



Accelerating Delivery System Transformation in Virginia's Medicaid Program



Virginia Department of Medical Assistance
Services: Notice of Public Comment Period
September 11, 2015 – October 19, 2015 at
4:00pm EST

1 Introduction

Virginia is accelerating transformation of its Medicaid delivery system to ensure that high-value care is the norm and even the most medically complex enrollees with significant behavioral, physical, sensory, and developmental disabilities can live safely and thrive in the community. To begin this process, the Virginia Department of Medical Assistance Services (DMAS) is seeking approval of a demonstration project under section 1115 of the Social Security Act (Act) to implement three strategic initiatives. Alignment of the following three initiatives creates a powerful opportunity to strengthen and integrate Virginia Medicaid's community delivery structure and accelerate a shift toward value-based payment.

1. Medicaid Managed Long Term Services and Supports (MLTSS);
2. Continuum of Care for Individuals with Substance Use Disorders (SUD); and
3. Delivery System Reform Incentive Payment (DSRIP).

DMAS recognizes that this approach is monumental, however the opportunity is greater. To accomplish this, DMAS seeks to build on its current managed care delivery system and extend access to managed care through the MLTSS initiative. MLTSS will provide coordinated medical, behavioral health, and long-term services and supports for over 100,000 enrollees who are still receiving at least a portion of their care through fee-for-service. In addition, DMAS intends to take advantage of the newly proposed opportunity to strengthen the capability to identify Substance Use Disorder (SUD) among Medicaid members, and redesign the benefits offered and community support structure for those who need access to these critical services. By aligning SUD with the implementation of MLTSS and DSRIP, Virginia can accelerate the transition to contracting for

care and services based on value, not utilization. Further, enrollees will have a better care experience when DSRIP is used to invest in resources that offer an enhanced person-centered care model, access to integrated services and providers, and expanded availability of community supports and services.

Current Request for Public Comment on DSRIP

DMAS' ultimate approach will combine these three initiatives into one §1115 Waiver application with the Centers for Medicare and Medicaid Services (CMS). Due to the importance and complexity of this effort, however, DMAS believes that soliciting input independently for each initiative will yield the most comprehensive, focused, and valuable input. This concept paper represents DMAS' intention to offer the opportunity for public input and comment into the design of the DSRIP portion of this waiver application. Public comment for the other two initiatives is requested as follows:

- **MLTSS:** The public engagement process for the MLTSS program is underway and those efforts can be followed through the [MLTSS webpage](#). The Department is not requesting public comment on the MLTSS initiative through this concept paper.
- **Continuum of Care for Individuals with Substance Use Disorders (SUD):** DMAS is currently analyzing the opportunities to strengthen the existing program and benefit structure. DMAS will utilize guidance issued through the July 27, 2015, CMS Medicaid Directors Letter ([CMS letter, SMD # 15-003](#)) as well as the recommendations created by [Governor McAuliffe's Task Force](#) to strengthen how Virginia educates individuals, providers, and communities on SUD; treats those identified with SUD; collects and monitors data pertaining to SUD; and enforces new policies and practices for SUD. A separate document

soliciting public comment will be posted in mid-September to ensure appropriate attention is given to this critical area of need within Virginia’s Medicaid program. DMAS will make announcements on the [Virginia Town Hall](#) and other traditional lines of communication in the upcoming weeks as plans are made for the SUD public comment opportunity.

NOTE: DMAS is currently soliciting feedback on the DSRIP initiative, only. Specific instructions for public input and comment can be found at the end of this paper.

2 Background

The Virginia Medicaid program covers approximately 1,000,000 individuals. Seventy-five percent of enrollees receive care through contracted health plans and twenty-five percent of enrollees receive care through a fee-for-service arrangement. The majority of enrollees in the Virginia Medicaid program are children, pregnant women, and caretaker adults. These enrollees tend to be relatively healthy. Virginia pays an average monthly capitated payment for each enrollees’ services (a “per-member, per-month” (PMPM)) of \$234, translating to an annual payment of \$2,808.

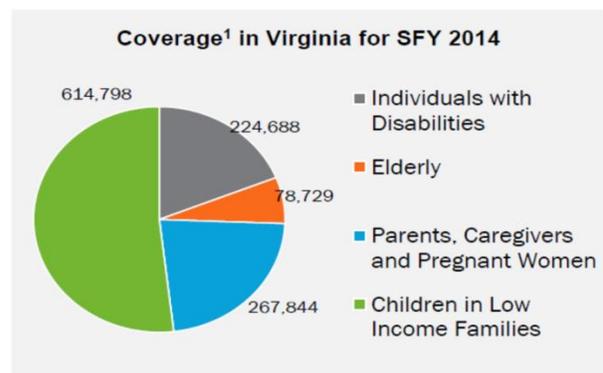
Also included in Virginia’s Medicaid population are over 200,000 individuals who are included in the Aged, Blind, and Disabled (ABD) coverage group. Out of the 200,000 individuals who are in the ABD group, 80,000 enrollees are in capitated health plans with an average monthly cost around \$1,100 PMPM, an annual payment around \$13,000. This spending amount for ABD enrollees, however, does not include costs for expensive long-term services and supports (LTSS) for this population and it does not

include the subset of ABDs who are also enrolled in Medicare. Approximately 115,000 ABDs are Medicare-Medicaid enrollees where Medicare pays for the vast majority of their medical costs, and Medicaid pays for the majority of their long-term services and supports through fee-for-service.

Long-Term Services and Supports (LTSS):

A disproportionate share of Virginia’s Medicaid spending is allocated toward enrollees who receive LTSS. This population is only 6% of enrollment, yet accounts for 30% of total Medicaid expenditures. The majority of LTSS recipients are also enrolled in Medicare, so the majority of this Medicaid spending is for LTSS - not medical services. In 2014, 56% of Virginia’s LTSS expenditures were for home and community-based services (HCBS). Two-thirds of Virginians accessing LTSS, now do so in the community. Virginia, however, still has a significant opportunity to improve its LTSS delivery system. In 2014, Virginia spent close to \$1.1 billion of its \$7.8 billion total Medicaid spend on institutional care (public and private ICF/IDs and nursing homes).

In March 2014, Virginia launched the Commonwealth Coordinated Care (CCC) program. CCC is a CMS Medicare-Medicaid Financial Alignment Demonstration. These demonstrations seek to test models to integrate



Medicaid coverage is primarily available to Virginians who are children in low-income families, pregnant women, elderly, individuals with disabilities and parents meeting specific income thresholds.

Medicare and Medicaid services, rules, and payments under one delivery system for individuals who are eligible for both Medicare and Medicaid (dual eligible individuals). CCC operates as a managed care program with three health plans and includes a strong, person-centered service coordination/care management component, integration with an array of provider types for continuity of care, ongoing stakeholder participation, outreach and education, and the ability for innovation to meet the needs of the population.

CCC will operate through December 31, 2017, in five regions of the state (Tidewater, Central Virginia, Northern Virginia, and the Roanoke and Charlottesville areas). As of June 2015, there were 66,106 Virginians eligible for CCC. Of those eligible, 29,970 have opted to participate in the voluntary program.

Behavioral Health: Like many other states, building the infrastructure to deliver the highest quality behavioral health services in the community continues to be a challenge. Behavioral health services that are typically offered to a commercial population are currently offered through Virginia's contracted health plans. Community-based behavioral health services – those services that are more typically accessed by the Medicaid population - are offered through a contracted behavioral health services administrator (BHSA). In the early 2000's states began a strong effort to strengthen their home and community based service offerings. Coupled with this move were federal policy shifts that required that Virginia's behavioral health services be opened up to allow private providers the opportunity to administer services. Virginia implemented the change without substantially strengthening state regulatory, policy, and oversight requirements.

This resulted in some providers taking advantage of the Medicaid program. Ultimately, Virginia's Medicaid funded behavioral health expenditures increased by 400% over 10 years. In a desire to ensure that individuals were getting high quality care, and providers were appropriately qualified, DMAS worked with the legislature and sister agencies to overhaul licensing qualifications and processes for providers and implemented a pre-screening requirement for select services to ensure a stronger program. Virginia also contracted with a BHSA to administer the community behavioral health services component of the Medicaid program. Virginia is just beginning to see improved outcomes as a result of the BHSA arrangement. As a result of the BHSA partnership, DMAS has seen a decrease in psychiatric inpatient admissions and an increase in follow up care upon discharge. Spending on institutional mental health services has remained relatively constant over the past five years, and in 2014, \$136 million was spent on these services (state and private psychiatric hospitals and Level C residential treatment centers). Virginia's 2014 community-based mental health services spending was just under \$600 million.

2.1 Current Limitations in Infrastructure and Reimbursement Strategy

Over the past fifteen years, the Commonwealth of Virginia has been committed to a vision of community transformation. Together, with federal, local, and community partners, the Commonwealth has invested a significant amount of time and effort into shifting the cultural paradigm from institutional living to One Community, where all individuals, regardless of ability, disability, or age, can live full lives in the community. In 2011, Virginia's

expenditures on community-based services exceeded its institutional spend for the first time, and Virginia’s investment in community-based services has increased each year since.

Despite these efforts, Virginia’s provider capacity remains strained and lacks the resources and state-wide infrastructure to meet the needs of all Medicaid enrollees. Virginia is still operating a fragmented, fee-for-service, facility-based, volume-driven system for a significant portion of individuals needing LTSS and behavioral health services. Virginia’s current payment structure does not significantly incent value and quality of care.

Virginia still has a system where individuals often seek treatment in the emergency department because community-based providers are not available or are neither trained nor incented to effectively treat or support an individual’s condition. Medical, behavioral health, and HCBS providers remain “siloes” and the Commonwealth’s providers are not trained to fully integrate a member’s care. While some exist, neither interdisciplinary nor crisis intervention teams are available statewide. Inadequate care transitions between settings and a lack of coordination across providers and

community-based supports result in unnecessary and expensive institutional care. For example, individuals discharged from hospitals with complex medical or behavioral health needs often do not receive sufficient care transition support to successfully integrate into the community or prevent institutional readmissions.

While there is broad engagement among stakeholders, the underlying payment reform and systemic changes needed to truly facilitate lasting, positive, improvements, are missing.

In short, full transformation in Virginia’s Medicaid delivery system is constrained by limitations in our infrastructure and how DMAS pays for services. Specific challenges include:

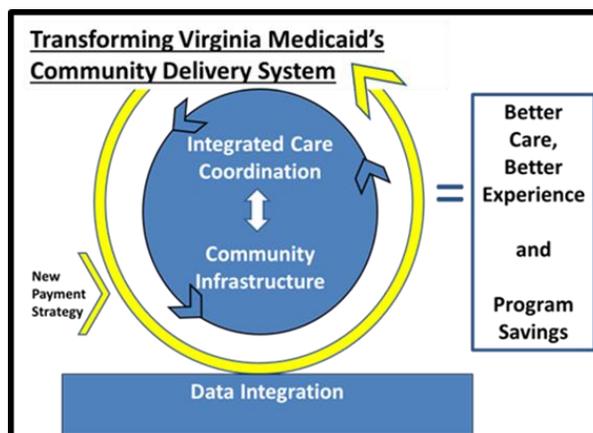
- Virginia’s community capacity is disparate across the state. There are many regions where there is a:
 - Lack of community-treatment options;
 - Lack of expertise in serving individuals of varying abilities; and,
 - Over-reliance on institutionalization and emergency department use.

Current System	Transformed System
Fragmented clinical and financial approaches to care delivery	Integrated systems that delivery whole person care
Disjointed care and care transitions	Coordinated care and care transitions
Confused Medicaid members	Informed Medicaid members
Limitations and lack of access in some critical service areas	Optimal access to appropriate services
Limited ability to measure delivery system performance	Standardized performance measurement with accountability and responsibility
Inadequate data and reporting infrastructure	Robust capacity to obtain and share data to measure performance
Volume-based payment	Risk-based/value payment across the system
Frequent institutionalization due to inadequate community infrastructure	Robust and integrated system of community based services that provides whole-person care

- Virginia lacks an integrated clinical and social data infrastructure. The Medicaid program is not yet able to:
 - Optimally provide person-centered coordinated care;
 - Effectively link to and collaborate with vital social supports such as housing, employment, and social services;
 - Encourage timely care in the most appropriate setting; and,
 - Leverage technology to promote real-time clinical information exchange across providers and across systems.
- Positive outcomes and high quality care is not financially rewarded. Currently:
 - Most Medicaid reimbursement in Virginia is currently tied to utilization;
 - Many providers, health plans, and DMAS do not have the capacity to support alternative payment models; and,
 - There is limited financial incentive for interdisciplinary community-based care.

3 Proposed Strategies for Medicaid Delivery System Transformation

As the designated single state Medicaid agency, DMAS will lead the DSRIP initiative, but will leverage best practices recommended by stakeholders and partnerships with entities such as the: Department of Behavioral Health and Developmental Services (DBHDS), Department of Aging and Rehabilitative Services (DARS), Department of Health (VDH), the Virginia Board for People with Disabilities, and other state agencies; Medicaid Managed Care Plans (MMPs); Health Systems; community providers; the Virginia Center for Health Innovation (VCHI); and State Innovation Model (SIM) workgroups.



DSRIP is a strategic opportunity for Virginia to partner with the federal government and invest in the transition of its payment and delivery system- to ensure robust community capacity, integrated service delivery, and reimbursement based on achievement of high quality outcomes. **DSRIP funding may not be used to cover services or new populations. It must be focused on transforming care for the Medicaid population.** Virginia will use DSRIP funding to transform the current system, so that Medicaid providers are financially incented to deliver care in a way that results in healthier person-centered outcomes. As a result, Virginia's rate of Medicaid spending will slow down. Through DSRIP, Virginia seeks to create:

- A transformed Medicaid delivery system that enables even the most high-cost and medically complex individuals to thrive in the community;
- A new payment model designed to reward high-quality, interdisciplinary care; seamless transitions of care; and the integration of social supports; and,
- More value-driven outcomes at the provider level.

The transformed system will encourage innovation for better care and reduce the rate of Medicaid spending growth.

3.1 Transformation Step #1: Integrate Service Delivery

Virginia’s university and community college systems produce phenomenal medical, behavioral health, and community support professionals. The expertise among the disciplines of care is top notch; however, the Commonwealth lacks the ability to effectively integrate care and services needed to fully treat Virginia’s Medicaid beneficiaries. Virginia seeks to leverage DSRIP funding to integrate service delivery, eliminating silos of care between providers, through the establishment of provider communities throughout the state.

Virginia seeks to create an opportunity where providers, of all appropriate disciplines, will come together and create community-based networks known as Virginia Integration Partners (VIPs). These networks will be contractual arrangements between interested public and private providers and community supports, including but not limited to Community Services Boards (CSBs,) Federally Qualified Health Centers (FQHCs), Area

Agencies on Aging (AAA), Centers for Independent Living (CILS), and schools. These entities will work together to integrate the care and services needed to support individuals who are receiving care and living in that community. Participating VIPs must demonstrate that there is a sustainability plan in place to ensure that contractual arrangements with proven partners (public and private entities) will last when the 5 year demonstration ends.

The Commonwealth plans to invest in the provider community and intends to make sure that the impact is lasting and meaningful. DMAS and its partners will spend a significant amount of time working with interested stakeholders to develop and refine all necessary policies, protocols, contracts, and expectations to ensure successful implementation of VIPs throughout the Commonwealth. There are many communities throughout Virginia that have already considered this concept, and some are already participating in similar arrangements through Medicare Accountable Care Organizations (ACOs). While this opportunity will not replicate what is already in place,

Transformation Step # 1: Virginia seeks DSRIP funding to back groups of providers through Virginia Integration Partners (VIPs)

What are Virginia Integration Partners?

Multi-Provider Partnership:

- Coalitions of willing providers interested in forming partnerships
- Public and Private interdisciplinary partnership of providers focused on care coordination
- Partnership may include social worker, medical care and behavioral health providers, and mobile care teams

Coordinating Entity:

- One coordinating entity serves in leadership role across the partnership
- State contracts with coordinating entity for DSRIP funding





State provides planning funds to providers to support formation of VIPs



State consults VIPs to establish a menu of projects to achieve integrated service delivery



VIPs select projects that will equip them to meet outcome goals



State funds VIPs based on achieving pre-determined metrics and outcomes



Transition to value based payment and reimbursement based on attainment of outcomes

DMAS intends to build upon existing arrangements and use lessons learned and best practices of these models in an aim to build and deploy strong VIPs, ready to work together to serve Virginia’s Medicaid enrollees. In order to accomplish this task, DMAS understands that a strong and robust data platform is needed. That system will be described in the subsequent section.

There are four key pillars to ensuring that service delivery is integrated and these will be implemented by Virginia Integration Partners. Through this demonstration, Virginia will work diligently with the VIPs to strengthen:

- a) The concept of team-based, bidirectional, integrated behavioral health and primary care;
- b) The availability of mobile care teams;
- c) The models of care transitions and diversions from hospitals and institutional care; and,
- d) The approach to avoiding unnecessary or preventable hospital utilization.

After the 5 year demonstration, Virginia will be able to show achievement in reaching the desired DSRIP goals, through the established measures, negotiated between DMAS and CMS. Outcomes of this approach will be identified through the waiver application and federal negotiation process but could include measures such as: seeing a reduction in per member cost for Medicaid members, a decrease in unnecessary hospital visits, and a decrease in readmission rates.

3.1.1 Team-based, Integrated Behavioral Health and Primary Care

Team-based, integrated behavioral health and primary care aims to increase interdisciplinary care teams (including public and private providers) so that holistic, person-centered care becomes the standard practice for Medicaid enrollees. Additionally, there will be a focus on integrating behavioral health and medical care so that behavioral health is a natural extension of primary care and primary care is a natural extension of behavioral health. This will be a

Virginia envisions creation of VIPs who are ready to transform to provide team-based, person-centered, integrated care and share in risk and reward of optimal service delivery

Team-based, integrated behavioral health and primary care	<ul style="list-style-type: none"> ▪ Increase interdisciplinary care teams to achieve holistic, person-centered care as the norm ▪ Integrate behavioral and medical care no matter where the individual initiates care (bidirectional)
Mobile Care Teams	<ul style="list-style-type: none"> ▪ Increase access to primary and behavioral care in all regions ▪ Increase access to primary and behavioral care for adults and children with limited mobility or who are otherwise hard to reach through home visits
Care Transitions & Diversions from Institutional Care	<ul style="list-style-type: none"> ▪ Implement comprehensive interdisciplinary care coordination models like the Coleman Model to increase success when transitioning enrollees between care settings (e.g., hospital discharge, nursing facility to home, Psychiatric Residential Treatment Facility) ▪ Transform transition protocols and develop pathways so that home and community based services are easy to establish and maintain
Emergency Department Super-Utilizer Diversions	<ul style="list-style-type: none"> ▪ Implement evidenced-based protocols to reduce non-emergency ED visits for super-utilizers ▪ Expand access for urgent care through extended hours and new providers

bidirectional approach, understanding that individuals will initiate care where they are most comfortable, be it a center or practice whose main focus is behavioral health, or physical health.

3.1.2 Mobile Care Teams

DMAS, along with sister state agencies and community partners, has been working diligently over the past decade to strengthen the connection of individuals who live in the community to the providers and support services that care for them. In many communities this connection is best served by a mobile care team and there is a need to further support and multiply the number of mobile care teams throughout the Commonwealth. Through DSRIP, Virginia intends to increase access to primary and behavioral care in all geographic regions by increasing mobile clinics and/or providers. Another targeted approach will be to increase access to primary and behavioral care to adults and children with limited mobility or who are otherwise hard to reach, through home visits. Essentially, DMAS will look to the VIPs to put their resources on wheels and engage and provide care throughout Virginia's communities.

3.1.3 Care Transitions and Diversions from Institutional Care

Institutional care is not always needed, but is sometimes relied upon as a quick hospital discharge alternative. In addition, when an individual is ready to transition from an institution back into the community, care transitions are often difficult to manage and Medicaid members are at risk of confusion, chaos, and readmission to the institution. DSRIP will allow Virginia to implement principles of the [Coleman Model](#) to increase

What will DSRIP mean for Medicaid beneficiaries?

- Care, supports and services centered on the individual's needs, goals and preferences;
- Expanded opportunities for community living and engagement;
- Providers who are rewarded for improving their health outcomes, not just paid per visit; and
- An entire system that, "follows the person"



success when transitioning Medicaid members between care settings (e.g. hospital discharge, nursing facility to home/community, Psychiatric Residential Treatment Facility to home/community). In order to best support providers and individuals who are transitioning, protocols will be refined and pathways will be developed to ensure that home and community based services and supports are easy to both establish and maintain.

3.1.4 Addressing Super-Utilizers

Throughout Virginia, individuals often rely on emergency departments (ED) to receive non-emergency care. This is often due to a lack of access to primary care. Additionally, there are individuals who are "super – utilizers" of inpatient hospital care. DMAS will utilize DSRIP funding to support the VIPs implementation of protocols that increase access to patient navigation tools, expand hospital care coordination efforts, and extend office hours through partnering primary care practices.

3.2 Transformation Step #2: Build a Data Platform for Integration and Usability

In order to successfully achieve the proposed DSRIP strategies, Virginia’s Medicaid providers need to be better supported in their ability to capture, report, and analyze their Medicaid member data and information. Virginia will use DSRIP to help VIPs build an integrated clinical, behavioral, social, and support data platform to accelerate provider integration and enable value-based payment models (later explained). DMAS would benefit from better understanding the needs of the provider community as it pertains to data support from DMAS. Could DMAS accomplish its goals for data analytics, beneficiary information exchange, and revised payment structure without a single statewide support structure?

3.2.1 Data System Development within VIPs

The technology platform will support data system development within VIPs and will:

- Establish data-readiness for providers to conduct team-based care;
- Establish data-readiness for providers to be reimbursed for outcomes;
- Develop real-time data exchange between providers;
- Develop capacity for business intelligence; and,
- Develop capacity for data analytics.

3.2.2 Providers Link to a Statewide Care Management System

In addition to the data system development, there will also be support for providers and managed care organizations to link to a statewide care management system, which will serve as the backbone to the integrated care vision for Virginia’s Medicaid members. This system will provide the transparency and data needed to move Virginia to value-based payment.

Virginia seeks DSRIP funding to design the data architecture and build the data platform to enable providers to connect with each other and payors, track outcomes, and be reimbursed for high-value care

Data System Development within VIPs

- Build integrated clinical, behavioral, social, and support data platform to accelerate provider integration
- Establish data-readiness for providers to conduct team-based care
- Establish data-readiness for providers to be reimbursed for outcomes
- Develop near real-time data exchange between providers
- Develop capacity for business intelligence
- Develop capacity for data analytics

Providers Link to a Statewide Care Management System

- Build integration to statewide care management system which serves as a central system to enable integrated clinical, behavioral, social data

Statewide Set of Minimum Data Standards

- Define and implement evidenced-based data standards to enable transparency and tracking of meaningful measures

3.2.3 Statewide Set of Minimum Data Standards

Finally, there will be a statewide effort to establish a uniform set of minimum data standards (MDS). Standardization is an important lynchpin to ensuring meaningful analysis of provider data. Virginia aims to utilize data analytics to improve care and institute value based payments which reward providers for the delivery of quality care to Medicaid members.

3.3 Transformation Step #3: Build Community Capacity

Systemic policy shifts will have minimal impact if Virginia’s Medicaid providers are not fully ready and equipped to transition into a new system of care model. Through DSRIP, Virginia’s Medicaid provider community will be supported through various resources in order to keep individuals healthy, safe and help them facilitate a life of meaning in the community. In doing so, Virginia will expand its community capacity to address the spectrum of medical, LTSS, behavioral health and substance use

needs of Medicaid beneficiaries. Community capacity will be addressed through several different strategies:

1. Training;
2. Statewide Crisis Management;
3. Telehealth; and,
4. Housing and Employment.

3.3.1 Training

DMAS recognizes that training of Virginia’s workforce and caregivers/peers/health workers is critical for Virginia’s communities to have the breadth of expertise to care for the entire Virginia Medicaid population. DSRIP will support workforce training for medical professionals, including school based providers, to help meet this need. Training will be developed so that behavioral health can be integrated as an extension of primary care. Additionally, resources will be focused to ensure medical professionals are trained so they are competent and confident to work with individuals of all ability levels, as appropriate. Not only will a focus be on training the existing

Virginia seeks DSRIP funding to build the array of needed community services and providers in a way that is self-sustaining within 5 years

Training for Workforce and Caregivers & Peers

- Enhance training for medical professionals so that behavioral health can be integrated as an extension of primary care
- Enhance training for medical professionals so that providers are competent and confident to work with people of all ability levels
- Expand scope of practitioners to meet capacity and geographic access needs

Statewide Crisis Management

- Expand crisis management for children and adults to support and stabilize individuals in their homes and limit the escalation of a crisis that leads to hospitalization

Telehealth

- Expand home monitoring for chronic condition management, long-term services and support monitoring, crisis prevention and safety
- Expand access to preventative screenings via telehealth
- Expand access to providers via telehealth; especially for behavioral health treatment

Housing & Employment

- Establish a statewide process for recruiting and tracking safe, affordable housing for Medicaid enrollees
- Establish a process for recruiting and tracking employers committed to employing individuals with SPMI or of varying abilities
- Develop a platform to make this information available to providers, care managers, and individuals

workforce, but there will also be efforts to strengthen the provision of training designed to aid in addressing the concerns of adequate capacity and geographic access needs throughout portions of the Commonwealth. Caregivers, peers (individual and family), and community health workers will also have enhanced training made available; ensuring that people are aware of the resources, preferred pathways for care, and care supports that are accessible to the individuals they care for. DMAS recognizes that schools are often a central point of care for many children with complex needs who receive Medicaid. DMAS will seek to use DSRIP funding to develop continuing education models that ensure that school nurses are trained to meet the most demanding needs of these children (diabetes, asthma, behavioral health, etc.) and are able to more appropriately partner with other community providers when caring for Medicaid members in the school setting.

3.3.2 Statewide Crisis Management

Virginia has witnessed time and again too many tragedies resulting from the lack of crisis management resources statewide. Through DSRIP, DMAS will infuse resources into the implementation of effective crisis management strategies and models for children and adults. These crisis management models would allow individuals to be supported and stabilized in their homes, limiting the escalation of a crisis that could lead to hospitalization or worse. DSRIP could support DMAS and community partners throughout the Commonwealth by:

- Providing a comprehensive crisis support system across the Commonwealth and across individuals' lifespans that shifts the focus from disposition to resolution;

- Ensuring 24/7 access to crisis stabilization programs; and,
- Developing needed workforce competency to support the crisis management strategies and models across the state.

3.3.3 Telehealth

Virginia is one of the leading states in the country when it comes to utilization of telehealth as a mode of Medicaid care delivery. While we celebrate the successes of this accomplishment, there are significant opportunities to strengthen the use of telehealth in order to better support Virginia's Medicaid members and the providers that care for them. Through DSRIP, Virginia seeks to expand home monitoring for chronic condition management, long-term services and supports, and intends to deploy resources and tools, to aid in crisis prevention and beneficiary safety. Telehealth has the ability to make preventive health screenings more timely and accessible, both incredibly valuable when focusing on sustaining health and wellness. With the extended focus towards integration of care, telehealth has the ability to enhance access to providers, especially for behavioral health treatment. Further, Virginia seeks to expand the ability of providers to consult with expert and specialty care providers.

3.3.4 Housing and Employment Support

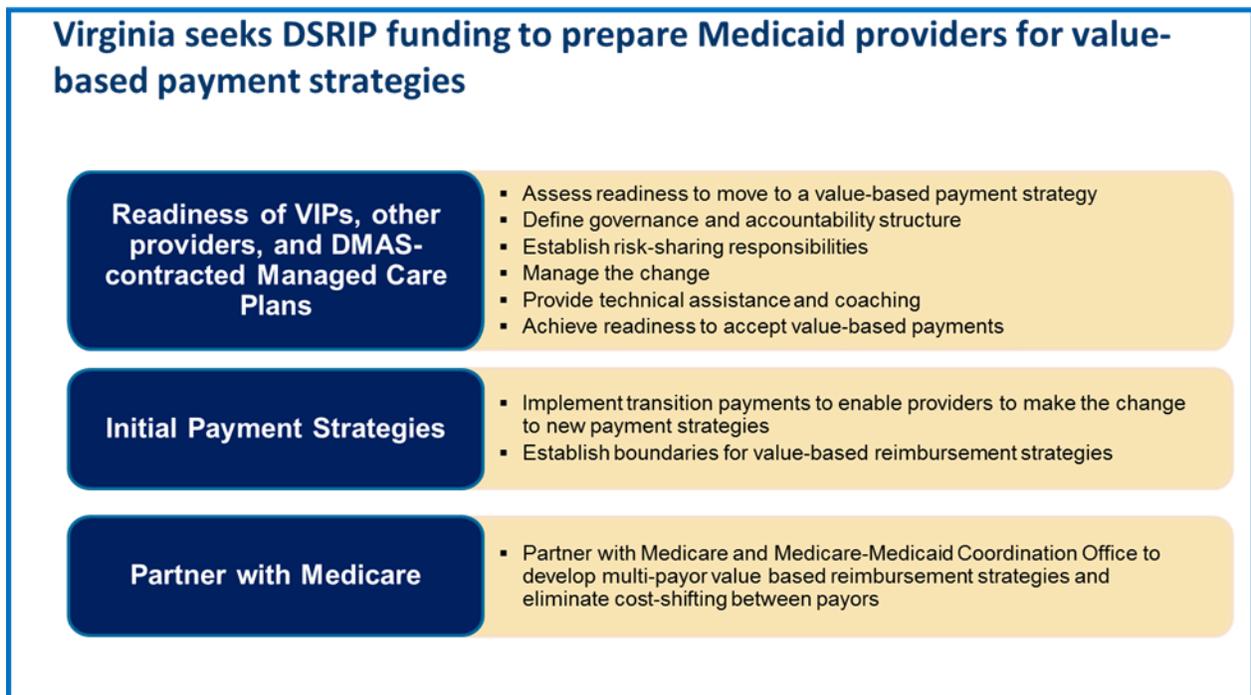
Virginia desires a clear statewide process for identifying, tracking, and disseminating appropriate and available safe housing options for Medicaid enrollees. DMAS is committed to working with statewide experts and partners to ensure Virginia's policies are appropriate and person-centered. Through DSRIP, Virginia intends on developing a data platform to make

this information available to providers, care managers, and the individuals who are in need of housing, or better housing options. In addition to housing, employment is desired by many Medicaid beneficiaries, and considered to be an important piece of meaningful community living. DMAS intends for DSRIP to enable investment in the development of partnerships with representatives from the business community as well as workforce training experts, such as DARS, across the state in order to make sure that DMAS establishes a process for recruiting and tracking employers committed to employing individuals with Serious and Persistent Mental Illness (SPMI) and other varying abilities. Mirroring the platform for housing, DSRIP funding will also be used to make this employment information available to providers, care managers, individuals, and family members.

3.4 Transformation Step #4: Redesign How DMAS Pays for Services

All previously explained steps for use of DSRIP funding coalesce to support DMAS' desire to establish readiness within VIPs, other DMAS providers, and contracted health plans to embrace and implement value-based payments. DMAS plans to focus its initial value-based payment work in its MLTSS program. It then plans to further the work of the contracted [Medallion 3.0](#) health plans in this area.

Value-based payments require a strategy that is transparent and data-driven. This transition will not be easy, and will require significant dialogue and discussions in order to create a baseline of understanding and commonly accepted practices and protocols.



Readiness of DMAS-contracted VIPs, other Providers, and Managed Care Plans

To transition to a value-based payment reimbursement methodology, DMAS anticipates the need to invest DSRIP funding to support providers to:

- Assess readiness to move to a value-based payment strategy;
- Identify risk-sharing responsibilities between providers;
- Ensure that data architecture and systems support the transparency essential to value-based payment;
- Develop and implement change management processes; and,
- Support additional technical assistance and practice coaching needs.

3.4.1 Initial Payment Strategies

DMAS does not believe that it is responsible to expect this type of change within the payment structure without significantly supporting Virginia's Medicaid providers in this transition. The department will work with providers and contracted health plans to ensure needs are identified and policies are developed for successful implementation of value based purchasing strategies. To do this, DMAS will include initial value-based payment standards in its upcoming MLTSS program. The department will focus on a core set of payment models to begin the transition payments and establish boundaries for value-based reimbursement strategies.

3.4.2 Partner with Medicare

DMAS sees the CMS Medicare-Medicaid Coordination Office as a strong partner and has learned many lessons through this partnership

and implementation of the Commonwealth Coordinated Care program. DMAS intends on consulting with the CMS Medicare and Medicare-Medicaid Coordination Office to determine best practices within multi-payor value based purchasing and eliminate cost shifting between the Medicare and Medicaid programs.

DMAS understands the discrepancy in provider readiness and experience with tested models of value based reimbursement strategies. During the public comment phase, the Department seeks comment specific to experiences of providers, as well as needed support from DSRIP in order to encourage and facilitate participation from providers and realize a successful transition to Medicaid value based purchasing arrangements.

4 Description of the current or new beneficiary groups that will be impacted by the demonstration

The DSRIP program does not seek to alter eligibility, therefore will serve individuals who are currently eligible for Medicaid in the Commonwealth of Virginia. Additionally, it is important to note that DSRIP will not alter the current benefit package for Medicaid enrollees. Virginia's Medicaid enrollees are children, pregnant women, individuals who are aged, blind, or disabled (ABD), and a small portion of working parents. Pregnant women and children cannot have income higher than 133% of the federal poverty level (FPL), the ABD population cannot have income higher than 80% of the FPL, and working parents cannot have income higher than around 40% of the FPL.

5 Benefit and Cost-Sharing Requirements

The §1115 waiver application will build upon the existing benefit structure. Waiver specifics and project scope will be defined after soliciting public comment and in consultation with state and national experts and CMS officials. The final details and information will be incorporated into DMAS' §1115 waiver application to CMS and any subsequent Special Terms and Conditions (STC) agreement between DMAS and CMS.

The lens through which DMAS is working to determine program enhancements includes an understanding that:

- Coordinated, integrated care for Medicaid enrollees benefits not only members, but also their providers, caregivers, and the Medicaid program at large.
- Value based purchasing and requiring program contracts that incent quality and value over volume is critical to sustaining a Medicaid program that focuses on whole person care, including care transitions. Ultimately, the result will be higher quality of care and better patient outcomes.
- Program oversight and administration will be provided by the Virginia Department of Medical Assistance Services.
- Administration of actual benefits and care coordination between health and behavioral health care services will be conducted by DMAS contractors and partners.

This demonstration does not include any cost-sharing requirements that are not currently authorized through the Virginia State Plan.

6 Overview of Budget Neutrality

For all portions of the waiver, Virginia must meet the budget neutrality test, meaning that the cost of the waiver may not exceed what would have been spent without the waiver. If the Commonwealth were to exceed the budget neutrality cap, Virginia would have to repay the federal share of amounts above the cap. In calculating budget neutrality, CMS and DMAS will agree on the baseline spend and annual trends over the five year period of the waiver. The ultimate goal is to continue to bend the cost curve of the Virginia Medicaid program.

7 DSRIP Financing

Apart from the other portions of the waiver, the financing of the DSRIP component of the waiver is nuanced and determined by CMS. Under §1115(a)(2) states receive authority to receive federal matching funds for DSRIP payments, which would not otherwise qualify as “medical assistance.” States must use non-federal dollars through an equal investment of state or local shares to draw down the federal matching funds for the DSRIP pool, just as they do for other Medicaid expenditures. This is significant because it determines the amount of funding the state can receive to finance transformational activities. For all funding sources, the dollars leveraged for the non-federal share cannot already be used for federal claiming. As part of the waiver development process, DMAS will work with state partners and the Governor’s Office to identify the best source of the non-federal share of DSRIP financing.

For Virginia, there are three potential sources of the non-federal share:

1. State General Funds

Virginia may use general fund revenue to provide the non-federal share of the DSRIP pool in the same way it covers the non-federal share of expenditures for the regular Medicaid program. This would require an appropriation by the legislature. To date, CMS has not articulated a requirement that Virginia's DSRIP program be funded using general funds.

2. Designated State Health Programs (DSHP)

DSHPs are existing health care related programs that are funded only with state or local dollars, and are not currently matched with federal dollars. DSHPs can be matched either at the medical or administrative match rate, depending on the type of program it is. Once the program is designated through the waiver as a DSHP, the state may receive federal matching dollars for the previously unmatched program. This frees up money that would otherwise have been spent to fund the unmatched program.

3. Intergovernmental Transfers (IGT)

IGTs must be transferred from a "public agency," which could be a public hospital, public entity, or a county/city. Public hospitals must use non-federal funds (e.g., commercial revenue) and cannot be guaranteed to have their IGT funds returned. DSRIP payments are "non-patient service revenue"; and do not count towards Disproportionate Share Hospital (DSH) or Upper Payment Limit (UPL) caps.

8 Public Comment and Engagement Opportunities

This winter, DMAS plans to request authority for DSRIP via an §1115 Waiver submission to CMS. DMAS is seizing the opportunity to turn years' worth of suggested ideas and concepts into a promising reality. Various programs and stakeholder groups meet with the Department on an ongoing basis to share ideas and valued practices to strengthen community capacity for Virginia's Medicaid members and the providers and caregivers who support them. Of late, the public comment processes for the MLTSS efforts and the significant lift of the VCHI's SIM workgroups have infused many ideas, including care and payment models, into this opportunity.

We continue to ask interested stakeholders to help us further redesign the Medicaid system in Virginia, to ensure high-value care is the norm and even the most medically complex enrollees with significant behavioral, physical, sensory, and developmental disabilities can live safely and thrive in the community. Your questions and suggestions will help us build and structure the goals and key strategies as we develop the waiver application. Over the next months, stakeholders, providers, managed care plans, and state agency partners will be able to further contribute to the specific design of this transformation.

As stated earlier, the opportunity for SUD public comment will be provided at a later time. All requests for public engagement and comment on this important opportunity will follow DMAS traditional announcement processes.

DMAS is partnering during September, with VCHI to present specific highlights at the Accountable Care Community meetings being held in 5 locations across the state. To find out where the closest meeting is, visit: <http://www.vahealthinnovation.org/what-we-do/the-virginia-health-innovation-plan/regional-accountable-care-communities-information/>.

9 Public Comment Instructions

All public comments pertaining to this DSRIP concept paper should be received by DMAS no later than 4:00pm EST on Monday, October 19th, 2015. All submissions shall be a Microsoft Word document, 12 pt. Times New Roman font, and no more than 5 individual pages.

Mail Submission– written comments shall be addressed to Ashley Hazelton, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300 Richmond, VA 23219

Electronic Submission – for ease in compilation of comments, please ensure the submission is a Microsoft word document, adhering to the instructions below. Please submit the electronic submission as an email attachment to: dsrip@dmas.virginia.gov.

Due to the significant amount of stakeholder input expected, it is important that the Department have a method to catalogue and consider all received information. Please adhere to the instructions in order to ensure your valued comment and feedback is incorporated into the stakeholder review process. Please note, DMAS must adhere to the Freedom of Information Act (FOIA) standards. Therefore,

once you or your company submits public comment, that information is in the public domain and may be made available on the DMAS webpage or to any entity that requests it. Please make every effort to refrain from including proprietary or protected health information (PHI) in your comments, as striking this information is incredibly cumbersome for DMAS staff.

Specific Instructions:

The key components for DSRIP feedback are found within this document on pages 6-11. Specifically labeled are the four transformation steps that Virginia Medicaid must take through the support of DSRIP:

1. Integrate Service Delivery;
2. Build a Data Platform for Integration and Usability;
3. Build Community Capacity; and,
4. Redesign How DMAS Pays for Services.

The strategies associated with each transformation step have an associated numerical heading in parenthesis. Please organize your feedback to reflect the numerical reference. An example is provided in Appendix A.

In addition to your public comment regarding components found in this concept paper, please submit questions that will assist the Department in clarifying the role of DSRIP in Virginia. DMAS will compile these questions and provide responses within several weeks of the close of the public comment period.

If you anticipate that you or your organization will consider participating in DSRIP, please include in your public comment: contact

information and information pertaining to projected implementation needs and appropriate timelines to achieve readiness and successful engagement in the DSRIP demonstration.

This is your initial opportunity to provide formal public comment to the waiver application process. However, DMAS intends to seek additional stakeholder input throughout the DSRIP process. Please visit the DMAS DSRIP webpage often to see the latest materials and progress on the DSRIP development. Questions can be sent to DSRIP@dmas.virginia.gov. Thank you in advance for making Virginia successful in this important delivery system transformation initiative.

Appendix A

Example

Preferred Comment Format

3.2.1 Data System Development within VIPs

Public comment regarding needed data elements for participating VIPs, ideas, promising practices from experience, etc. Recommendations for measurable goals and outcomes, etc.

3.2.3 Statewide Set of Minimum Data Standards

Public comment regarding the anticipated need for a minimum data set, ideas for who should be included on a working group to establish MDS, etc. Recommendations for measurable goals and outcomes, etc.

3.4.3 Partner with Medicare

Public comment regarding possible partnerships with Medicare. Please include any concepts, ideas, promising practices, concerns, how to address stated concerns, etc. Recommendations for measurable goals and outcomes, etc.