COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services

CYNTHIA B. JONES
DIRECTOR

SUITE 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804/786-7933
800/343-0634 (TDD)
www.dmas.virginia.gov

November 1, 2017

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 2017 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

Annual Report on Care Coordination Activities - FY 2017

A Report to the Virginia General Assembly *November 1, 2017*

Report Mandate:

Item 306 MM of the 2017 Appropriation Act 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."

Background

Care coordination is the organization of member care activities between all participants involved in a member's care to ensure the appropriate delivery of health care and to reduce disconnected care. There are many care coordination models. Proper care coordination involves organizing a combination of health care personnel and other resources necessary to carry out all required member care activities. Proper care coordination often includes the exchange of information among participants responsible for different aspects of care. Effective communication and collaboration within and across providers and institutions ensures all providers utilize relevant diagnostic and treatment information which creates better health outcomes, prevents redundant care processes, and promotes accurate diagnosis and treatment. Further, this communication and collaboration can reduce reliance on more costly interventions that do not focus on community based care, thus reducing the growth rate of overall health care costs for the Commonwealth.

The Department of Medical Assistance Services (DMAS) seeks to expand coordinated care to all geographic areas, populations, and services under programs it administers and to meet the stated objectives of the Virginia

About DMAS and Medicaid

DMAS' mission is to ensure Virginia's Medicaid enrollees receive high quality and cost effective health care.

Medicaid plays a critical role in the lives of over a million Virginians, providing health care for those most in need. Medicaid enrollees include children, pregnant women, parents and care takers, older adults and individuals with disabilities. Virginians must meet income thresholds and other eligibility criteria before qualifying to receive Medicaid benefits.

Medicaid covers primary and specialty health care, inpatient care, and behavioral health and addiction and recovery treatment services. Medicaid also covers long term services and supports, making it possible for thousands of Virginians to remain in their homes or to access residential and nursing home care.

Quick Medicaid facts:

- Covers 1 in 8 Virginians
- Covers 1 in 3 births and 33% of children
- Supports 2 in 3 nursing facility residents

Virginia Medicaid and Children's Health Insurance Program (CHIP) are administered by the Department of Medical Assistance Services (DMAS) and are jointly funded by Virginia and the federal government under the Title XIX and Title XXI of the Social Security Act. Virginia generally receives $1 of federal matching funds for every $1 Virginia spends on Medicaid.

legislature. DMAS received federal authority to operate a mandatory managed long term services and support program on April 28, 2017. Implementation of the Commonwealth Coordinated Care (CCC) Plus program began August 1, 2017 and includes individuals with complex care needs, through an integrated delivery model, across the full continuum of care. Care coordination is at the heart of this high-touch, person-centered program design. The expansion of managed care arrangements has increased the number of Medicaid members who have access to coordinated care. Additionally, recent program initiatives which remain under Fee-For-Service (FFS) have incorporated applications of person-centered care coordination.

Increasing Access to Care Coordination Within Managed Care and Fee-for-Service

Most Medicaid and Children Health Insurance Program (Virginia's CHIP is called FAMIS) members get their care through a Managed Care Organization (MCO). Virginia has been expanding its use of MCO programs to serve individuals with complex care needs because of the value it provides to members and the Commonwealth. Managed care is designed to improve access to care, enhance health outcomes, and reduce costs by eliminating inappropriate and unnecessary care through the use of preventive services and improved care coordination. By the end of 2018, DMAS expects that 99 percent of full benefit Medicaid members will receive their benefits through a MCO.

MCO	CCC Plus	216,851	
	Medallion 4, PACE or FAMIS Managed Care	760,065	
FFS	Fee For Service – Full Benefit	7,766	
	Fee For Service – Limited Benefit	188,852	
Total Members		**1,173,534**	

Numbers reflect projections by December 2018

Additionally, DMAS has collaborated with the current Behavioral Health Services Administrator (BHSA), Magellan of Virginia, and implemented initiatives designed to enhance principles of care coordination within the FFS delivery model for those members who remain in FFS.

CCC and CCC Plus

At the heart of managed care is the principle that coordinating care improves both the experience and outcomes for individuals while controlling cost to the health and long-term care systems and taxpayers. In 2014, Virginia implemented the launch of CCC, a demonstration program that blends and coordinates Medicare and Medicaid benefits for eligible Virginians. Given the opportunity to combine their existing Medicare and Medicaid benefits into one managed care health plan, all members were provided a Care Coordinator from the health plan. The Care Coordinator completed a comprehensive evaluation to understand the member's situation and worked directly with the member to develop a plan of care specific to their needs and preferences. This was the first time a dedicated Care Coordinator was assigned to each member in the program, all of whom had chronic and complex care needs. Beginning August 1, 2017, DMAS implemented the new CCC Plus program. The existing CCC program is sun-setting and all CCC members will transition into CCC Plus on January 1, 2018.

CCC Plus will operate statewide across six regions as a mandatory Medicaid managed care program, and will serve approximately 216,851 individuals (adults and children) with disabilities and complex care needs. CCC Plus was launched in the Tidewater region on August 1, 2017, and will continue with regional launches through December 2017. CCC Plus members will have access to an individualized, person-centered system of care that integrates medical, behavioral, and long-term services and supports. CCC Plus members have a dedicated Care Coordinator who will work with the member and their provider(s) to ensure timely access to appropriate, high-quality care.

Care coordination starts with the role of the Care Coordinator who works with the member to conduct a +Health Risk Assessment (HRA) from which a comprehensive, person centered Individualized Care Plan (ICP) is developed. The Care Coordinator will then link the individual to services and supports identified in ICP; assist the individual directly for the purpose of locating, developing, or obtaining needed services and resources; coordinate services and service planning with other agencies, providers and family members involved with the individual; make collateral contacts to promote the implementation of the ICP and community integration; monitor progress and ensure service delivery; and provide training, education, and counseling

that develops a supportive relationship and promotes the ICP.

All six of the CCC Plus MCOs will have business offices in each region. This will promote awareness and understanding of geographical differences among the regions in addition to allowing closer proximity to members for outreach and communications. Care Coordinators will better understand their members' community and local resources, will be better able to evaluate the sufficiency of and barriers to services and ensure access to timely and quality services.

PACE

The Program of All-inclusive Care for the Elderly (PACE) was established to help adults ages 55+ who are living with chronic healthcare needs and/or disabilities receive community-based healthcare services and supports. Care in PACE is coordinated through an interdisciplinary team (IDT) of professionals who work with each participant and his or her care giver(s) to develop an individualized plan of care. The PACE IDT consists of multiple healthcare providers, including a primary care physician, registered nurse, social worker, physical therapist, occupational therapist, recreational therapist, dietitian, transportation coordinator, and home Care Coordinator. In addition to the development of a plan of care, the IDT is responsible for the initial assessment and periodic reassessments of participants, as well as coordination of care 24-hours a day.

As of July 1, 2017, there were 1,503 PACE participants in 12 locations across the Commonwealth.

Medallion

The Medallion 3.0 program is a fully capitated, risk-based, mandatory managed care program for Medicaid/FAMIS Plus members. Under Medallion 3.0, DMAS contracts with MCOs for the provision of most Medicaid covered services. Currently there are 784,000 Medicaid and FAMIS eligible members enrolled in Medallion 3.0 who are eligible to receive care coordination through their respective health plan. DMAS estimates that fewer than 5 percent of members are in active care coordination/case management at any given time. In January 2018, approximately 70,000 current Medallion 3.0 members will shift to the new CCC Plus program.

DMAS currently is under procurement for the new Medallion 4.0 Health Plans in an effort to streamline program requirements, and ensure member-focused high quality health care. When fully implemented in December 2018, DMAS anticipates that Medallion 4.0 will cover over 760,000 Medicaid and FAMIS eligible members.

Care coordination in Medallion 3.0 and 4.0 is the process of identifying patient needs and the subsequent development, implementation, monitoring, and revision (as necessary) of a plan of care to efficiently achieve the optimum quality patient outcomes in the most cost-effective manner. Care coordination by the MCOs is typically seen among members with complex medical needs such as diabetes, hypertension, and cardiac disease and includes individuals with comorbidities, behavioral health needs, substance use disorders, foster care and children with special health care needs.

Though most Medicaid and FAMIS members will be enrolled in an MCO, some will continue their coverage through fee for service and some services are only provided through fee-for-service even for individuals enrolled in an MCO. Also, certain populations are currently excluded from enrolling in an MCO including those in limited coverage groups such as the Governor's Access Plan and Plan First.

GAP

Implemented in 2015, the Governor's Access Plan (GAP) provides limited medical and behavioral health care coverage for low income individuals with Serious Mental Illness (SMI). Magellan of Virginia provides care coordination services for GAP members. Care coordination includes identification of the individual's behavioral health, medical and social/community support needs and the development, implementation, monitoring, and revision (as necessary) of a plan of care to efficiently achieve the individual outcomes in the most cost-effective manner. Care coordination in GAP has two main goals: (1) to improve the health and wellness of individuals with complex and special needs; and (2) to integrate services around the needs of the individual at the local level by working collaboratively with all partners, including the individual, family and providers. Care coordination services through Magellan include two tiers, Community Wellness and Community Connection. These tiers optimize the physical, social and mental functioning of individuals by: increasing community tenure, reducing readmissions, enhancing support systems, and improving treatment efficacy through advocacy, communication, and resource management.

As of August 2017 there are 12,033 members enrolled in GAP. There are a total of 2,312 members who have successfully engaged with coordination of care services through Magellan.

Behavioral Health Services Administrator

The 2011 General Assembly directed DMAS to implement a coordinated care model for individuals in need of behavioral health services that are not currently provided through a managed care organization. To that end, DMAS involved the Department of Behavioral Health and Developmental Services (DBHDS), Community Services Boards, and numerous stakeholders in planning for the development of the new care coordination model. The goals of this care coordination were established as twofold: 1) improve the coordination of care for individuals receiving behavioral health services with acute and primary services; and 2) improve the value of behavioral health services purchased by the Commonwealth without compromising access to behavioral health services for vulnerable populations. After a competitive proposal and contracting process, DMAS awarded the contract for the BHSA to Magellan of Virginia and the new care coordination model was launched on December 1, 2013.

As the BHSA, Magellan became responsible for the management and administration of the DMAS behavioral health benefit programs for Medicaid and FAMIS members, including members who participate in Medicaid home and community based waiver programs. For the first time, behavioral health claims, service authorization and network development and management were brought under a single entity, the BHSA. A highlight of the new Magellan program was the addition of care management. Licensed behavioral health clinicians were now available by phone 24 hours a day, 7 days a week to personally assist members and providers. A crisis line was implemented to immediately respond to members in crisis to assess and ensure access to timely, appropriate care; members started utilizing the crisis line within the first few days of its implementation.

Since 2013, Magellan has significantly opened communication with the behavioral health provider network, providing weekly provider calls, individualized review of authorization requests and care planning and ongoing training opportunities to improve the delivery of behavioral health services. Magellan began dialogue with providers regarding health outcomes, best practices and documentation to demonstrate individualized care planning and care coordination needs. The Magellan website offers extensive tools to support various aspects of care coordination, integrated care and best practices. Since 2015, DMAS has worked with Magellan and community and behavioral health stakeholders to redesign Medicaid psychiatric residential services. In 2017, the new Independent Assessment, Certification and Coordination Team (IACCT) was launched to provide a person centered, trauma informed and evidence based residential services to high risk children and adolescents in Virginia.

DD Waiver Redesign

Virginia's Developmental Disabilities Waivers (DD Waivers) serve individuals of any age with a developmental disability. The DD Waivers, which were redesigned in September 2016, provide a continuum of services that respond to individual needs so that recipients of services may live full lives in the community. They offer new supports and services that promote family inclusion as well as offer reimbursement rates that respond to individual needs. The redesigned waivers are now called the Building Independence (BI), Family & Individual Support (FIS) and Community Living (CL) waivers. Approximately, 13,000 individuals receive active coordination/case management through their DD waivers.

Support Coordination/Case Management is provided to those individuals on the DD waivers and in some cases offered to those that are also on the waiting list for those waivers as well as to those that have an intellectual disability and require that service. Basic case management includes: assessing the needs, wants, strengths and preferences of individuals seeking services and supports; creating a viable plan to assist in referring to, accessing, and utilizing needed services and supports; actively monitoring the delivery of services and their outcomes; supporting and assisting in the process to address unmet needs; and collaborating and coordinating with others to ensure effectiveness and avoid duplicative services. Targeted case management includes many of the elements of care coordination, basic case management, and a full range of care and support that individuals with more severe disabilities require in order to live successfully in the community.

CCC Plus members who are enrolled in one of the DD waivers will continue to receive their long term services

and supports through Medicaid FFS. However, non-waiver services such as medical, behavioral, substance use disorder, and pharmacy will be managed through CCC Plus. All DD waiver system members who are enrolled in CCC Plus will have a care coordinator assigned by the CCC Plus health plan who will work in conjunction with the case manager to ensure the member's needs are identified and met.

New Program Initiatives

Residential Treatment Services for Children and Adolescents

Residential Treatment Services, including Psychiatric Residential Treatment and Therapeutic Group Home services, are covered through fee-for-service and administered by the BHSA, Magellan. On July 1, 2017, DMAS implemented a new independent certification process using an Independent Assessment, Certification and Coordination Team (IACCT). The IACCT ensures the most clinically appropriate, least restrictive setting, and care that best suits the needs of each youth and family. Each child requiring admission to residential services will receive the support of the local IACCT to assess the child's needs; this team will include the child, the child's family/legal guardian and clinical professionals from the child's community. Whenever possible, a primary care physician or psychiatrist who knows the child's history will be involved in the assessment. Magellan will support the IACCT through Magellan-employed positions including Residential Care Managers (RCM) and Family Support Coordinators (FSC). A Magellan Intensive Care Manager (ICM) will assist with care coordination for the IACCT. A Magellan FSC with experience as the parent of a child receiving behavioral health services will connect with the family throughout the course of treatment to enhance family engagement through outreach and support. After the IACCT completes the assessment, the team will develop an appropriate plan of care to meet the individualized needs of the child and family. Coordination occurs with all families for up to 90 days after discharge from residential care and when community based services are used instead of residential care.

This dynamic collaboration between the child and family, experienced community clinicians and physicians, and Magellan can create a system that more wholly addresses the needs of the child. Whether in a residential program or in the community, the new process will offer continuous support accessing resources for resiliency and coordinated care. This new process assists families to navigate a very complex service environment, establishes effective aftercare, and ensures care coordination and higher probability for improved outcomes.

Addiction Recovery and Treatment Services

Implemented April 1, 2017, the comprehensive Addiction Recovery and Treatment Services (ARTS) benefit was designed to guarantee access to a full continuum of evidence-based best practices for the immediate and long-term physical, mental, and addiction and recovery treatment care needs of all Medicaid members.

Care coordination for ARTS benefits will be managed using an integrated care approach by the DMAS contracted MCO health plans and Magellan of Virginia. The ARTS benefits will be implemented in a manner that will allow integration of physical and behavioral health care for individuals with substance use disorders. Care coordination practices are built on person-centered planning, principles of recovery and resiliency, and fidelity to Wraparound principles of an individualized care planning and management process.

The new ARTS benefit will allow Opioid Treatment Providers and Office-Based Opioid Treatment providers the option of billing for Substance Use Disorder care coordination that includes:

- Integrating behavioral health into primary, monitoring member progress and tracking member outcomes;
- Supporting conversations between physicians and behavioral health professionals to develop and monitor individual service plans;
- Linking members with community resources to facilitate referrals and respond to social service needs or peer supports; and
- Tracking and supporting members when they obtain medical, behavioral health, or social services outside the practice.

Summary

DMAS' commitment to improving care delivery, efficiency, and outcomes within both Managed Care and FFS has resulted in more access to care coordination for Medicaid members in the Commonwealth. The advancement of managed care for the majority of Medicaid members means more members have a Care Coordinator assigned to them whose goal is to ensure

that they receive high quality, person-centered health care focused on their specific needs. Additionally, DMAS' most recent program initiatives have incorporated care coordination principles that integrate services around the needs of the individual in order to improve the health and wellness of individuals with complex and special needs. Advancing care coordination in today's complex and fragmented healthcare delivery system requires a planned, coordinated, and fully integrated approach. Care coordination can bring order, focus, and direction not only to the member, but also to the member's family and caretakers by establishing partnerships with all those involved in the member's healthcare.