COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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November 5, 2019

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: Karen Kimsey KK
Director, Virginia Department of Medical Assistance Services

SUBJECT: Annual Care Coordination Report

This report is submitted in compliance with the Virginia Acts of the Assembly, Item 303EE, which states:

EE. 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.

KK/ALV

Enclosure

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

Annual Care Coordination Report

A Report to the Virginia General Assembly

November 1, 2019

Report Mandate:

The 2019 Appropriation Act, Item 303 EE states that 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 expanded coordinated care to all geographic areas, populations, and services under programs it administers to meet the stated objectives of the Virginia legislature. Turning to managed care to deliver and coordinate care and supports for Medicaid members, most Medicaid and FAMIS members now get their health care services through managed care, which incorporates the value-added service of care coordination. The expansion of Medicaid this year has resulted in approximately 270,000, as of June 2019, more Virginians with access to quality health care and care coordination through enrollment into one of DMAS's managed care programs. At the heart of managed care is the principle that coordinating care improves both the experience and health outcomes for individuals while controlling costs. For those members not enrolled in managed care, such as those under Fee-For-Service (FFS), applications of person-centered care coordination are still available. This report will discuss the features of care coordination within the various Medicaid programs and will include the number of individuals enrolled, the geographic areas served, populations and services affected and the

DMAS's mission is to improve the health and well-being of Virginians through access to high-quality health care coverage.

DMAS administers Virginia's Medicaid and CHIP programs. Through the Medallion 4.0 and Commonwealth Coordinated Care (CCC) Plus managed care programs, more than 1 million Virginians access primary and specialty health services, inpatient care, behavioral health, and addiction and recovery treatment services. In addition, Medicaid long-term services and supports enable thousands of Virginians to remain in their homes or to access residential and nursing home care.

Medicaid members historically have included children, pregnant women, parents and caretakers, older adults, and individuals with disabilities. In 2019, Virginia expanded the Medicaid eligibility rules to make health care coverage available to close to 400,000 newly eligible, low-income adults.

Medicaid and CHIP (known in Virginia as Family Access to Medical Insurance Security, or FAMIS) are jointly funded by Virginia and the federal government under Title XIX and Title XXI of the Social Security Act. Virginia generally receives a dollar-for-dollar federal spending match in the Medicaid program. Medicaid expansion qualifies the Commonwealth for a federal funding match of no less than 90 percent for newly eligible adults, generating cost savings that benefit the overall state budget.

development of any changes or advances. Demonstration of cost savings achieved directly resulting from care coordination is difficult to quantify, however highlights of successes associated with care coordination can be found in Appendix A of this report. DMAS is working on a methodology to calculate savings, and anticipates having data to report next year.

Background

Care coordination is the organization of member care activities across all participants involved in a member's care, including the member, to ensure the appropriate delivery of health care. The aim of care coordination is to reduce the fragmentation of care and the reliance on more costly interventions. There are variations in the prescriptiveness of care coordination features and requirements across the various Medicaid programs, but despite the variation, individual member needs, goals and preferences serve as a cornerstone for each program.

Expanding the Principles of Care Coordination

Care coordination has been expanded to all geographic areas, populations, and services within both the managed care environment and in Fee-For-Service. With Virginia's expansion of Medicaid, approximately 270,000, as of June 2019, more Virginians have access to care coordination. Beyond the managed care programs, Commonwealth Coordinated Care Plus (CCC Plus) and Medallion 4.0, the principles of care coordination are also found in Virginia's Programs of All-Inclusive Care (PACE) for adults ages 55+ who are living with chronic healthcare needs, as well as in the current Behavioral Health Services Administrator (BHSA), Magellan of Virginia, and within the FFS delivery model for those members receiving certain behavioral health services. Advancements in DMAS technology continue and will enhance and promote improved care coordination for all members across programs.

Enrollment

The enrollment chart below illustrates the Managed Care and Fee-for-Service enrollment as of June 30, 2019. Approximately 96 percent of all full benefit Medicaid members currently receive their benefits through one of the six (6) managed care organizations (MCO) contracted by DMAS. Those six (6) MCOs are: Aetna Better Health of Virginia, Anthem HealthKeepers, Magellan Complete Care of Virginia, Optima Health, United Healthcare and Virginia Premier Health Plan. Individuals eligible for coverage through Medicaid expansion enroll into one of the managed care programs depending on whether they classify as medically complex or non-medically complex.

Managed Care/Fee for Service Enrollment:

Program		Enrollment
MCO	CCC Plus	242,431
	Medallion 4, PACE or FAMIS Managed Care	1,013,052
FFS	Fee For Service – Full Benefit	56,583
	Fee For Service – Limited Benefit	106,687
Total Members		**1,418,753**

Numbers reflect total as of June 30, 2019

To date, the expansion of Medicaid has resulted in approximately 270,000, as of June 2019, more Virginians now having access to quality health care.

Systems/Technology Enhancements

DMAS is replacing its Medicaid Management Information System (MMIS) with a modernized technology system called Medicaid Enterprise System (MES). A dynamic Care Management Solution (CRMS) is being developed internally by DMAS as part of MES.

Slated to become operational July 2020, CRMS will provide improved collaboration and continuity of care among DMAS and MCOs, while benefiting all regions of the Commonwealth, and improving services for all provider and member populations. To accomplish its goals, CRMS will collect and facilitate the secure exchange of member-centric data, through data collection, data sharing, and performance management. CRMS integrates with other MES 'modules,' facilitating the coordination and storage of data, along with meaningful analytics for stakeholders and DMAS business areas.

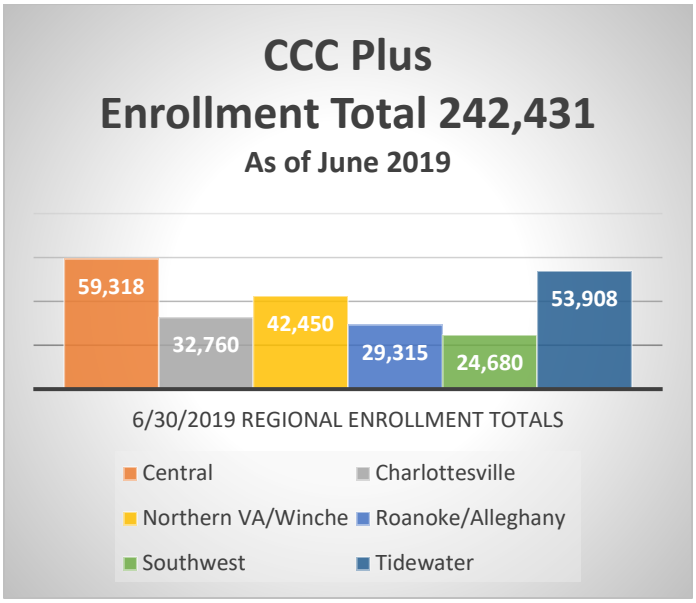
When MCO's report members transferring from one plan to another, CRMS will securely capture the member's

summary to improve the quality and safety of care with the added benefit of reducing unnecessary and redundant testing. Central coordination and management of patient information is a key goal of CRMS and will aid MCOs with proactive care planning.

Streamlining and standardizing information exchange among all stakeholders and DMAS business areas will reduce challenges when connecting other systems and improve collaboration and continuity of care among DMAS and MCO Care Managers, providers, and the member.

Populations and Services

CCC Plus



The CCC Plus program has just entered its third year of operations integrating medical, behavioral, and long-term services and supports for the Commonwealth's most vulnerable and medically complex individuals. Every CCC Plus member is assigned a dedicated care coordinator from the member's health plan who works with them and their provider(s) to ensure timely access to appropriate, high-quality care. DMAS's dedicated care management unit continues to initiate opportunities to engage with the care coordinators in order to continuously assess and address their current training needs.

Of the roughly 270,000 new enrollees related to Medicaid Expansion, 20,000 have been enrolled into CCC Plus. Those individuals who received limited benefits through the Governor's Access Plan (GAP) transitioned into the CCC Plus program on January 1, 2019.

Training, Support and Oversight of Care Coordination

Even with the growth in enrollment, meaningful growth in CCC Plus care coordination also occurred. The following are initiatives implemented by the care management unit and managed on an ongoing basis:

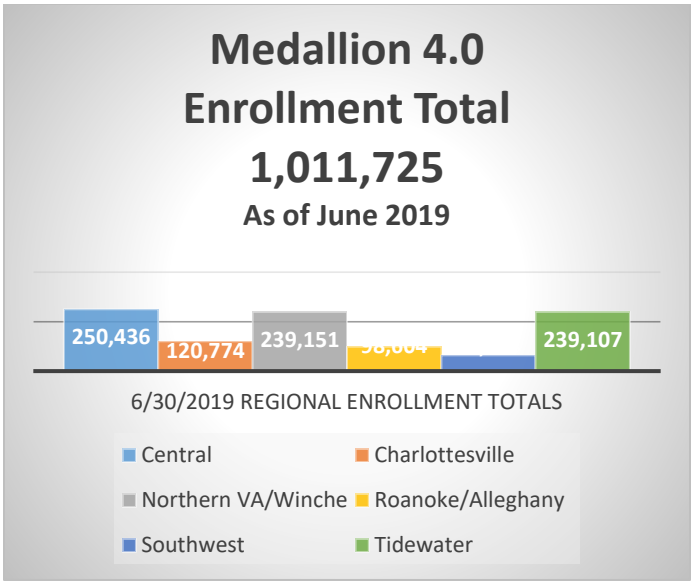
- Dedicated email addresses for the health plan care coordinators to send questions related to certain specialized program processes.
- A dedicated email address remains available for Early Intervention providers, health plan staff and Virginia's Department of Behavioral Health and Developmental Services (DBHDS) to report issues and barriers related to care coordination. The email box is managed daily. In an effort to expand the discussion and resolution to improving care coordination, DMAS's care management unit has joined a workgroup formed in collaboration with DMAS, DBHDS and the health plans.
- Weekly webinar trainings continue with the Care Coordinators, now averaging over 400 Care Coordinators in attendance. Participation and engagement among attendees for the weekly webinar has increased with care coordinators now assisting and supporting one another with recommendations and best practices.

New initiatives are planned by the care management unit to further advance care coordination in CCC Plus. These initiatives include:

- A workgroup for care coordinator supervisors and managers on how to best support the care coordinators to improve integrated care, inter-departmental communications within the health plans and collaboration with providers and stakeholders.
- Case record reviews to better understand the level of care coordinator performance. Areas of focus will include case documentation involving members receiving Early Intervention services, those with serious mental illness and cases involving transitions of care. Customized training will be offered based on review findings.
- Joint visits or 'ride-alongs' with care coordinators to visit members to allow for observation, partnership and open communication around

appropriate utilization and creative planning to best meet the needs of the members.

Medallion 4



As the Medallion 4.0 program recently marked its one year anniversary, its members have experienced notable changes since its regional launch began in August 2018. The program differs from the former Medallion 3.0 program with an increased focus on providing high quality care for the Commonwealth's pregnant women, children, and adults. Medallion 4.0 also covers new populations including individuals receiving Community Mental Health Rehabilitation Services and Behavioral Therapy (CMHRS), members with Third Party Liability (TPL), and children who receive Early Intervention Services.

Of the roughly 270,000 new enrollees related to Medicaid Expansion, 250,000 have been enrolled into Medallion 4.0. The Medallion 4.0 program continues to focus on assessing each member in a timely manner and providing care coordination where needed. Those Medallion 4.0 members found to have complex medical conditions that qualify for CCC Plus will transition to the CCC Plus program and remain under the same health plan they had under Medallion.

In keeping with the focus of providing increased care coordination, each Medallion 4.0 health plan must make an effort to conduct an initial screening of each new member within ninety (90) days of enrollment. The plans must make subsequent attempts to conduct this initial screening if the initial attempt to contact the member is unsuccessful.

Medallion 4.0 mandates care coordination for vulnerable populations. Vulnerable populations include children and youth with special health care needs, adults with serious mental illness, children with serious emotional disturbances, members with substance use disorders, children in foster care or adoption assistance, women with a high-risk pregnancy, and members with other complex or multiple chronic conditions including asthma and chronic obstructive pulmonary disease, heart disease including coronary artery disease and congestive heart failure, diabetes, behavioral health conditions, cancer, and children and youth with special health care needs.

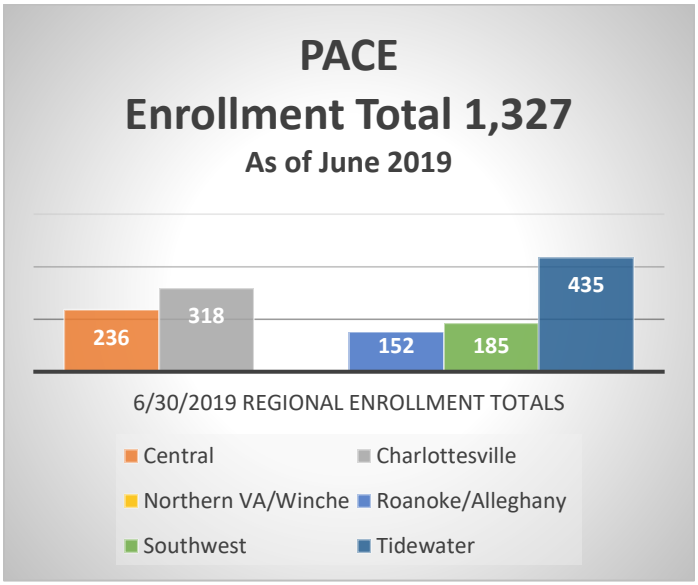
Training, Support and Oversight of Care Coordination

The implementation of Medallion 4.0 has increased reporting requirements directing the health plans to demonstrate their care coordination efforts. Examples of the required reporting include but is not limited to the following:

- Foster care and adoption assistance member care coordination report
- Screening and Care Coordination Report for Substance Exposed Infants (SEI)
- Foster care transition planning report for members age 17 and older in foster care
- Emergency Department encounter alerts and care coordination efforts to identify high utilizers and to address their needs outside of emergency settings
- Care coordination provided and offered to all members under the age of 21 including children and youth with special healthcare needs
- Care management to pregnant and postpartum women with substance abuse disorders
- Care coordination efforts to identify, address and track member access to housing services, job training and food security

The increased reporting requirements highlight the program's priorities to work with the health plans in addressing the health needs of pregnant women, young children, and the management of chronic conditions such as diabetes.

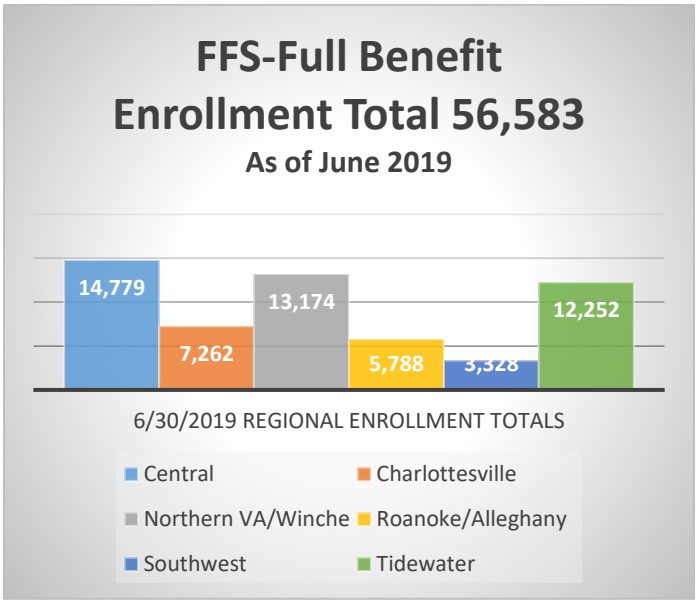
Virginia's Programs of All-Inclusive Care (PACE)



PACE is a Medicare and Medicaid funded program operated via a partnership between the Centers for Medicare and Medicaid Services (CMS) and DMAS. Using per-person per-month capitated payments from Medicare and Medicaid, PACE has the flexibility to offer a spectrum of health and long-term services and supports through an interdisciplinary team (IDT) of healthcare professionals, all with the goal of providing person-centered, coordinated care. The unique PACE model offers individuals and their caregivers the support they need to remain living at home, surrounded by their family and friends. The PACE interdisciplinary team is the core of the PACE model of care. Team members meet daily to review changes in participant health conditions and concerns. This frequent and detailed communication produces robust and person-centered care coordination that promotes early intervention and prevents a need for a higher level of care such as hospitalization or nursing facility placement.

Virginia's five PACE organizations, AllCare, Centra, InnovAge, Mountain Empire and Sentara, as of June 1, 2019 serve 1,327 individuals across their eleven PACE sites. Through PACE, each of these individuals has access to an interdisciplinary team of healthcare professionals dedicated to providing person-centered care aimed at not only maintaining their health and ability to remain living within the community, but also to ensuring the highest quality of life.

Behavioral Health Service Administrator (BHSA)



The BHSA continues to manage the behavioral health services for individuals who are in fee-for-service in addition to child and adolescent residential services that are currently outside of the CCC Plus and Medallion 4.0 managed care plans; namely psychiatric residential treatment facility (PRTF) services and Therapeutic Group Homes for individuals under the age of 21. Implemented in 2017, the Independent Assessment, Certification and Coordination Team (IACCT) was launched to provide person centered, trauma informed and evidence based residential services for high risk children and adolescents in Virginia. Since July 1, 2018, the BHSA has managed a total of 2,519 care coordination IACCT cases.

The BHSA continues to coordinate with the managed care organizations for youth enrolled in managed care who are admitted to residential treatment. Care Coordinators in IACCT, called Residential Care Managers (RCMs), engage in care coordination both during the IACCT assessment process, the level of care determination, and again during the residential stay to support the service authorization process. RCMs collaborate with residential providers to make sure that plans are individualized, viable and clinically appropriate. BHSA Family Support Coordinators (FSCs) offer assistance to guardians by ensuring understanding of the process and access to community resources. The FCSs encourage guardians to remain actively involved in treatment while the member is in the residential facility. The FSCs also support families and guardians by assisting with connection to community-based resources when members are discharged.

Appendix A: Care Coordination Accomplishments and Success Stories

CCC Plus

A Member with Autism Spectrum Disorder, Attention Deficit Hyperactivity Disorder and Mild Asthma was living in the community with a parent and receiving Applied Behavior Analysis (ABA) therapy. The Care Coordinator attempted to contact the parent without success. There were no current medication refills or authorizations for the Member. The Care Coordinator reached out to the ABA provider who indicated no knowledge of the Member's location and indicated Child Protective Services likely removed the Member. The Member's Primary Care Provider (PCP) was contacted and confirmed the child's placement in foster care. The PCP provided the Care Coordinator with the contact information for the foster care caseworker. The foster care caseworker provided an update on the Member and agreed to a face-to-face visit with the child. At that time, the Care Coordinator learned the child was not on any medications, did not have a nebulizer and was not receiving ABA therapy services. During the face-to-face visit, the foster parent welcomed any additional services for the Member. The Care Coordinator discussed with Member's plan of care with the foster care caseworker.

Due to the Care Coordinator's involvement, the Member received needed medications, Durable Medical Equipment and an ABA therapy evaluation. The Care Coordinator significantly influenced this Member's health and overall wellbeing. As a result, the Member will be able to receive necessary medical and behavioral health care while living with a foster family.

Medallion 4.0

Ms. Hope Jackson, a Care Coordinator at Optima, recently won the Daisy Award for her efforts to provide holistic support to one of our members both during her pregnancy and postpartum. The member, "Ms. N.," called and stated she had just had her baby around 1:00pm and had to let Hope know how all of the talks and teachings throughout her pregnancy really prepared her for labor and breastfeeding. Hope was in contact with "Ms. N.'s" OBGYN office and assisted her with obtaining needed medications, groceries, baby items, a car seat and breastfeeding items. After the baby was delivered, Hope was contacted by the labor and delivery nurse and thanked Hope for all of the assistance that was provided to "Ms. N." throughout her pregnancy.

BHSA

A 17-year-old female with a significant history of aggression, multiple placement disruptions, and non-compliance with medication and medical treatment. The member has been asked to leave several placements due to her aggressive behavior and property destruction. As a resident at a Psychiatric Residential Treatment Facility (PRTF), it was reported that the member continued to be non-compliant with treatment, display aggressive behaviors, and made minimal progress. The Residential Care Manager (RCM) worked with the Department of Social Services (DSS) social worker to identify additional placements that may be able to meet the member's needs. The PRTF, the RCM, and the DSS social worker engaged in care coordination through several treatment team meetings to identify ways to best meet the member's needs. The member was able to remain at the PRTF. The provider was able to report that member was making progress. There was a significant decrease in aggression and an increase in compliance.

PACE

In May 2019 a PACE program accepted a participant who had been at a local nursing facility from November of 2018 to late April 2019. This participant was unable to return home due to the lack of handicap accessibility. PACE helped the family transition into a senior living apartment community that is handicap accessible prior to PACE acceptance into the program. PACE was able to take this participant out of the nursing facility and return her into the community with her husband. She now comes into the PACE center 2 days a week, and loves being back in the community and having independence again.