Overview of Program Reforms Required for Medicaid Expansion in Virginia

May 21, 2013

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Phase One Requirements

- Implementation of the Medicare-Medicaid ("dual-eligible") pilot program
- Enhanced program integrity and fraud prevention efforts
- Inclusion of foster care children in managed care
- Implementation of a new eligibility and enrollment system
- Improved access to Veterans services through the creation of the Veterans Benefit Enhancement Program
- Tightening of standards, services limits, provider qualifications, and licensure requirements for community behavioral health services

Phase Two Requirements

- Provide services and benefits that are the types that are provided by commercial insurers and may include appropriate and reasonable limits on services such as occupational, physical, and speech therapy, and home care with the exception of non-traditional behavioral health and substance use disorder services
- Place reasonable limitations on "non-essential benefits" such as non-emergency transportation
- Require patient responsibility including reasonable cost-sharing and patient participation in wellness activities
- This reformed service delivery model is mandatory, to the extent allowed, and should, at a minimum, include:
  - Limited high-performing provider networks and medical/health homes
  - Financial incentives for high quality outcomes and alternative payment methods
  - Improvements to encounter data submission, reporting, and oversight
  - Standardization of administrative and other processes for providers
  - Support of the health information exchange
- Administrative simplification of the Medicaid program through any necessary waiver(s) and/or State Plan changes to provide maximum flexibility and expedited ability to develop and implement pilot programs to test models that:
  - Leverage innovations and variations in regional delivery systems
  - Encourage innovations that improve quality of services and yield cost savings to the Commonwealth
  - Link payment and reimbursement to quality and cost containment outcomes

Phase Three Requirements

- The state is required to seek delivery system reforms that
  - Focus on "cost-effective, managed and coordinated delivery systems"
  - Move all remaining Medicaid populations and services, including long-term care (LTC) and home- and community-based waiver services into cost-effective, managed and coordinated delivery systems
- A report shall be provided to the 2014 General Assembly regarding the progress of designing and implementing such reforms.

Other Components

- Virginia's 2013 Appropriations Act includes language instructing DMAS to disenroll and eliminate coverage for the expanded population if the state's required match exceeds 10 percent of the program costs
- A reserve fund was created to collect savings attributable to expanded coverage
  - DMAS estimates that the state will save $1.32 billion between 2014-2022 due to
    - Reduced general fund payments to hospitals for uncompensated care, resulting from the decreased number of uninsured Virginians ($637 million)
    - The use of federal Medicaid dollars for
      - The Department of Corrections' inmate hospital costs ($290 million)
      - Some CSB services ($292 million) and temporary detention orders and other programs ($104 million)

DEVELOPMENTS IN MENTAL HEALTH LAW

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Mental Health Related Provisions of the Patient Protection and Affordable Care Act and the Potential Impact of Medicaid Expansion in Virginia

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President Lyndon Johnson once commented that the process of implementing the Medicare program represented "the largest managerial effort the nation had undertaken since the Normandy invasion."[1] Almost half a century later, with the passage of the Patient Protection and Affordable Care Act (Affordable Care Act), the United States has embarked on an even larger task: to reform the fiscal viability, accessibility and quality of the American health care system. The Affordable Care Act is comprised of a broad range of provisions including health insurance market reforms; the creation of new health insurance marketplaces (exchanges); coverage mandates and incentives; changes to Medicare, Medicaid and the Children's Health Insurance Program (CHIP); improvements to quality of care and system performance and programs to address workforce shortages.

Almost all of the provisions impact behavioral health care either directly or indirectly by, for example, awarding grants for mental illness research, incentivizing the movement toward coordinated and comprehensive person-centered care, and providing greater access to insurance coverage and health care services. Given that approximately 34 percent of Virginia's uninsured population is believed to have mental health or substance use needs, whether or not these individuals will be able to obtain insurance either through the exchange or the expansion of the state's Medicaid program will have significant implications for the future of behavioral health care in Virginia.[2] This year the budget passed by the General Assembly and approved by Governor McDonnell allows expansion to occur only if a commission of legislators agrees that a series of reforms to the Medicaid system have been accomplished.

Provisions of the Affordable Care Act Related To Behavioral Health Care[3]

- Insurers no longer will be allowed to deny coverage or charge a higher premium due to pre-existing conditions, including mental illnesses such as schizophrenia, bipolar disorder and major depression.
- Health insurance enrollees no longer can have annual or lifetime dollar limits placed on their coverage or have their coverage arbitrarily rescinded.
- Children are allowed to stay on their parent's plan until their 26th birthday, even if they are married. Over 66,000 young adults are now covered in Virginia as a result of this provision.

[1] Longest, Beaufort B. 2010. *Health Policy Making in the United States (5th Ed.).* Chicago, IL/Health Administration Press, p.103.
[2] Population estimate provided by the Virginia Association of Community Services Boards.
[3] Additional information about these, and other, provisions of the Affordable Care Act can be found at http://kff.org/health-reform/ and http://kaiserfamilyfoundation.files.wordpress.com/2011/04/8061-021.pdf.

- Prior authorization is no longer required for emergency care.[4]
- All health insurance plans, both within and outside of the health insurance exchanges, must comply with the Domenici-Wellstone Mental Health Parity Act of 2008.
- Mental health and substance abuse treatments must be included among the essential health benefits (EHBs) for all individual and small group plans within and outside of the health insurance exchange.[5]
- Prescription drug coverage, including medications for mental health disorders, also must be included among the essential health benefits for all individual and small group plans within and outside of the health insurance exchange. However, the final regulations for essential health benefits prescription drug coverage recently released by the Department of Health and Human Services (HHS) does not require that plans adopt the Medicare Part D program's mandated coverage of substantially all medications in six protected classes. Instead, plans must cover at least the greater of a) one drug in every category and class or b) the same number of drugs in each category and class as the benchmark plan.[6] [7]
- Beginning January 2014, smoking cessation drugs, barbiturates, and benzodiazepines will be removed from Medicaid's excludable drug list.
- The Medicare Part D coverage gap ("the doughnut hole") for prescription medications has been reduced by providing a $250 rebate in 2010 and a 50% discount on brand-name drugs in 2011. The coverage gap will be completely closed in 2020 by reducing coinsurance to 25% for all spending between the deductible and the catastrophic limit for both brand name and generic drugs. As of this year, Virginians have saved $84 million by the reduction in the Medicare Part D doughnut hole.
- Preventive care, including depression and alcohol misuse screenings, will be provided without patient cost-sharing obligations.
- Loan repayment programs are funded for pediatric subspecialists including providers of child and adolescent mental and behavioral health services who are or will be working in a Health Professional Shortage Area, Medically Underserved Area, or with a Medically Underserved Population.
- The Mental and Behavioral Health Education and Training Grants program provides funding to schools for the development, expansion, or enhancement of training programs in social work, graduate psychology, professional training in child and adolescent mental health, and pre-service or in-service training to paraprofessionals in child and adolescent mental health. Norfolk State University is one of 24 schools to receive the grant and has been awarded $458,277.
- The Melanie Blocker Stokes Post-Partum Depression Act provides education for mothers, support services to women experiencing post-partum depression and to their

[4] Some exceptions apply.

[5] Virginia has chosen to let the federal government run the exchange for the state. The largest small group plan in Virginia, Anthem Blue Cross Blue Shield's KeyCare PPO (along with CHIP and the Federal Employees Dental and Vision Plan for supplemental pediatric dental and vision benefits, respectively) was chosen as the benchmark for determining the essential health benefits package.

[6] The final rule adopts essential health benefit standards for plan years 2014-2015 only. After 2015, HHS may reconsider its requirements for EHBs and will offer additional guidance in the future.

[7] Academy of Managed Care Pharmacy. February 21, 2013 News Release. *HHS Finalizes Rule for Prescription Drug Benefit Design Under Essential Health Benefits to Implement Affordable Care Act Provisions and Clarifies Preventive Coverage for Certain OTC Items*.

families, and funding for research on the causes, diagnoses, and treatment of post-partum depression.

- In Virginia, the Centers for Medicare and Medicaid Services (CMS) is working with a VCU consortium of medical practices on a Medicare Independence at Home demonstration program to provide chronically ill or high-need Medicare beneficiaries with primary care services in their home. The teams of participating health professionals may share in savings resulting from preventable hospitalizations and readmissions, reductions in cost of care, and improvement in health outcomes, efficiency, and patient satisfaction.
- Grant funding has been provided for co-locating primary and specialty care in community-based mental health settings. The Norfolk Community Services Board (CSB) received $2 million to integrate primary care. The CSB's Medical Services Unit will be expanded to include primary care to serve 225 individuals per year in one setting, using the person-centered healthcare home model.[8]
- Virginia has received $72 million for Community Health Centers to prepare for the expected doubling of the number of patients seen in the next 5 years.
- Finally, the Affordable Care Act includes provider incentives for adopting service delivery models (such as medical homes and accountable care organizations) that replace the fee-for-service system with quality outcomes-based coordinated and comprehensive person-centered care.

Access to Affordable Health Insurance

In order for individuals with behavioral health care needs to benefit from the majority of the Affordable Care Act's components mentioned above, they must first have access to affordable health insurance. Currently over one million Virginians, fourteen percent of the state's population, are uninsured. Sixty percent have incomes at or below 200% of the Federal Poverty Level (FPL), and many with mental health and/or substance use needs are now being served by CSBs or are receiving care through the use of emergency departments.[9] While Virginia has an extensive network of healthcare safety net providers, it only has capacity to treat approximately 30% of the uninsured.[10]

However, over 500,000 uninsured Virginians could obtain health insurance as a result of the Affordable Care Act. This population includes working parents, uninsured veterans, children who age out of Medicaid, the disabled who must wait two years for Medicare coverage, and other low income adults. Approximately 400,000 adults will qualify for Medicaid if the program is expanded to include all qualified persons with incomes up to 138% of FPL (e.g. about $15,400 per year for an individual and $32,000 per year for a family of four).[11] One hundred thousand

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[8] APA Advocacy Rush Notes, Health Reform Special Report. 2010.

[9] Kaiser Family Foundation. *State Health Facts* (www.statehealthfacts.org). Mary Ann Bergeron, Virginia Association of Community Services Boards, Presentation on Health Care Reform: Impact and Benefits for Virginia and Citizens with Behavioral Health and Developmental Needs.

[10] Jill Hanken, Virginia Poverty Law Center, Presentation on The Affordable Care Act: What's Next for Virginia? (December 2012).

[11] In Virginia, over 834,000 people have health coverage through Medicaid/FAMIS. The program covers mostly seniors in nursing homes, people with disabilities, pregnant women, children, and working families. The current

individuals (adults and children) are expected to obtain coverage through the exchange in which premium tax credits and cost-sharing subsidies are available for individuals and families with incomes up to 400% of FPL, and 71,000 currently eligible but uninsured children are expected to enroll in FAMIS or Medicaid. The rest will remain uninsured, highlighting the continuing need for community health centers and other safety net providers in Virginia.[12]

The Question of Medicaid Expansion in Virginia

In June of 2012, the U.S. Supreme Court ruled that the federal government could not force states to expand their Medicaid programs by withholding federal funds from the existing Medicaid programs. With the expansion decision now left to each state, at the close of Virginia's 2013 General Assembly Session, Governor McDonnell, the House of Delegates and the Senate reached an agreement that if the state is to expand its Medicaid program in 2014, a series of reforms must first be accomplished. Whether reforms meet the criteria established in the budget (HB 1500) will be determined by a bi-cameral Medicaid Innovation and Reform Commission (Commission) consisting of five Senators and five Delegates, and the Secretary of Health and Human Resources and the Secretary of Finance as ex-officio members. The House members, appointed by the House Appropriations Committee Chair, are: Steve Landes (R-Augusta), Jimmie Massie (R-Henrico), Beverly Sherwood (R-Frederick), John O'Bannon (R-Henrico) and Johnny Joannou (D-Portsmouth).[13] The Senate members are Walter A. Stosch (R-Henrico), Senate Finance Committee Chair, and his appointees: Emmett W. Hanger, Jr. (R-Augusta), John Watkins (R-Powhatan), Janet D. Howell (D-Reston), and L. Louise Lucas (D-Portsmouth). A majority of Commission members from each chamber is required to determine if Medicaid will be expanded based on their assessment of whether the reforms specified in the budget amendment have been achieved. The Commission is scheduled to meet every other month, beginning in June of this year.

During the General Assembly Session, some legislators questioned the constitutionality of empowering a sub-group of legislators with the ability to determine whether Virginia expands its Medicaid program without allowing the full Assembly to vote on the issue either during a special session or during next year's session. At the request of Delegate Robert Marshall, Attorney General Ken Cuccinelli issued an opinion that the Assembly could not delegate budget authority to a special committee.[14] Budget negotiators from the House and Senate addressed the problem by introducing a revised amendment that appropriates the federal funding for expansion in 2014 once the Commission determines that the required reforms are complete. In so doing,

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eligibility levels in Virginia are less than 30% of FPL for working parents; 80% of FPL for the aged, blind, or disabled; up to 200% of FPL for children and pregnant women during their pregnancy (through Medicaid or FAMIS). Childless adults are not eligible.

[12] The almost 500,000 individuals who will remain uninsured include U.S. citizens who either choose not to be covered or are exempt from the mandate, low income legal immigrants who are ineligible for Virginia's Medicaid program and cannot afford exchange products, and undocumented immigrants.

[13] Lacey E. Putney (I-Bedford), House Appropriations Chair, chose to not serve on the Commission due to his upcoming retirement.

[14] The Opinion is available on the Attorney General's website at: http://www.oag.state.va.us/Opinions%20and%20Legal%20Resources/OPINIONS/2013opns/13-013%20Marshall.pdf.

the appropriation was approved by the Assembly, not the Commission, returning oversight and authority to the legislature as a whole.[15]

Required Medicaid Reforms:[16]

The program reforms, outlined in Virginia's 2012-2014 Appropriations Act, which must be achieved in order for Medicaid expansion to be approved by the Commission are organized into three phases.

Phase One Requirements:

- Implementation of the Medicare-Medicaid ("dual-eligible") pilot program
- Enhanced program integrity and fraud prevention efforts
- Inclusion of foster care children in managed care
- Implementation of a new eligibility and enrollment system
- Improved access to Veterans services through the creation of the Veterans Benefit Enhancement Program
- Tightening of standards, services limits, provider qualifications, and licensure requirements for community behavioral health services

Phase Two Requirements:

- Provision of services and benefits that are the types that are provided by commercial insurers and may include appropriate and reasonable limits on services such as occupational, physical, and speech therapy, and home care with the exception of non-traditional behavioral health and substance use disorder services
- Placement of reasonable limitations on "non-essential benefits" such as non-emergency transportation
- Requiring patient responsibility including reasonable cost-sharing and patient participation in wellness activities
- This reformed service delivery model is mandatory, to the extent allowed, and should, at a minimum, include:
  - Limited high-performing provider networks and medical/health homes
  - Financial incentives for high quality outcomes and alternative payment methods
  - Improvements to encounter data submission, reporting, and oversight
  - Standardization of administrative and other processes for providers
  - Support of the health information exchange
- Administrative simplification of the Medicaid program through any necessary waiver(s) and/or State Plan changes to provide maximum flexibility and expedited ability to develop and implement pilot programs to test models that:

[15] Michael Martz, Richmond Times-Dispatch: Reforms at 'Front End' of Medicaid Expansion (Feb. 24, 2013).
[16] Budget language for the reforms can be found in Item 307, Number 20c of the 2012-2014 Appropriations Act (HB 1500). Additional sources for this section: 1) Jill Hanken ,e Virginia Poverty Law Center, and Michael Cassidy, The Commonwealth Institute, Presentation to the Children's Health Insurance Program Advisory Council on Medicaid Expansion in Virginia: A Path Forward (with Some Speed Bumps)(March 1, 2013); 2) Communication with Virginia's Department of Medical Assistance Services. March-May, 2013.

    - Leverage innovations and variations in regional delivery systems
    - Encourage innovations that improve quality of services and yield cost savings to the Commonwealth
    - Link payment and reimbursement to quality and cost containment outcomes

Phase Three Requirements:

- The state is required to seek delivery system reforms that
    - Focus on "cost-effective, managed and coordinated delivery systems"
    - Move all remaining Medicaid populations and services, including long-term care (LTC) and home- and community-based waiver services into cost-effective, managed and coordinated delivery systems
- A report shall be provided to the 2014 General Assembly regarding the progress of designing and implementing such reforms.

All of the reforms specified in Phase One are currently underway and are the least likely to delay expansion. While the Medicare/Medicaid dual eligibility demonstration project is a large and difficult program to implement, it is progressing and interaction between the Department of Medical Assistance Services (DMAS) and CMS is positive. Importantly, the project includes an option for individuals with serious mental illness (SMI) within the dual-eligible population to choose a behavioral health organization, such as a Community Services Board, as a health home. This will enable the utilization of targeted case management in overall care coordination, and ultimately provide greater "flexibility in paying for needed and effective services, including peer services, to support individuals with SMI in their communities."[17]

Also, DMAS is currently moving foster care children into the managed care system, and the process is on track for completion in the Richmond and Tidewater regions by July 1, 2013, and statewide in October of next year. The Veterans Benefit Enhancement Program is in development; and DMAS has been focusing efforts in the area of community behavioral health, working on regulations to better specify the qualifications needed for providers to assure that mental health services are administered appropriately.

The reforms in Phase Two apply to all Medicaid populations, except dual eligibles and individuals in long-term care, and are intended to bring substantial changes to Virginia's current Medicaid benefits structure, requiring it to be more like a commercial health insurance plan. However, given that non-traditional behavioral health and substance use disorder services (e.g. community mental health services) typically are not covered in commercial insurance products, the language does specify that these services should continue to be included in the Medicaid health plan. According to DMAS staff, moving to a commercial health insurance plan model with limitations on non-essential benefits and increased cost-sharing obligations for patients appears to be possible under current federal regulations. However, the budget language does not specify the degree to which benefits must be limited and cost-sharing increased. Until specific metrics are determined by the Commission members, DMAS officials cannot say whether further

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[17] Mary Ann Bergeron, Virginia Association of Community Services Boards, Update on Community Support Boards and Managed Care in Virginia, The National Association of County Behavioral Health and Developmental Disability Directors Newsletter (September 2012), p. 2.

approval from CMS will be needed. Simplification of how Virginia administers the Medicaid program, including consolidation of waiver programs for community based services, and the development of delivery and payment reform pilot programs likely will require further negotiations with CMS before they can be approved.

Lastly, Phase Three requires DMAS to seek innovative ways to deliver more cost-effective, managed and coordinated care to all Medicaid participants. The use of the word "seek" suggests that the Commission will recognize that broad system reforms take years to fully implement and, therefore, will only require that progress is being made in order for Medicaid expansion to occur.

Other Components of the Medicaid Reform Requirements:

In order to address concerns that the promised federal medical assistance percentages specified in the Affordable Care Act may be reduced through federal law or regulation in the future, leaving Virginia to pay a greater share of the costs for Medicaid expansion, Virginia's 2013 Appropriations Act includes language instructing DMAS to disenroll and eliminate coverage for the expanded population if the state's required match exceeds 10 percent of the program costs.[18] In addition, a reserve fund was created to collect savings attributable to expanded coverage. DMAS estimates that the state will save $1.32 billion between 2014-2022 due to reduced general fund payments to hospitals for uncompensated care, resulting from the decreased number of uninsured Virginians ($637 million), and the use of federal Medicaid dollars for the Department of Corrections' inmate hospital costs ($290 million), some CSB services ($292 million) and temporary detention orders and other programs ($104 million).[19] Currently all of these programs are funded by state and/or local dollars. If expansion occurs, the federal government will pay 100 percent of the cost for three years, and 90 percent thereafter. The savings realized by the state will be used to support reforms outlined in Phase Two and to be used after 2020 when Virginia will pay 10 percent of the Medicaid expansion costs.

Conclusion

The Patient Protection and Affordable Care Act is the most extensive healthcare reform legislation since the passage of Medicare and Medicaid, and it is not surprising that the law, two years after its passage, remains highly controversial. The debates over the law's provisions, like Medicaid expansion, highlight the ideological diversity of Americans and the challenge of reforming a massive health care system that needs to be fixed. However, there does appear to be general agreement that many of the law's provisions, if implemented fully, accurately, and efficiently, can improve how behavioral health care is accessed and provided in our society. Medical homes, Accountable Care Organizations, and other models of integrated care link physical and mental health services; and they emphasize payment based on the quality, rather than the quantity, of the services provided. As a result, these system-wide models of change

[18] The Affordable Care Act includes the provision that states that choose to expand their Medicaid program will receive 100% federal funding for years 2014-2016, phasing down to a 90% federal match after 2020.
[19] Go to The Commonwealth Institute's website (www.thecommonwealthinstitute.org) for a more detailed analysis of DMAS estimates of the expected state savings from Medicaid expansion and the Affordable Care Act overall.

hold significant promise for many individuals with mental health needs and substance use disorders who have experienced the challenge of finding care in a fragmented service system.

However, given that approximately 34% of Virginia's uninsured population has some type of behavioral health care need, the expansion of the state's Medicaid program is seen as a necessity by many health care professionals in order for health care reform to be fully realized in Virginia. During the 2013 General Assembly Session, state lawmakers came to an agreement that efforts to reform the state's Medicaid program must first be in place before expansion can occur. Many of these reforms already are being implemented and should not pose a problem for expansion, while others likely will require further approval from CMS. At this point, it would be inaccurate to claim that Medicaid expansion in Virginia definitely will occur; but it is clear that Virginia's Medicaid program is being reformed, hopefully resulting in more efficient, effective, and comprehensive care for individuals with behavioral health care needs.

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