COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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November 1, 2015

MEMORANDUM

TO: The Honorable Terence R. McAuliffe
Governor of Virginia

The Honorable Charles J. Colgan
Co-Chairman, Senate Finance Committee

The Honorable Walter A. Stosch
Co-Chairman, Senate Finance Committee

The Honorable S. Chris Jones
Chairman, House Appropriations Committee

FROM: Cynthia B. Jones Cynthia B. Jones
Director, Virginia Department of Medical Assistance Services

SUBJECT: Report on the Efforts to Expand the Principles of Care Coordination

The 2015 Appropriation Act, Item 301 OO states:

The Department of Medical Assistance Services shall seek federal authority through the necessary waiver(s) and/or State Plan authorization under Titles XIX and XXI of the Social Security Act to expand principles of care coordination to all geographic areas, populations, and services under programs administered by the department. The expansion of care coordination shall be based on the principles of shared financial risk such as shared savings, performance benchmarks or risk and improving the value of care delivered by measuring outcomes, enhancing quality, and monitoring expenditures. The department shall engage stakeholders, including beneficiaries, advocates, providers, and health plans, during the development and implementation of the care coordination projects. Implementation shall include specific requirements for data collection to ensure the ability to monitor utilization, quality of care, outcomes, costs, and cost savings. The department shall report by November 1 of each year to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees detailing implementation progress including, but not limited to, the number of individuals enrolled in care coordination, the geographic areas, populations and services affected and cost savings achieved. Unless otherwise delineated, the department shall have authority to implement necessary changes upon federal approval and prior to the completion of any regulatory process undertaken in order to effect such change.

Should you have any questions or need additional information, please feel free to contact me at (804) 786-8099.

CBJ/

Enclosure

pc: The Honorable William A. Hazel, Jr., MD, Secretary of Health and Human Resources

Report to the House Appropriations and Senate Finance Committees
from the
Department of Medical Assistance Services

November 2015

Report Mandate

The 2015 Appropriation Act, Item 301 OO requires:

The Department of Medical Assistance Services shall seek federal authority through the necessary waiver(s) and/or State Plan authorization under Titles XIX and XXI of the Social Security Act to expand principles of care coordination to all geographic areas, populations, and services under programs administered by the department. The expansion of care coordination shall be based on the principles of shared financial risk such as shared savings, performance benchmarks or risk and improving the value of care delivered by measuring outcomes, enhancing quality, and monitoring expenditures. The department shall engage stakeholders, including beneficiaries, advocates, providers, and health plans, during the development and implementation of the care coordination projects. Implementation shall include specific requirements for data collection to ensure the ability to monitor utilization, quality of care, outcomes, costs, and cost savings. The department shall report by November 1 of each year to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees detailing implementation progress including, but not limited to, the number of individuals enrolled in care coordination, the geographic areas, populations and services affected and cost savings achieved. Unless otherwise delineated, the department shall have authority to implement necessary changes upon federal approval and prior to the completion of any regulatory process undertaken in order to effect such change. The intent of this Item may be achieved through several steps, including, but not limited to, the following:

a. In fulfillment of this item, the department may seek federal authority to implement a care coordination program for Elderly or Disabled with Consumer Direction (EDCD) waiver participants effective October 1, 2011. This service would be provided to adult EDCD waiver participants on a mandatory basis. The department shall have authority to promulgate emergency regulations to implement this amendment within 280 days or less from the enactment of this act.

b. In fulfillment of this item, the department may seek federal authority through amendments to the State Plan under Title XIX of the Social Security Act, and any necessary waivers, to allow

individuals enrolled in Home and Community Based Care (HCBC) waivers to also be enrolled in contracted Medallion II managed care organizations for the purposes of receiving acute and medical care services. The department shall have authority to promulgate emergency regulations to implement this amendment within 280 days or less from the enactment of this act.

c. In fulfillment of this item, the department and the Department of Behavioral Health and Developmental Services, in collaboration with the Community Services Boards and in consultation with appropriate stakeholders, shall 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 managed care organization. The overall goal of the project is to improve the value of behavioral health services purchased by the Commonwealth of Virginia without compromising access to behavioral health services for vulnerable populations. Targeted case management services will continue to be the responsibility of the Community Services Boards. The blueprint shall: (i) describe the steps for development and implementation of the program model(s) including funding, populations served, services provided, timeframe for program implementation, and education of clients and providers; (ii) set the criteria for medical necessity for community mental health rehabilitation services; and (iii) include the following principles:

1. Improves value so that there is better access to care while improving equity.

2. Engages consumers as informed and responsible partners from enrollment to care delivery.

3. Provides consumer protections with respect to choice of providers and plans of care.

4. Improves satisfaction among providers and provides technical assistance and incentives for quality improvement.

5. Improves satisfaction among consumers by including consumer representatives on provider panels for the development of policy and planning decisions.

6. Improves quality, individual safety, health outcomes, and efficiency.

7. Develops direct linkages between medical and behavioral services in order to make it easier for consumers to obtain timely access to care and services, which could include up to full integration.

8. Builds upon current best practices in the delivery of behavioral health services.

9. Accounts for local circumstances and reflects familiarity with the community where services are provided.

10. Develops service capacity and a payment system that reduces the need for involuntary commitments and prevents default (or diversion) to state hospitals.

11. Reduces and improves the interface of vulnerable populations with local law enforcement, courts, jails, and detention centers.

12. Supports the responsibilities defined in the Code of Virginia relating to Community Services Boards and Behavioral Health Authorities.

13. Promotes availability of access to vital supports such as housing and supported employment.

14. Achieves cost savings through decreasing avoidable episodes of care and hospitalizations,

strengthening the discharge planning process, improving adherence to medication regimens, and utilizing community alternatives to hospitalizations and institutionalization.
15. Simplifies the administration of acute psychiatric, community mental health rehabilitation, and medical health services for the coordinating entity, providers, and consumers.
16. Requires standardized data collection, outcome measures, customer satisfaction surveys, and reports to track costs, utilization of services, and outcomes. Performance data should be explicit, benchmarked, standardized, publicly available, and validated.
17. Provides actionable data and feedback to providers.
18. In accordance with federal and state regulations, includes provisions for effective and timely grievances and appeals for consumers.

d. The department may seek the necessary waiver(s) and/or State Plan authorization under Titles XIX and XXI of the Social Security Act to develop and implement a care coordination model, that is consistent with the principles in Paragraph e, for individuals in need of behavioral health services not currently provided through managed care to be effective July 1, 2012. This model may be applied to individuals on a mandatory basis. The department shall have authority to promulgate emergency regulations to implement this amendment within 280 days or less from the enactment date of this act.

e.1. The department may seek the necessary waiver(s) and/or State Plan authorization under Title XIX of the Social Security Act to develop and implement a care coordination model for individuals dually eligible for services under both Medicare and Medicaid. The Director of the Department of Medical Assistance Services, in consultation with the Secretary of Health and Human Resources, shall establish a stakeholder advisory committee to support implementation of dual-eligible care coordination systems. The advisory committee shall support the dual-eligible initiatives by identifying care coordination and quality improvement priorities, assisting in securing analytic and care management support resources from federal, private and other sources and helping design and communicate performance reports. The advisory committee shall include representation from health systems, health plans, long-term care providers, health policy researchers, physicians, and others with expertise in serving the aged, blind, and disabled, and dual-eligible populations. The department shall have authority to implement necessary changes upon federal approval and prior to the completion of any regulatory process undertaken in order to effect such change.
2. There is hereby created in the state treasury a special nonreverting fund to be known as the Commonwealth Coordinated Care Pay for Performance Fund, hereafter referred to as the "fund." The fund shall be established on the books of the Comptroller and any moneys remaining in the Fund at the end of each fiscal year shall not revert to the general fund but shall remain in the fund. Moneys deposited to the fund shall be used solely for bonus payments to managed care organizations participating in the Commonwealth Coordinated Care program that meet the performance criteria of the pay for performance program specified in paragraph OO.e.1.

3. The department is authorized to implement a quality withhold program in the context of the initiative implemented pursuant to OO.e.1. Quality withhold funds, withheld from health plan capitation payments, shall be deposited in the fund created pursuant to OO.e.2. At the time and in the amounts determined by DMAS and Centers for Medicare and Medicaid Services, DMAS shall be authorized to make payments from the fund to health plans that meet quality performance measures stipulated in the Memorandum of Understanding and contract with health plans entered into pursuant to OO.e.1. Funds deposited in the fund may be used only for such payments.

4. The Department of Planning and Budget in collaboration with the Department of Medical Assistance services shall transfer general fund appropriation withheld from funds set aside in connection with a pay for performance program related to the dual eligible initiative pursuant to paragraph OO.e.1., to the fund

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This legislative mandate requires multiple comprehensive program implementations and thus is a multi-year process. This report provides updates on past program implementations and the status of upcoming program implementations for steps a through h.

a. allowed DMAS to implement a care coordination program for Elderly or Disabled with Consumer-Direction (EDCD) Waiver participants effective October 1, 2011.

DMAS has not implemented a care coordination program specifically for EDCD Waiver participants. The majority of individuals enrolled in the EDCD Waiver will receive care coordination through one of the other care coordination initiatives DMAS is implementing. For example, 63% of individuals enrolled in the EDCD Waiver are enrolled in both Medicaid and Medicare and some of these individuals have opted to receive coordinated care by participating in the Commonwealth Coordinated Care program (See item (e) below). Other EDCD Waiver participants receive care coordination of medical needs through the Health and Acute Care Program (See item (b) below). Further, additional EDCD Waiver participants will receive coordinated care through the upcoming Managed Long-Term Services and Supports (MLTSS) program that is currently under development.

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b. allowed DMAS to enroll individuals in home and community-based care services (HCBS) waivers to also be enrolled in managed care for the purposes of receiving acute and medical care services.

Health and Acute Care Program (HAP)

Item 307 RR.b. of the 2012 Appropriation Act allowed 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. Beginning September 1, 2007, individuals who were enrolled in an 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. This includes individuals enrolled in the Elderly or Disabled with Consumer Direction (EDCD), the Intellectual Disability (ID) Waiver, the Individuals and Family Developmental Disabilities Support (IFDDS) Waiver, the Day Support (DS) Waiver, and the Alzheimer's Assisted Living (AAL) Waiver.

Effective December 1, 2014, the Department launched the Health and Acute Care Program (HAP). The Health and Acute Care Program includes Medicaid members who are concurrently enrolled in the managed care delivery system and one of five home and community-based waivers. As part of this new initiative, the Department transitioned individuals in the EDCD Waiver, who were receiving acute and primary medical services in the fee-for-service program and who were eligible for managed care, (i.e., do not have any managed care exclusions), into one of the six Medallion 3.0 managed care health plans for coverage of their medical services. The individual's home-and-community based services, including transportation to the waiver services, are paid through the Medicaid fee-for-service system as a "carved out" service.

As of July 1, 2015, there were 8,216 individuals enrolled in HAP.

Proposed Managed Long-Term Services and Supports (MLTSS)

Beginning in 2011 and continuing through the 2015 legislative session, the Virginia General Assembly directed DMAS to continue with reform efforts to transition Medicaid individuals utilizing fee-for-service into managed care so that the advantages and benefits of managed care as a delivery model could be offered to all individuals utilizing Medicaid. Item 301 TTT specifically directs DMAS to "seek federal authority through any necessary waiver(s) and/or State Plan authorization under Titles XIX and XXI of the Social Security Act to implement a comprehensive value-driven, market-based reform of the Virginia Medicaid/FAMIS programs. This reform shall be implemented in three phases." An MLTSS program is currently under development to meet this requirement.

Initially, DMAS proposed to implement the MLTSS program in two phases. The first would have begun July 1, 2016, and enrolled the approximately 36,000 dual eligible beneficiaries that opted-out of CCC. The second phase would have begun on July 1, 2017, and enrolled approximately 70,000 other beneficiaries utilizing long-term services and supports. In June 2015, as a part of DMAS' commitment to stakeholder involvement, DMAS released an opportunity to provide public comment on the proposed design and implementation of DMAS' proposed MLTSS initiatives. DMAS received input from 53 stakeholders, totaling over 137 pages of comments. A resounding theme that emerged from the public comment period was that numerous stakeholders requested that DMAS delay implementing mandatory managed care initiatives until after the CCC program ends on December 31, 2017 (new individuals will no longer be able to enroll in CCC starting June 30, 2017).

DMAS takes stakeholder input seriously. Accordingly, DMAS has decided to revise its proposed MLTSS plan. The revised MLTSS approach merges the originally two phased proposal into one comprehensive implementation design. As a result, DMAS will implement a single mandatory Medicaid MLTSS program beginning mid-year 2017. Under this single MLTSS program, the majority of the remaining fee-for-service populations, including those eligible for the CCC program, dual eligible members currently not eligible for the CCC program, and individuals receiving long term services and supports either through a waiver or who reside in a nursing facility, will be mandatorily enrolled in managed care. In December 2017, when the CCC program ends, DMAS will enroll these individuals into the MLTSS program on a phased-in basis.

DMAS will procure health plans to administer the MLTSS program through a competitive procurement. The MLTSS program will operate state-wide and will be phased-in regionally. Health plans may vary by region and at least two or more health plans will be selected to participate in each region. MLTSS health plans must be National Committee on Quality Assurance (NCQA) accredited or be in the process of acquiring NCQA accreditation and have the legal capacity to enter into a contract with the Department and have current certificates of authority to operate in the Commonwealth, as determined by the Virginia Bureau of Insurance and the Virginia Department of Health. MLTSS plans must also have a contract approved by the Centers for Medicare & Medicaid Services (CMS), or be in the process of being approved by CMS, to operate as a Dual Eligible Special Needs Plan (D-SNP) in the localities where the health plan operates as an MLTSS plan.

The MLTSS populations will include: (1) individuals with full Medicaid and Medicare benefits (known as dual eligibles) and (2) individuals who receive Medicaid and long term services and supports (LTSS) either through an institution or through one of

DMAS' six (6) home and community based services (HCBS) waivers. At this time, Medicaid managed care for individuals enrolled in the Day Support for Persons with Intellectual Disabilities (DS); Intellectual Disabilities (ID); and, Individual and Family Developmental Disabilities Support (DD) Waivers is being considered for their acute and primary care services only. While DMAS is exploring the feasibility of managed or integrated care models for the ID, DD, and DS Waivers, these individuals will continue to receive their home and community-based LTSS through Medicaid fee-for-service until the Department of Behavioral Health and Developmental Services (DBHDS) completes the redesign of these Waivers.

Please go to http://www.dmas.virginia.gov/Content_pgs/mltss-home.aspx for more information.

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c. and d. directed 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.

Following the collaboration among stakeholders and the Community Services Boards (CSB), a blueprint for the Department of Medical Assistance Services (DMAS) behavioral health services became the basis of contract procurement for a Behavioral Health Service Administrator (BHSA). Beginning on December 1, 2013, Magellan Healthcare began serving as the contracted BHSA and implemented a care coordination model for DMAS behavioral health services. Under this model, Magellan provides administrative and care coordination services through a single, centralized healthcare system for over 1,075,000 Medicaid and FAMIS beneficiaries who are in need of behavioral health services. Magellan administers the full continuum of behavioral health care services for Medicaid members not covered under a Managed Care Organization (MCO) and all of the non-traditional, community-based services for individuals covered under the Medicaid MCO Medallion 3.0 program. This comprehensive care coordination model for behavioral health services offers multiple program supports which include:

- A toll-free 24-hour centralized call center for both members and providers with access to licensed clinicians for non-routine calls;
- Rigorous behavioral health provider credentialing and network management;
- Member outreach;

- Provider education;
- Quality improvement initiatives and ongoing care monitoring, and
- Extensive resources provided through a member-focused website.

Magellan works to ensure members have easy access to information, referrals and assistance. The care coordination model provided by Magellan has allowed members to gain timely access to quality care that is appropriate to their clinical needs. Members are also becoming more informed about their treatment options and their freedom of choice in selecting a provider.

Magellan is continuing to implement several quality initiatives, care management and utilization review activities, while continuing to develop a challenging set of quality outcome measures that demonstrate overall effectiveness of the care coordination model. The quality measures include data that supports improvement in access to care, member satisfaction, provider performance and reduced frequency of avoidable emergency care. The outcome measures also support adherence to the 18 principles of the coordinated care model that were identified in the 2011 Acts of Assembly and are essential components of the BHSA contract. 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.

Some of the highlights of the accomplishments Magellan has achieved are described below:

- Member handbook and 'Passport to Care' outlining program information are available to all members and serves as a means to organize personal healthcare information.
- Implementation of Mental Health Skill-building Services (MHSS) and Community Mental Health Rehabilitation Services (CMHRS) regulation changes which include changes in medical necessity criteria, program requirements, provider enrollment requirements and quality of care requirements.
- Implementation of website enhancements related to electronic submissions of service authorization requests by providers.
- Authorization decisions were determined within a 3-day turnaround timeliness standard on a consistent basis.
- Implementation of a Network Strategy Committee made up of providers and stakeholders to review network development.

- Provider Gateway, an online submission process for providers to request to join the network, implemented on 4/6/15.
- A Magellan Governance Board was established and is comprised of stakeholders, providers and Medicaid members. The Board meets monthly to address areas for potential improvement. These meetings are held bi-monthly and are open to members and providers.
- An extensive Quality Improvement Plan was implemented to monitor member services, utilization management, regulatory compliance, provider credentialing and includes a Consumer Family Stakeholder Advisory Group.
- Two learning collaboratives with a wide range of stakeholder representation have been underway to examine the use of psychotropic medication in children and in integrated care.
- Resources are dedicated to the collaboration with all of the Medicaid MCOs, in order to ensure coordination and integration of care.
- The Peer Bridger pilot program RFP was announced by Magellan. This program was designed to promote reduced readmissions to hospital settings and measure the effectiveness of Peer Bridger services, which are services that assist individuals with avoiding recurring inpatient admission and facilitate recovery using community care
- Recovery Navigation launched as part of the Governor's Access Plan (GAP) to provide a new peer support service.
- Weekly calls conducted for GAP information and technical assistance including one for screeners, one for all providers and one for members and other stakeholders.

Specific functions and performance levels of the Magellan contract have been regularly monitored and several results are outlined below:

Call Center

- In FY2015, the Magellan call center received over 41,000 calls. Nearly 18,000 calls were from providers, approximately 15,100 calls were from members, of which, over 12,000 calls that required care coordination.
- All calls have been answered in an average of less than 10 seconds demonstrating excellent customer service to all callers.
- In FY2015, there were 216 crisis calls. These are calls sent to a care manager for clinical assistance. GAP members account for over 25% of the crisis calls since April 2015 when the crisis calls began to be traced to GAP members specifically (the Magellan call center services all Medicaid program members who have behavioral health benefits).

Crisis Call Example:

A 39 year old female GAP member called in crisis because she was being evicted from her home. The Customer Service Associate transferred the call to a Care Manager (CM);

- The member was agitated, tearful, and hysterical. The member stated that she has experienced suicidal ideations in the past, and that if she does not find some places to go, she will experience suicidal ideations again. The CM assessed that the member was in crisis.
- The CM learned that the member needed to find a place to live within the next month.
- The member stated that she has a therapist but that her therapist is on vacation so she was not able to process this with her therapist.
- The member began to cry hysterically and the CM obtained assistance from other CMs.
- A CM contacted the local Community Service Board and a crisis worker attempted to engage member. The member started to scream and yell because she thought she was going to be sent to an inpatient facility.
- When the Crisis Worker and the CM could not deescalate the situation, another CM attempted to call the police to conduct a wellness check, but the member refused to give her address. The CM gave the police the address on file for the member.
- The member then hung up the phone and the CM could not then reach the member.
- The CM referred the member, through an internal process, to a GAP Recovery Navigator.
- The Navigator reached the member the following day. The member was tearful and talked about her impending eviction and the need for a place to stay.
- The Navigator engaged the member by talking about the member's cat, which the member views as therapeutic. The Recovery Navigator shared some organizations that could provide a temporary place for the member's cat if member needed to stay at a temporary shelter.
- The Navigator established enough rapport with member that she agreed to an in-person meeting with the Navigator. The Navigator met with the member face to face and shared recovery, housing, pet, and health resources with the member.
- A few days later the Navigator made a follow-up call to the member who reported that she had met with her therapist. She also reported that she was being asked to leave her current housing situation sooner than she thought. The member stated that despite the increased stress, she felt that talking to the Recovery Navigator really helped.

- The Navigator worked with the member to develop a crisis plan that involved contacting the local CSB if needed. They also made a plan to meet again in person and to attend the member's first NAMI support group together.

Provider Relations Activity

Table 1: DMAS Behavioral Health Network Providers

Point in Time	Number of Provider Locations	Unique NPI Count
6/30/15	8,455	4,941
8/5/14	6,913	4,112

During 2014, the DMAS provider network was analyzed and improved, removing inactive providers and those who no longer wanted to participate in the network. Providers who did not meet the credentialing requirements established by Magellan were also removed from the network.

During SFY2015, the network has expanded to include 1,500 additional service sites and an increase of 800 additional providers to serve DMAS enrolled members.

Service Authorizations and Registrations of Provided Services

Since 7/1/2014, there have been:
- Over 137,000 service authorizations (review of care quality and the individual medical necessity for the service)
- Over 49,000 service registrations (authorize reimbursement without reviewing the actual service details)

These service authorization reviews may be for initial or concurrent care decisions. Magellan Care Managers contact providers directly when additional information is needed to confirm compliance with medical necessity criteria and when there is the need for education and guidance on improved care delivery and discharge planning. Each review and communication with providers offers an opportunity for care coordination and monitoring for efficiency and effectiveness of care.

Claims

Provider reimbursements have been consistently issued timely.

- The electronic fund transfer (EFT) rate of claims paid to providers was approximately 97.51% as of the end of June 2015. This is the highest reported EFT rate in the Magellan product nationwide.
- 99.51% of claims are paid within 30 days and 100% of claims are paid within 60 days.
- 91.7% of claims are automatically adjudicated.

Utilization Management

Magellan administers a continuum of traditional outpatient mental health and substance abuse treatment counseling services, community based rehabilitation services, residential treatment options and inpatient psychiatric care including services for temporary detention orders. Preliminary utilization data indicates a downward trend for inpatient admissions and readmissions, as well as an increase in follow-up care after an inpatient admission. Utilization data is reviewed routinely with DMAS and shared with the Department of Behavioral Health and Developmental Services and the Office of Comprehensive Services. Data for the most highly utilized services are presented below.

Figure 1: Unduplicated Members by Month by Service: Residential Treatment (Level C), Inpatient and Temporary Detention Order

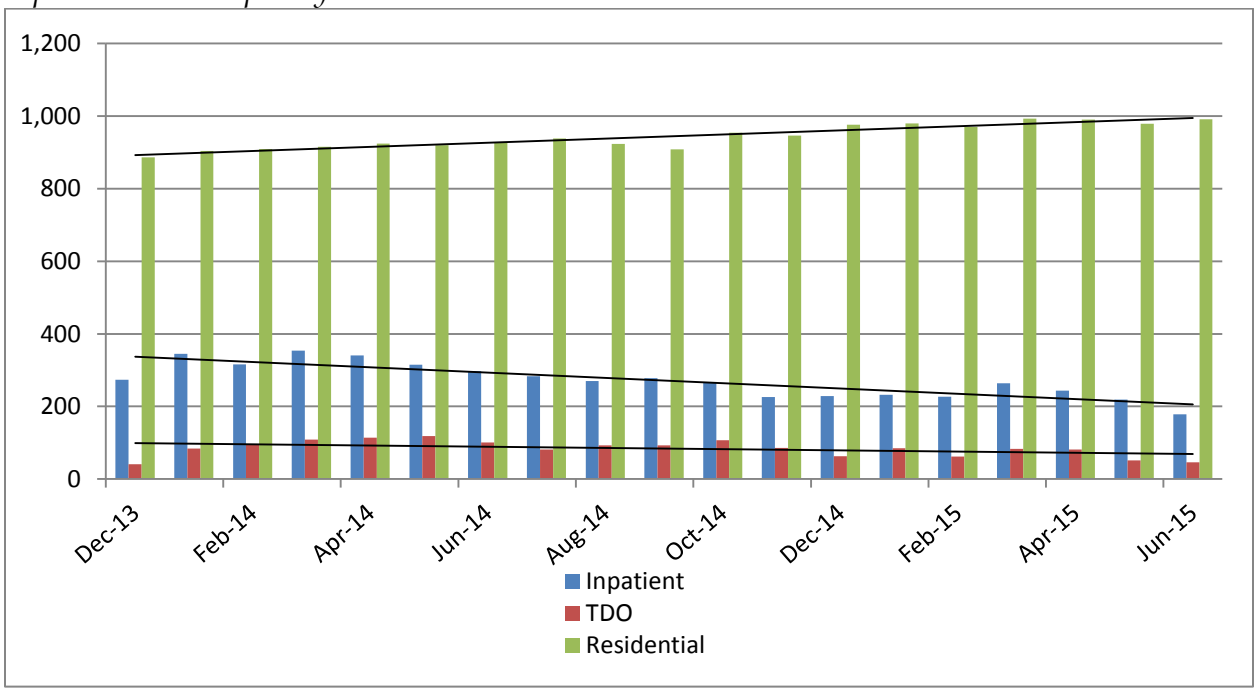
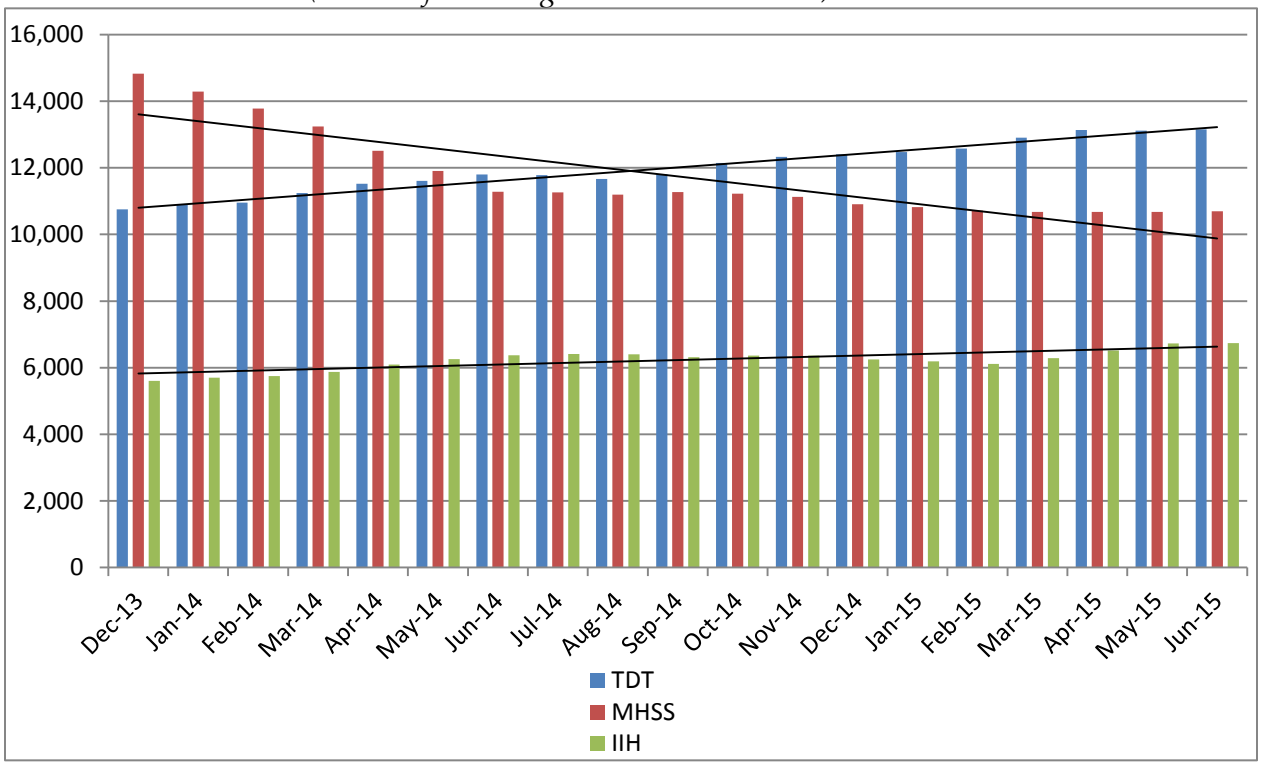


Figure 2: Unduplicated Members by Month by Service: Community Mental Health Rehabilitation Services (selected for the highest utilization rates)



Service Utilization

While care expenditures are being monitored, service utilization is also reviewed for trends, such as changes in the length of treatment episodes and in practice patterns. The comprehensive coordinated care delivery system is yielding decreases in the number of units billed, changes in the number of members served, and a decrease in the overall number of units billed per member, specifically for services that historically have demonstrated uncontrolled growth. Since services are now authorized based on continued effectiveness, members are being discharged when treatment goals are met or when an alternate level of care is clinically indicated, as opposed to unnecessarily running out the remaining allowable benefits.

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e. allowed DMAS to develop and implement a care coordination model for individuals eligible for Medicare and Medicaid (dual eligibles) to be effective April 1, 2012.

Commonwealth Coordinated Care - Improved Coordination for Populations Receiving Medicare and Medicaid (Dual Eligible)

In August of 2011, the Centers for Medicare and Medicaid Services (CMS) Office of Medicare and Medicaid Integration offered an opportunity for states to participate in the Medicare-Medicaid Financial Alignment Demonstration (FAD). The Virginia FAD, titled Commonwealth Coordinated Care (CCC), seeks to integrate Medicare and Medicaid services, rules and payments under one delivery system for dual eligible individuals. CCC includes a strong, person-centered service coordination and care management component, integration with an array of provider types for continuity of care, ongoing stakeholder participation, outreach and education and flexibility for innovation.

The goals of CCC include: reducing service fragmentation; providing high-quality and coordinated care; improving the health and lives of enrolled individuals; reducing the need for avoidable services, such as hospitalization and emergency room use; encouraging individual participation in treatment decisions; and supporting the goal of providing treatment in the least restrictive, most integrated setting.

Individuals over the age of 21 years who have full Medicare and Medicaid benefits are eligible to participate in CCC. CCC is a completely voluntary program, and as such, allows the individual the ability to 'opt out' of the demonstration at any time. CCC is available in five regions (Tidewater, Central Virginia, Northern Virginia and the Roanoke and Charlottesville areas) encompassing 103 localities. CCC will operate for three years in addition to the initial enrollment year (although CMS has indicated that DMAS may be allowed to operate the demonstration for an additional year).

Since the beginning of FY 2015 DMAS, in consultation with the CCC Advisory Committee, other important stakeholders, CMS, and members of the State Administration, has made significant strides in operating the CCC program. Some of the accomplishments achieved by DMAS under this initiative include:

1. Completed passive enrollment process and began service coverage in all five CCC regions,
2. Initiated joint CMS and DMAS Contract Monitoring Team to oversee the Medicare-Medicaid Plans (MMPs) contract compliance and their effectiveness in the provision of services,
3. Conducted comprehensive beneficiary, provider, and advocate education and outreach initiatives,
4. Continued IT Systems coordination and monitoring,
5. Began gathering and analyzing quantitative and qualitative quality measure data required by CMS and DMAS, in order to determine the success of the program, and

6. Conducted program evaluation interviews, focus groups and surveys with stakeholders (MMP staff, providers, enrollees and their caregivers) in order to gage satisfaction and the overall success of the program. This is done in consultation and conjunction with George Mason University staff.

As of June 6, 2015, there were 66,106 Virginian's eligible for CCC. Of those eligible, 29,970 have opted into the program, 27,494 have opted out and the remaining 8,642 have not decided or taken action either way. (The undecided are in single MMP localities and therefore are not eligible to be passively assigned; however, they also have not opted out of the program.) Up-to-date and more detailed enrollment data can be seen in the monthly Enrollment Dashboard on the DMAS website: http://www.dmas.virginia.gov/Content_pgs/altc-stkhld.aspx.

To monitor and ensure the high quality of health care and other services provided to CCC enrollees, CCC staff implemented a series of contract and quality monitoring activities. As part of the contract monitoring activities, MMPs are required to submit bi-weekly dashboards that include information on the timeliness and completion rate of Health Risk Assessments (HRA's) and Plans of Care (POC); claims processing; quality of care concerns, including grievances and appeals; and, other measures focused on the operational progress and contact compliance of the MMPs. For quality monitoring, the MMPs are required to submit annual quality management and evaluation results on over 107 quality measures. CCC staff has developed several Quality Management Dashboards for public consumption. Each dashboard requires CMS review and approval prior to publication. The dashboards along with other information on the CCC Quality Monitoring efforts can be found at:
http://www.dmas.virginia.gov/Content_pgs/ccc-qm.aspx.

To guarantee that care coordination services are being provided in the most effective and efficient manner possible, DMAS began training each MMPs Care Coordinators. Various topics covered to date include POCs, HRAs, interdisciplinary care teams, Elderly or Disabled with Consumer Direction Waiver requirements, person centered care planning, advance directives and goal setting. Pre and post tests were conducted to evaluate understanding as well as a survey for rating the training session. The average pre-test score across the plans was 69.6% correct, and the average post test score was 80.3%. A second round of trainings began in July 2015. In addition to the trainings, DMAS began hosting biweekly conference calls with the Care Coordinators as an opportunity for questions and answer from staff as well as a venue for sharing best practices.

Additionally, since April of 2014, DMAS, along with the three MMPs, the Virginia Health Care Association (VHCA), and the Virginia Association of Health Plans (VAHP) have been collaborating to identify and resolve issues related to CCC as they arise. These parties have met and worked through many different venues (formal meetings, one-on-one discussions, informal staff interactions, etc.) but recently formed two small work groups focusing on claims processing and care coordination. These groups have been able to identify solutions to address concerns such as administrative burden placed on providers. The work groups will continue to meet until the implementation issues are resolved to the satisfaction of all parties, with a goal of resolution no later than October 1, 2015.

In the past year DMAS staff, in cooperation with CMS, the CCC Advisory Committee, stakeholders, and members of the State Administration will continue to monitor the activities of the three MMPs to ensure that the principles of care coordination are being applied as effectively as possible. In the coming year, DMAS will continue the collaborative meetings and workgroups. Additionally, DMAS will continue to perform extensive community outreach and education with providers and beneficiaries in coordination with VICAP. Finally, DMAS staff will continue contract monitoring activities including onsite reviews, audits and technical visits.

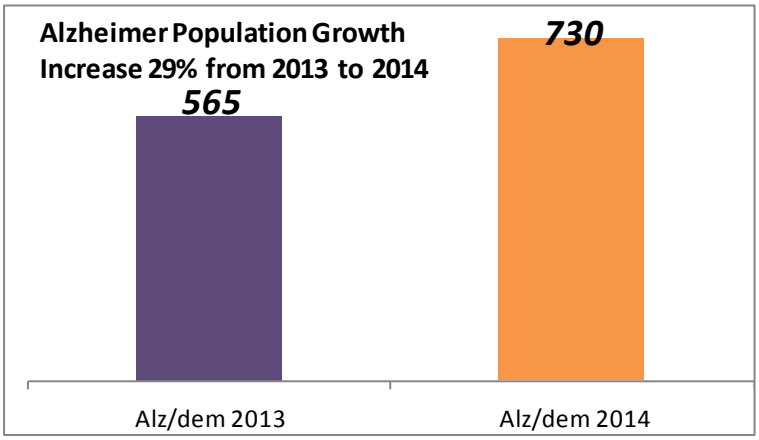
Program of All-Inclusive Care for the Elderly (PACE)

PACE is a full-risk, long-term care delivery model that provides all Medicare & Medicaid services (medical, behavioral and social) generally focused around an adult day care center. PACE utilizes interdisciplinary teams that coordinate with the individual and their families for all service needs. PACE began in Virginia in 2007 as a result of a successful ten year pre-PACE demonstration in Virginia Beach operated by Sentara. DMAS has continued to expand PACE over the years; currently, there are 15 PACE sites operated by 8 providers. PACE programs have formed partnerships with the Veteran's Administration, local community services boards and private providers, to successfully serve more veterans, individuals with intellectual disabilities, and those with mental health issues. PACE sites are located in:

- Big Stone Gap
- Cedar Bluff
- Charlottesville
- Fairfax
- Farmville
- Hampton
- Lynchburg
- Newport News
- Petersburg
- Portsmouth
- Richmond (2 sites)
- Roanoke
- Virginia Beach
- Gretna/Danville area
- Halifax, VA

In 2014, PACE programs in the Commonwealth served 730 individuals diagnosed with a form of dementia reflecting a 29% increase over 2013.

Figure 3: Number of Individuals in PACE living with Alzheimer's disease – 2013 to 2014 (calendar years).



PACE also continues to care for an increasing numbers of persons with intellectual disabilities (ID).

Figure 4: Growth in the Number of Persons with ID Enrolled in Pace 2013 to 2014.