Update on Medicaid Reform & Long-Term Care Initiatives

Presentation to the

Joint Commission on Health Care Long-Term Care and Medicaid Reform Subcommittee

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Department of Medical Assistance Services

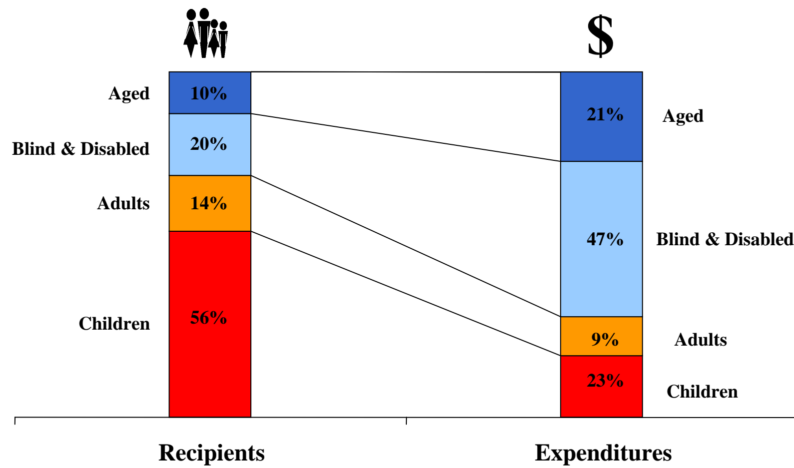
September 4, 2008

Presentation Outline

- ***Long Term Care Reforms***
  - ***Asset Sheltering Reforms – Life Estates***
  - Long-Term Care Partnership
  - Integration of Acute & Long-Term Care
  - Money Follows the Person
- Other Medicaid Reforms
  - Specialty Drug Program
  - Disease / Chronic Care Management
  - Enhanced Benefit Accounts
  - Medicaid Works Program

Medicaid Enrollment & Expenditures: Aged and Disabled Utilize Nearly 70% of the Costs

(Fiscal Year 2007)



Treatment of Life Estates in Medicaid

- A life estate is the right to occupy and use property during a person's lifetime (without direct ownership of the property)
  - Prior to the Deficit Reduction Act (DRA) of 2005, life estates had not been considered a countable resource under Medicaid eligibility rules
  - Under the DRA, the purchase of a Life Estate is an uncompensated transfer unless the individual purchases a life estate in property that has served as their principal residence for at least one year
    - The value of life estates is calculated based on a number of factors, including a person's age, life expectancy, and value of the property in which he or she will have a life estate

The JLARC Asset Transfer Report

- HJR 97 and SJR 122 (2006) directed DMAS and JLARC to monitor changes in federal restrictions on sheltering assets to qualify for Medicaid long-term care services
- Regarding Life Estates, JLARC recommended:
  - The General Assembly may wish to direct DMAS to pursue authority to consider all life estates as a countable resource for determining Medicaid eligibility

The JLARC Asset Transfer Report
(continued)

- In response to the JLARC recommendation, the 2008 Acts of Assembly (Chapter 879, Item 306 NN) directed DMAS to consider life estates retained in property in the same manner as other real and home property in the Medicaid eligibility determination
  - All life estates will be *evaluated* as a resource
    - Life estates used as home property be exempt in the eligibility determination
    - For eligibility for long-term care services, life estates used as home property will be exempt as a countable resource for six months following admission to a nursing facility
  - DMAS has drafted a regulatory change pursuant to the language in the Appropriations Act
    - Regulatory package currently under review by the Governor's office

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Overview of Long-Term Care Partnership Programs

- Long-Term Care (LTC) partnerships are public-private ventures created to address the financing responsibility of LTC
  - LTC partnerships are designed to encourage individuals to plan for their future through the purchase of a private LTC insurance policy. This policy will help fund an individual's LTC needs, rather than relying on Medicaid to do so
  - LTC partnerships combine private LTC insurance with special asset protection if the need to apply for Medicaid arises. Typically this would occur for individuals who exhaust their LTC insurance benefits

Long-Term Care Partnership Opportunity Under the DRA

- The Deficit Reduction Act of 2005 (DRA) lifted the moratorium on estate recovery disregards thereby encouraging new development of LTC partnerships as an option for state Medicaid programs
  - states are now allowed to develop LTC partnerships using what is termed the "dollar-for-dollar" model
    - Dollar-for-dollar policies protect a specific amount of personal assets. For every dollar that a LTC Partnership insurance policy pays out in benefits, a dollar of assets can be protected during the Medicaid eligibility determination
    - These assets would also be protected from estate recovery upon the recipient's death

The Long-Term Care Partnership Program In Virginia

- After much planning and collaboration, DMAS and the Bureau of Insurance (BOI) established and delineated shared responsibilities for implementing the partnership program
  - On September 1, 2007 Virginia was the third state (since the DRA) to launch its LTC Partnership and the first state to launch its Partnership with a coordinated consumer outreach campaign
  - To date, 3,000 LTC partnership policies have been sold in Virginia.
- Virginia has used grant funding (Center for Health Care Strategies LTC Partnership Expansion Grant - $50,000) to develop a website (www.valtcpartnership.org), brochure, and is currently working with the Robert Wood Johnson Foundation and SpitFire Strategies to develop a strategic marketing campaign

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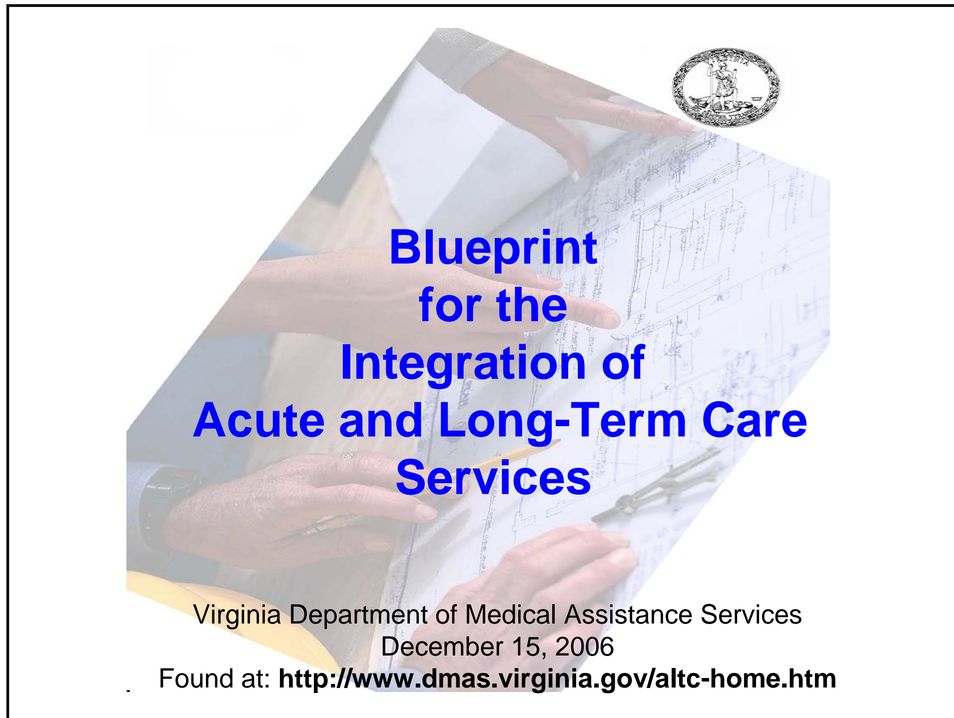
Governor Kaine Directs DMAS to Develop A Blueprint for the Integration of Acute and Long Term Care

2006 Virginia Acts of the General Assembly (Item 302, ZZ)

- The degree of chronic illness and disability among seniors and persons with disabilities is a key policy and budget issue for the Commonwealth.
- Our current long term care system is a patchwork of care without the benefit of care coordination.
- Integration of all the services into a single program offers a strategy that promises to control Medicaid expenditures without curbing access to services needed by our most vulnerable citizens.



Blueprint for the Integration of Acute and Long-Term Care Services

Virginia Department of Medical Assistance Services
December 15, 2006
Found at: **http://www.dmas.virginia.gov/altc-home.htm**

Implementation of the Blueprint to Integrate Acute and Long-Term Care

- DMAS is actively engaged in two approaches to better integrate and coordinate the acute and long-term care of the vulnerable Medicaid population in need of both types of services

Model 1 - Community: Adult day health care – the Program for All-inclusive Care for the Elderly (PACE)

Model 2- Regional: Regional managed care – the Virginia Acute and Long-Term Care (VALTC) program

Model 1 - Community: The Program for All-Inclusive Care for the Elderly

- The PACE model is centered on the belief that it is better for the well-being of the elderly, with chronic care needs, and their families to be served in the community whenever possible
- The goal of PACE is to keep participants healthy and safe in their own homes and communities
- PACE uses an interdisciplinary team to determine, along with the recipient/caregiver, what services will best benefit their condition to achieve their goals
- Recipients must:
  - be age 55 or older and prescreened to meet nursing facility criteria
  - reside in the PACE service area
  - have an income equal to or less than 300% of the current Social Security Income

PACE Services

- PACE recipients receive:
  - Adult day care offering:
    - nursing
    - physical therapy
    - occupational therapy
    - recreational therapy
  - Meals
  - Nutritional counseling
  - Social services
  - Personal care
  - Medical care
  - Home health care
  - Prescription drugs
  - Medical specialists Services (such as dentistry, optometry and podiatry)
  - Respite care
  - Hospital and nursing facility care when necessary
  - Transportation
  - Assisted living facilities for housing when the need arises

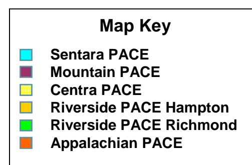
In other words, there are no excluded services

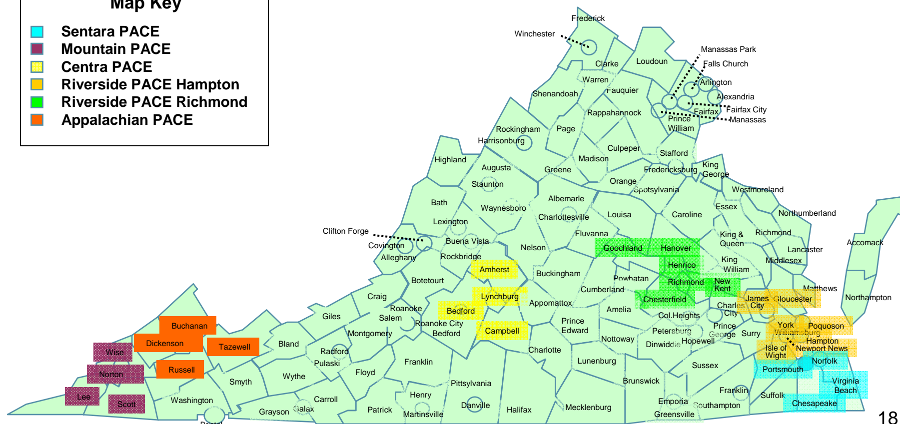
PACE Sites in Virginia – Providers

- Three Health Systems:
  - PACE of Sentara (Virginia Beach) - Began November 2007, 131 participants
  - PACE of Riverside (Peninsula) - Began February 2008, 73 participants
  - PACE of Riverside (Richmond) - Target date: December 2008
  - PACE of Centra (Lynchburg) - Target date: January 2009
- Two Area Agencies on Aging:
  - PACE of AllCARE for Seniors AAA (Appalachian AAA - Cedar Bluff) – Began May 2008, 14 participants
  - PACE of Mountain Empire AAA (Big Stone Gap) – Began March 2008, 25 participants

243 Total Participants

PACE Sites in Virginia – Location





Future PACE Sites

- DMAS has published two Request for Applications (RFA) for the development of a PACE site in other areas in Virginia:
  - RFA for the development of PACE in Northern Virginia will be republished in October 2008. The following areas have been identified as potential PACE site locations - Falls Church, Arlington, Fairfax, Vienna, Manassas, Alexandria (One PACE site will be designated to serve all areas – with the potential for satellite centers)
  - On June 24, 2008, in response to a RFA, Sentara Life Care Corporation received approval from the Department of Medical Assistance Services to develop a PACE site for the cities of Chesapeake, Norfolk, Portsmouth and Suffolk. The PACE site will be located in the city of Suffolk, and is targeted to open in 2009

Model 2 - Regional: The Virginia Acute & Long-Term Care Program (VALTC)

- Over 60% of Virginia Medicaid participants are enrolled in a Managed Care Organization (MCO).
  - The majority of MCO participants are children and pregnant women
  - 50,000 Aged and Disabled are included
- However, a large portion of Aged and Disabled populations are currently excluded from participation in Managed Care.
  - Both Medicare and Medicaid (dually eligible) and
  - Participants in DMAS' seven home and community-based long-term care waiver programs

VALTC: What is it?

- Main concept: Offer primary, acute, and long-term care services through a managed care program
- To accomplish this, DMAS is integrating populations and services previously excluded from managed care into managed care.
  - Populations: Dual Eligibles and Elderly or Disabled with Consumer Directed (EDCD) Waiver Participants
  - Services: Primary, acute, and long term care services (those in EDCD waiver)

VALTC: An Overview

- VALTC is a first step toward bridging Medicare and Medicaid and integrating medical and long-term care services across the spectrum of care
- Nationally, interest in integrated care is gaining momentum
  - 7 other state Medicaid programs currently offer some form of integrated care: Arizona, Florida, Massachusetts, Minnesota, New York, Texas, and Wisconsin
  - Hawaii just received approval to implement its program
- VALTC creates a new managed care program designed for individuals who are dually eligible and individuals who participate in DMAS Elderly or Disabled with Consumer Direction waiver program
- DMAS is developing VALTC as a pilot program
- It is scheduled to launch in the Tidewater area in 2009 and in Richmond at a later date

VALTC: Mission

- To improve the quality of life of Virginia's Medicaid-enrolled seniors and adults with disabilities
- To empower participants to remain independent and reside in the setting of their choice for as long as possible
- To provide a streamlined primary, acute, and long-term care service delivery system that offers ongoing access to:
  - Quality health and long-term care services,
  - care coordination, and
  - referrals to appropriate community resources

VALTC: Population Summary

- Projected Number of VALTC participants in Tidewater:

as of 2/1/08*	Full Benefit Duals	Duals With EDCD	EDCD Only	Total
Tidewater	12,003	1,732	371	14,106

*Actuarial estimates based on estimated member continuous months

- Participants will fall into one of three groups: dual eligible, dual eligible enrolled in the EDCD waiver, and EDCD participant who is not a dual eligible

VALTC: Program Highlights

- DMAS will contract with at least two MCOs for each region to administer the program
- VALTC will offer care coordination to participants. This will provide assistance with setting up appointments, arranging transportation, and conducting assessments to ensure that the proper level of services is being provided
- VALTC participants who become enrolled in a nursing facility will remain in VALTC for the first 60 days of their stay
- Participants who require personal care (assistance with activities of daily living) will be able to “consumer direct” this service – just like they are able to with the current EDCD waiver program

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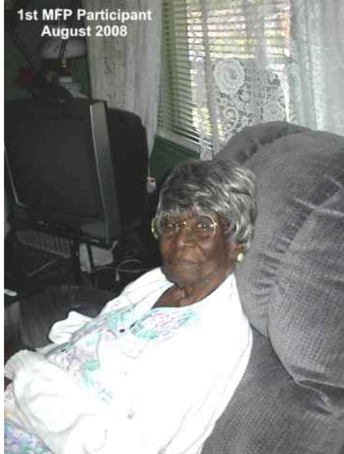
Money Follows the Person (MFP)

- MFP is a federal opportunity to further develop community integration strategies, systems, and infrastructure for individuals with long-term care needs
- Four Main Components:
  - A program that identifies individuals in institutions (over 6 months) who wish to move back into the community (over 1,000 in a four year period)
  - Assists them with the transition process
  - Assists states by providing an enhanced Medicaid match for individuals who transition from institutions into the community (75/25)
  - Enhances community services to better support individuals who transition into the community

MFP Service Enhancements

- MFP creates permanent changes to Virginia's home and community-based waivers by:
  - Adding existing services to select home and community-based waivers
  - Creating new waiver services
    - **Transitional Services** – a one-time, life-time $5,000 benefit for those individuals leaving from institutional settings
    - **Transition Coordination** - responsible for supporting the individual with the activities associated with transitioning

Virginia's MFP Demonstration: Virginia's First MFP Participant



- Mrs. W, a 97 year old widow, lived in her home until a fall caused a week long hospitalization in January 2008
- She was transferred to a nursing facility where she continued rehabilitation for the next 6 months
- In July 2008, Mrs. W working with the facility discharge planner, a transition coordinator, and Mrs. W's Power of Attorney, Mrs. W elected to participate in the MFP Project
- Mrs. W developed her service plan with assistance from a transition coordinator and was able to purchase needed household items to re-establish her home prior to her discharge through Transition Services/Funding
- Arrangements were also made to have needed environmental modifications made to her home
- She moved home in late July and now receives services through the Elderly or Disabled with Consumer Direction waiver

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DMAS Development of the Specialty Drug Program

- Item 306 CC of the 2008 Appropriations Act directs DMAS to modify the delivery system of pharmaceutical products to include a specialty drug program
  - Budget language specifies that the program should include both care management and cost control components
- Specialty drugs include biological drugs, select oral, injectable and infused medications
  - generally target and treat specific chronic or genetic conditions, such as Hemophilia, Hepatitis C, and Multiple Sclerosis
  - generally require
    1) tailored patient education
    2) patient specific dosing
    3) close patient monitoring
    4) refrigeration or special handling

DMAS Development of the Specialty Drug Program

(continued)

- Specialty drugs are expensive medications
  - nationally the fastest growing segment of drug costs
  - estimated at $40 billion in total cost (nationally) at the end of 2006
- In developing the program, DMAS staff solicited input from external stakeholders:
  - Specialty drug vendors;
  - Pharmaceutical manufacturers;
  - Other state Medicaid programs; and,
  - The Centers for Medicare & Medicaid Services

  and existing professional partners:
  - DMAS Pharmacy Liaison Committee
  - DMAS P&T Committee
- Based on research & recommendations, DMAS decided to phase-in the implementation of the specialty drug program

DMAS Phase I Implementation of the Specialty Drug Program

- The Drug Utilization Review (DUR) Board conducted typical drug review (e.g., therapeutic duplication, drug to diagnosis alert, adverse drug reactions) for Growth Hormone, Hepatitis C, and Low Molecular Weight Heparin drug classes in August 2007
- The Pharmacy and Therapeutics (P&T) Committee reviewed and approved (in October 2007) initial drug classes for inclusion on the Preferred Drug List (PDL). The approved drug classes, with criteria established for recipients' health and safety were:
  - Hepatitis C
  - Growth Hormones

DMAS Phase II Implementation of the Specialty Drug Program

- The Specialty Maximum Allowable Cost (SMAC) program was implemented July 1, 2008 to begin to address the cost control goal of the budget directive
  - the discounted pricing model is administered by Optima Health (which also administers the generic drug MAC Program)
    - the SMAC program has a design similar to the existing MAC program (for generic drugs)
  - Initial drug classes include:
    - Hematapoietic Agents
    - Anti Tumor Necrosis Factor Agents (Rheumatoid Arthritis)
    - Immunomodulator Agents
    - Agents to treat Muscular Sclerosis
    - Growth Hormones
    - Interferon Agents for Hepatitis C

DMAS Phase II Implementation of the Specialty Drug Program
(continued)

- Additional drug classes will be phased in as deemed appropriate
- Drugs are priced (for reimbursement to the dispensing pharmacy) according to rates based on a fair, "market bearing" price with consideration for pharmacies' acquisition costs and a reasonable margin

- Phase II will also include the implementation of care management for specialty drug recipients
  - DMAS is currently evaluating existing care management programs in developing an approach to care management for specialty drugs

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Chronic Disease Management Under Virginia Medicaid

- Virginia currently operates a Disease Management program, called *Healthy Returns*^{SM}, focused on a handful of specific diseases
- Virginia is currently in the process of developing a chronic care management program focused on other recipients with chronic illness with a probability of substantial health care costs as the condition progresses

Disease Specific Care Management: *Healthy Returns*^{SM}

- Virginia *Healthy Returns*^{SM} disease management (DM) program has been operated by Health Management Corporation since January 2006
- *Healthy Returns*^{SM} provides DM services to Medicaid/FAMIS fee-for-service recipients with one or more the following conditions:
  - Asthma (all individuals)
  - Chronic Obstructive Pulmonary Disease (individuals 18 years old and over)
  - Congestive Heart Failure (individuals 18 years old and over)
  - Coronary Artery Disease (individuals 18 years old and over)
  - Diabetes (all individuals)

Eligibility for Disease Management

- All Medicaid and FAMIS enrollees identified with one or more of the five covered diseases are eligible EXCEPT:
  - Individuals enrolled in Medicaid/FAMIS managed care organizations (MCOs) – the program is Fee-for-Service only;
    - All Medicaid MCOs have their own DM programs
  - Individuals enrolled in both Medicaid and Medicare (dual eligibles);
  - Individuals who live in institutional settings; and
  - Individuals who have third party insurance
- Virginia is the first state to offer DM services to participants receiving long-term care services through one of seven home and community-based waivers

Three Levels of DM Services

- ***Standard Program:*** includes an initial letter, a welcome kit including detailed information on his/her condition, and quarterly educational newsletters. Standard enrollees may also contact the 24-Hour Call Line
- ***Moderate Intensity Program (new as of June 2008):*** individuals receive scheduled phone calls from a HMC nurse, in addition to services that are provided in the standard program
- ***High Intensity Program:*** individuals receive same services as moderate intensity members, but more frequent scheduled phone calls from a HMC nurse

Individuals are placed into service levels based on proprietary predictive modeling factors including, but not limited to, recent emergency room utilization and progression of the condition.

Cases Under Management August 2008

Intensity Level	Number of Participants
Standard	3,254
Moderate	491
High	1,984
TOTAL	**5,729**

Virginia's Chronic Care Management Program

- DMAS is currently developing a Chronic Care Management (CCM) program that will provide face-to-face and telephonic intervention designed to reduce unnecessary utilization of Medicaid services while providing specialized care management to individuals with chronic illness
  - The care management will be a structured process that will define treatments to manage the chronic conditions by utilizing a holistic approach of treatment, taking into account cultural, educational, social, and economic issues that affect the participants' ability to manage their chronic diseases
  - Includes psycho-social issues and behavioral health integration

CCM Goals

1. Educate and train participants to assist themselves in managing their disease(s) while assisting in the coordination of their medical services
   - This reduces the chance of exacerbation of current health conditions that could lead to catastrophic illness
2. Reduce health care costs
   - Cost savings will be a direct outcome as medical treatment plans are focused on prevention and health services management; thereby avoiding unnecessary acute care services, emergency room visits, and clinical and physician visits, which are the more expensive and easily accessed services
     - Services to those with a chronic illness account for 80 percent of all Medicaid expenditures nation-wide in 2004.
     - DMAS spent approximately $825 million in Fiscal Year 2005 on health care expenses related to chronic illness.

Target Population of CCM

- The CCM program will include Medicaid and FAMIS fee-for-service participants who are identified through a predictive modeling methodology and who are:
  - diagnosed with a chronic illness
  - determined to be at highest risk for catastrophic health problems
  - determined to be at risk of having the highest cost of Medicaid services

  Coverage will exclude those recipients already enrolled in the disease-specific care management program, *Healthy Returns*SM
- The number of the potential enrollee population is approximately 90,000. The initial goal is to reach from 1% to 5% of this high risk population

Virginia's CCM Program Status

- The Centers for Medicare and Medicaid Services (CMS) is currently reviewing DMAS' State Plan Amendment requesting federal authority to implement the CCM program
- DMAS will contract through a Request for Proposal (RFP) process with an experienced and accredited company in CCM services
  - RFP posted on July 16, 2008
  - RFP close date: August 27, 2008
  - Anticipated contract award date: October 3, 2008
  - Anticipated implementation date: January 5, 2009

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Enhanced Benefit Accounts

- The 2008 General Assembly (2008 Acts of Assembly, Chapter 879, Item 306 SS) directed DMAS to:
  - Develop a plan to implement 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 into Enhanced Benefit Accounts so participants can purchase healthcare services not covered under Medicaid
  - Identify federal requirements and changes to state regulations and funding needed to implement the program
  - Submit the plan to the Governor, Secretary of Health and Human Resources, Joint Commission on Health Care, and the Chairmen of House Appropriations and Senate Finance Committees by October 30, 2008 for their consideration for future implementation

Enhanced Benefit Accounts - Background

- Enhanced Benefit Accounts (EBAs) are incentive based health care programs designed to reward clients for healthy behaviors – a relatively new concept for Medicaid programs
  - Examples of healthy behaviors:
    - Receiving all scheduled immunizations
    - Receiving all scheduled well-child screenings
    - Following treatment plans for chronic health conditions
  - Examples of incentives:
    - Gift certificates
    - Vouchers to purchase a gym membership
    - Credits to buy over the counter medications not covered by Medicaid

General Research on the Effect of Patient Incentives

- Most studies show that financial rewards for low income populations have a positive impact on efforts to promote one-time behaviors; however,
  - the ability of rewards to impact more complex lifestyle changes, such as smoking cessation for example, is not as clear
  - not much research has been done on the impact of varying the amounts and types of rewards
- Researchers generally have concluded that patient incentives must go hand-in-hand with education on the importance of healthy behaviors

Patient Incentives in Other State Medicaid Programs

- Only a few states have implemented EBAs in their Medicaid programs, although several states have expressed an interest in the concept
  - Florida and Idaho have the most experience (to date) with EBAs under Medicaid
  - It may be too soon to judge the effectiveness of these programs; however, an evaluation conducted by Georgetown University points to several challenges faced by the Florida EBA program

An EBA Proposal for Virginia

- The goal of a Virginia EBA program could be to incentivize individuals with chronic conditions to manage their condition through adherence to a plan of care and through healthy behaviors
- In response to the General Assembly's directive, DMAS is currently developing a proposal that will offer suggestions regarding how a program might be implemented. These suggestions will include:
  - which behaviors to reward (and how to measure compliance);
  - the nature of the rewards (debit card for purchase of health-related products/services, for example); and,
  - the amount of the rewards

  [It should be noted that available funding and federal approval may dictate answers to some of these decision points]

EBA Implementation Issues

- DMAS is currently working toward a formal proposal for consideration by the Governor and General Assembly, which is required to be submitted by October 30, 2008
- If a decision is made to implement an EBA program, certain state and federal requirements would need to be met:
  - State Requirements:
    - Budget authority and funding
    - State regulations and the Medicaid State Plan may need to be amended
    - A contractor would need to agree to take on the project
  - Federal Requirements:
    - CMS has indicated the program would most likely require an 1115 Research and Demonstration Waiver, a process that can take 3-12 months
    - Even if funding is provided by the 2009 General Assembly, federal approval may delay implementation until January 2010 or even later

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MEDICAID WORKS

- *MEDICAID WORKS* is Virginia's Medicaid Buy-In program, as authorized under the Ticket to Work and Work Incentives Improvement Act
- The program is essentially a work incentive opportunity for individuals with disabilities who are currently employed or who would like to be employed
- The program allows workers with disabilities to retain health care coverage under Medicaid while earning higher income and keeping more in savings, or resources, than is usually allowed
  - Prior policy created a disincentive for employment because earnings from employment threatened financial eligibility under Medicaid for these disabled individuals
  - Medicaid generally represents these recipients' only option for (affordable) health care coverage, regardless of employment status

Eligibility for *MEDICAID WORKS*

- To enroll, individuals must be
  - disabled
  - employed (or have offer letter from employer)
  - 16 through 64 years of age
  - a current or new Medicaid recipient who meets the income, asset and eligibility requirements for the Blind and Disabled 80% Federal Poverty Level ($694/mo. in 2008) covered groups
- Upon enrollment, individuals can have:
  - Earned income of up to 200% of Federal Poverty Level ($20,800 in 2008)
    - Medicaid/SSI methodology for countable income
    - gross earnings up to $41,665
  - Resources from earnings of up to annual SSI threshold ($29,348 in 2008) for Virginia
    - excludes amounts in IRS-approved accounts (e.g., 401(k), traditional & Roth IRAs, Thrift Savings Plan)

Recent Developments in the *MEDICAID WORKS* Program

- CMS recently approved our State Plan Amendment to include Personal Assistance Services (PAS) with standard Medicaid coverage for enrollees in *MEDICAID WORKS*
  - PAS is not otherwise available as a Medicaid State Plan service
  - waivers include PAS, but waiver rules regarding earned income and resources are more restrictive than *MEDICAID WORKS*
- The inclusion of PAS under *MEDICAID WORKS* was extremely important for the success of this incentive program given the needs of this disabled population
- With PAS included in the benefit, more eligible individuals have an opportunity to contribute to Virginia's work force

Recent Developments in the *MEDICAID WORKS* Program

(continued)

- As of August 2008, 15 participants are enrolled in the program
  - Age range = 20 to 57
  - Hourly wage range = $5.75 to $16.00
  - Average Hours = 10 to 40 hours weekly
  - Enrollments from the following regions:
    - Central = 2
    - Eastern = 6
    - Northern = 2
    - Western = 2
    - Piedmont = 3