REPORT OF THE VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Implementing Medicaid Reform in Virginia

TO THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 6

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2014

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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January 10, 2014

MEMORANDUM

TO: Members of the General Assembly

FROM: Cynthia B. Jones

SUBJECT: Implementing Medicaid Reform in Virginia
Report on Item RRRR(4)

Per requirements of the 2013 Appropriation Act, Item RRRR(4) requires the Department of Medical Assistance Services (DMAS) submit a report that describes DMAS' proposed reforms to include remaining Medicaid populations and services in cost-effective, managed and coordinated delivery systems. The attached report meets this requirement. This report is due to the General Assembly by January 1, 2014.

Should you have any questions or need additional information, please feel free to contact me at (804) 786-8099.

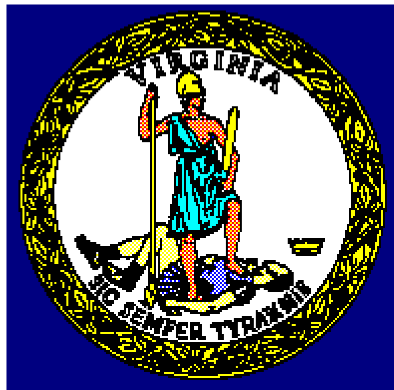
CBJ/

Enclosure

Cc: The Honorable William A. Hazel, Jr., MD, Secretary of Health and Human Resources

IMPLEMENTING MEDICAID REFORM IN VIRGINIA

Moving Forward with Improved Coordination and Management of Long-Term Services and Supports: A Summary of Planned Reforms



Virginia Department of Medical Assistance Services
January 1, 2014

EXECUTIVE SUMMARY

As the single state agency responsible for delivery of Virginia's Medicaid program, the Virginia Department of Medical Assistance Services (DMAS) seeks to transform the Virginia Medicaid program into a cutting-edge payment and delivery system that rewards quality and in which efficiency and cost-effectiveness are paramount. To accomplish this, DMAS, in collaboration with other state agencies with stakeholders, plans to implement a number of programmatic changes to improve and change the way long-term services and supports (LTSS) are administered. This report provides attention to the reforms that will impact LTSS.

Since the inception of the Virginia Medicaid program in 1969, the Commonwealth has worked diligently to offer coverage for qualifying individuals with disabilities and low-income. The program operates as authorized under Titles XIX and XXI of the Social Security Act (SSA). As of July 2013, over one million individuals receive coverage through Virginia Medicaid and the Children's Health Insurance Program (CHIP). There are 938,095 enrollees in programs offered through Title XIX of the SSA, and Virginia serves qualifying individuals in need of long-term services and supports through Title XXI.

Virginia's Medicaid program offers health care benefits through several payment and service delivery models, including the fee-for-service (FFS) model and a full-risk capitated managed care model. DMAS also contracts with administrative service organizations to improve administration of certain services and functions provided through FFS. The delivery models are authorized through the Virginia State Plan for Medical Assistance, coupled with several different Federal waiver authorities. Waivers are vehicles states can use to test new or existing ways to deliver and pay for health care services in Medicaid and FAMIS. Virginia has tailored its program to best meet the needs of the Commonwealth by developing §1915(c), §1915(b), and §1115 waivers. The §1915(c) waivers provide authority for the state to provide LTSS to individuals who qualify for institutional level of care in the community, versus in an institution. The §1915(b) wavier provides authority to mandatorily enroll beneficiaries into the MCO program. Virginia's current §1115 waiver allows DMAS to provide services to individuals who would not otherwise be eligible for Medicaid benefits due to their income level or other disqualifying characteristics.

Most of the individuals who receive services predominantly through the FFS model are receiving LTSS, either through an institution or through one of the six home and community-based services waivers that DMAS operates through §1915(c) waiver authority. With some exceptions, individuals eligible for the managed care model generally include children; pregnant women; parents of dependent children; and aged, blind, or disabled individuals residing in the community who are not receiving Medicare benefits.

Often individuals receive services through both payment and service models simultaneously, as some services are *carved out* of the MCO contracts and provided through FFS, such as non-traditional community behavioral health care services.

Virginia began operating a managed care program in 1996, when it launched the Medallion II managed care program in the Tidewater region of the state. Today, the Medallion II program operates statewide, and DMAS currently contracts with seven managed care organizations (MCOs) that participate in the fully capitated, risk-based, mandatory managed care program. Virginia recently added a seventh MCO to operate in Northern Virginia. In addition to the Medallion II program, DMAS operates a full-risk managed care program for individuals who receive both Medicaid and Medicare benefits – the Program for the All-inclusive Care for the Elderly (PACE). The PACE program provides all Medicare and Medicaid benefits under one entity anchored by an adult day health center. Lastly, DMAS is working toward the implementation of the Commonwealth Coordinated Care Program in early 2014, which is a demonstration in partnership with CMS that will serve individuals receiving Medicare and Medicaid under a capitated, full-risk managed care model.

Since its inception, Virginia's Medicaid program has received national recognition for a number of its programs. Overarching reform, however, is still needed in order to transform this program and enable them to achieve a broader vision of:

(i) **Coordinated Service Delivery**-Virginia seeks a Medicaid program where costs are predictable, services are coordinated, quality innovation is rewarded, and provider compensation is based on the quality of the care provided;

(ii) **Streamlined Administration**-DMAS is efficient, streamlined, and user-friendly. Tax payer dollars are used effectively and for their intended purposes; and

(iii) **Significant Beneficiary Engagement**- Beneficiaries take an active role in the quality of their health care and share responsibility for using Medicaid dollars wisely.

In order to remain on the cutting edge of program design, service delivery, and provider reimbursement, the 2013 Virginia General Assembly directed DMAS through budget language to achieve a number of reforms to the Medicaid program. This language identifies three pathways to continued reform: (1) Advancing reforms currently in progress; (2) Implementing innovations in service delivery, administration, and beneficiary engagement; and (3) Ongoing progress towards expanding coordination of care for long-term services and supports. These directives set forth an ambitious Medicaid reform agenda, which directs DMAS to expand principles of care management to all geographic areas, populations, and services under programs administered by DMAS.

In order to accomplish a number of the tasks set out before DMAS, Virginia must obtain additional authorities from CMS. DMAS will seek expanded flexibility from CMS to ensure that the Commonwealth can implement reforms outlined by the General Assembly in a manner that best meets the needs of Virginia's Medicaid beneficiaries, providers, and the Commonwealth as a whole. Virginia will also continue working closely with stakeholders to ensure that LTSS reforms address the needs of Virginia's citizens. Between the reforms already in progress and those being pursued in the months and years ahead, DMAS seeks to accomplish the following changes to best achieve LTSS reforms:

1. **Continue Implementation of Current Reforms:** DMAS will continue in its work with stakeholders to ensure both (1) the development and successful implementation of the Commonwealth Coordinated Care Program for individuals who are dually eligible for Medicare and Medicaid Services, and (2) the successful implementation of the Behavioral Health Services Administrator to improve coordination of behavioral health services that are not currently included in a managed care system.

2. **Rapid Cycle Implementation of Innovative Pilots:** DMAS will seek approval from CMS to implement pilot programs that meet agreed upon assurance parameters on an expedited basis. This will allow DMAS to work with stakeholders to develop and implement innovative pilots for managed long-term services and supports, including but not limited to health homes or PACE models of support for individuals with developmental disabilities including intellectual disability.

3. **Comprehensive Coordination of Long-Term Care Services and Supports:** DMAS will work with stakeholders and CMS to develop a number of initiatives and programs that will provide comprehensive coordination of Virginia's community-based and institutional long-term supports and services. This includes a restructuring of Virginia's service delivery system for individuals with intellectual and developmental disabilities.

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I. Purpose

The Virginia Department of Medical Assistance Services (DMAS), the single state agency responsible for delivery of the Virginia Medicaid program, seeks to transform Medicaid-funded long-term services and supports (LTSS) into a cutting-edge payment and delivery system in which quality is rewarded, services are planned and coordinated with the beneficiary in a person-centered manner, and services are integrated and delivered seamlessly in an efficient and cost-effective manner. To accomplish this, DMAS, in collaboration with other state agencies with stakeholders, plans to implement a number of programmatic changes to improve the way LTSS are administered.

This document provides an overview of proposed LTSS reforms and associated timeframes to the Members of the General Assembly and stakeholders. It provides an overview of Virginia's current LTSS system, summarizes the federal authority that Virginia currently has in place to operate this system, and outlines the reforms that the Commonwealth will put in place to improve the coordination of Medicaid-funded services and supports for this vulnerable population.

II. Overview of the Virginia Medicaid Program

Medicaid is an entitlement program that provides coverage of medical services for certain individuals who are disabled and who are of low-income, as authorized under Title XIX of the Social Security Act. Virginia has participated in the Medicaid program since 1969. Medicaid is financed jointly by the state and federal governments, and is administered by the states, adhering to federally established and approved guidelines. Federal financial assistance is provided to states in the form of matching dollars, and the federal match rate is based on the state's per capita income. For the majority of the Virginia program, the current federal match rate is 50 percent (the federal minimum), meaning that for every dollar expended in the Medicaid program, 50 cents comes from the federal government and 50 cents comes from the state. As of July 2013, Virginia served 938,095 beneficiaries through Title XIX, as well as 63,692 children and 1,553 pregnant women through Title XXI of the Social Security Act, (the Children's Health Insurance Program). Of these beneficiaries, 60,727 individuals received community and institutional long-term services and supports (LTSS).

A. Who Does the Virginia Medicaid Program Cover?

While Medicaid was created to assist people with low-income, coverage is dependent upon individuals meeting additional criteria. Individuals who are eligible for Medicaid primarily fall into particular eligibility categories such as low-income children, pregnant women, the elderly, individuals with disabilities, and parents meeting specific low-income thresholds. Virginia does not provide Medicaid coverage for childless adults who do not otherwise meet the requirements of an aforementioned eligibility category. Within federal guidelines, states set their own income and asset eligibility criteria for Medicaid, which results in a large variation among the states as to who is eligible. In Virginia, income and resource requirements vary by eligibility category.

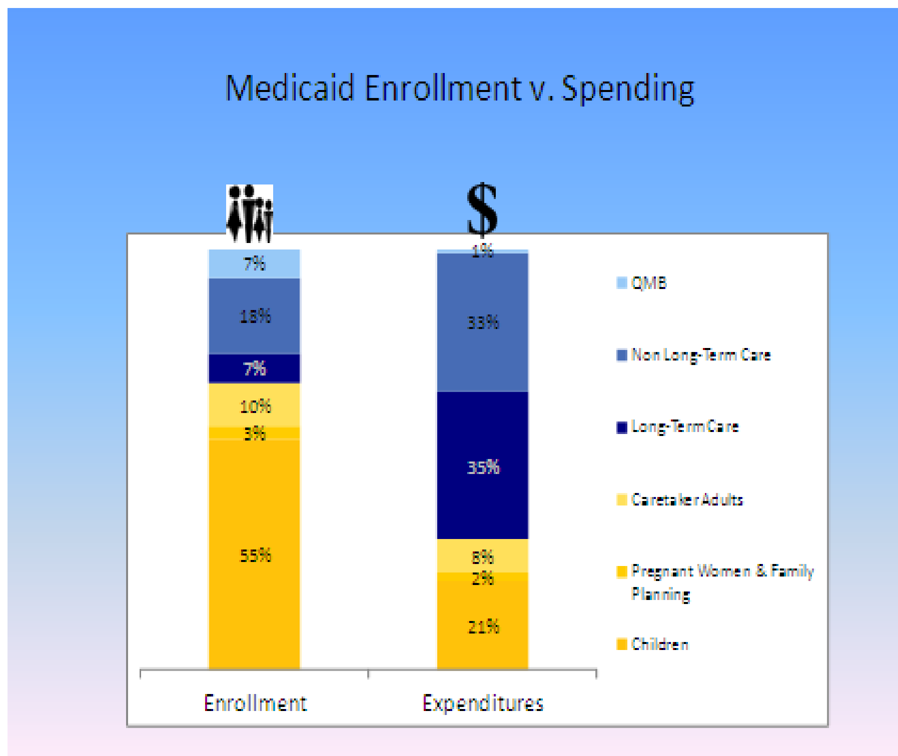
During state fiscal year (SFY) 2012 (July 1, 2011 – June 30, 2012), the monthly average number of individuals receiving Medicaid benefits in Virginia was 834,876 individuals with an annual total expenditure of approximately $7.0 billion. Children and adult caregivers make up about 68 percent of the Medicaid beneficiaries, but they account for only 31 percent of Medicaid spending. While a minority in terms of the percent of recipients served (32 percent), the elderly and persons with disabilities account for

the majority (69 percent) of Medicaid spending, due to their intensive use of acute, behavioral and long-term services and supports (Figure 1).

The total number of individuals in Virginia who received Medicaid benefits at any time during SFY 2012 was 1,096,470 and was comprised of:

- 604,442 children,
- 195,681 parents or caregivers of children and pregnant women,
- 79,613 elderly individuals, and
- 216,734 individuals with a disability.

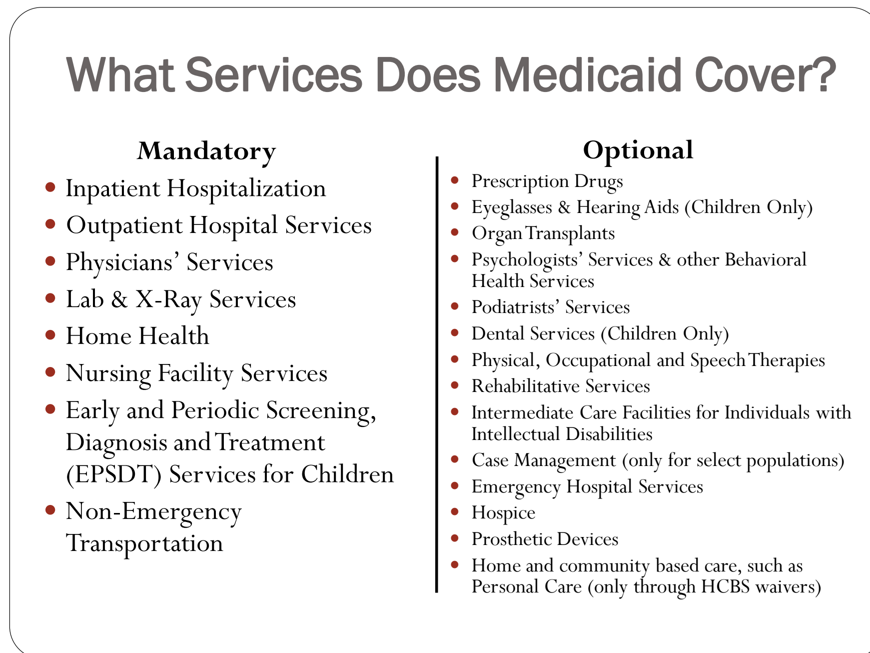
Figure 1 – 2012 Enrollment & Expenditures



B. What Services do Medicaid Beneficiaries Receive?

The Virginia Medicaid program covers a broad range of services, including all federally mandated services and many optional services that the state chooses to provide. Nominal cost-sharing for some services is permitted under federal law for some beneficiaries. The mandated and optional covered services are listed in Figure 2.

Figure 2 – Mandatory and Optional Services Covered by Virginia Medicaid



In addition to the mandatory and optional services, certain qualifying Medicaid beneficiaries also receive coverage through home and community-based services (HCBS) waiver programs. These waivers provide community-based long-term services and supports as an alternative to institutionalization. The following six waiver programs are available to Virginia Medicaid beneficiaries who meet the established level of care criteria:

1. Alzheimer's Assisted Living Waiver,
2. Day Support for Persons with Intellectual Disabilities (DS) Waiver,
3. Elderly or Disabled with Consumer-Direction (EDCD) Waiver,
4. Intellectual Disability (ID) Waiver,
5. Technology Assisted ("Tech") Waiver, and
6. Individual and Family Developmental Disabilities Support (DD) Waiver.

The Department of Behavioral Health and Developmental Services (DBHDS) operates the ID, DD and DS waivers, while DMAS administers the rest of the waivers. DBHDS assumed operational responsibility of the DD Waiver on November 12, 2013. Waivers are initially approved by CMS for three years, with renewals occur every five years. Waiver services are reimbursed on a fee for service basis.

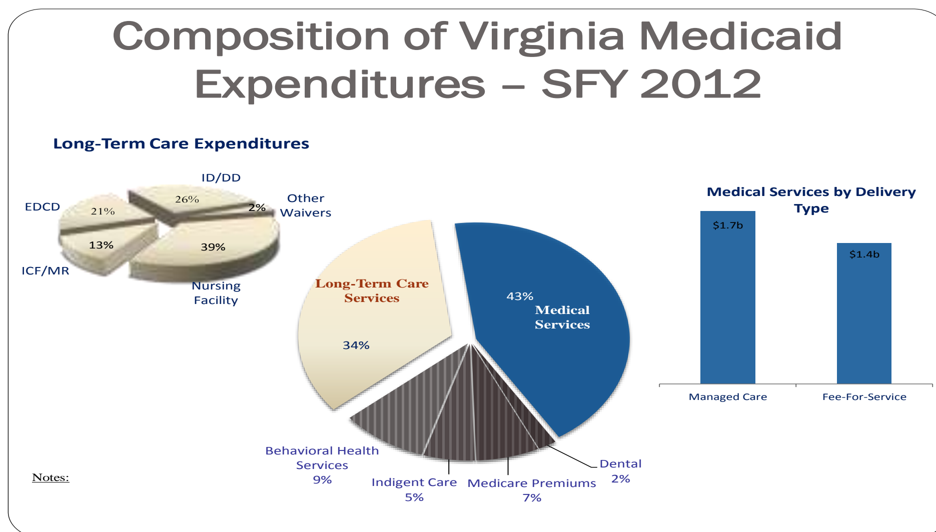
C. How Are Services Delivered?

Medicaid beneficiaries receive services through two general delivery models: fee-for-service (FFS), the standard Medicaid program in which DMAS directly reimburses providers for services rendered, and managed care, the avenue by which DMAS contracts with managed care organizations that pay providers. Virginia pays managed care organizations a "per member per month" (PMPM) fee through a full risk contract to manage the majority of the beneficiaries' care.

i. Fee-for-Service

The majority of individuals receiving services through fee-for-service model include most HCBS Waiver participants, individuals residing in facilities (e.g., nursing facility, Intermediate Care Facility for the Intellectually Disabled (ICF/ID), long-stay hospital), individuals enrolled in both Medicare and Medicaid,[1] individuals enrolled in another insurance program in addition to Medicaid,[2] and individuals waiting to be assigned to an MCO (typically a one-month period). Individuals receiving services through FFS receive very little support and coordination of their services. DMAS is actively moving away from the FFS delivery system in order to provide a more integrated and seamless delivery system for all beneficiaries. In July 2013, 68 percent of total Medicaid beneficiaries were enrolled in managed care. Figure 3 presents the proportion of healthcare expenditures by the major service delivery model in FY 2012.

Figure 3 – FY 2012 Medical Expenditures Composition



To improve administration of certain services delivered through FFS, DMAS can contract with an administrative services organization (ASO). When contracting with an ASO, DMAS pays the ASO a fee to provide administrative services related to particular health care services (e.g., children's dental services, preauthorization, and provider credentialing), but the service providers are paid on a FFS basis by DMAS.

ii. Managed Care

Contracted Health Plans: Virginia's Medicaid managed care program, known as Medallion II, began in 1996 and is available in all regions of the state as of July 1, 2012. The program is a fully capitated, risk-based, mandatory managed care program. It includes children up to age 19, pregnant women, caretaker parents of eligible children, and individuals enrolled in the aged, blind, and disabled (ABD) aid categories who do not utilize long-term care services.

[1] The majority of medical services for these individuals are covered by Medicare.
[2] Medicaid may provide premium assistance or wrap around services for these beneficiaries.

Under Medallion II, DMAS contracts with MCOs for the provision of most Medicaid covered services. The contracted MCOs receive a capitated payment from DMAS each month that covers a comprehensive set of services, regardless of how much care is used by the beneficiary. The MCO pays claims for contracted services in accordance with Federal and State guidelines, as well as contractual terms between the MCOs and service providers. As of July 1, 2013, MCOs operated in all Virginia localities with enrollment of 696,008 individuals. Currently, DMAS contracts with seven MCOs - Anthem HealthKeepers Plus, CoventryCares of Virginia, InTotal Health, MajestaCare, Optima Family Care and Virginia Premier Health Plan, and Kaiser. Participating Medicaid beneficiaries have a choice of at least two MCOs in each area of the Commonwealth.

Although MCOs cover the majority of services for individuals enrolled in their program, some services for MCO enrollees continue to be covered through the fee-for-service system. These services are referred to as "carved out" services. In Virginia, such services include community behavioral health services and early intervention.

Program for the All-Inclusive Care for the Elderly: An additional managed care delivery option for individuals who receive managed LTSS paid by both Medicare and Medicaid is the Program for All-Inclusive Care for the Elderly (PACE). This program is designed to allow Medicaid eligible individuals aged 55 or older, who meet the nursing facility level of care, to access comprehensive coordinated care of both Medical and LTSS in their homes and communities. The goal is to keep participants in the community and provide the entire continuum of medical and supportive services as needed, utilizing both Medicaid and Medicare funding and providing coordinated care through a capitated program available to the Commonwealth's seniors. The central hub of PACE program activities is an adult day health center. Virginia opened its first PACE program in 2007, and has since expanded to fourteen PACE programs serving over 1000 people across the Commonwealth. Virginia is considered a leader in the development of both rural and urban PACE sites, with demonstrated positive health outcomes and supports for PACE beneficiaries.

The success of the PACE program has led to significant interest in use of this integrated delivery model for other vulnerable populations. Virginia's current Medicaid State Plan and regulatory requirements, however, do not allow this program to be created for individuals with disabilities younger than age 54 who may be eligible for nursing facility care, or for individuals who need other institutional (ICF/ID) care. The Social Security Act limits this program to individuals who are age 55 and older and who are at risk of nursing facility placement. In addition, not all individuals in need of these supports would desire to attend an adult day health care setting on a regular basis as their support "hub" – their support "hub" during the day may utilize a different service delivery model, such as day support or a job placement.

III. Existing Federal Authority for Virginia Medicaid Long-Term Services and Supports

The Virginia State Plan for Medical Assistance approved by CMS provides federal authority for the Virginia Medicaid program. This includes operation of PACE programs.

Title XIX requires that Medicaid services be provided in the same *amount, duration, and scope* to all beneficiaries within a state and meet a number of other requirements. Virginia has tailored its program to

best meet the needs of the Commonwealth by also developing §1915(c), §1915(b), and §1115 waivers and using the §1932(a) State Plan authority. The waivers and State Plan authority are agreements between the state and CMS that CMS will "waive" or not require that the state adhere to the requirements of certain sections of the Social Security Act, as long as the state meets other standards and criteria. Section §1915(c) waivers allow states to provide long-term care services in community settings as an alternative to institutional settings. The Section §1915(b) waiver and §1932(a) State Plan authority provide authority for mandatory enrollment in manage care on a statewide basis or in limited geographic areas. Section §1115 waivers provide broad waiver authority at the discretion of the Secretary of Health and Human Resources to approve projects that test policy innovations likely to further the objectives of the Medicaid program. Section §1115 waivers permit states to provide the demonstration population(s) with different health benefits or have different service limitations than are specified in the Medicaid State Plan.

A. §1915(c) Home- and Community-Based Waivers:

Virginia offers six home- and community-based services (HCBS) waivers to enable individuals to receive long-term services and supports in the community instead of institutional settings.

Figure 4 – §1915(c) Home and Community Based Long-Term Care Waiver

Home- and Community- Based Long-Term Care Waivers	Number of Enrollees as of October 2013
Day Support Waiver	246
Developmental Disability Waiver	802
Intellectual Disability Waiver	9,414
Alzheimer's Waiver	38
Technology Assisted Waiver	344
Elderly or Disabled with Consumer Directed Waiver	27,078
TOTAL §1915(c) Waiver Enrollment	**37,912**

B. §1915(b) Waiver to Require Mandatory Participation in Managed Care

Within §1915(b) authority, states have substantial flexibility to tailor their managed care program in order to best meet the needs of the state. Virginia offers Medallion II, its capitated managed care program, statewide to children, pregnant women, caretaker parents, and individuals meeting requirements as aged, blind, or disabled. The Medallion II program supports approximately 56,000 individuals who are in the ABD category.

Virginia has worked closely with CMS over the course of the Medallion II managed care program to strengthen the contract obligations and deliverables of the managed care organization (MCO) contracts. Significant changes in quality and innovation took effect on July 1, 2013. Highlights of these changes

include: (i) enhanced technical guidance to improve reporting, automation of MCO report filing and submission, encounter data, and scoring of MCO compliance with reporting requirements; (ii) a new quality incentive program in which high quality is financially rewarded; (iii) a new Medallion II Care System Partnership encouraging development of new payment and delivery models; (iv) improved maternity care requirements; (v) improved chronic disease management for aged, blind, or disabled individuals; and (vi) improved wellness programs for managed care members.

C. §1932(a) Authority to Offer Voluntary Participation in Managed Care

Virginia received approval to operate the Commonwealth Coordinated Care (CCC) Program in June 2013 using the §1932(a) State Plan authority. This authority allows Virginia to operate the voluntary CCC managed care program in limited geographic areas and enables the Commonwealth to include individuals who are dually eligible for Medicare and Medicaid services in the CCC Program. More information about the CCC Program will be provided later in the report.

IV. Reforming Virginia's Medicaid Program

A. Prior Efforts to Reform Medicaid Long-Term Services and Supports

Although Virginia has provided services under a capitated managed care model to both Temporary Assistance for Needy Families (TANF) and the Aged, Blind and Disabled (ABD) populations since 1991, individuals who need LTSS or who are dually eligible for both Medicare and Medicaid services are excluded from participating in current Medicaid managed care programs other than PACE. Dually eligible individuals receive services driven by conflicting federal rules and separate funding streams that result in fragmented and uncoordinated care, and they continue to receive services through a patchwork of health and social programs that are neither person-centered nor responsive to individual needs. Acute care is provided in a fee-for-service (FFS) environment with few opportunities to receive management and support for chronic conditions. LTSS are provided in a nursing facility or through a variety of HCBS waivers with no assigned primary care providers or coordination between providers. This fragmented system encourages cost shifting between Medicare and Medicaid, contributes to a lack of accountability, and results in sub-optimal quality and health outcomes for beneficiaries, as well as unnecessary costs.

To address these problems, DMAS established the goal of developing service coordination programs to integrate acute and LTSS for the Commonwealth's most vulnerable citizens. In 2006, with support from both the Governor and the General Assembly, a major reform of the Virginia Medicaid-funded LTSS system was set in motion. New legislation (Special Session I, 2006 Virginia Acts of Assembly, Chapter 3) directed DMAS, in consultation with the appropriate stakeholders, to develop a long range blueprint for the development and implementation of an integrated system. The legislation directed DMAS to move forward with two different models for the integration of acute and LTSS: a community model and a regional model.

DMAS successfully developed a community model by implementing robust PACE programs, which was presented earlier in this report. DMAS achieved partial success in implementing a regional model that would provide all Medicaid acute and most LTSS under a capitated managed care model. The first phase of the capitated model, referred to as *Acute and Long-Term Care* (ALTC), became effective on September 1, 2007. Under ALTC, individuals enrolled in a MCO remain in the MCO for their primary

and acute medical services after they are approved for long-term services and supports through a HCBS waiver. Prior to ALTC, these individuals were dis-enrolled from managed care into a HCBS waiver.[3] Their HCBS waiver services, including transportation to the waivered services, continue to be paid through the FFS program and are not managed by the MCO. Approximately 3,585 individuals now receive primary and acute services through the ALTC program. However, this program neither addressed dually eligible individuals nor individuals residing in nursing facilities or other institutional care facilities. It also did not fully integrate acute, primary, behavioral, or LTSS into one service delivery model

After successfully implementing ALTC, DMAS spent two years developing a full-risk capitated model that would provide Medicaid covered primary, acute, and LTSS in an integrated, person-centered managed care system. DMAS encountered the following barriers that affected program implementation:

- The new service coordination costs would not have been offset by savings to Medicaid; rather, the majority of savings would have accrued to Medicare.
- Keeping the program budget-neutral under the above constraints resulted in capitation rates that were not attractive to MCOs.
- There were challenges associated with federal review and approval of the §1915(b) and §1915(c) waivers amendment, including inconsistencies and conflicting requirements between §1915(b) and §1915(c) quality and reporting requirements.
- The model did not include individuals in nursing facilities due to the concerns expressed by the nursing facility industry (a key stakeholder).

B. Legislative Directive to Reform Virginia's Medicaid Program

Virginia's Medicaid program strives to deliver high-quality, person-centered, cost-effective care and has received national recognition for a number of its programs. In order to remain a national leader, the Department must consistently strive to strengthen and refine the program. Virginia leaders have also continued to look for opportunities to implement integrated and coordinated service models for individuals in need of LTSS and behavioral health services. To bolster the culture of continuous improvement, the 2013 Virginia General Assembly directed DMAS through budget language to achieve a number of reforms to the Medicaid program.

This language outlines three phases: (1) Advance reforms currently in progress, (2) Implement innovations in service delivery, administration, and beneficiary engagement, and (3) Move forward with coordination of long-term services and supports. In full, this directive sets forth an ambitious Medicaid reform agenda that directs DMAS to expand principles of care management to all geographic areas, populations, and services under programs it administers.

The Commonwealth's Medicaid reform agenda emphasizes the implementation of comprehensive, value-driven, market-based reforms that improve quality of care and contain spending growth. The reform plan also establishes a Medicaid Innovation and Reform Commission (MIRC) to assess progress made. The process includes an opportunity for public comment and stakeholder input. The following reform areas will assist in the transformation of Medicaid behavioral and LTSS:

[3] ALTC excluded enrollees receiving Technology Assisted Waiver, nursing facility, and PACE services.

i. Phase One: Advance Reforms Currently in Progress

- Implement a three-year Medicare and Medicaid Enrollee (dually eligible) Financial Alignment Demonstration, called Commonwealth Coordinated Care (CCC); and

- Implement a Behavioral Health Services Administrator contract to employ a coordinated care model for individuals in need of behavioral health services that are not currently provided through a managed care organization.

ii. Phase Two: Implement Innovations in Service Delivery, Administration, and Beneficiary Engagement

- Simplify the administration of Medicaid through any necessary waivers and/or State Plan authorization under Title XIX or XXI of the Social Security Act

- Outline parameters and metrics to provide maximum flexibility and expedite the development and implementation of pilot programs that test innovative models that: (i) leverage innovations and variations in regional delivery systems; (ii) link payment and reimbursement to quality and cost containment outcomes; or (iii) encourage innovations that improve service quality and yield cost savings to the Commonwealth (e.g., PACE or home health models).

iii. Phase Three: Move Forward with Coordination of Long-Term Services and Supports

- Implement reforms to include all remaining non-coordinated Medicaid populations and services, including long-term care and home and community based waiver services, in cost-effective, managed, and coordinated delivery systems.

C. Vision for Reform

As directed by the General Assembly, the three phases of reform are program and population specific. However, they fit directly within DMAS' broader vision of Medicaid reform, which includes:

(i) Effective service delivery – *Virginia seeks a Medicaid program in which costs are predictable and that coordinates services, rewards innovation, and bases provider compensation on the quality of the care*

(ii) Efficient administration – *DMAS is efficient, streamlined, and user-friendly. Tax payer dollars are used effectively and for their intended purposes*

(iii) Significant beneficiary engagement – *Beneficiaries take an active role in the quality of their health care and share responsibility for using Medicaid dollars wisely*.

To achieve this vision and meet the directives of the General Assembly, DMAS seeks broader flexibility in structuring programs from CMS. DMAS plans to continue work with stakeholders and CMS to hone this plan prior to the January 2014 General Assembly Session.

D. Working with CMS to Implement Reforms in Virginia

As CMS must approve program reforms proposed by the Department, DMAS is working closely with CMS regarding these projects on a near daily basis. Subsequently, CMS continues to support several significant, recent reforms undertaken by Virginia. An example of these reforms includes the Medicare-Medicaid Enrollee (dually eligible) Financial Alignment Demonstration.

DMAS has implemented a number of the reforms that are allowed within existing federal authority, and is seeking expanded flexibility from CMS to ensure that it can implement the reforms outlined by the General Assembly in a manner that best meets the needs of Virginia's Medicaid beneficiaries and the Commonwealth. A number of LTSS reforms will likely require changes to DMAS' current authority with CMS. The following is a discussion of select reforms.

i. Phase One Reforms

DMAS has an unprecedented number of significant reforms currently under way. Many of these reforms are outlined in Phase One of the budget language. Two long-term and behavioral health Phase One reforms are the Commonwealth Coordinated Care program and the Behavioral Health Services Administrator contract that are discussed below.

- *Commonwealth Coordinated Care:* Legislative and Executive leadership have provided exemplary support through the 2011-2013 *Acts of the Assembly*, which direct DMAS to implement in integrated support model for individuals who are dually eligible for Medicare and Medicaid services. DMAS has made significant strides in implementing a coordinated, integrated model of care for dual eligible individuals via the Medicare-Medicaid Financial Alignment Demonstration (FAD) through the §1932(a) State Plan authority. The FAD is an opportunity authorized by the Patient Protection and Affordability Care Act to integrate covered Medicare and Medicaid benefits under one system of coordinated care using a full-risk capitated model operated jointly by the state and CMS. Virginia was the sixth state to sign a Memorandum of Understanding with CMS which signifies Virginia's formal acceptance into the FAD. Over the past twelve months, DMAS held regular meetings with the Medicare-Medicaid Advisory Committee (directed by the *Acts of Assembly* and appointed by the Secretary of Health and Human Resources) and other important stakeholders, and finalized the design and name of the Demonstration.

  Commonwealth Coordinated Care (CCC) is a voluntary program which will serve up to approximately 78,000 dually eligible elderly and disabled individuals in five regions of the Commonwealth: Central Virginia, Tidewater, Northern Virginia, Charlottesville/West, and Roanoke. The CCC Program will be phased in on a regional basis over the first twelve months of the Demonstration, starting with the Central Virginia and Tidewater regions. Eligible individuals will be notified of the opportunity to enroll during December 2013 and the first opportunity for enrollment is targeted for March 1, 2014. The remaining three regions will be phased in later in the 2014, with the first enrollment opportunity targeted for August 2014. The CCC Program will operate through December 2017, in order to allow for three years of operation after full implementation.

  Over the past 18 months, DMAS worked with CMS and stakeholders to develop the terms and conditions under which the CCC Program will operate, including:

- who will be eligible to enroll;
- covered benefits;
- the method of enrollment and the enrollment timeline;
- requirements and timeframes for participating plans to perform important functions, such as indentifying vulnerable enrollees, performing health risk assessments, forming Integrated Care Teams, and developing individual care plans;
- beneficiary protections, including an ombudsman program and requirements for ensuring the continuity of care;
- quality and performance outcome measures that are tied to reimbursement and other monitoring infrastructure;
- savings expectations;
- a partially integrated appeals processes; and,
- other necessary operational details.

In April 2013, DMAS solicited proposals for managed care organizations to operate in the CCC Program. DMAS is currently negotiating with three health plans and is working with CMS to determine the health plans' readiness for program participation.

In addition, DMAS redesigned its organizational structure to place a higher emphasis on LTSS and behavioral health services by creating a Deputy Director of Complex Care and Services position. The position oversees all long-term and behavioral health services, and will oversee the CCC Program. DMAS also already hired the Division Director of Integrated Care and Behavioral Services, the CCC Program Manager, an Education and Outreach Coordinator, and Program Analysts who will monitor CCC Program activities and health plans. All are fully devoted to this project, and DMAS anticipates completely staffing this division prior to program launch.

- *Behavioral Health Services Administrator:* In collaboration with stakeholders, DMAS is implementing a new non-risk care coordination model for behavioral health and substance abuse services for eligible Medicaid and FAMIS beneficiaries. A contracted behavioral health services administrator (BHSA) will implement and administer this new model for covered services beginning in December 2013 for a period of three years, with options for two one-year extensions. Covered services include traditional behavioral health services (i.e. inpatient psychiatric hospitalization and outpatient therapy services) for members not enrolled in the Medallion II, CCC, or PACE programs, as well as non-traditional behavioral health services, such as community-based mental health services (i.e. intensive in-home services, mental health support services). The BHSA contract includes a centralized call center for member and provider assistance, service authorizations, provider network management, and claim payments. The BHSA contractor will also work with the managed care health plans to better coordinate the delivery of behavioral health services.

ii. Phase Two Reforms

Phase Two of the budget language directs DMAS to become a quality-driven, rapid responder to innovation. To achieve this, DMAS will seek to establish pre-set parameters with CMS through which pilot programs can be developed quickly. These mandates will require a number of authority changes for Virginia. The following discussion of Phase Two reforms includes highlights from the budget language.

Rapid-Cycle Implementation of Innovative Pilots: Due to an unprecedented level of interest in health care and delivery system innovation, in addition to overall system reform, DMAS seeks approval to implement smaller pilot programs that test reforms on a rapid-cycle basis. DMAS needs the ability to implement improvements on a rapid basis in order to take advantage of opportunities within the Virginia delivery system. The normal time it takes to implement new programs is anywhere from18-24 months; this timeframe is not feasible when significant momentum and federal funding are at stake.

DMAS will work with CMS to establish a process that allows Virginia to maximize flexibility and expedite the implementation of pilot programs testing models that: (1) leverage innovations and variations in regional delivery systems; (2) link payment and reimbursement to quality and cost containment outcomes; and (3) encourage innovations that improve service quality, coordinate care, and yield cost savings to the Commonwealth. DMAS envisions testing these pilots within the current Medicaid population and an expansion population, if the expansion is mandated by the Governor and legislature.

Specifically, DMAS will work with CMS to develop static assurance parameters that facilitate federal approval for pilot programs that meet these parameters within an expedited 30-60 day time frame. DMAS will collaborate with stakeholders and CMS to develop assurance parameters that would ensure beneficiary safeguards and guarantee quality, access to providers, and cost effectiveness of each pilot. In exchange for meeting the established assurance parameters, DMAS would be allowed to waive select sections of the Social Security Act.

DMAS recognizes that it must consider more than one model for improving coordination or LTSS populations. Preliminary discussions with stakeholders have identified PACE-like models for individuals with intellectual and developmental disabilities, and health home opportunities that will require flexibility from CMS in order to pilot these innovative concepts in Virginia. DMAS will continue to work with DBHDS, as well as other state agencies and stakeholders, to identify these models and the parameters in which they will operate.

iii. Phase Three Reforms: Managed Long-Term Services and Supports

Managed long term services and supports (MLTSS) refers to an arrangement between state Medicaid programs and managed care plans or other entities through which the organizations receive capitated payments for LTSS, including both HCBS and/or institutional-based services. In fully integrated models, these payments for MLTSS are combined with payments for primary, acute, and behavioral health services, and the capitation payment is more comprehensive.

MLTSS systems provide a tremendous opportunity to create a seamless, integrated health services delivery program. Integrating and coordinating services across the spectrum of services should result in fewer gaps in service, as all health care and LTSS needs will be managed by one entity. Aligned quality measurement and reporting can facilitate a more efficient monitoring system and improve both health

outcomes and satisfaction. Lastly, the Demonstration could reduce emergency department use, hospital admissions, nursing facility days, and duplicative or unnecessary services over time. The primary goals of MLTSS systems include:

- Improving the quality of life, health outcomes, and experience for individuals in need of MLTSS;
- Providing a seamless, one-stop system of services and supports;
- Reducing service gaps with focused attention on individuals with complex needs, such as individuals with intellectual disabilities, multiple chronic conditions, and/or serious mental illness;
- Delivering services in settings that meet the needs of beneficiaries with cognitive impairments, behavioral health needs, physical support needs, and other special medical needs;
- Offering service coordination – the non-clinical but important functions of providing information and logistical help in navigating the service environment, assuring timely and effective transfer of information, and tracking referrals and transitions to identify and overcome barriers to accessing timely services and/or support;
- Providing care management – the more intensive service provided by health professionals, including interdisciplinary care teams, to individuals with complex needs who currently do not have this benefit in Virginia. Care management encompasses both referral/transition management and clinical services such as monitoring, self-management support, and medication review and adjustment. Care management will integrate the medical and social models of care, ensure individual choice and rights, and include individuals and family members using a person-centered model. This will not duplicate existing case management services; rather, the two will intersect and work in collaboration to better support the individual;
- Establishing disease and medication management, especially for individuals with disabilities, behavioral health disorders, and/or chronic health conditions;
- Support for seamless transitions between treatment settings that reduce unnecessary inpatient and nursing facility admissions;
- Reduction of emergency department visits;
- Facilitation of effective communication between providers to improve the quality and cost-effectiveness of care;
- Arranging services and supports to maximize opportunities for community living;
- Implementation of system-wide quality improvement and monitoring;
- Providing needed behavioral health services, including services for individuals residing in nursing facilities, in collaboration with the individual, the individual's family, and all others involved in the individual's care, such as other agencies or systems or health and social service providers; and
- Coordination between physical health, behavioral health, and LTSS, as well as collaboration with relevant social and community providers.

MLTSS programs have grown significantly nationally over the past decade and are expected to increase even more in the coming years as the number of seniors expands. Between 2004 and 2013, the number of states with MLTSS programs more than doubled from eight to eighteen, with an increase in this number expected in the next three years due to the implementation of Medicare-Medicaid financial alignment models.

Developing a managed, coordinated delivery system for Virginia's long-term services and supports is a top priority for the Commonwealth. Significant and ongoing stakeholder work will be necessary to ensure that this reform effectively meets the needs of beneficiaries, those in their support systems, and providers. This reform will be accomplished through existing authority and includes:

A. Implementation of the Commonwealth Coordinated Care Program (Virginia's Medicare-Medicaid Enrollee Demonstration).

B. Reform and consolidation of the §1915(c) waivers for individuals with intellectual and other developmental disabilities. DMAS and DBHDS have long sought enhancements to the current community system of support for such individuals. DBHDS procured the services of the Human Services Research Institute (HSRI) to address the following areas and provide recommendations to the Commonwealth regarding streamlining and enhancing waiver supports. Topics of review include:
   - Establishing a unified HCBS waiver system focused on supporting the individual based on the level of need rather than on the diagnosis of disability.
   - Establishing provider reimbursement rates which are determined by the actual cost of delivering high quality support to each individual.
   - Enabling individuals receiving supports and services to achieve maximum levels of independence in a person centered driven support environment.
   - Achieving cost efficiencies by allocating costs based on the allocate costs to the amount of support needed.

   Phase One of the HSRI contract is currently underway and will be complete Fall 2013. This phase will be a careful study of Virginia's current system and will result in general and specific recommendations for system structural changes. Phase Two will be a more in depth study of the rate and funding structure with recommendations due in June of 2014. This will included a plan to re-design the current intellectual and developmental disability (ID/DD) service delivery system and reconstruct a new system of support based on need.

C. Transitioning all HCBS Waiver beneficiaries into managed care for their medical (acute and primary) services; and subsequently gradually transitioning all HCBS Waiver and LTSS facility-based services into coordinated, managed delivery system(s) that best support beneficiaries and their individualized medical, behavioral health, and LTSS needs.

Figure 5 on the following page outlines the proposed implementation phases of this effort.

Figure 5 - Virginia's Timeline for Providing Improved Coordinated Care to All LTSS Participants

Time-frame	Population	Number of Beneficiaries Impacted *(as of July 2013)*	Services	Description	Geographic Regions
January 2014	**Medicare-Medicaid Enrollees**	78,600	All Medicare and Medicaid medical, behavioral health, and LTSS, including nursing homes and services that are provided through the EDCD Waiver	Implementation of the CCC Program. (Coordinated Care Phase One)	Richmond, Tidewater, Northern Virginia, Charlottesville, Roanoke
Phase 1: July 2014 Phase 2: July 2015	**ID/DD/ Day Support Waiver Enrollees**	10,162	ID/DD/Day Support1915(c) Waiver Services	• **Phase 1**: ○ October 2013, first HSRI study completed. ○ The current 1915(c) ID Waiver renewal is due in July 2014; minimal changes (maintain waiver services in Fee-For-Service). • **Phase 2:** ○ Review recommendations of HSRI and identify the scope of program redesign for services currently provided through the ID/DD/Day Support HCBS waivers. ○ Make changes to waivers as authorized and appropriated by the 2015 General Assembly. ○ New waiver(s) designed for July 2015.	Statewide
October 2014	**HCBS waiver enrollees**	23,038[4]	Medical services through managed care	All HCBS waiver participants who are not currently enrolled in a coordinated delivery system will move to managed care for their medical services and traditional behavioral health services, including ID/DD. Community behavioral health services covered through the behavioral health service administrator (BHSA) will remain in the BHSA. This will not include nursing home residents.	Statewide
July 2015	**Individuals with ID and DD**	100-400	PACE programs, PACE-like programs, or health	PACE, PACE-like sites, or health homes as an alternative to waiver participation for individuals with ID/DD	Northern Virginia,

[4] 36,772total waiver enrollment – 10,217 (EDCD that will be in Duals) – 3,517 (ALTC enrollment) = 23,038

Time-frame	Population	Number of Beneficiaries Impacted *(as of July 2013)*	Services	Description	Geographic Regions
			homes for individuals with Intellectual and Developmental Disabilities		Central, Southside, Southeastern, and Southwestern Virginia.
July 2016	• **EDCD** • **Alzheimer's** • **Tech Waiver** • **Nursing home** • **Hospice** • **MFP** *(pending Congressional reauthorization)*	48,298	• Behavioral Health Services • Long-Term Services and Supports *(Medical services would have been added in October 2014)*	Coordinated Care for LTSS Phase Two: Add behavioral health and long-term care services for individuals enrolled in the following programs (Medical services were already transitioned into coordinated care) • EDCD • Alzheimer's • Tech Waiver • Nursing home • Hospice • MFP	Statewide
July 2016	**ID/DD/Day Support Enrollees**	11,331	Behavioral health, ID/DD/Day Support Services and ICF-IDs* into coordinated care **This does not include moving IMDs (freestanding psychiatric, residential treatment centers, and state psychiatric hospitals)*	Coordinated Care for LTSS Phase Three: Move ID/DD/Day Support Waiver services from Fee-For-Service into coordinated delivery systems	Phase-In to Statewide coverage
January 2018	**Statewide Commonwealth Coordinated Care expansion**	TBD	All LTSS, medical, and behavioral health services and Medicare Services	Geographically expand the CCC Program for Medicare-Medicaid Enrollees statewide and include coverage for children who are dually enrolled (pending Congressional authorization of the CMS FAD)	Statewide

Further, as a part of this effort, the Commonwealth will also explore the following concepts:

1) ***Expand funding and coverage for transition and housing services for individuals transitioning into the community from state facilities (per the Department of Justice settlement) and nursing facilities***. The Commonwealth seeks flexibility to offer some HCBS waiver services, such as home modifications *prior* to individuals leaving facilities. Enhanced funding could build on services covered by the Money Follows the Person (MFP) program and include stipends for housing and coverage of assisted living. MFP is time-limited, and federal restrictions on qualified residences (maximum of four beds), as well as a restriction on the authorization and provision of HCBS services prior to an individual's discharge from the institutional setting, do not allow enough flexibility for the state. Some individuals are prohibited from transitioning to the community because transition services, hiring and training of personal assistants, environmental modifications to housing, or assistive technology cannot be completed *prior* to discharge from a facility.

2) ***Inclusion of bed-hold days for ID Waiver residential providers, other than sponsored residential providers who routinely provide 24 hour support.*** ID Waiver residential providers, unlike their institutional counterparts, suffer direct and immediate loss of revenue when a resident is admitted for treatment or rehabilitation to a hospital or nursing home. This is due to federal regulations that do not allow for payment of waiver services if an individual is not present in the community residential setting. Since the current residential service model is to create a "home" for the individual resident, discharge from the residential service is rarely even an item of consideration when medical or psychiatric hospital care is required. In addition, while unable to bill for services, residential providers are frequently the only support that the resident has and, in that role, the provider and their staff serve as the communicator with hospital staff, as well as provider of support in completing activities of daily living and supervision to ensure that the hospital rules are followed, etc. Staff who provide these supports are paid at their regular wage rates by providers, and as all of the normal activities of the provider continue during this period, the hours worked with the hospitalized individuals are "additional," even though these costs are not currently allowed to be funded through the Medicaid program. DMAS will explore the feasibility of this option with CMS.

E. Next Steps for Virginia

DMAS recognizes this dramatic shift in delivery system design for MLTSS and wants to maximize the positive experience of beneficiaries and their families as they make the transition to more integrated service models. In the development of these systems, DMAS will follow the ten key principles identified by CMS[5] in working closely with stakeholders to develop strong MLTSS programs. These principles are:

1.Adequate Planning and Transition Strategies: The most effective MLTSS systems are the result of a thoughtful and deliberative planning process that permits enough time to develop a clear vision for the program that includes the solicitation and consideration of stakeholder input; education of program participants; assessment of readiness at both the state and managed care

[5] May 2013, *Summary – Essential Elements of Managed Long Term Services and Supports Programs*. Center for Medicare and Medicaid Services.

systems level; and development of quality standards, safeguards, and oversight mechanisms to ensure a smooth transition and effective ongoing implementation of MLTSS.

2. Stakeholder Engagement: DMAS will ensure that stakeholders (including beneficiaries, providers and advocacy groups of all affected LTSS populations) have the opportunity to provide significant insight to the Commonwealth's planning, implementation, and ongoing oversight of MLTSS programs. Stakeholders have already been engaged in Phase One projects. Input for Phase Two and Three initiatives are already being provided through the Virginia Health Reform Initiative and are being incorporated into concept design for MLTSS (see Attachment 1). DMAS staff have also begun meeting with stakeholders at conferences and conventions to share the concepts outlined in Figure 5. Stakeholders include:

- The Arc of Virginia
- The Virginia Association of Community Services Boards
- The Virginia Health Care Association
- The Virginia Association of Personal Care Providers
- The Virginia Network of Private Providers
- State Agency Boards (Department of Behavioral Health and Developmental Services)

3. Enhanced provision of Home and Community-Based Services: Including this element into the planning and oversight of MLTSS programs is a priority, and DMAS will ensure that the program achieves and maintains progress towards community integration goals.

4. Alignment of Payment Structures with MLTSS Programmatic Goal: Payment to managed care systems will support the goals of Virginia's MLTSS programs, including the essential elements established in this document. It will also support the three goals of improving the health of populations, enhancing the beneficiary experience of care, and reducing costs through these improvements. Capitation rates will encourage the delivery of high-quality services in home- and community-based settings and support the goal of community integration. Contracts will also provide performance-based incentives tied to outcome measures, such as those that are currently planned for the CCC Program.

5. Support for Beneficiaries: All beneficiaries, particularly those most vulnerable, will need support and education throughout their experience in MLTSS programs. Common support resources that will be provided by the Commonwealth at no cost to the beneficiary will include enrollment/disenrollment services, including choice counseling and education on additional opportunities for disenrollment, and an advocate or ombudsman to help beneficiaries understand their rights, responsibilities, and how to handle a dispute with the managed care system or state.

6. Person-centered Processes: DMAS will work with stakeholders to meet beneficiaries' medical and non-medical needs, and ensure that beneficiaries have the quality of life and level of independence they desire within the MLTSS program through person-centered processes and practices.

7. Comprehensive and Integrated Service Package: DMAS will work with stakeholders to achieve integrated MLTSS systems and ensure that providers developing and monitoring service plans

will provide comprehensive person-centered service planning and oversight of care across all available settings.

8. Qualified Providers: MLTSS systems must have an adequate network of qualified providers to meet the needs of enrolled beneficiaries. Virginia will assure that managed care networks also meet the needs of MLTSS beneficiaries, including adequate capacity and expertise to provide access to services that support community integration, such as employment supports, and the provision of training and technical assistance to providers.

9. Participant Protections: DMAS will address this vulnerability through program design, contracts with appropriate health and welfare assurances, a strong critical incident management system, and an appeals process that allows access to continuation of services while an appeal is pending.

10. Quality: DMAS will work with stakeholders to construct a comprehensive quality strategy and oversight structure that takes into consideration the acute and primary care, behavioral health, and LTSS needs of beneficiaries. This will also provide a framework for the Commonwealth to incorporate more meaningful goals into its program that focus on quality of care and quality of life for beneficiaries.

Virginia intends to work with CMS over the next several months to develop a plan for obtaining authority for the reforms described herein and develop a plan by mid-fall, in preparation for the upcoming legislative session beginning in January 2014. DMAS looks forward to continued involvement with this process.

Attachment 1

Public Comments on Virginia Health Reform Initiative

Phase 1 #1 Advancing Reforms in Progress through Dual Eligible Demonstration Project

Comments	Stakeholder
By unifying licensure, oversight and administrative processes across payment plans, Virginians will see administrative simplification and service efficiencies. Building on strengths of individual providers will create a successful project.	Virginia Association of Area Agencies on Aging
It is important to consider structure of program given the variation in the fee schedules and payment policies between Medicare and Medicaid. MSV encourages DMAS and managed care organizations (MCOs) to offer opportunities to providers to weigh in on plan design and communicate early and often with providers. MSV is willing to support these efforts.	Medical Society of Virginia (MSV)
VACSB is pleased the demonstration project includes behavioral health homes for people with serious mental illness and intellectual disabilities. We hope that these are co-located within or near the CSBs.	Virginia Association of Community Service Boards (VACSB)
Strategies should be developed to encourage physicians, hospital discharge planners and nursing facilities to become more knowledgeable about Medicaid long term care supports that can be provided in the community. Health plans should offer services equal to or greater than what is available in the Money Follows the Person program.	Association for Independent Living
We support the concept of placing a behavioral health consultant in a primary care setting and placing a primary care clinician in a behavioral health setting, thereby integrating "silos." Where the patient has a primary diagnosis of mental illness, the behavioral health component needs to be more developed and clinicians need to be experienced in dealing with serious mental illness.	National Alliance on Mental Illness
Move forward cautiously so that neither beneficiary access to services or provider viability is compromised. To reduce administrative burden and costs, we recommend MCOs use uniform processes and forms to the extent possible. Prompt and efficient processing of claims will be critical to success.	Virginia Health Care Association
We strongly recommend that medical nutritional therapy (MNT) services because this population has the most complex health care needs of any population served by Medicaid/Medicare. The demonstration should be designed to include referrals to registered dieticians for the Medicare Part B MNT benefit as s strategy for cost effective management of chronic conditions.	Virginia Academy of Nutrition and Dietetics
We encourage MCOs to provide education and access to oral health services for this population to improve health outcomes and lower costs, given that oral health is linked to chronic conditions like heart disease and diabetes. We are willing to work with MCOs and DMAS to design such a program.	Virginia Oral Health Coalition

Phase One #6 Behavioral Health

Comments	Stakeholder
VHHA encourages DMAS to maximize opportunities to integrate primary and behavioral health services; strengthen the continuum of care so that the right care is provided in the right setting at the right time; ensure that the outcome objectives benefit from full stakeholder input; and be fully transparent about the results that are being achieved.	Virginia Hospital and Healthcare Association (VHHA)
The contractor for these services should have expertise in best practices for behavioral health interventions with HIV/AIDS consumers and others with contagious infectious diseases.	Edward Strickler
The Commission has concerns with all Medicaid home and community-based service waivers and MFP being placed under the behavioral health services administrator. Not all categories within the waiver are related to mental health and placing individuals with disabilities and seniors under the category of behavioral health is not appropriate. These populations should be referred to the AAAs and CILs by the MCOs.	Prince William Commission on Aging
Providers should be trained and skilled in what they are contracted to do, e.g., dementia care. State agencies should ensure the Code, regulations and provider manuals are up to date.	Virginia Association for Area Agencies on Aging (AAA)
The BHSA contractor should provide technical assistance when providers need it, identify gaps in services in localities and regions and make recommendations to DMAS about how these may be closed. VACSB also recommends that DMAS and BHSA engage staff of DBHDS in oversight of services and determining medical necessity.	Virginia Association of Community Services Boards (VACSB)
We recommend DMAS and the BHSA involve the families/parents and of persons who receive services and that the staff of DBHDS be involved n oversight of the BHSA.	National Alliance on Mental Illness

Phase Two: Implementing Innovations in Service Delivery, Administration and Beneficiary Engagement
#7 Commercial- Like Benefit

Comments	Stakeholder
We are pleased that the plan contains mental health and substance abuse services, particularly those services that help them avoid emergency services. We recommend that supported housing, employment, vocational and educational services, peer support and other services not reimbursed by Medicaid now, be included to help individuals with SMI remain in the community and avoid jail, public and private hospital placement and prolonged residential treatment. VACSB cautions that general funds will need to remain rather than considering them part of matching funds. Local funds to CSBs may	Virginia Association of Community Services Boards National Alliance on Mental Illness

be compromised if costs shift to localities.	
The mental health/substance abuse benefits provided by Medicaid are superior to those offered by commercial insurers. Those services that contribute to long-term recovery include case management, programs of assertive community treatment, psycho-social rehabilitation, crisis intervention and stabilization and mental health support services. We support wrap around services for certain populations but these need to be further defined and clarified.	National Alliance on Mental Illness
We encourage DMAS and MCOs to evaluate the effectiveness and value of skilled nursing facilities in providing safe, lower cost rehabilitative care. We also urge the continuation of nonemergency transportation to ensure beneficiaries can be seen by physician specialists when needed.	Virginia Healthcare Association
Medical nutrition therapy services are currently provided in commercial benefit packages and should also be in Medicaid. These services have been found to be cost effective.	Virginia Academy of Nutrition and Dietetics

#10 Limited Provider Networks and Medical Homes

Comments	Stakeholder
Consider provider scope of practice in addition to quality through volume. Limited choices may help ensure satisfaction and success.	Virginia Association of Area Agencies on Aging
MSV appreciates the promotion of a patient-centered medical home model. It is important DMAS consider approaches that are consistent across health plans to mitigate the effect of plan switching for patient benefits and reimbursement levels that allow for the level of care coordination needed for successful programs. Care coordination is best delivered by a team that works with the patient's primary care physician, rather than through outsourcing to call centers. MSV is very concerned about DMAS's interest in limited provider networks and urge caution and close monitoring and evaluation of access to care, care coordination, patient satisfaction and utilization outcomes.	Medical Society of Virginia
The behavioral health home should be a choice for recipients and the CSB the home. VACSB believes limiting the provider network to certain categories would be step in the wrong direction.	Virginia Association of Community Services Boards
It is essential that any care network include access to dental services and education about the systemic links between chronic diseases and oral health services	Virginia Oral Health Coalition

Phase Three. Moving Forward with Coordination of Long-Term Services and Supports

Comments	Stakeholder
Provide the same protections for gay and lesbian Virginians that other Medicaid-eligible people receive in considering spousal assets and income allowances.	Edward Strickler
Evaluate the duals demonstration before expanding managed care to all populations. Carefully evaluate the benefits of modifying the existing approach to care delivery and funding.	Virginia Association of Area Agencies on Aging Virginia Health Care Association Virginia Association of Community Service Boards
We are concerned the decision was made to move waivers to managed care without discussion or feedback from individuals with ID/DD and their families. If carried out in a haphazard, hasty manner, it will place the health and well-being of Medicaid beneficiaries at risk. Shift to a system of LTC needs to be synchronized with efforts to fulfill its obligations under the terms of the Dept. of Justice Settlement and after reform of the ID and DD waiver programs. DMAS should include in its concept paper to CMS the essential elements of an effective long-term services and supports program as outlined in guidelines from CMS. This paper should be posted on the DMAS web site for comments and a summary of those comments and the DMAS response should be posted.	ARC of Virginia
DMAS needs to ensure that the necessary supports can be provided to individuals with intellectual and developmental disabilities to achieve community integration.	Virginia Association of Area Agencies on Aging