January 10, 2014

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 Appropriation 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; Pulaski; Radford; Roanoke City and County; Rockbridge; Salem; and, Wythe. Medicaid and FAMIS eligible individuals in these localities now access Medicaid benefits through one of the following MCOs: INTotal Health; Anthem HealthKeepers Plus; MajestaCare-a Health Plan of Carilion Clinic; CoventryCares of Virginia; Optima Family Care; and VAPremier 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 Medicaid benefits through one of the following MCOs: INTotal Health; Anthem HealthKeepers Plus; MajestaCare-a Health Plan of Carilion Clinic; CoventryCares of Virginia; Optima Family Care; and VAPremier Health.

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 stakeholders 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 forum and approximately 220 individuals attended the May 2nd forum. The October 19th forum was videotaped and uploaded to You-Tube – the Virginia Government Channel, which can be accessed at http://www.youtube.com/watch?v=KUc0_Z6U1PU.

Furthermore, 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 2, 2013. 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) more effective medical management; (2) larger and more comprehensive provider networks and network management; (3) supportive benefits (care management, nurse and other member service call lines, maternity and disease management and education programs); and, (4) focused quality improvement programs.

These expansions have proven to be overwhelming successes, demonstrated by the fact that the Department has received very few complaints from providers and/or members living in these areas who are receiving services through the managed care organizations. In May 2013, Department staff conducted a provider meeting in Abingdon and allowed providers to ask questions or raise concerns. In addition to DMAS staff and a large number of providers from the far southwest area of the Commonwealth, the meeting was attended by executives and medical directors from each of the contracted health plans. Following the meeting, many providers expressed appreciation of the visit and the information provided.

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, including the mobility of the population. But, as managed care became operational in large contiguous portions of the Commonwealth, and eventually statewide on July 1, 2012, the ability to provide continuity of coordinated care for somewhat more transient populations, such as foster care children, is now a realistic goal.

Implementation of the Richmond pilot was completed in SFY 2012. As of May 2013, two hundred and twelve (212) children receiving foster care were enrolled in managed care and receiving additional services such as a 24-hour nurse hotline, toll-free member helpline, and disease management programs.

Item 307.DDD of the 2013 Appropriations Act builds on the city of Richmond pilot and authorizes DMAS to expand managed care to children in foster care and adoption assistance on a regional basis. Preparations are underway to expand managed care to the Central, Tidewater and Northern Virginia managed care regions beginning in September 1, 2013 with completion date by the end of CY 2014. The local departments of social services are identifying children in foster care and adoption assistance via the

Medical Management Information System. Training sessions on Medicaid managed care in expansion regions have been conducted for foster care and adoptive parents.

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 a MCO and subsequently became enrolled in a home and community-based waiver remained in their MCO for acute and medical services and were not disenrolled from managed care. Currently, over 3,500 waiver enrollees receive medical services through MCOs. Waiver services are still provided through fee-for-service. Individuals who are not enrolled in an MCO prior to becoming eligible for a waiver remain in fee-for-service for medical and waiver services.

DMAS is currently exploring MCO enrollment for medical services for all waiver participants (with certain exceptions) and will outline these plans in its report to the General Assembly this fall on Phase Three of Medicaid Reform: Developing a Coordinated Delivery System for All Long-Term Services and Supports.

RR.e. and RR.f. directs 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.
In February 2013, DMAS resumed the review of proposals submitted from qualified organizations who responded to the Request for Proposals (RFP) for a Behavioral Health Services Administrator (BHSA). This RFP, issued in December 2011, 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. The goal of the care coordination model is to improve the coordination of care for individuals receiving behavioral health services, ensure that the care provided is appropriate to the individuals' needs, and to improve the value of these services paid for by the Commonwealth of Virginia.

In May 2013, DMAS posted an "Intent to Award" to Magellan Health services, with a signed agreement on June 6, 2013. The contract with Magellan is 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. Plans are underway for an expected implementation date of December 1, 2013.

Beginning December 1, 2013, the new contract will provide a single, centralized system for over 570,000 children and over 300,000 adult Medicaid and FAMIS beneficiaries who are in need of behavioral health services that are currently carved out of the Medicaid managed care system. Additional supports provided through this comprehensive behavioral health services model will include a toll-free 24-hour centralized call center, member and provider education, quality improvement initiatives and rigorous network management. Beneficiaries will also have easy access to information, referrals and assistance. They will gain timely access to quality care appropriate for their clinical needs and will be more informed about treatment options for better decision making about their care and provider selection.

Through quality initiatives, care management and utilization review activities, decreased care costs and expenditures are expected to be realized through reducing avoidable episodes of higher levels of care, accessing community services early when problems are identified, attending to the discharge planning process and encouraging adherence to and participation in treatment. Planned quality initiatives include the development and monitoring of quality outcome measures, a focus on integration of medical and behavioral health services, appropriate pharmacological treatment for children under age six and piloting peer support services.

All Medicaid fee-for-service behavioral health providers will be credentialed and enrolled through Magellan into a single network. In SFY2012, there were over 2,000

Medicaid providers who submitted over three million behavioral health claims. Network management will include ongoing analysis of geographical needs of beneficiaries in addition to provider performance monitoring and training.

The implementation of a comprehensive coordinated care model, developed in collaboration with many critical stakeholders, is a significant achievement for DMAS and Virginia. It demonstrates the shared commitment to a reform initiative that will not only improve the behavioral health care delivery system, but also the 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.

Improved Coordination for Dual Eligible Populations

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 multiple chronic health 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.

Over the past year, DMAS has made significant strides in implementing a coordinated, integrated model of care for dual eligible individuals via the Medicare – Medicaid Financial Alignment Demonstration (FAD). The FAD is an opportunity authorized by the Accountable Care Act (ACA) to integrate Medicare and Medicaid benefits under one system of coordinated care using a capitated model. Over the past twelve months DMAS held three quarterly meetings with the Medicare-Medicaid Advisory Committee (appointed by the Secretary of Health and Human Services), and other important stakeholders, and finalized the design and name of the Demonstration. The *Commonwealth Coordinated Care* (CCC) Program is a voluntary program and will serve up to approximately 78,600 individuals who are eligible for both Medicare and Medicaid services in five regions of the Commonwealth; Central Virginia, Tidewater, Northern Virginia, Charlottesville/West and the Roanoke regions. The CCC Program will be phased in on a regional basis over the first twelve months of the Demonstration, starting with the Central Virginia and Tidewater regions. Eligible individuals will be notified of the opportunity to enroll during December 2013 and the first opportunity for enrollment will be effective on February 1, 2014. The remaining three regions will be

phased in later in the 2014, with the first enrollment opportunity effective August 2014. The FAD will operate through December 2017, in order to allow for three years of operation after full implementation.

Over the past year, DMAS worked with CMS and stakeholders to develop the terms and conditions under which the CCC Program will operate, including: who will be eligible to enroll; covered benefits; the method of enrollment and the enrollment timeline; requirements and timeframes for participating plans to perform important functions, such as indentifying vulnerable enrollees and gathering health risk assessments, form Integrated Care Teams, and develop individual care plans; beneficiary protections, including an ombudsman program and requirements for ensuring the continuity of care; quality and performance outcome measures and other monitoring infrastructure; savings expectations; a partially integrated appeals processes; and other necessary operational details. In April 2013, DMAS released a Request For Proposal (2013-5) to solicit proposals for managed care organizations to operate in the CCC Program. Proposals were received on May 15, 2013, and DMAS has entered into negotiations with three of the Offerors. And on May 21, 2013, Virginia became the sixth state to sign a Memorandum of Understanding with CMS which signified Virginia's formal acceptance into the FAD.

In addition to the above accomplishments, over the past year DMAS created a new section within the Agency to reflect the priority of improved coordination of long-term care and behavioral health services. A new position, the Deputy Director of Complex Care and Services, was filled to oversee all long-term and behavioral health services. In addition, a Division of Integrated Care and Behavioral Services was created to oversee the implementation of the CCC Program and the new behavioral health administrator contract. Recently, the Director of the Integrated Care and Behavioral Services Division and the Director of the Office of Coordinated Care within the Division were hired, and DMAS anticipates filling several staff positions in the near future for contract management, quality and enrollment monitoring, data analysis, and other key functions required for effective operation of the CCC Program.

Other recent CCC Program accomplishments include:

1. Development of requirements for Medicaid Management Information Systems (MMIS) changes required to operate the CCC Program, in conjunction with the DMAS contracted Fiscal Agent;
2. Developed base expenditure data, in conjunction with the DMAS contracted actuary, and is in the process of developing risk-adjusted capitation payment rates with CMS;

3. Creation of an independent evaluation process of the CCC Program in conjunction with staff from George Mason University;
4. Submitted and received approval of a Medicaid State plan amendment required to enroll dual eligible individuals into managed care organizations;
5. Hired an Outreach and Education Coordinator and convened an Outreach and Education Committee that meets weekly to develop communication materials and an outreach and education plan;
6. Developed the template for the MCO readiness reviews that will began once DMAS entered negotiations with selected RFP Offerors;
7. Being accepted by the Centers for Health Care Strategies to participate in the *INSIDE (Implementing New Systems of Integration for Dual Eligibles)* Initiative; and
8. Initiating development of the three-way contract between DMAS, CMS and the MCOs.

Over the past year, DMAS met all CMS requirements for participation in the required timeframes and is scheduled to implement the CCC Program in 2014.

PACE

In addition to implementing the CCC Program, DMAS continues to expand the Program of All-Inclusive Care for the Elderly (PACE) program, which was Virginia's first coordinated long-term care service delivery model. PACE began in Virginia in 2007 as a result of a successful ten year pre-PACE demonstration in Virginia Beach. Over the past several years, DMAS has enhanced and expanded PACE so that it now serves 36 percent of regions in the Commonwealth.

PACE as a coordinated care model utilizes two key elements: (1) an interdisciplinary team that coordinates with the individual for all of their service needs (medical and social); and (2) the PACE model is a full-risk model that provides all of the Medicare & Medicaid services and more.

In 2012, there were six PACE providers in Virginia who provide services through twelve PACE sites. Because of the breadth of the program, the program is now serving rural areas where other coordinated care services have yet to reach. Two new providers are scheduled to begin PACE programs in 2013, with nine other providers having expressed interest in expanding PACE to new underserved areas of Virginia.

Discussions are ongoing with DBHDS and stakeholders regarding the PACE model as a possible model for individuals with Intellectual Disabilities or Developmental Disabilities.

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.

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 CCC described in Item 307 RR.g above. Under the Demonstration proposal, dual eligible individuals with ESRD living in the Demonstration regions who are not receiving the ESRD Medicare benefit at the time of implementation 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 receive care coordination, which has the potential to prevent or reduce further deterioration of their kidney disease and other related conditions. And individuals who begin to receive the ESRD Medicare benefit while in a CCC MCO may remain in the CCC, unless they chose to disenroll. Given this, DMAS has decided not to pursue a health home for chronic kidney disease under Section 2703 at this time.

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 of these items has either not yet been completed or has just been completed and it is too early 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
Director

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