May 3, 2006, CMS approved Kentucky's state plan amendment to restructure its benefits package.
Goals	• Stretch resources to most appropriately meet the needs of members • Encourage personally responsibility for health care • Provide a continuum of care options • Expand individual choice and engagement • Ensure future solvency of the Medicaid program
Main Program Elements	• Targeted benefits • Cost-Sharing • Employer-Sponsored Health Insurance • Integrated Care • Disease Management • Get Healthy Accounts
Quick Summary	• *KyHealth Choices* is the name of Kentucky's revised Medicaid program. The program will provide tailored benefit packages to four categories of beneficiaries, including the general Medicaid population, children, elderly and beneficiaries with disabilities or mental retardation. • Most Medicaid beneficiaries will receive a standard benefit package, known as Global Choices, which will provide basic medical services for most members, including mental health services. Other packages will target services to the needs of children and individuals requiring long-term care. Benefits may vary in amount, duration, and scope. Benefits may include dollar amount limits and limits on the number of office visits. • *KyHealth Choices* will require beneficiaries to enroll in employer-sponsored private health insurance if it is available and if it is more cost-effective. • The program will draw on the private sector's experiences and use best practices to coordinate mental health, physical health and mental retardation, and developmental disabilities. • *KyHealth Choices* will implement disease management programs for chronic conditions such as cardiovascular disease, pulmonary disease, and pediatric obesity and diabetes. • The program will provide incentives to beneficiaries who engage in healthy behaviors. Funds will be deposited into accounts to offset health care-related costs, such as co-payments, smoking cessation, and weight loss programs. Initially, disease conditions for participation will be limited to pulmonary disease,

Component	KENTUCKY - Description
	diabetes, and cardiac conditions; however, conditions will be added later.
Populations Covered	• *KyHealth Choices* applies to all Medicaid enrollees throughout Kentucky except those in the counties surrounding the Louisville area. where an existing Medicaid managed care demonstration waiver (Kentucky Passport) operates. • The state enrolls members in one of the following four plans: o Global Choices covers the general Medicaid population o Family Choices covers must children and the KCHIP population o Optimum Choices covers individuals with mental retardation in need of long-term care. o Comprehensive Choices covers individuals who are elderly and in need of a nursing facility level of care and individuals with acquired brain injuries.
Service Providers	• Approved Kentucky Medicaid providers are required to provide all services included in a member's benefit package. • Providers providing services to members receiving benefits for one of four new packages will be reimbursed on a fee-for-services basis using fee schedules approved by Kentucky. • Claims will be submitted and reimbursed by the State's Fiscal Intermediary in accordance with requirements and fee schedules in effect for the program.
Benefit Packages	• Coverage is based upon financial and categorical eligibility. Many disabled and long-term unemployed individuals will continue to receive care on a fee-for-service basis. In addition, special packages will be developed to ensure appropriate care for those who need long-term care. All of the benefit packages will cover mandatory Medicaid services. • Global Choices is the standard package provided for most Medicaid members and is the benchmark to which the other plans are compared. This plan provides basic medical services, including mental health services in inpatient and outpatient settings. Hearing and vision services are limited to those 18 and under unless the service is EPSDT related. • The Comprehensive Choices plan will include all benefits in Global Choices and it will cover individuals who need a nursing facility (NF) level of care, are at risk of institutionalization and/or have been previously covered under the home and community based (HCB) Waiver, Model II (ventilator services), or the acquired brain injury (ABI) Waiver. The plan includes NF level of care services and all services currently available under the current ABI, Model II and HCB waivers as well as nursing facility services. • Optimum Choices covers disabled adults in need of ICF/MR level of care, are at risk of institutionalization and/or are currently being served in the supports for community living waiver (SCL) waiver. The plan will include all benefits in Global Choices and it will include ICF/MR level of care services such as all services under the current SCL waiver and the ICF/MR services. Optimum Choices also includes a new lower level of services aimed at keeping people in their homes longer. • The Family Choices package is designed for children and will serve those currently by the KCHIP program and some children currently served under the traditional Medicaid program.

Component	KENTUCKY - Description
	• To provide additional or special services to the target populations, the *KyHealth Choices* benefit packages may vary the amount, duration, and/or scope of certain services and may contain service-specific coverage limits, such as the number of visits or dollar cost. These limits are "soft" rather than "hard" and additional visits or services beyond the stated limit may be approved if medically necessary.

Cost Sharing	• *KyHealth Choices* will require some members to pay certain pharmacy and non-pharmacy related services; co-pays are based on income levels.
	• Co-pays are due to the provider at the time of service. *KyHealth Choices* members will not have to pay co-pay for any covered service if the member is:
	  o A child under the age of 18 covered by Medicaid;
	  o Pregnant
	  o Receiving a Medicare-covered drug at a pharmacy that is a certified provider for Medicare;
	  o Receiving inpatient services in a nursing facility chronic disease or rehabilitation hospital or intermediate-care facility for the mentally retarded, or is admitted to a hospital from such a facility;
	  o Receiving hospice care;
	  o Has reached the co-pay cap for the year. The co-pay cap for all plans is $225 per individual for pharmacy services and $225 per individual for all other medical services.

Get Healthy Benefits Accounts	• Program promotes wellness, self-care, and health management by providing a direct incentive to enrollees to take an active role in their health. • All members who have one of several targeted conditions will be eligible. • Initially, disease conditions for participation will be limited to pulmonary disease, diabetes, and cardiac conditions; however, additions may be added later. • Get Healthy Benefits will include additional dental and vision services or obtaining nutritional or smoking cessation counseling.

Appendix H:

Idaho Medicaid Reform

Component	IDAHO - Description
Reform Authority	• State Plan Amendment (SPA)
Reform Name	• Modernizing Idaho Medicaid
Time Frame	• Approved by CMS on May 25, 2006 • Implementation date: October, 2006 • The SPA will be implemented statewide
Goals	• Encourage prevention and wellness to improve individuals' health and reduce future healthcare expenditures • Promote responsible use of the healthcare system to reduce unnecessary services that are often expensive • Use limited resources wisely and invest carefully in targeted services to achieve long-term savings
Main Program Elements	• Divide Medicaid beneficiaries into three groups based on health needs • Tailor benefit packages aimed at these three groups • Manage delivery of services more efficiently (provider pay for performance, selective contracting with vendors, use of health information technology)
Quick Summary	• Medicaid beneficiaries will be divided into three groups according to their identified health needs (pregnant women and children, children and adults with disabilities or special needs, and people who are elderly who also may have disabilities • A health risk assessment will be part of the eligibility determination process and beneficiaries will be placed in the plan that best meets their needs • There are three health benefit packages: the Basic Plan, the Enhanced Plan, and the Medicare/Medicaid Plan. • Personal Health Accounts to reward healthy behaviors. Credits for weight loss and tobacco cessation, current immunization and well-child checks. Credits can be used for fitness memberships, nicotine patches, weight loss memberships, bicycle helmets, premium payments.
Populations Covered	• The entire Medicaid population will be covered, but it will be phased in starting with new enrollees and annual eligibility re-determinations.
Enrollment	• Newly eligible Medicaid beneficiaries will be enrolled in Basic Plan or Enhanced Plan. Existing Medicaid beneficiaries will be transitioned to new plans as part of their annual eligibility re-determination. • Enrollment for disabled in the Enhanced Plan, and for the elderly in the Medicare/Medicaid plan is voluntary

Component	IDAHO - Description
Service Providers	• The Basic and Enhanced Plans will be furnished through either a primary care case management system (fee-for-service basis). Individuals with selected chronic diseases may enroll with a PCCM provider who receives an enhanced PCCM fee for measured clinical best practices. Enhanced fees are performance-based incentive payments for individuals with the following chronic diseases: diabetes, asthma, cardiovascular disease, or depression. • Individuals selecting the Medicare/Medicaid Plan will select and enroll in a Medicare Advantage Plan.
Benefit Packages	<u>Basic Plan</u> • For low income children and working age adults of average health and average health care needs (73% of the Medicaid population, or 130,000 individuals). • Designed to look similar to commercial health plans. • Specific Benefits/Limits: ❑ Wellness benefits for children and adults ❑ 26 outpatient mental health visits, 10 inpatient days ❑ No psycho-social rehabilitation or partial care ❑ Dental, PT, OT, ST, DME are covered ❑ No LTC or personal care ❑ EPSDT for those under 21 ❑ Case management only under EPSDT. Must be pre-authorized. • Will attempt to encourage individuals to make good health decisions and provide disincentives to discourage inappropriate services. Idaho's goals are to: ❑ Emphasize preventive care and wellness by implementing personal health accounts that encourage healthy behavior, promoting wellness for children in non-clinical settings such as schools, and restructuring provider payments to offer pay-for-performance incentives for delivery of key prevention services such as immunizations. ❑ Increase participant ability to make good health choices by implementing common-sense, enforceable cost-sharing to increase the responsibility of Medicaid beneficiaries. ❑ Strengthen the employer-based health insurance system by expanding the option of premium assistance to all children and working-age adults who would prefer to enroll in commercial insurance over Medicaid. <u>Enhanced Plan</u> • For children and adults with disabilities or special needs from birth to 64 years of age. All individuals with disabilities, regardless of age, may elect to be covered under this plan (20% of the Medicaid population, or 20,000 individuals). • This plan will mirror existing Medicaid benefits. The goal is to deliver cost-effective individualized care by providing more individual choice and control. ❑ Will provide community supports modeled after the National Cash and Counseling Demonstration. Will transform mental health system to address goals in the president's New Freedom Commission on Mental Health. ❑ Will provide increased opportunities for employment for persons with disabilities. • Includes pay-for-performance incentives for providers for preventive care, key outcomes and chronic disease management.

<table>
<tr><th>Component</th><th>IDAHO - Description</th></tr>
<tr><td></td><td><u>Medicare/Medicaid Plan</u>
Medicaid benefits for adults over age 65 who are covered under Medicare. (7% of the Medicaid population, or 12,800 individuals.)
The plan will be implemented in selected counties and will be expanded to additional counties as Medicare Advantage Plans become available in those counties.
Younger adults with disabilities may choose this plan if they are covered under Medicare.
The goal is to deliver more cost-effective care integrated with Medicare coverage:
Will improve coordination between Medicaid and Medicare, e.g. by contracting with vendors to provide prescription drugs for "dual-eligibles".
Will increase non-public financing options for long-term care, e.g. by participating in the Long-Term Care Partnership Program.
Will use strategies such as expanding home and community-based services waivers and the use of respite care to help individuals live independently as long as possible.</td></tr>
<tr><td>Cost Sharing</td><td>Premiums and co-pays will be implemented depending on a family's ability to pay under the Basic Plan.</td></tr>
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