COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services

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The Honorable Robert F. McDonnell
Governor of Virginia

The Honorable Lacey E. Putney, Chair
House Appropriations Committee

The Honorable Walter A. Stosch, Chair
Senate Finance Committee

Dear Sirs:

Item 307 RR of the 2012 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 307 RR.

RR.a: allows DMAS to expand managed care to the Roanoke/Alleghany area by January 1, 2012, and far Southwest Virginia by July 1, 2012. DMAS successfully completed two managed care expansions in 2012. As a result, the managed care program is now operational statewide. Now, approximately 700,000 Medicaid and FAMIS members receive care through a managed care organization (MCO).

The first expansion, the Roanoke/Alleghany expansion, became effective January 1, 2012 and impacted approximately 30,000 fee-for-service Medicaid and FAMIS members. The expansion impacted the following 24 localities: 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. Medicaid and FAMIS eligible individuals in these localities now access health care services through one of the following MCOs: Amerigroup Community Care; Anthem HealthKeepers Plus; MajestaCare-a Health Plan of Carilion Clinic; Care Net/Southern Health; Optima Family Care; and, Virginia Premier Health Plan.

The second expansion occurred in the far Southwest and became effective July 1, 2012. This expansion impacted approximately 45,000 fee-for-service Medicaid and FAMIS members. This expansion impacted the following 15 localities: Bland; Bristol; Buchanan; Carroll; Dickenson; Galax; Grayson; Lee; Norton; Russell; Scott; Smyth; Tazewell; Washington; and, Wise. Medicaid and FAMIS managed care recipients in the far Southwest region now receive their benefits through one of the following MCOs: Amerigroup Community Care; Anthem HealthKeepers Plus; MajestaCare-a Health Plan of Carilion Clinic; Care Net/Southern Health; Optima Family Care; and, Virginia Premier Health Plan.

DMAS worked diligently with stakeholders to educate and prepare them for the far Southwest expansion. More specifically, DMAS met with hospitals, providers, health departments, and legislators, among other stakeholdres to discuss the expansion. DMAS also conducted two public forums in Abington-one on October 19, 2011 and one on May 2, 2012. These meetings provided opportunities for provider groups and members of the health care community to learn about the far Southwest expansion, ask questions, and meet senior staff from DMAS and each of the health plans. Approximately 175 individuals attended the October 19th meeting and approximately 220 individuals attended the May 2nd forum. The October 19th meeting was videotaped and uploaded to You-Tube – the Virginia Government Channel, which can be accessed at http://www.youtube.com/watch?v=KUc0_Z6U1PU.

Futhermore, in mid to late May 2012, DMAS conducted several training and educational sessions in Abingdon, Bristol, and Big Stone Gap for providers, the Department of Social Services, and recipients. DMAS also held a health fair in Abingdon on June 2nd. The six MCOs and DentaQuest (DMAS' dental vendor) were in attendance. Each of these events was well received and well attended. DMAS also shared information on the far Southwest expansion via a press release, provider letters, and Medicaid Memos.

The Roanoke/Alleghany and far Southwest Virginia expansions resulted in the availability of MCO coverage to eligible individuals in all areas of the Commonwealth and eliminated the primary care case management program. Managed care eligible individuals across the Commonwealth now 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.

RR.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 managed care for a variety of reasons. But, as managed care became operational in large contiguous portions of the Commonwealth, and eventually became statewide on July 1, 2012, continuity of care coordination for somewhat more transient populations, such as foster care children, is now a goal of the Department.

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. In December 2011, after a lot of intense work, including systems changes, trainings, regulations, and a §1915(b) waiver amendment, DMAS piloted a project to enroll children in foster care in Richmond City into Medicaid MCOs. Since that time, 215 youth have been enrolled in managed care and are now receiving care coordination and additional services such as a 24 hour nurse hotline, toll free member helplines, and disease management programs.

Item 307, DDD of the 2012 Appropriation Act builds on the city of Richmond DSS pilot project and directs DMAS to expand managed care to children in foster care and adoption assistance statewide. DMAS has assembled a Statewide Workgroup that includes representatives from foster care parents, state and local Departments of Social Services, MCOs, and private providers to assist with this effort. Implementation will be rolled out regionally starting with Central Virginia and Tidewater regions in the spring of 2013 (preassignment is scheduled for May 2013). Statewide implementation is planned by April 2014.

RR.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 full benefit dual eligible individuals 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.

RR.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. As of September 1, 2007, individuals who were enrolled in an MCO and subsequently become enrolled in a home and community-based waiver remained in the MCO and were not disenrolled from managed care. However, individuals who would otherwise be managed care eligible remained in home and community-based waivers because they were enrolled in the waiver first. In the future, 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). This is expected to impact approximately 5,000 individuals.

RR.e and RR.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. DMAS remains committed to the principles and implementation of a care coordination model for individuals in need of behavioral health services not currently provided through a MCO. This model will help improve the coordination of care for individuals receiving behavioral health services with acute and primary services, as well as improve the value of behavioral health services purchased by the Commonwealth of Virginia without compromising access to behavioral health services for vulnerable populations.

DMAS made significant progress toward fulfilling the mission of this directive. After extensive consultation and collaboration with the Department of Behavioral Health and Developmental Services (DBHDS), Community Service Boards (CSBs), national behavioral health experts, and numerous stakeholders, DMAS released a Request for Proposal (RFP) on December 16, 2011, for a Behavioral Health Services Administrator (BHSA). This competitive procurement solicited proposals from qualified organizations for a single BHSA vendor. When awarded, the BHSA contract will be an Administrative Services Only (ASO) non-risk model for the first three (3) years of the contract, with the option of two one-year renewals.

The RFP also served as the blueprint for a care coordination model for Medicaid/FAMIS Plus/FAMIS individuals in need of behavioral health services not currently provided through a MCO. Functions of the BHSA vendor will include comprehensive care coordination (including targeted case management); provider recruitment, network management, and training; member outreach and education; service authorization; utilization management; 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.

Although the targeted implementation date for the BHSA vendor was July 1, 2012, the Department continues to be engaged in the procurement process. Despite the delay, DMAS has continued with its preparations for implementation, including drafting programmatic changes to the Medicaid Management Information (known as VaMMIS) system to allow the contractor to perform service authorizations and provide reimbursements. DMAS anticipates fully implementing the new program within six (6) months of the contract award date. Once the contract is awarded, the BHSA will join the Department in its mission to ensure the provision of appropriate, consumer-focused, quality-driven behavioral and substance abuse services, rendering better health outcomes for Virginia's Medicaid and FAMIS beneficiaries.

RR.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. Nationally, and in the Commonwealth of Virginia, dual eligible individuals have among the most complex health care needs of any Medicaid or Medicare members, including chronic conditions, behavioral health needs, and disabling conditions. In Virginia, dual eligibles are currently excluded from participating in managed care and receive care driven by conflicting state and federal rules and separate funding streams, potentially resulting in fragmented and poorly coordinated care. Therefore, addressing quality and costs for these individuals has been a priority in the Commonwealth.

On July 8, 2011, the Centers for Medicare & Medicaid's Medicare-Medicaid Coordination Office (MMCO), in partnership with the Center for Medicare & Medicaid Innovation (CMMI), announced a Demonstration opportunity for States to align incentives between Medicare and Medicaid through the *Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees.* Through this Demonstration, CMS created two models that States can test to align financing between the Medicare and Medicaid programs; the capitated model and the managed fee-for-service model. Both models are designed to achieve State and Federal health care savings while enhancing the quality of care furnished to full benfit dual eligibles individuals (individuals who have both Medicare and full Medicaid coverage), with the goal of increasing access to seamless, quality programs that integrate primary, acute, behavioral, prescription drugs and long term care services and supports.

In October 2011, the Commonwealth of Virginia submitted a letter of intent to the MMCO indicating that the Commonwealth will pursue the capitated model. Under the capitated model, States, CMS, and health plans will enter into three-way contracts through which the health plans will receive a blended capitated rate for the full continuum of benefits provided to full benefit dual eligible individuals. Plans jointly selected by the respective States and the Federal government to offer the capitated financial alignment demonstration plans will be required to meet established quality thresholds.

DMAS intends to implement the capitated model in Central Virginia, Northern Virginia, Tidewater and Western/Charlottesville, potentially impacting 65,415 full benefit dual eligible individuals (DMAS intends to implement the Demonstration in the Roanoke region in Year Two, if approved by CMS). Only adult (21 years of age and older) full benefit dual eligibles will be included in the Demonstration, including those enrolled in the Elderly or Disabled with Consumer Direction (EDCD) Waiver, and those who reside in nursing facilities. At a minimum, the selected MCOs will provide the full array of benefits and supportive services afforded individuals under Medicare (including inpatient, outpatient, hospice, durable medical equipment, skilled nursing facilities, home health, and pharmacy) and the majority of state plan primary and acute care services, including community behavioral health, EDCD Waiver services, and nursing facility coverage.

In addition, each MCO will provide person-centered care coordination that integrates medical and social care coordination models and is appropriate to the needs of the targeted population. Supplemental/enhanced services will be at the option of participating MCOs. Medicare Part D requirements will apply to MCOs including, but not limited to, benefits, cost sharing, network adequacy, and formularies. MCOs will be selected through a joint DMAS and CMS procurement process. The Department and CMS plan to contract with a minimum of two, and a maximum of three MCOs, in each Demonstration region.

Under the Demonstration, DMAS proposes to use passive enrollment with an opt-out option. If an individual does not select an MCO within a prescribed time frame, the member will be assigned to a Demonstration MCO using algorithms that connect individuals with MCOs based on past enrollment and provider networks, where feasible. At any time, individuals can express a desire to change from one MCO to another in their geographic region or to opt out of the Demonstration and return to the fee-for-service environment.

According to MMCO requirements, DMAS drafted a proposal outlining how the Demonstration will operate in the Commonwealth (e.g., included and excluded populations, services, consumer protections, care model, quality measures, etc). DMAS complied with CMS' requirements and posted the draft proposal for thirty (30) days prior to submitting it to CMS. The draft proposal was posted from April 13, 2012 through May 13, 2012. DMAS received approximately forty (40) comment letters and twenty-five (25) letters of support from various organizations, individuals, etc. DMAS reviewed all comments and incorporated them, as appropriate, into the revised Demonstration proposal. On May 31, 2012, DMAS submitted the revised proposal to MMCO. The MMCO then posted the proposal for a second 30-day public comment period, which ended on June 30, 2012. DMAS received 12 comments through this process.

To date, DMAS has involved a broad range of stakeholders in the planning and development phases of the Demonstration. In March 2012, DMAS conducted a series of stakeholder meetings with providers, health plans, nursing facilities, hospitals, state agencies, advocacy groups, associations, and individuals, among others. The meetings were open to the public, but some of the meetings focused on specific aspects of the Demonstration that were most relevant to targeted groups. During the meetings, stakeholders provided feedback on various elements of the proposed Demonstration's design, such as care coordination, enhanced/supplemental benefits, nursing facility transitions, and payment, among other topics. Approximately 200 individuals attended the March meetings. DMAS continues to meet with stakeholders on an ongoing basis. DMAS also plans to schedule a series of Workgroup meetings to obtain additional input on operational aspects of the Demonstration, such as enrollment, care coordination, beneficiary protections, educational materials, grievances and appeals, etc. The first meeting to discuss care coordination is scheduled for July 27, 2012.

DMAS also created a web site dedicated to the Demonstration (http://dmasva.dams.virginia.gov/Content_pgs/altc-enrl.aspx). The website provides

public access to information related to the Demonstration, such as meeting announcements, presentations, and other relevant information and materials. The Department also created a dedicated e-mail address (DualIntegration@dmas.virginia.gov) so interested parties can submit questions, comments or concerns related to the Demonstration.

If CMS accepts DMAS' proposal, CMS and DMAS will sign a Memorandum of Understanding then release a Request for Applications to solicit Applications to Contract with MCOs. DMAS and CMS will then enter into three-way agreements with selected MCOs. Virginia has proposed to implement the Demonstration on January 1, 2014. Demonstrations will run for three years, after which they *may* become permanent. If Virginia is selected to participate, this Demonstration has the potential to significantly advance the shared goals of both the Commonwealth and CMS to expand access to care and improve the lives of dual eligible individuals, while streamlining the delivery of services and achieving cost savings. There is no limit on the number of states that CMS will select to participate, but CMS has indicated that they plan to include 1-2 million full benefit dual eligible individuals in the Demonstration across all participating states.

RR.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. Based on DMAS' research, implementing a health home under Section 2703 would be challenging because (1) health homes must include all Medicaid members, including the dual eligibles, who meet program criteria (a significant portion of Medicaid members with CKD are or become dual eligible); (2) care coordination services would be new Medicaid services and would require new funds despite the temporary increased match rate; (3) 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; (4) after the first two years, the match rate would revert to Virginia's standard match rate; and, (5) the other care coordination activities outlined in Item 307 RR will cover individuals with CKD; so separating them out would fragment care. In the past year, CMS has not released any additional guidance that would help address any of these issues.

Furthermore, DMAS was 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. DMAS requested additional information from the vendor, but to date, the vendor has not provided additional information. Given this, DMAS has decided not to pursue a health home under Section 2703 at this time.

Consequently, DMAS has dedicated staff and resources toward the other care coordination initiatives outlined in Item 307 RR, several of which will cover individuals with CKD. For example, full benefit dual eligible individuals with End Stage Renal Disease (ESRD) will be included in the Financial Alignment Demonstration described in Item 307 RR.g above. Under the Demonstration proposal, dual eligible individuals with ESRD living in the Demonstration regions will be passively enrolled in a MCO and will receive a full spectrum of services and supports through MCOs, including care coordination. Full benefit dual eligibles with chronic kidney disease that has not advanced to ESRD will also be passively enrolled in the Demonstration. These individuals will also receive care coordination, which has the potential to prevent or reduce further deterioration of their kidney disease.

As outlined in this letter, DMAS has made significant progress in attaining the goals outlined in Item 307 RR of the 2012 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. 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 has either not yet been completed or has just been completed and it is too soon to evaluate cost savings. 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

CBJ/

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