Medicaid Revitalization Committee

Meeting 2

Department of Medical Assistance Services

August 2, 2006

Presentation Outline

- ***Long-Term Care / Acute Care Integration Project***
- Additional Information on Florida's Medicaid Program
- Summary of Other State Reform Proposals/Plans
- Disease Management Approach to Care Management
- Enhanced Benefit Accounts/Other Participant Incentives
- Enhanced Electronic Access to Virginia Medicaid

Development of Blueprint for the Integration of Acute and Long Term Care

- As directed by the **2006 Virginia Acts of the General Assembly** (Item 302, ZZ): *The Department of Medical Assistance Services, in consultation with the appropriate community and state stakeholders, shall develop a long-range blueprint for the development and implementation of an integrated acute and long-term care system. This plan shall*
  - *(i) explain how the various community and state level stakeholders will be involved in the development and implementation of the new program model(s);*
  - *(ii) describe the various steps for development and implementation of the program model(s), include a review of other States' models, funding, populations served, services provided, education of clients and providers, and location of programs; and*
  - *(iii) describe the evaluation methods that will be used to ensure that the program provides access, quality, and consumer satisfaction.*

The Governor and the General Assembly Also Directs DMAS to Move Forward With Two Models by July 2007

- A Community Model (Item 302, AAA)
  - PACE is a Program of All Inclusive Care for the Elderly
  - Serves persons 55 and older that meet nursing facility criteria in the community
  - Provides all health and long term care services centered around an adult day health care model
  - Combines Medicaid and Medicare funding
- A Regional Model (Item 302, BBB)
  - This model could range from a capitated payment system for Medicaid and/or Medicare for acute care costs only and care coordination for long term care services to a fully capitated systems for all acute and long term care services

Start-Up Funds are Provided for PACE

- *The Department of Medical Assistance Services shall implement one or more Program for All Inclusive Care for the Elderly (PACE) programs by July 2007. Out of this appropriation, $1.5 million from the general fund the first year is for six grants up to $250,000 each for start-up funds for potential Programs for All Inclusive Care for the Elderly (PACE) programs. Grant funding may be used for staffing, development of business plans, and other start-up activities. To be eligible for grant funding, organizations must submit the following documentation to the Department of Medical Assistance Services no later than September 1, 2006:*
  - *(i) completion of a market assessment that demonstrates sufficient potential PACE participants to develop a PACE program; (ii) demonstration of partnerships with acute care hospitals, nursing facilities, and other potential partners; (iii) designation of an adult day health care center from which to operate a PACE program; and (iv) identification of funding partners to sustain a PACE project.*

DMAS Plans a Series of Three Meetings on Acute and Long Term Care Integration Models and Issues

- First Meeting: September 7, 2006 (9:00 a.m.- 3:30 p.m.)
  - Purpose: To provide an overview of Medicaid funded acute and long term care services in Virginia and across the United States
- Second Meeting: September 26, 2006 (9:30 a.m.- 12:00 p.m.)
  - Purpose: To provide information on the options for developing an integrated acute and long term care program in Virginia
- Third Meeting: October 18, 2006 (9:30 a.m.- 12:00 p.m.)
  - Purpose: To hear public comment on the Integration of Acute and Long Term Care

Blueprint Report Due to the General Assembly December 15, 2006

- Next Steps
  - DMAS will place a draft of the Blueprint report on its website and allow time for written comments
  - Written comment can be sent throughout the process to altc@dmas.virginia.gov

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Follow-Up on Florida Reform

- The MRC requested additional information on Florida's Reform effort (DMAS has provided additional information it hopes will be useful in your folders).
  - Specific questions raised at the last meeting:
    - MCO penetration rate: (Florida—66%; Virginia 62%)
    - Number expected to be affected: 200,000
    - Populations Included—See information packet
    - State Plan Comparison—A summary comparison by Kaiser Family Foundation is included in packet
    - Mental Health Services—See information packet

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Other State Reform: Overview

- To date, DMAS has focused on the reform efforts of Florida, South Carolina, West Virginia, Kentucky, and Idaho for various reasons:
  - these recent reform initiatives include provisions similar to the ones in HB 758
  - while Florida and South Carolina are waivers, the rest are State Plan amendments (SPAs) obtained under new provisions in the Deficit Reduction Act. CMS wants states to first try the SPA route before looking at a waiver.

- Obviously, DMAS will continue review other states' reforms and present information to the Committee as requested.

Other State Reform: Overview

(continued)

- This presentation will only highlight the most important features of selected states' reform efforts. Additional information detailing each of the reform initiatives is provided in your packets.

- It is important to understand that many of these reforms represent an outline of a desired approach, with details still very much in development.

- We will attempt to keep the Committee aware of any changes from our current understanding of these states' reform efforts as the Committee continues its work in the weeks to come.

Other State Reform: Overview

(continued)

- Reform terminology has broad, and often different meaning depending on the state or the reform source (DRA v. SPA). For example:
  - Enhanced Benefit Accounts (EBAs) and Health Opportunity Accounts (HOAs) are used almost interchangeably.
    - EBAs (Florida Waiver) address the broad concept of wellness incentives (providing incentives to recipients so they will engage in wellness activities). Various states offer a wellness incentive, but have different terms for them.
    - HOAs 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 health care services until a high deductible is met. The high deductible health plan would cover catastrophic costs.
  - Personal Health Accounts refer to risk-adjusted premiums in South Carolina, but they refer to wellness incentive accounts in Idaho.

Other State Reform: Overview

Stated Goals

(continued)

General Goal	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**	

Other State Reform: Overview

(continued)

	FL	SC	WV	KY	ID
Authority	Waiver	Waiver (Not Approved)	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	Yes	Yes	Yes
Electronic enhancements	Yes	Yes	Yes	No	No
Cost sharing changes	No	Yes	Yes	Yes	Yes

Other State Reform:
South Carolina

- The following components were proposed in South Carolina's waiver which has not been approved by CMS:
  - Risk Adjusted Premiums (Personal Health Accounts or PHAs) allowing recipients to choose a plan with benefits tailored to their needs. If a plan's premium is less than the State's contribution, the recipient can use any residual to pay for cost sharing or services not covered by the plan. The state will still pay for services if a recipient exceeds his PHA.
  - Self-Directed Plan—Only state so far to propose using the HSA concept with a high deductible plan for Medicaid recipients. The health plan would include catastrophic coverage plus selected screenings and preventive care. As with other South Carolina initiatives, this proposal is still in the concept phase.
  - Enrollees have the option of enrolling in employer-sponsored health insurance.

Other State Reform:
West Virginia

- The following components have been approved by CMS through a SPA:
  - West Virginia is reducing 29 Medicaid eligibility categories down to 4: healthy children, healthy parents, special needs individuals, and those over 65.
  - Healthy adults and children will be offered a choice between a Basic Medicaid Plan and an Enhanced Medicaid Plan. The basic plan reduces some of the current Medicaid benefits; the enhanced plan offers some additional benefits.
  - To receive the enhanced Medicaid plan, beneficiaries must sign a "member agreement" stating they will comply with all medical treatments and wellness behaviors.
  - Healthy Rewards Accounts reward recipients for making healthy decisions by providing credits that can be used for co-pays and for non-covered services.

[Additional information is provided later in the presentation]

Other State Reform: Kentucky

- The following components have been approved by CMS through a SPA:
  - Medicaid recipients will be assigned to four categories: general Medicaid population, children, elderly, and those with disabilities or mental retardation; each category will receive a different health plan.
    - *Family Choices* will cover most children (including SCHIP)
    - *Optimum Choices* will cover MR, developmentally disabled, and LTC population
    - *Comprehensive Choices* covers elderly in need of nursing facility level of care and those with acquired brain injuries
    - *Global Choices* will cover all others.
  - Employer-sponsored insurance enrollment required if available.
  - Get Healthy Accounts for members with targeted diseases provides rewards such as additional dental and vision services or nutritional or smoking cessation counseling for participating in healthy practices (keeping appointments, filling medications in timely manner).

Other State Reform: Idaho

- The following components have been approved by CMS through a SPA:
  - Idaho is reducing its eligibility categories to three: healthy adults and children, beneficiaries with disabilities, elderly beneficiaries.
  - A health risk assessment during the eligibility process will be used to place beneficiaries in one of three plans: a basic plan, an enhanced plan and a Medicare/Medicaid plan.
    - The basic plan emphasizes preventive care and wellness.
    - Enrollment in the enhanced and Medicare/Medicaid plans is optional.
  - Personal Health Accounts reward healthy behaviors (credits for weight loss, tobacco cessation, current immunizations and well-child visits. Credits can be used for fitness memberships, nicotine patches, weight loss).
  - An employer-sponsored health insurance option will be added to Medicaid. (Currently available only in SCHIP.)

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Overview of Disease Management

- House Bill 758 (HB758) directs the Revitalization Committee to consider:

"***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." (emphasis added)

and,

"A transitioning of all recipients remaining in the fee-for-service program to a ***disease management program***, care coordination program, or enrollment in MCOs." (emphasis added)

Overview of Disease Management
(continued)

- According to the Centers for Disease Control and Prevention, in 2004 more than 75 percent of the $1.4 trillion spent on healthcare in the U.S. was on care for chronic disease

- According to Johns Hopkins University, people with chronic conditions account for 88 percent of all prescriptions filled, 72 percent of all physician visits, and 76 percent of all inpatient stays

- Numerous challenges and deficiencies exist in the current treatment of chronic conditions including:
  - Some providers not following established practice guidelines
  - Lack of care coordination
  - Lack of active follow-up to ensure the best outcomes
  - Patients inadequately trained or unwilling to manage their illnesses

Overview of Disease Management
(continued)

- Healthcare delivery is more effective and efficient if patients take an active role in their care and providers are supported with necessary resources and expertise to better assist patients in managing illness

- Disease Management (DM) targets chronic illness/conditions (asthma, diabetes, congestive heart failure, coronary artery disease, HIV/AIDS, etc.)

- DM addresses chronic illness by:
  - Empowering the patient (with professional resources) to *manage* the condition, rather than forcing the healthcare system to treat acute episodes
  - Improving a patient's quality of care through promotion of evidence-based treatment

- Beyond health status improvements, DM has the potential to contain the costs of healthcare by focusing on prevention and therefore, avoidance of acute care services

Overview of Disease Management
(continued)

- Well-designed DM programs typically include the following components:
  - Targeting of high-risk patient populations
  - Promotion of evidence-based treatment plans with primary care physicians
  - Patient monitoring, education, and provider feedback
  - Rigorous program evaluation
- Two main program designs:
  - Provider-Centric
    - Physician conducts assessment and develops treatment plan in accordance with national standards
    - “Team Approach”
    - “Pay for Performance” incentive structure/compensation
    - Provider buy-in essential to success of the program
  - Patient-Centric
    - Nurse care manager conducts assessments, monitors treatment, and supports patient often from remote location (telephonically)
    - Interventions are designed to promote self-care
    - Provider participation is ideal, but not essential

Overview of Disease Management
(continued)

- Current Debate:
  - Which program design is more effective: provider-centric or participant centric programs?
  - What should the focus of DM be:
    - Providing education and support to patients, or
    - Changing the healthcare delivery system to realign and promote preventive care rather than acute care?

- Consensus exists that DM programs should include:
  - Development of a treatment plan in accordance with national standards
  - Extensive patient tracking in a medical records/database system
  - Active engagement of patients is essential

Overview of Disease Management
(continued)

- Medicare Disease Management Best Practices:
  - Initial assessment and development of a written, clear, practical, individualized plan of care with specific goals
  - Development of ongoing relationships with the primary care physician, other providers, the client, and family members
  - Excellent client education (self-care, diet, medical compliance, and self-monitoring)
  - Monitoring to make certain that planned interventions are completed
  - Periodic reassessment and adjustment of goals

Mathmatica Policy Research, Inc. Review of Medicare DM Programs (April 2004, Number 3)

Disease Management in Virginia Medicaid

- In 2004, Health Management Corporation proposed *Healthy Returns* - a pilot DM program targeting congestive heart failure and coronary artery disease for Virginia Medicaid fee-for-service participants at no cost to the Commonwealth

- The program showed some success and in 2005, Virginia issued an RFP to expand its DM initiatives

- Health Management Corporation was awarded the contract and the expanded *Healthy Returns* DM program was implemented on January 13, 2006

Disease Management in Virginia Medicaid

(continued)

- *Healthy Returns* focuses on preventative care, promotion of self-management, and appropriate use of medical services in the fee-for-service system (patient-centric)

- *Healthy Returns* provides DM services to Medicaid/FAMIS fee-for service recipients with the following conditions:
  - Asthma (adults and children)
  - Congestive Heart Failure (adults)
  - Coronary Artery Disease (adults)
  - Diabetes (adults and children)

Disease Management in Virginia Medicaid

(continued)

Healthy Returns Participation:

Active Participants as of June 13, 2006

Condition	Medicaid	FAMIS
Asthma	8,039	368
CAD	830	0
CHF	632	0
Diabetes	3,687	33
TOTAL	13,188	401

Disease Management in Virginia Medicaid

(continued)

Healthy Returns Participation :

Total Participation from 1/13/06 - 6/13/06

Condition	Medicaid	FAMIS
Asthma	8,540	402
CAD	958	0
CHF	753	0
Diabetes	4,065	38
TOTAL	14,316	440

Disease Management in Virginia Medicaid
(continued)

- *Healthy Returns*' main program interventions include:
  - Care Management:
    - Baseline health status assessment
    - Routine monitoring
    - Education on health needs and self-management
    - Monitoring of participant compliance with self-management protocols
    - Facilitation of contact with providers and community agencies
  - Nurse Line:
    - Available to participants 24 hours per day, 7 days per week through a centralized toll-free number
    - Provides clinical support to answer questions for DM program participants and assist participants with referrals
  - Evidence-Based Treatment:
    - Utilization of national evidence-based guidelines for the specialized conditions

Disease Management in Virginia Medicaid

(continued)

- *Healthy Returns*' is currently a "Opt-in" program where recipients identified with one of the four chronic conditions voluntarily participate in the program
  - Eligible recipients are identified through claims analysis or by referral
  - Eligible recipients are invited to participate through initial outreach by the vender
- DMAS is pursuing a transition from "Opt-in" to "Opt-out" with the Centers for Medicare and Medicaid Services (CMS)
  - Under an "Opt-out" program, individuals with a relevant chronic condition are automatically enrolled and receive program material
  - Automatically enrolled individuals may disenroll from the program at any time

Disease Management in Virginia Medicaid

(continued)

- Virginia Innovations in DM - Virginia is the **first state** to offer Disease Management to Home and Community-Based waiver participants
  - Virginia's Home and Community-Based Waivers (HCBS waivers) provide specialized services that allow participants to reside in and receive services in the setting of their choice, instead of in an institutional setting
  - HCBS waivers include: Elderly and Disabled with Consumer Direction, HIV/AIDS, Mental Retardation (MR) Day Support, Developmental Disabilities, Technology Assisted, and Alzheimer's
  - Special protocols were developed to optimize DM resources for HCBS waiver participants – particularly MR waiver participants

Disease Management in Virginia Medicaid
(continued)

- Virginia Innovations in DM - Virginia was one of eight states selected to participate in the national Agency for Healthcare Research and Quality (AHRQ) Disease 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 be informed about initiatives and innovations in other states

Disease Management in Virginia Medicaid

(continued)

- In addition to the *Healthy Returns* program for the fee-for service Medicaid population, the Medicaid managed care program, Medallion II, includes DM programs as well
  - 431,529 Medicaid recipients are enrolled in Medicaid Managed Care (2005)
  - Virginia's Medicaid Managed Care Organizations provide the following DM programs:

CareNet	Asthma, Diabetes, Depression, CHF, High-risk Pregnancy
VA Premier	Asthma, Diabetes
Anthem	Prenatal, CHF, CAD, Asthma, Diabetes
Optima	Asthma, Diabetes, Prenatal, CVD, COPD, Schizophrenia
Amerigroup	Asthma, Diabetes, HIV/AIDS

Disease Management Nationwide

- DM programs are operated by managed care plans, provider groups, state agencies, and DM companies
- Georgetown University Center on an Aging Society estimates that 97 percent of health plans are currently pursuing some type of DM program
- As of March 2004, the Centers for Medicare and Medicaid Services (CMS) reported that over 30 states (including Virginia) have Medicaid DM programs for Fee-For-Service clients.

Medicaid Disease Management Nationwide

State	Conditions
Arkansas	High Risk OB and neonatology
Colorado	Asthma, Diabetes
Illinois	Asthma, High 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
Mississippi	Asthma, Diabetes, Hypertension
Montana	Asthma, Diabetes, Hypertension
New Hampshire	Asthma, Diabetes, CAD, CHF, COPD, ESRD

Medicaid Disease Management Nationwide

(continued)

State	Conditions
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, high risk maternity, and depression

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Incentive Programs for Healthy Behaviors

"An ounce of prevention is worth a pound of cure" – B. Franklin

- Healthy behaviors should promote preventive care and diminish the demand for acute care, thereby stemming the rate of growth in Medicaid expenditure

- HB758 directs the Medicaid Revitalization Committee to consider the use of voluntary enhanced benefit accounts (or health opportunity accounts) for:
  a) individuals with chronic diseases or at risk of having or developing one or more chronic diseases;
  b) individuals for whom healthcare costs are or may become high; and
  c) 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;
  d) or individuals wishing to exercise the option to purchase private health insurance through their employer.

Incentive Programs for Healthy Behaviors
(continued)

- HB758 goes on to require consideration of:
  - a system of monetary incentives for Medicaid recipients to make healthy decisions and to engage in self-management of their healthcare, including
    - a process for the creation and award of incentive funds that can be earned by or awarded to enrollees to be accessed to purchase healthcare services or items that are not otherwise covered
    - 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
    - the phased implementation of electronic benefits cards for enrollees to access voluntary enhanced benefits and services
    - enhanced benefits accounts with actuarially defined premium amounts to be used to purchase private health insurance through employers

Incentive Programs for Healthy Behaviors
(continued)

- a mechanism by which (i) enrollees who lose Medicaid eligibility while enrolled in the voluntary program may retain access to the money in their enhanced benefits accounts, and (ii) enrollees could access services in the event of a depletion of the voluntary program funding.
- 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.

- As such, incentive programs for healthy behavior represent a major component of the Revitalization Committee's Medicaid Reform deliberations

Incentive Programs for Healthy Behaviors
(continued)

- Some state Disease Management programs utilize rewards for conformance to the plan of care
- Literature indicates that the use of pay for performance (P4P) / evidence based incentive programs for healthcare providers is on the rise
  - Some P4P plans include immunization rates and other preventive care measures thereby creating an incentive for the healthcare provider to actively encourage basic care for patients

Incentive Programs for Healthy Behaviors
(continued)

- Large-scale healthy behavior incentives are a relatively new concept for state Medicaid programs – Virginia Medicaid has no such incentive program
  - The Deficit Reduction Act of 2005 allowed some flexibility in states' ability to provide certain healthy incentive programs
  - Many states are considering some form of incentive program (Florida, Kentucky, Idaho, West Virginia)
    - State reforms appear to incentivise recipients through both "carrot" and "stick" approaches
      - Enhanced benefit accounts used to purchase health-related goods/services
      - Reduction to a streamlined basic benefit with behavior-based enhancement packages
  - Literature reveals some success in the commercial managed care market with healthy behaviors incentive programs
  - The jury is out on the effect of relatively moderate healthy behavior incentives on a Medicaid population that historically underutilizes preventive care services

What is an Enhanced Benefit Account?

- The primary reform model for enhanced benefit accounts (EBAs) is the Florida model.
  - Under the Florida reform, the EBA is a debit account which is capitalized by credits earned by recipients
    - Recipients earn credits through demonstrating certain healthy behaviors (attendance of routine vision exam, participation in Disease Management, receipt of immunizations, etc.)
    - Healthy behaviors are verified through claims analysis (Florida), self-reporting and/or direct reporting by healthcare providers

What is an Enhanced Benefit Account?

(continued)

- Credits are utilized to purchase non-covered, health-related goods and services (over-the-counter medicines, vitamins, orthopedic aids, etc.)
  - The EBA is accessed through a debit card mechanism designed to allow purchase of specified goods/services

- Access to EBA credits may be continued for a specified period even after Medicaid eligibility has ceased
  - Florida's reform plan allows access to EBAs for up to three (3) years after Medicaid eligibility has ended

Administrative Considerations of Enhanced Benefit Accounts

- The use of EBAs and the debit card structure may require significant collaboration among the Medicaid agency, provider, Managed care organizations, and private venders/retailers
  - Florida Medicaid is planning to manage policy and procedures
    - An “Enhanced Benefit Panel” will be formed with 7 members from provider and recipient advocacy groups to provide guidance on the development and evaluation of the program
  - Florida may contract the administration of the EBA program to a third party administrator
- Careful consideration should be given to the determination of populations eligible for participation in EBAs

Incentives Through Additional Benefits

- Other reform plans include access to additional non-basic benefits as an incentive for healthy behavior
  - West Virginia is implementing a two-tiered Medicaid benefit (generally for healthy adults and children)
    - All applicable recipients receive a basic benefit package depending on their eligibility (age) category. This package includes all mandatory services and some limited state-option services (is a lower benefit than pre-reform).
    - Recipients have the option to enroll in the enhanced benefits package through a “member agreement”. Members agree to:
      - Utilize a “medical home” (primarily a PCP or sometimes a particular specialist)
      - Comply with appointments
      - Use the emergency room only in emergencies
      - Comply with plans of care, including prescriptions

Incentives Through Additional Benefits
(continued)

- "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
  - Medication Compliance

[West Virginia indicates outcome measures will be used to track enrollees' compliance with member agreements. It appears the "medical home" provider will assess compliance, but we have been unable to obtain information as to how that compliance monitoring will be undertaken and whether financial compensation for monitoring is made to the provider]

- Non-compliance with member agreements will result in a reduction in benefits to the basic plan for at least 12 months, after which a recipient could sign a new agreement at the next scheduled eligibility redetermination.

Incentives Through Additional Benefits
(continued)

- Enhanced Benefits include:
  - Orthotics / Prosthetics (children)
  - Preventive Diabetes Care (adults & children)
  - Skilled Nursing Care (children)
  - Substance Abuse / Mental Health Services (adults & children)
  - Tobacco Cessation (adults & children)
  - Nutritional Education (adults & children)
  - Cardiac Rehabilitation (adults)
  - Chiropractic Services (adults)
  - Emergent Dental Services (adults)
  - Higher benefit allowances for basic plan services - removal of prescriptions per month limits, for example (adults & children)

[Note: It appears that many of the enhanced benefits are optional services that were more broadly available under West Virginia's pre-reform Medicaid Program]

Incentives Through Additional Benefits
(continued)

- Recipients with member agreements also have access to "Healthy Rewards Accounts" (similar to Florida's EBAs) in which credits are deposited for healthy behaviors
  - Credits can be used for co-payments, non-covered services, etc.

- EPSDT services are still required for children under age 19 regardless of participation in the basic or enhanced benefit plans – this appears to mitigate the incentive effect of the two tiered plan approach for children

- The West Virginia plan is expected to be implemented in November 2006.

Administrative Considerations of Additional Benefit Approach

- The West Virginia approach moves many services from current Medicaid coverage to the “enhanced benefit” package or limits coverage more strictly in the basic plan than was allowed pre-reform – unless recipients enter into and comply with member agreements, this represents a reduction in the scope of services covered by Medicaid

- Enforceability of member agreements is the key component of this approach – specifying measurable benchmarks and data sources is extremely important

- Careful consideration should be given to the determination of populations eligible for participation in tiered benefit approaches. [Opportunities under the DRA for benefit design flexibility will be discussed further at the August 9th meeting]

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Enhanced Electronic Access in the Virginia Medicaid Program

- The Revitalization Committee's specified responsibilities in HB758 includes a requirement 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.
  - It appears that the intent of this item is primarily for electronic access to enhanced benefit or health opportunity accounts which has been discussed previously in this presentation
  - However, the intent may also be to expand the use of electronic claims submission by providers and electronic payments back to providers

Enhanced Electronic Access in the Virginia Medicaid Program

(continued)

- DMAS Definitions:
  - Electronic Funds (EFT) - the capability to electronically transfer funds from the DMAS/fiscal agent claims account to an individual provider bank account for money owed for approved healthcare services.
  - Electronic Claims Submission – the capability to submit HIPAA compliant claims transactions electronically to the DMAS fiscal agent, First Health Services

Electronic Funds Transfer (EFT): Current Status

- Medicaid Fee for Service
  - EFT was implemented by Virginia Medicaid 2000
  - Approximately 32% of Virginia Medicaid providers participate in EFT, however this represents 71 percent of the claims dollars spent
  - EFT is optional, but strongly encouraged by DMAS
  - Providers can still receive “paper checks” and paper remittance advices
- Managed Care
  - Use of EFT ranges from 0% to 50% of the Medicaid MCO’s contracted providers participating
  - One MCO does not currently offer EFT (a relatively new plan which intends to offer EFT in 2007)
  - All other plans provide EFT as an *optional* payment method

Electronic Claims Submission: Current Status

- 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 also excluded (virtually all pharmacy claims are electronically submitted)
  - Electronic claims submitting providers must submit HIPAA compliant claims transactions through an electronic claims vendor
  - DMAS is currently exploring the option of allowing providers to submit individual claims through the internet
    - Providers with an internet connection (dial up or broadband) could submit claims without charge directly to First Health Services
    - Claims would be converted to a HIPAA compliant EDI format
    - Electronic Remittance Advices would be generated back to the provider in multiple formats

Electronic Claims Submission: Current Status

(continued)

- Managed Care
  - Medicaid MCOs report electronic claims submission percentages from a low of 41 percent to a high of 83 percent
  - One MCO (with the highest rate of electronic submission) has implemented a free web-based claims submission technology.