COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services

JENNIFER S. LEE, M.D.
DIRECTOR

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

December 12, 2018

**MEMORANDUM**

TO: The Honorable Ralph S. Northam
Governor of Virginia

The Honorable Thomas K. Norment, Jr.
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: Jennifer S. Lee, M.D. JL
Director, Virginia Department of Medical Assistance Services

SUBJECT: Annual Report on Care Coordination – FY 2018 due November 1, 2018

This report is submitted in compliance with Item 303 EE of the 2018 Appropriation Act which 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."

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

JSL/

Enclosure

pc: The Honorable Daniel Carey, M.D., Secretary of Health and Human Resources

# Annual Report on Care Coordination – FY 2018

## *A Report to the Virginia General Assembly* *November 1, 2018*

## Report Mandate:

*Item 303 EE of the 2018 Appropriations 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."*

## Executive Summary

The Department of Medical Assistance Services (DMAS) has advanced the development and implementation of care coordination for all Medicaid members across the Commonwealth. DMAS has expanded coordinated care to all geographic areas, populations, and services under programs it administers to meet the stated objectives of the Virginia legislature. The expansion of managed care in Virginia has increased the number of Medicaid members who have access to coordinated care. Additionally, members not enrolled in managed care, such as those under Fee-For-Service (FFS) have access to applications of person-centered care coordination. Highlights of DMAS' successes can be found in Appendix A of this report.

## 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 in order to reduce disconnected care and reliance on more costly

### 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.

interventions thus reducing the growth rate of overall health care costs. Virginia has expanded managed care programs because of the value it provides 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. DMAS estimates that 99 percent of full benefit Medicaid members receive their benefits through a managed care organization (MCO).

## Expanding Care Coordination

Commonwealth Coordinated Care Plus (CCC Plus) and Medallion 3.0 are Virginia's two statewide and mandatory managed care programs. By December 1, 2018, coverage under the new Medallion 4.0 will be available in all regions of the Commonwealth. The same six (6) MCOs across the Commonwealth that currently serve CCC Plus members will serve Medallion 4.0 members: Aetna Better Health of Virginia, Anthem HealthKeepers, Magellan Complete Care of Virginia, Optima Health, United Healthcare and Virginia Premier Health Plan.

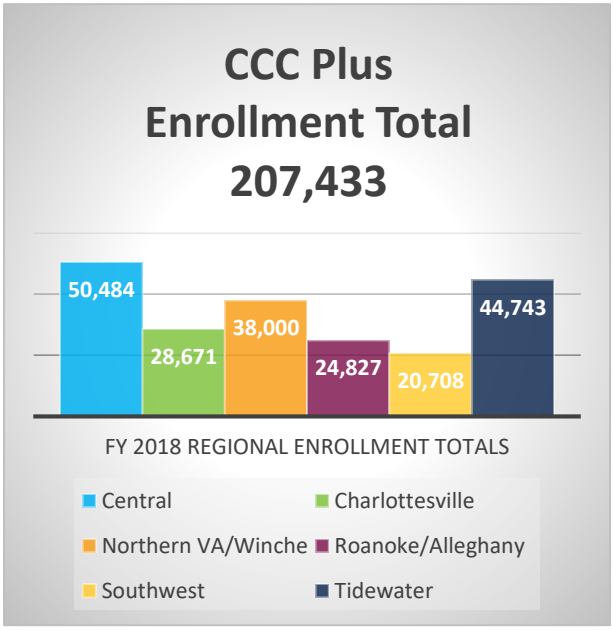
Additionally, principles of care coordination can be found in Virginia's Programs of All-Inclusive Care (PACE) for adults ages 55+ who are living with chronic healthcare needs as well as with the current Behavioral Health Services Administrator (BHSA), Magellan of Virginia, within the FFS delivery model for those members receiving certain behavioral health services.

**Managed Care/Fee for Service Enrollment:**

| | | |
|---|---|---|
| **MCO** | CCC Plus | 207,433 |
| | Medallion 4, PACE or FAMIS Managed Care | 733,298 |
| **FFS** | Fee For Service – Full Benefit | 76,493 |
| | Fee For Service – Limited Benefit | 212,976 |
| **Total Members** | | **1,230,200** |

*Numbers reflect total as of June 30, 2018*

### *CCC Plus*




August 1, 2018 marked the first anniversary of the Commonwealth Coordinated Care Plus (CCC Plus) program. Leveraging the successes of Virginia's Medicare-Medicaid enrollee financial alignment demonstration program, the Commonwealth Coordinated Care (CCC) program, CCC Plus strengthens the earlier model by including additional populations, operating statewide, and mandated enrollment of eligible individuals into competitively selected managed care plans.

All CCC Plus members have access to an individualized, person-centered system of care that integrates medical, behavioral, and long-term services and supports. Every CCC Plus member has a dedicated Care Coordinator who works with them and their provider(s) to ensure timely access to appropriate, high-quality care.

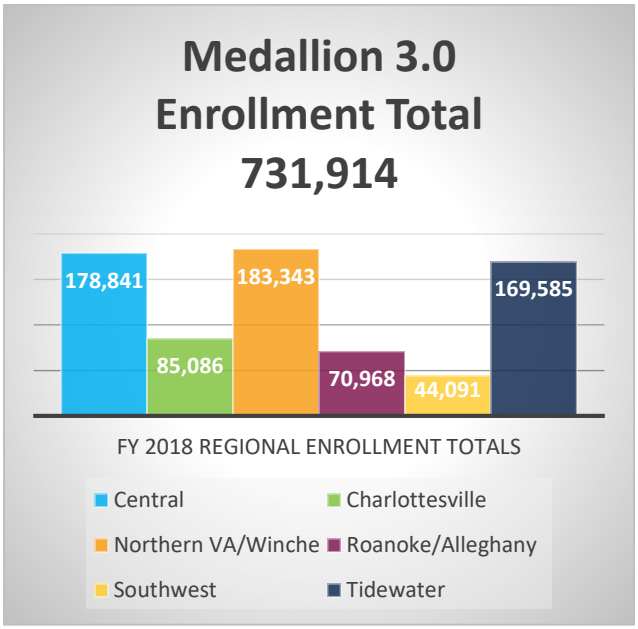
Care coordination in the CCC Plus program starts with the role of the Care Coordinator who works with the member to conduct a Health Risk Assessment (HRA) from which a comprehensive, person centered Individualized Care Plan (ICP) is developed. The Care Coordinator then links the individual to services and supports identified in the ICP; assists the individual directly for the purpose of locating, developing, or obtaining needed services and resources; coordinates services and service planning with other agencies, providers and family members involved with the individual; makes collateral contacts to promote the implementation of the ICP and community integration;

monitors progress and ensure service delivery; and provides training, education, and counseling that develops a supportive relationship and promotes the ICP.

Several initiatives designed to ensure the success of Care Coordination within CCC Plus, have been implemented within the first year of the Program's launch. The initiatives implemented within the last year reflect DMAS' mission and vision to advance care coordination in today's complex and fragmented healthcare delivery system and include:

- A designated Care Management Unit to support, train and develop the Care Coordinators across all health plans.
- A dedicated email box for all health plan Care Coordinators to submit questions and identify training needs.
- A dedicated email box for Early Intervention providers, health plan staff, and Virginia's Department of Behavioral Health and Developmental Services (DBHDS) to address issues and/or barriers to the coordination of services.
- Weekly, topic-driven webinar trainings for Care Coordinators regarding various functions and subjects to enhance understanding of their role, the need for collaboration and awareness about available resources.
    - Weekly participation averages approximately 300 Care Coordinators.
    - Varied topics have included understanding brain injury, working with individuals with dementia and managing crisis calls to name a few.
    - Collaboration occurs with external subject matter experts such as the Alzheimer Association, DBHDS, and Department of Social Services to present specialized areas of interest.
- Expanded, weekly training opportunities, called "Coffee Talk", includes a Questions and Answers teleconference for Care Coordinators.
    - This has grown to include over 500 Care Coordinators.
- Customized training during the transition of individuals in DMAS' Tech Waiver into CCC Plus.

### *Medallion 3.0/4.0*

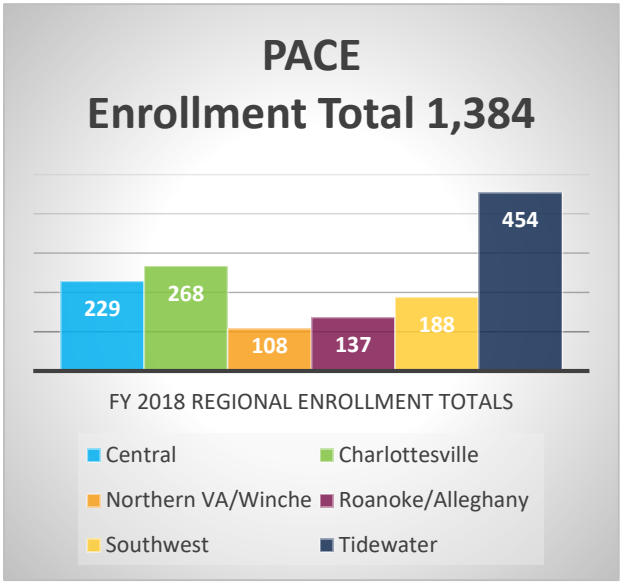



Virginia seeks to strengthen and reinvigorate the care coordination model by adjusting the included populations and services. Medallion 4.0 is the next iteration of the Department's long-standing Medallion II and Medallion 3.0 Medicaid and FAMIS Managed Care Programs and will focus on improving quality, access and efficiency. The regional launch of Medallion 4.0 began August 1, 2018 and will conclude December 1, 2018 with the final enrollment of members in both the Southwest and Roanoke/ Alleghany regions. Medallion 4.0 will focus on improving access and quality of care to pregnant women and children. The Medallion 4.0 Program will also include members with Third Party Liability (TPL) and those receiving Early Intervention (EI) Services and Community Mental Health Rehabilitation Services and Behavioral Therapy (CMHRS).

It is estimated that the Medallion 4.0 program will serve approximately 740,000 Medicaid and FAMIS eligible members across the Commonwealth including infants, children and adults in the low income families with children (LIFC) group, pregnant women, FAMIS MOMS, foster care and adoption assistance, children with special health care needs, and teens.

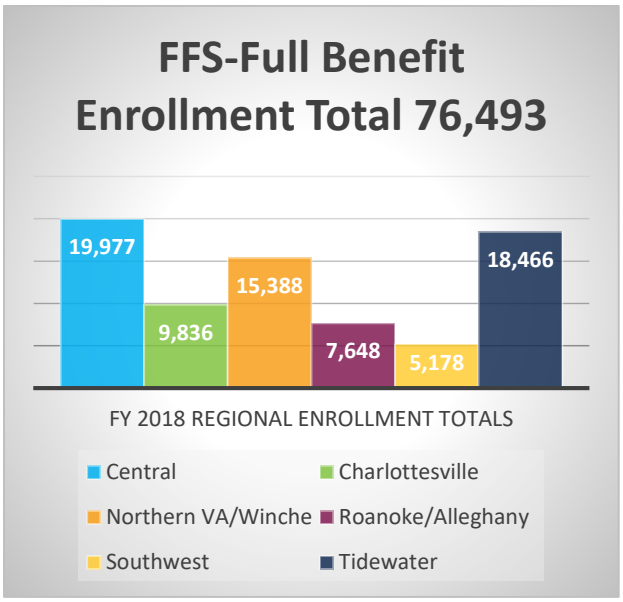
Care coordination in Medallion 4.0 is the process of identifying patient needs and the subsequent development, implementation, monitoring, and revision (as necessary) of a plan of care to efficiently achieve the optimum quality patient outcomes in the most cost-effective manner. Through the regional roll out of Medallion 4.0, DMAS has focused efforts on ensuring seamless transition of care coordination for high-risk members. That includes members with complex medical needs such as diabetes, hypertension, and cardiac disease, individuals with comorbidities, behavioral health needs, substance use disorders, high-risk pregnancies, foster care and children and youth with special health care needs.

### *Virginia's Programs of All-Inclusive Care (PACE)*




Care in PACE is coordinated through an interdisciplinary team (IDT) of professionals who work with each participant and his or her caregiver(s) to develop an individualized plan of care. The PACE IDT is mandated by CMS and 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. For most participants, the comprehensive service package enables them to remain in the community rather than receive care in a nursing home. Financing for the program is capped, which allows providers to deliver all services participants need rather than only those reimbursable under Medicare and Medicaid fee for service plans. PACE is a program under Medicare, and states can elect to provide PACE services to Medicaid beneficiaries as an optional Medicaid benefit. The PACE program becomes the sole source of Medicaid and Medicare benefits for PACE participants.

### *Behavioral Health Service Administrator (BHSA)*




Following the 2011 General Assembly mandate, the BHSA, Magellan of Virginia, implemented a coordinated care model for individuals in need of behavioral health services that are not currently provided through a managed care organization. The goals established were 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. The BHSA manages the CMHRS services for individuals who are in the fee-for-service program (including GAP), individuals who are excluded from managed care, and individuals who are awaiting managed care enrollment. Child and Adolescent Psychiatric Residential Treatment Facility (PRTF) Services and Therapeutic Group Homes (TGH) services are administered by the BHSA for individuals under the age of 21.

The BHSA partners with participating health plans to facilitate member care coordination through active collaboration with service providers and to ensure

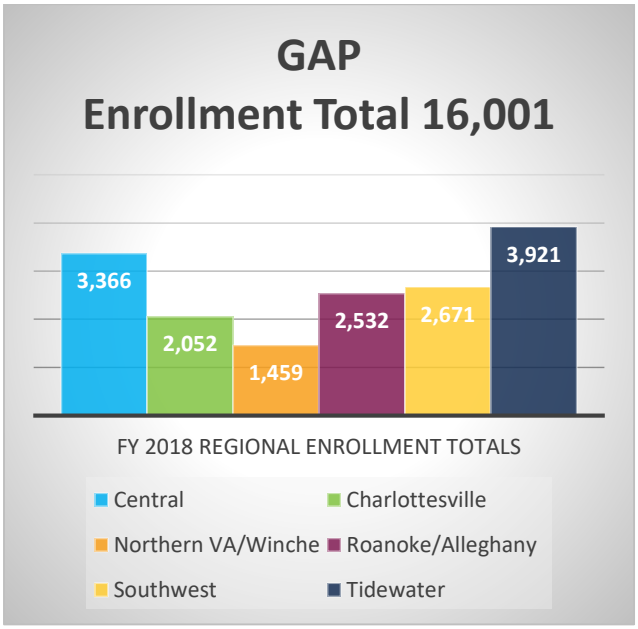
members identified with co-morbid behavioral health and medical needs receive needed services and supports.

Care Coordination within the BHSA has 3 main goals:

- To improve the health and wellness of individuals with complex and special needs
- To integrate services around the needs of the individual at the local level by working to make sure members receive appropriate services and experience desirable treatment outcomes
- To promote the member's self-identified goals for treatment

Implemented in 2017, the 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. Care Coordinators in IACCT, called Residential Care Managers (RCMs), engage in care coordination both during the IACCT process to coordinate the assessment and level of care determination and again during the residential stay to support the service authorization process. Through high touch care coordination, RCMs have been able to collaborate with residential providers to make sure that plans are individualized, viable and clinically appropriate. In addition, through high touch care coordination, RCMs are better able to identify if another level of care, higher or lower, is needed. Since July 1, 2017, the BHSA has managed 2,926 care coordination IACCT cases.

## *Governor's Access Plan (GAP)*




Care coordination in GAP 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.

Access to care coordination for GAP members is available through various avenues. An individual, enrolled in GAP, who calls the BHSA in a crisis scenario, is automatically referred to Care Coordination. Other reasons for referral to care coordination include helping members find providers, frequent emergency room admissions, coordination of medical issues, high social stressors, minimal support system, and as part of discharge from certain inpatient levels of Care within the Addiction Recovery and Treatment Services (ARTS) program. Members can also be referred by a Community Services Board case manager or from the BHSA's Recovery Navigation unit. Enrollment in Care Coordination averages 100 days.

There are currently 236 GAP members enrolled in care coordination as of July 2018. Since GAP's inception, 3,037 individuals have received Care Coordination through the GAP Program.

## Appendix A: Care Coordination Accomplishments and Success Stories

### *CCC Plus*

A Care Coordinator recently began working with a member who had chronic medical conditions including hypertension, Type II diabetes, obesity and chronic pain. The member also had been diagnosed with Major Depressive Disorder. During the initial assessment, it was noted there was increased difficulty in independently performing Instrumental Activities of Daily Living (IADLs). During this same meeting, they discussed member concerns about smoking more than seven cigarettes per day, gaining unwanted weight and having high blood sugar readings. The Care Coordinator began planning how to join with the member and work towards better management of these medical and behavioral health needs.

The Care Coordinator contacted the local Community Services Board (CSB) to determine what behavioral health services were available to support the member's behavioral health needs. The CSB was able to implement services with the member in the home two times per week. The Care Coordinator met with the member and the pain management provider to discuss pain management as well as smoking cessation. The member agreed to see an endocrinologist who suggested better ways of diabetic management including nutritional planning to address unstable blood sugar levels and weight gain. The Care Manager arranged for home delivery of diabetic testing supplies to promote regular monitoring of blood sugar levels. The Care Coordinator encouraged the member to discuss knee pain with the Primary Care Provider (PCP). The PCP referred the member to an Orthopedist who saw the member the next day. The Care Coordinator responded to concerns about transportation problems and worked to arrange consistent cab transportation to physical therapy and other appointments.

With support from the pain management specialist, the member began to taper the use of Suboxone for breakthrough pain. Cigarette smoking has been significantly reduced. Diabetic supplies are now being consistently used to better manage blood glucose levels in consultation with the endocrinologist. Nutritional planning has resulted in better choices being made in regards to food and beverage intake. This has included drinking more water and eating healthier foods. Member was proud to report losing 24 pounds due to making these changes.

The Care Coordinator utilized a person-centered approach to address the member's medical and behavioral health needs. By providing support and encouragement, the member was empowered to take proactive steps to manage chronic illnesses and pain. This has led to positive changes in both physical and mental well-being using appropriate services and supports.

### *Medallion*

A Behavioral Health Home (BHH) pilot member was not attending his medical follow up appointments due to his mental illness symptoms. His Care Coordinator suggested to his Community Service Board (CSB) Case Manager and Mental Health Support Worker that they try to schedule a concurrent primary care exam and psychiatric appointment at the CSB. This dual appointment was successfully arranged with one of the physicians and he was seen at the CSB for his first physical exam in many years. The staff responded to the member's behavioral health needs and revealed high blood pressure levels that were uncontrolled and contributing to his symptoms of anxiety and paranoia. He received a new medication to help lower his blood pressure and was referred to a specialist for follow up treatment. The Care Coordinator arranged for a BHH team member to attend the specialty appointment to support the member.

### *PACE*

Many of the PACE programs have a falls prevention team composed of the IDT members and a pharmacist. If a participant falls, the team will determine if there are any key pieces of missing information. The team not only reviews the documentation but interviews the participant immediately after the fall to quickly determine the cause, make changes and prevent repeated falls. If the fall occurred in the home, the Occupational Therapist will schedule a home visit to inspect the residence and make safety recommendations. The pharmacist will review the participant's medications to determine if any might have contributed to the fall and make changes accordingly. The Transportation and Home Care teams may be given certain instructions based on safety and the Social Worker will review with the participant how to alert emergency assistance in the event of a future fall. Each fall is tracked by the team on a regular basis, often monthly, and discussed in the participant's care plan.

### *BHSA- IACCT*

A 13 year old female with a history of self-injury, hospitalization, and mood instability was evaluated by the IACCT for possible residential placement. She had

received Intensive In-Home services and medication management for aggression, truancy, aggression, and noncompliance. The member's father had passed away and she was having a difficult time coping with this loss. During the evaluation process, the IACCT recommended a placement at a PRTF and she was placed at a PRTF in March. The member has been placed at the facility for four months and has actively engaged in treatment. Magellan engaged in care coordination through reviews of the service authorization requests monthly. She processed issues related to grief and loss, increased self-awareness and self-esteem, and was able to identify several coping strategies to help stabilize mood and decrease aggressive behaviors. Her mother participated in family therapy and together they processed the loss of member's father. She was able to openly communicate with family and therapists about her trauma related to loss and they also discussed her noncompliance in the home. The member and her mother were able to identify ways to increase healthy communication and compliance. She will discharge from the facility in two weeks. Her behaviors have improved significantly with zero incidents of aggression. She learned new coping skills, and has been able to share those skills with her peers.

### *GAP*

A 58 year old male, who struggles with managing symptoms of depression, was referred for care coordination due to increased depression and suicidal ideation with a plan. He has a heroin addiction, is homeless, unemployed, and feels hopeless. He lacks a support network. He was worried for his stability after he was discharged from crisis services. The Magellan GAP Care manager and recovery navigator reached out to him to provide support in addition to the crisis stabilization staff and case manager at his local Community Services Board (CSB) to coordinate the discharge transition. Between the GAP Care Manager and CSB staff, the individual was admitted into a substance abuse treatment facility that could meet his needs. They also identified that his coverage would be ending soon and ensured completion of the necessary renewal paperwork to avoid a lapse in coverage. He has since enrolled in substance abuse and mental health services at the local CSB and reported feeling hopeful and supported by the treatment team he has in place now.