COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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November 1, 2016

MEMORANDUM

TO: The Honorable Terence R. McAuliffe
Governor of Virginia

The Honorable Thomas K. Norment
Co-Chairman, Senate Finance Committee

The Honorable Emmett W. Hanger, Jr.
Co-Chairman, Senate Finance Committee

The Honorable S. Chris Jones
Chairman, House Appropriations Committee

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

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

The 2016 Appropriation Act, Item 306 MM 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 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.

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

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

ADMINISTERING MEDICAID AND THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM IN VIRGINIA

DMAS' mission is to provide a system of high-quality and cost- effective health care services to qualifying Virginians and their families.

The Medicaid program, signed into law by President Lyndon B. Johnson on July 30, 1965, celebrated its 50th year in 2015.

Medicaid is a joint federal and state program authorized under Title XIX of the Social Security Act that provides health and long-term care coverage for specific groups of Virginians with low incomes. In Virginia, Medicaid is administered by the Department of Medical Assistance Services (DMAS) and is jointly funded by Virginia and the federal government. Virginia's federal matching rate, known as the Federal Medical Assistance Percentage (FMAP) is generally 50%, so Virginia receives $1 of federal matching funds for every $1 Virginia spends on Medicaid.

Medicaid is primarily available to children in families with low-income, pregnant women, elderly, individuals with disabilities, and parents below strict income limits.

DMAS also administers Virginia's Children's Health Insurance Program (CHIP) known as FAMIS. FAMIS covers children and pregnant women in families earning too much to qualify for Medicaid but too little to afford private insurance.

All states must follow federal Medicaid/CHIP guidelines regarding who is covered, but set their own income and asset eligibility criteria. Virginia's eligibility criteria are among the strictest in the nation.

Annual Report on Care Coordination Activities

November 2016

The 2016 Appropriation Act, Item 306.MM sets out the following requirement with respect to Medicaid care coordination:

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 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.

This report is being submitted in response to the requirement in Item 306.MM that the Department of Medical Assistance Services ("DMAS" or "the Department") annually report on the progress of DMAS' implementation of care coordination for Medicaid enrollees.

Currently, the Department is significantly enhancing access to care coordination through the extension of managed care for all Medicaid enrollees. Care coordination and disease management is at the heart of the Medallion 3.0 managed care approach to care delivery. Care coordination is a service delivery model where teams of health care providers work together to ensure that each member's health and wellness needs are being met effectively. Care coordinators act as a central hub for the health care needs of individuals. They maintain ongoing awareness of each client's medical needs and services.

As of December 2015, just over 68% of Medicaid enrollees were in the Medallion 3.0 managed care program.

The Medallion 3.0 managed care organizations (MCOs) coordinate care through primary care coordination and disease management programs. In both programs, care is provided through a multidisciplinary team that may include primary care physicians (PCPs), specialist physicians, nurses, therapists, nutritionists, and pharmacists. These care programs address numerous complex and often costly health conditions, including diabetes, behavioral health, prenatal/postnatal care, asthma, and complex cardiac care. The MCOs possess capabilities in program flexibility with seasoned analytical skills in assessing member needs.

On March 1, 2014, the Department implemented the Commonwealth Coordinated Care (CCC) Program in selected regions across the state to improve care for full benefit Medicare-Medicaid enrollees. Medicare-Medicaid enrollees often have substantial acute, behavioral, chronic, primary, and long-term service and support (LTSS) needs. While Medicare-Medicaid enrollees have access to a range of services, most are not coordinated because they are provided through the often fragmented fee-for-service programs. CCC seeks to improve care for enrollees by coordinating the delivery of *all* health and services for which they are eligible to receive through a managed care delivery system.

Because CCC represents a new care delivery model, DMAS partnered with George Mason University to form a team composed of faculty and agency staff to evaluate the effectiveness of this new program. As part of its activities, the evaluation team conducted extensive interviews with both CCC beneficiaries and providers in order to better understand what the program looks and feels like from the perspective of individuals who are directly involved in it. The following case study provides an example of the insights gained through the evaluation by briefly presenting the experiences of one beneficiary, their care coordinator, and the Elderly or Disabled with Consumer Direction Waiver home health agency nurse who worked this individual's case. For purposes of this report, we are using the name Cynthia for the beneficiary whose case is being highlighted.

Cynthia is 58 years old, has several chronic diseases, and is enrolled in Virginia's Elderly or Disabled with Consumer Direction (EDCD) Medicaid Waiver. She is dually eligible for Medicare and Medicaid, and previously received Medicare benefits through a Medicare Advantage Plan. She now receives those care services through the CCC program.

Cynthia's Story

In speaking of her CCC care coordinator, Cynthia said, "*[She] really stays in touch with me…she definitely knows what's going on and she makes sure I have everything I need…I don't even think of her as a coordinator, I just think of her as a friend…without her, who would I have to help me…nobody, except for the home care agency that works with me…she tells me about things that are available to me…she helps me when I do my over the counter [pharmacy] orders…I think that's a good idea, having a coordinator.*

The primary benefit of CCC is care coordination, which is provided by care coordinators who support beneficiaries across the care continuum. To achieve this, coordinators must not only have good communication and relationships with beneficiaries, but also with providers. In speaking of her coordinator, Cynthia said, "*I like my coordinator, she's always in touch…she and I not only talk [on the phone], but she sees me [in my home]." When asked about how her coordinator assists her, Cynthia said, "[She] tells me about things that are available, like Silver Sneakers [an exercise program]…she helps me when I do my over the counter [pharmacy] orders…she answers my questions…like when I had to find a dermatologist…if I have any problems [with providers or services], she straightens it out.*"

When Cynthia started having mobility issues, her coordinator ordered a personal emergency response system (PERS) pendant in case she fell and injured herself. Because Cynthia is in the EDCD Waiver, her coordinator works with a home health agency nurse to support Cynthia in her home. Cynthia's home nurse states that she likes CCC because she has a contact person, "I can call and I know [concerns] will be taken care of." This doesn't usually happen with Medicaid fee-for-service clients because their case workers change frequently. When comparing her relationships with her workers before CCC, Cynthia said, "…we do have a relationship…I have a relationship with [my nurse}…I have a relationship with [my coordinator]…we have a good relationship…they can tell when something's going on with me whether I say so or not…this is better…I like the one-on-one [contact] …I like this…yeah…I like this."

Summary

Over the past two decades, the Department has worked to extend the benefits of care coordination to additional members of the Virginia Medicaid population. This has, in turn, enhanced the quality of the members' medical care and significantly improved the quality of their lives.

The total net savings arising from the CCC was $2.5 million in FY 2015 and $4.4 million in FY 2016. These figures are based off the reduction in the capitated payment amounts and the savings in reduced service needs of the enrollees due to the more robust care coordination model in the CCC program.

Beginning July 1, 2017, the Department is phasing in several new managed care initiatives that will cover virtually all individuals in need of care coordination services, such as the Medicaid waiver enrollees, whose long-term service and support needs will be addressed through the new CCC Plus program.

The Department anticipates continuing this trend of care coordination into the future with the implementation of Medallion 4.0, providing managed care for the general Medicaid population, and CCC Plus to address care coordination needs of Medicare-Medicaid enrollees, individuals with long-term services and support needs, and other enrollees who qualify for Medicaid as aged, blind, or disabled.