COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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November 1, 2011

The Honorable Robert F. McDonnell
Governor of Virginia

The Honorable Lacey E. Putney, Chair
House Appropriations Committee

The Honorable Charles J. Colgan, Chair
Senate Finance Committee

RE: Report on Item 297 MMMM.1 of the 2011 Appropriations Act related to Expanding Principles of Care Coordination

Dear Sirs:

Item 297 MMMM.1 of the 2011 Appropriations Act directs the Department of Medical Assistance Services (DMAS) to expand principles of care coordination to all geographic areas, populations, and services under programs administered by the Department. These care coordination initiatives are part of Governor McDonnell's efforts to reform the Virginia Medicaid Program and were recommended by the Virginia Health Reform Initiative Advisory Council. The language stipulates that the expansion should involve shared financial risk, performance benchmarks, and improving the value of care delivered by measuring outcomes, enhancing quality, and monitoring expenditures. DMAS is charged with engaging stakeholders in the development and implementation of the care coordination activities. Furthermore, the Appropriations Act directs DMAS to report on the progress of implementing care coordination, including but not limited to, the number of individuals enrollees in care coordination, the geographic areas, populations and services affected and cost savings achieved by November 1 of each year. Therefore, the intent of this letter is to summarize DMAS' progress to date on each of the initiatives contained in Item 297 MMMM.1.

MMMM.1.a: allows DMAS to expand managed care (known as Medallion II) to the Roanoke/Alleghany area by January 1, 2012, and far Southwest Virginia by July 1, 2012. The 24 localities impacted by the Roanoke/Alleghany expansion include: Alleghany; Bath; Bedford City and County; Botetourt; Buena Vista; Craig; Covington; Floyd; Franklin; Giles; Henry; Highland; Lexington; Martinsville; Montgomery; Patrick; Pulaksi; Radford; Roanoke City and County; Rockbridge; Salem; and, Wythe. Effective January 1, 2012, Medicaid and FAMIS eligible individuals in these localities will access health care services through one of the following managed care organization (MCOs): Amerigroup Community Care; Anthem Health Keepers Inc.; MajestaCare-a Health Plan of Carilion Clinic; Southern Health Care Net; Optima Family Care; and, Virginia Premier Health Plan. This expansion will affect approximately 30,000 fee-for-service Medicaid and FAMIS members. DMAS and the six MCOs sponsored a Health Fair in Roanoke on October 1, 2011, at Washington Park for the potential Medicaid and FAMIS members.

The far Southwest expansion will impact 15 localities effective July 1, 2012. The 15 localities include: Bland; Bristol; Buchanan; Carroll; Dickenson; Galax; Grayson; Lee; Norton; Russell; Scott; Smyth; Tazewell; Washington; and, Wise. Six MCOs have submitted letters of intent and they are working to contract with providers to move into these areas. This expansion will affect approximately 45,000 fee-for-service Medicaid and FAMIS members. DMAS has conducted several site visits and conference calls with hospitals, providers, and legislatures in the far Southwest to discuss the far Southwest expansion. Furthermore, on October 19, 2011, DMAS will hold a public forum in Abingdon for the health care community. The intent of the public forum is to provide information on managed care and how the expansion will impact the far Southwest. Over 200 people are expected to attend.

When completed, the Roanoke/Alleghany and far Southwest Virginia expansions will result in the availability of MCO coverage to eligible individuals in all areas of the Commonwealth and eliminate the primary care case management program (known as MEDALLION). Managed care eligible individuals will benefit from (1) tighter and more complex medical management; (2) larger and more comprehensive provider networks and network management; (3) administrative benefits (care management, nurse and other member service call lines, maternity and disease management and education programs); and, (4) focused quality improvement programs.

MMMM.1.b: allows DMAS, on a pilot basis, to enroll foster care children under the custody of the City of Richmond Department of Social Services (DSS) in managed care effective July 1, 2011. Historically, foster care children have been excluded from Medallion II for a variety of reasons. Additionally, as Medallion II is operational in large contiguous portions of the Commonwealth, and is expected to be statewide by July 1, 2012, continuity of care coordination for somewhat more transient populations, such as foster care children, may be achievable. Consequently, since January 2011, DMAS has collaborated with the City of Richmond DSS and four of DMAS' contracted MCOs to implement a foster care pilot project. Approximately 230 Medicaid foster care children under the custody of the City of Richmond DSS are expected to be impacted by the pilot.

Although the Appropriations Act includes July 1, 2011, as the effective date for the pilot, various systems challenges necessitated delaying the implementation date until December 1, 2011. Toward that end, DMAS has achieved many milestones. For example:

- The foster care children have been correctly identified in both the DSS and DMAS systems.
- Medicaid eligibility and social workers have been trained in enrollment procedures.
- A training plan for DMAS, DSS, and the MCOs was developed and training will be completed by the end of October.
- Materials for DSS to provide to families regarding the pilot project as well as Fact Sheets for DSS and MCO staff have been developed.
- The regulations are in the Office of the Governor.
- The Centers for Medicare & Medicare Services approved the §1915(b) waiver for this program in June 2011.

MCO pre-assignment and assignment will occur in October and November 2011, respectively. MCO enrollment will occur on December 1, 2011. Upon completion of this pilot project, planning is underway to enroll additional foster care children in managed care in other areas of the State.

MMMM1.c: allows DMAS to implement a care coordination program for Elderly or Disabled with Consumer Direction (EDCD) waiver participants effective October 1, 2011. The majority of individuals enrolled in the EDCD waiver will receive care coordination through one of the other care coordination initiatives DMAS plans to implement (for example, 63% of individuals enrolled in the

EDCD waiver are dually eligible and may receive care coordination under (g) below; others would receive care coordination of medical needs under (d) below). Therefore, DMAS will not develop a care coordination program specifically targeted toward individuals enrolled in the EDCD waiver.

MMMM1.d: allows DMAS to enroll individuals in home and community-based waivers to also be enrolled in managed care for the purposes of receiving acute and medical care services effective January 1, 2012. As of September 1, 2007, individuals who are enrolled in an MCO and subsequently become enrolled in a home and community-based waiver remain in the MCO and are not disenrolled from managed care. However, individuals who would otherwise be managed care eligible remain in home and community-based waivers because they were enrolled in the waiver first. The Department plans to revise the managed care participation criteria to include home and community-based waiver participants (except those in the Technology-Assisted Waiver) effective September 1, 2012. This is expected to impact approximately 5,000 individuals.

MMMM1.e and MMMM1.f: direct DMAS, in collaboration with the Community Service Boards (CSBs) and in consultation with appropriate stakeholders, to develop a blueprint for the development and implementation of a care coordination model for individuals in need of behavioral health services not currently provided through a MCO. One or more models consistent with the blueprint principles may be implemented effective July 1, 2012. The overall goals of this care coordination model are twofold: 1) improve the coordination of care for individuals receiving behavioral health services with acute and primary services; and 2) improve the value of behavioral health services purchased by the Commonwealth of Virginia without compromising access to behavioral health services for vulnerable populations.

Pursuant to this directive, DMAS involved the Department of Behavioral Health and Developmental Services (DBHDS), CSBs, and numerous stakeholders in planning the development of a care coordination model. Specifically, four focus group meetings and a general stakeholder meeting were convened over the course of four weeks to obtain input from interested stakeholders. The first four focus group meetings were convened on August 16 and 17, 2011. The groups were divided into interest groups to allow free expression. The groups included: (1) state agency representatives; (2) vendors/managed care organizations; (3) service providers; and, (4) advocates and individuals who have behavioral health disorders and families. Overall, 102 participants representing advocates/families, state agencies, service providers, hospitals, MCOs, and behavioral health organizations attended the focus group sessions. A summary of the focus group meetings can be accessed at http://dmasva.dmas.virginia.gov/Content_pgs/obh-home.aspx. The general stakeholder meeting was convened on September 14, 2011, to discuss the general concept of the care coordination model being considered by the Department, and to obtain input from stakeholders.

After thoroughly researching the issues and consulting with stakeholders, DMAS decided to draft a Request for Proposal (RFP) for a Behavioral Health Services Administrator (BHSA) to provide care coordination services for individuals in need of behavioral health services not currently provided through an MCO. The draft RFP will serve as the blueprint in the development of a care coordination model for Medicaid/FAMIS Plus/FAMIS individuals in need of behavioral health services. The RFP was released for stakeholder comment on October 5, 2011. Stakeholder comments will be reviewed and considered, with the expectation that the final RFP will be published in November, 2011. The Department is soliciting proposals from qualified organizations through a competitive procurement process for a BHSA to include care coordination (including targeted case management); provider recruitment, management, and training; member education; service authorization and reimbursement of behavioral health services that are currently provided for Title XIX Medicaid members of all ages and Title XXI FAMIS members who are in the fee-for-service system or for behavioral health services that are currently carved out of managed care.

One statewide contract is expected to be awarded in January 2012 with an implementation date of July 1, 2012. The contract will be awarded for four years; as an Administrative Services Only (ASO) contract for the first two years, then moving to a full-risk Behavioral Health Organization (BHO) contract no earlier than the third year. Responsibilities, which are more fully described in the RFP, will include maintaining the Department's behavioral health provider network; monitoring member utilization of behavioral health services; handling service authorization requests; processing claims and submitting encounter data; conducting provider and member outreach activities; handling member and provider services issues; quality outcomes and reporting; and, interfacing with the Virginia Medicaid Management Information System (VaMMIS).

MMMM.1.g: allows DMAS to develop and implement a care coordination model for individuals eligible for Medicare and Medicaid (dual eligibles) to be effective April 1, 2012. Dual eligibles are currently excluded from participating in managed care and receive care driven by conflicting state and federal rules and separate funding streams, resulting in fragmented and poorly coordinated care. For these reasons, over the last several years, DMAS has explored including dual eligibles in managed care. Unfortunately, a number of barriers have precluded DMAS from achieving this goal (e.g., financial barriers, savings on acute care services would accrue to Medicare, provider concern with moving to a managed care environment). Therefore, DMAS continues to look for opportunities to integrate care for this population.

More recently, in December 2010, CMS' Center for Medicare and Medicaid Innovation released a RFP entitled "State Demonstrations to Integrate Care for Dual Eligible Individuals". DMAS submitted a proposal to develop a pilot program in the Tidewater area. However, DMAS was not among the 15 states selected for an award. If awarded, this grant would have provided planning funds for developing an integrated care model for dual eligibles to be implemented in 2012.

On July 8, 2011, CMS issued a State Medicaid Letter announcing an opportunity for states, CMS, and managed care entities to enter into three-way contracts to implement integrated health care programs for dual eligibles. No new funding is attached to the three-way contract, and at this point, it is not clear to what extent CMS authority will allow for streamlined operations, but the model is described as combining Medicare and Medicaid funding streams and savings. DMAS submitted a Letter of Intent (LOI) to CMS which was due on October 1, 2011. In the LOI, DMAS proposed a managed care model for the state's three major urban areas: Richmond/Charlottesville; Northern Virginia; and, Tidewater. These regions represent approximately 78,000 dual eligibles, of which a smaller number represent full benefit dual eligibles. The program may initially be limited to full benefit duals. A conference call was scheduled with CMS on October 14, 2011. During that call, CMS and DMAS reviewed: (1) DMAS' proposed model; (2) the timeline; and, (3) the standards and conditions for participation. If CMS and DMAS agree that DMAS can meet all the requirements, the two will sign a memorandum of understanding for technical assistance then move to a three-way agreement to develop and implement a model of care that includes blended Medicare and Medicaid funds. If Virginia is selected to participate, this initiative has the potential to help DMAS overcome past barriers that have prevented the Department from including dual eligibles in managed care. There is no limit on the number of states that CMS will select to participate, but CMS has indicated that they want to include 1-2 million individuals for the entire program across all participating states. Programs must be implemented by the end of 2012.

MMMM.1.h: allows for the implementation of a Health Home Program for chronic kidney disease (CKD) utilizing available funding included in the Affordable Care Act (ACA) [Section 2703] to be effective May 1, 2012. Toward that end, DMAS researched the feasibility of implementing a health home program for individuals with CKD under Section 2703 of the ACA which provides a ninety percent Federal match rate for two years for care coordination services for individuals enrolled in health homes.

Under Section 2703, health homes must include all Medicaid members, including the dual eligibles (a significant portion of Medicaid members with CKD are or become dual eligible), who meet program criteria. DMAS was also approached by a dialysis vendor that proposed health home services to Medicaid members with CKD. However, the vendor's proposal neither demonstrated a full understanding of the requirements under Section 2703 nor state requirements for handling federal matching funds. In the end, DMAS decided not to pursue this model because (1) care coordination services would be new Medicaid services and would require new funds despite the temporary increased match rate; (2) a health home under Section 2703 would not produce Medicaid savings because the majority of savings for dual eligibles would accrue to Medicare rather than Medicaid; (3) after the first two years, the match rate would revert to Virginia's standard match rate; and, (4) the other care coordination activities outlined in Item 297 MMMM will cover these individuals; separating out those with kidney disease would serve to fragment care.

As outlined in this letter, DMAS has made significant progress in attaining the goals outlined in Item 297 MMMM.1 of the 2011 Appropriations Act. As a result of DMAS' concentrated efforts, principles of care coordination are being expanded to new geographic areas, populations, and services under programs administered by the Department. A timeline for MMMM.1 activities may be found in Attachment I. While we expect to attain cost savings over time, we are unable to report cost savings achieved in this report, as implementation on these items is not yet completed. DMAS remains committed to expanding principles of care coordination and looks forward to further enhancing these services to better meet the needs of Medicaid and FAMIS members in the coming years. Please feel free to contact me at Cindi.Jones@dmas.virginia.gov or (804) 786-8099 if you have any questions or need additional information.

Sincerely,

Cynthia B. Jones

Attachment

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

Attachment I