COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services

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September 23, 2020

MEMORANDUM

TO: The Honorable Janet D. Howell
Chair, Senate Finance Committee

The Honorable Luke E. Torian
Chair, House Appropriations Committee

The Honorable Mark D. Sickles
Vice Chair, House Appropriations Committee

FROM: Karen Kimsey
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 313.EE, 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.

KK/LAH
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, 2020

Report Mandate:

EE. The Department of Medical Assistances 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 each year to the Governor and Chairmen of the House of 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 has resulted in approximately 450,000 more Virginians with access to quality health care and care coordination through enrollment into one of DMAS' 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 cost. 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 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'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 for more than 1.6 million Virginians. Members have access to primary and specialty health services, inpatient care, behavioral health as well as 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 more than 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.

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 Principals of Care Coordination

Care coordination has 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 450,000 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, 2020. Approximately 96 percent of all full benefit Medicaid members currently receive their benefits through one of the six (6) managed care organizations (MCOs) 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 CCC Plus if determined to be medically complex and enroll into Medallion 4.0 if determined to be non-medically complex.

Managed Care/Fee for Service Enrollment:

Program		Enrollment
MCO	CCC Plus	254,536
	Medallion 4, PACE or FAMIS Managed Care	1,125,090
FFS	Fee For Service – Full Benefit	61,233
	Fee For Service – Limited Benefit	112,339
Total Members		**1,631,053**

Numbers reflect total as of June 30, 2020

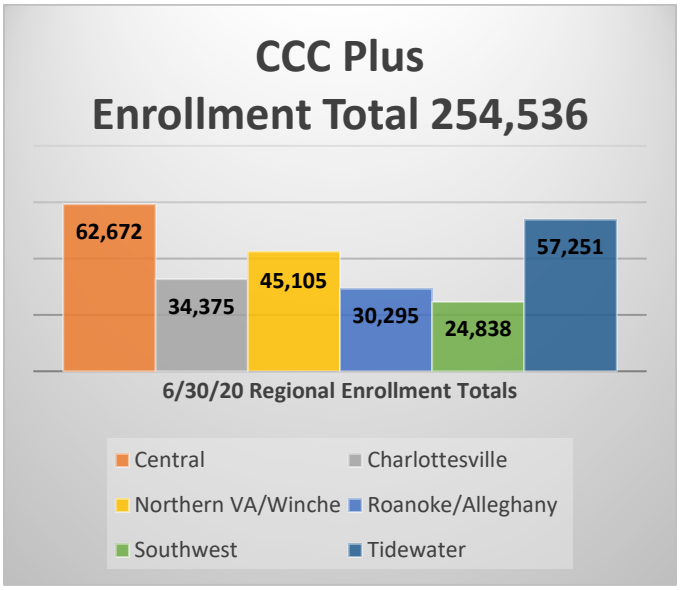
Systems/Technology Enhancements

DMAS is in the process of developing a new modularized technology called Medicaid Enterprise System (MES) to align the Agency's Information Technology Road Map with CMS' Medicaid Information Technical Architecture (MITA) layers including Business, Technical, and Data requirements. One of the MES 'modules' is a dynamic Care Management Solution (CRMS), the first phase of which was implemented in July 2020, that will facilitate care coordination activities for all Medicaid enrollees. CRMS collects and facilitates the secure exchange of member-centric data, through data collection, data sharing, and performance management. CRMS will securely capture the member's health summary, improving the quality and safety of care, reducing unnecessary and redundant patient testing, aiding MCOs with proactive care planning and reducing costs. Stakeholders and DMAS business areas benefit with CRMS, providing streamlined and standardized exchanges of information. This reduces challenges when connecting to other systems across the Commonwealth, and improves collaboration and continuity of care with DMAS, MCO Care managers, Providers and members.

Since July 2020, over 80 inbound and outbound interfaces have been established and DMAS has received millions of records with dates ranging from the beginning of the CCC Plus and Medallion 4.0 programs. This data exchange is the first step towards implementing a comprehensive Care Management solution that will be critical for supporting continuity of care when a member transitions across MCOs and programs.

Populations and Services

CCC Plus



Care coordination is the centerpiece of CCC Plus; every member is impacted in some way by care coordination. Each CCC Plus member is assigned a dedicated Care Coordinator from the member's health plan who works with the member and the member's provider(s) to ensure timely access to appropriate, high-quality care.

The CCC Plus program has entered its fourth year of operations integrating medical, behavioral, and long-term services and supports for the Commonwealth's most vulnerable and medically complex individuals. CCC Plus saw enrollment increase by over 20,000 with Medicaid expansion.

The CCC Plus model of care involves operating using person-centered care coordination for all members which involves using methods to identify, assess, and stratify certain populations, and use comprehensive health risk assessments, individualized care planning and interdisciplinary care team involvement to ensure competent care through seamless transitions between levels of care and care settings.

Training, Support and Oversight of Care Coordination

The value of care coordination continues to increase for the most vulnerable members in the CCC Plus program. The health plan Care Coordinators are engaged and continue to fulfill the mission of the CCC Plus model of care. DMAS' Care Management Unit continues to oversee care coordination through the health plans and offers the following ongoing efforts and resources for training and support to Care Coordinators.

- Dedicated care coordination email boxes are monitored by DMAS Care Management Unit staff for health plan care coordinators to send questions related to certain specialized program processes.
- Weekly training webinars are offered to Care Coordinators and health plans to address needs identified as well as announcements regarding agency initiatives or policy changes.
- Consultation and direct assistance is offered for problem solving around complex cases. There has been an increase in direct communication exchanges with Care Coordinator supervisors and managers on improving integrated care and collaboration with members, caregivers and providers.
- DMAS nurses have led joint visits with Care Coordinators and any members receiving private duty nursing services. Visits have allowed for direct observation, fostered partnership, and open dialogue regarding appropriate utilization and best practices.
- DMAS Care Management Unit staff participate in workgroups in collaboration with other departments and agencies to identify ways to improve care coordination in areas of specialized services such as Early Intervention and Private Duty Nursing, as well as covering disease management topics, such as Diabetes.
- The DMAS Care Management Unit has observed progress with members maximizing enhanced benefits by utilizing their Care Coordinators to obtain services such as dental and vision services as well as environmental modifications.

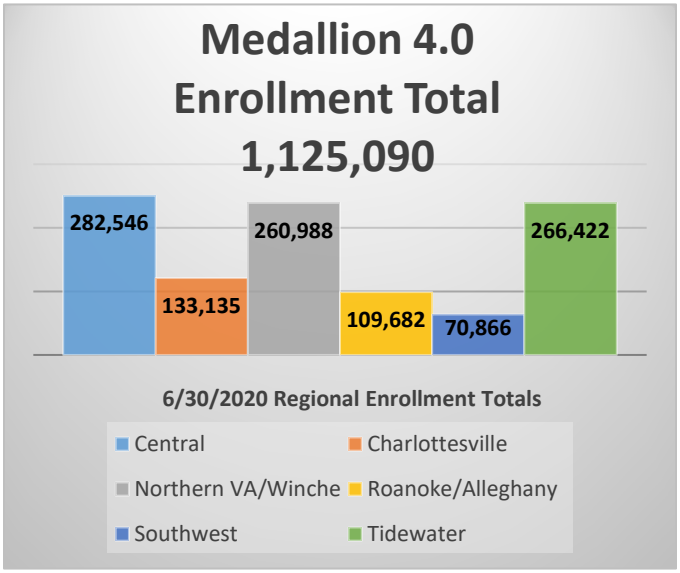
Going forward, the DMAS Care Management Unit plans for:

- Increased record reviews for various populations to provide a focused look at the quality of care coordination provided to members.
- Further engagement with care coordination supervisors, managers and

trainers in order to continue supporting their growth and experience.

In removing face-to-face contact with members due to COVID-19, the challenge has been to find alternate means to assess the member without relying on self-reports or information from others. To avoid disconnection with members, Care Coordinators have developed other means of communication like telephone and telehealth to attend to members' concerns and needs. The DMAS Care Management Unit has utilized the care coordination mailbox and training webinars to provide frequent and current information pertaining to COVID-19. These COVID-19 webinar sessions have had some of the highest attendance records, with regularly over 600 attendees with representation from all of the health plans. The health plans have stated that this frequent communication has been beneficial to them in order to carry out their care coordination roles and responsibilities. Although challenging, members and their families have reported that they are communicating well telephonically and by email with their Care Coordinators through the pandemic and its effects. Going forward, the DMAS Care Management Unit plans to conduct joint member visits with the Care Coordinators to resume post COVID-19 safety concerns.

Medallion 4



Medallion 4.0 serves approximately 1,219,432 individuals across the Commonwealth.

The Medallion 4.0 program focuses on providing high quality care for the Commonwealth's pregnant moms, children, and adults. Medallion 4.0 also provides Community Mental Health Rehabilitation Services (CMHRS) and Behavioral Therapy services, services for Third Party Liability (TPL) members and Early Intervention (EI) Services for children.

Like CCC Plus, Medallion 4.0 members currently receive their benefits through one of the six (6) managed care organizations (MCO) contracted by DMAS: Aetna Better Health of Virginia, Anthem HealthKeepers, Magellan Complete Care of Virginia, Optima Health, United Healthcare and Virginia Premier Health Plan.

Care coordination in Medallion 4.0 is not mandatory for every member, however it is strongly encouraged for the vulnerable populations. The vulnerable populations include children and youth with special health care needs, adults with serious mental illness, members with substance abuse disorders, children in foster care or adoption assistance, women with a high-risk pregnancy, and members with other complex or multiple chronic conditions. Comprehensive health risk assessments are conducted for children and youth with special health care needs and members in foster care and adoption assistance. The MCOs are required to develop and maintain a program to address and improve the care and access of services among members requiring assessments.

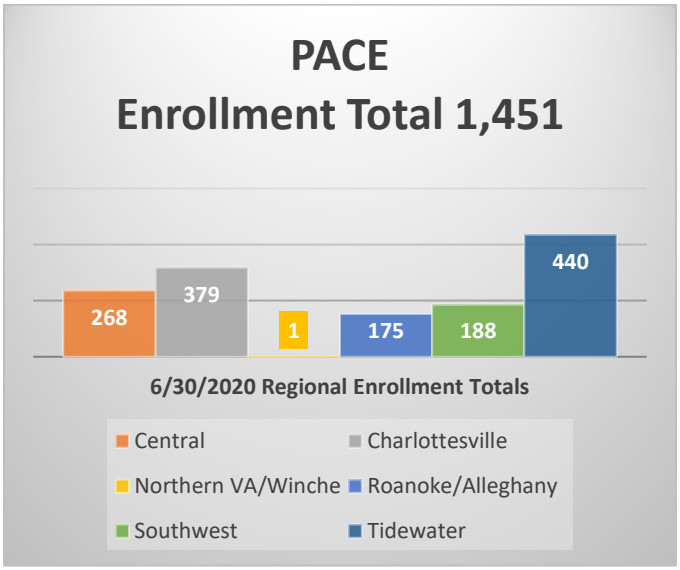
Training, Support and Oversight of Care Coordination

Medallion 4.0 continues to require the MCOs' care management reporting on emergency department encounter alerts, care coordination efforts to identify high utilizers, and efforts to address and track social determinants of health and foster care transition planning for members age 17 and older in foster care.

In response to COVID-19, Care Coordinators have increased their outreach to members ensuring access to services using telehealth medicine, suspending FAMIS copays, and automatically extending service authorizations and out-of-network providers when necessary. Medallion 4.0 health plans and their Care Coordinators have sent food kits each containing twenty-one meals to members in need of food, provided masks to members, and provided outreach to members who have filled a Buprenorphine prescription in the last 45 days and who were missing a refill or set to need a refill in the next 10 days. Medallion 4.0 Care Coordinators have developed an after-hours process to assist COVID-19 positive or exposed members with non-emergent

transportation needs after discharge from the hospital and to ensure dialysis and chemotherapy appointments are not missed. In addition, Medallion 4.0 Care Coordinators have initiated an intense outreach process to support discharge planning and post-acute care for all members pending or confirmed COVID-19 positive. To assist members with their pharmaceutical needs during the pandemic, Care Coordinators have temporarily paused new pharmacy lock-ins for Patient Utilization and Safety program (PUMS) members and conducted outreach calls to high risk members not using the mail order pharmacy benefit to ensure that members receive their medications in time.

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 has five PACE organizations: AllCare, Centra, InnovAge, Mountain Empire, and Sentara, which in total serve participants through 11 PACE centers.

PACE participants have 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 ensuring the highest quality of life.

The most significant change in PACE coordination due to the COVID-19 pandemic is that the majority of care is now provided in the home versus the participant being brought to a PACE center. Face-to-face assessments have transitioned to phone calls and video conferencing through Zoom, Facetime, and Webex in order to meet participants' needs while minimizing COVID-19 exposure for participants and staff. Through telehealth, providers have been able to continue to manage care for PACE participants who reside in their homes, assisted living facilities, and nursing facilities. Arranging telehealth sessions within some contracted facilities was initially a challenge due to scheduling conflicts. PACE staff were able to work with the facilities to arrange a schedule day to complete assessments for the PACE participants residing there.

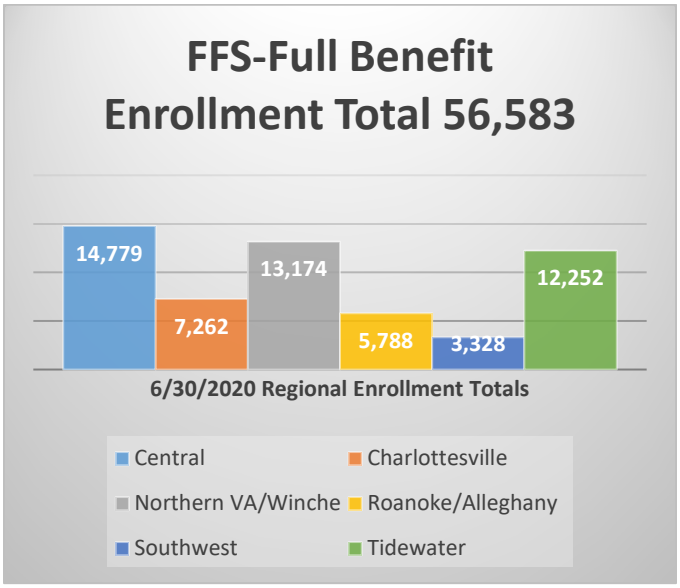
PACE staff are in communication with contracted facilities and arranging partnership meetings to increase communication regarding the coordination of participant care. They are also in constant communication with caregivers, specialists and contractors to address urgent needs as they arise, in person or through telehealth. Nursing staff, physical therapists and occupational therapists are making home visits for Physical therapy and Occupational therapy needs, medication needs, wound care, and urgent visits. PACE drivers and other staff have delivered meals, groceries, personal protective equipment, activity packets, and other supplies to the participants' homes. More personal care and homemaker hours of services have been made available for participants and some, if needed, transportation to the center to receive a bath.

Participants who live in rural areas with limited cell or internet service has proven difficult for the PACE clinical staff to assist them and provide services. As a result, some PACE sites have been able to assist and deliver equipment such as iPhones or iPads to participants who need them for assessments. Many of the assisted living and nursing facilities that PACE organizations contract with were not allowing PACE staff into their facilities due to COVID-19 exposure. PACE sites have partnered with them to follow their safety protocols to limit risk for

participants and staff. Through weekly wellness calls, PACE staff continue to monitor for any changes in the home and implement interventions to meet the participant and caregiver needs. Wellness calls have also provided an opportunity for participants and staff to enhance communication and relationships.

PACE staff have shared their best practices, challenges, and concerns with other Virginia PACE sites to ensure participant needs are met and participant plans of care are carried out during the pandemic.

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 who 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 to high risk children and adolescents in Virginia. Since January 1, 2020, the BHSA has managed a total of 1,165 care coordination IACCT cases.

Over the last year, the BHSA successfully managed transition authorizations to ensure that members transitioning between Medallion 4.0 or CCC Plus to Medicaid Fee-For-Service were able to maintain an active authorization and access services in the interim. From July 2019 to June 2020, the BHSA processed 493 transition authorizations. The BHSA proactively alerts the health plans when it identifies that a member with care coordination needs, such as complex needs or high utilization is transitioning to a CCC Plus or Medallion 4.0 health plan.

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 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. RCMs collaborate with residential providers to ensure that plans are individualized, viable and clinically appropriate which involves participation in care coordination meetings with the provider and all stakeholders involved in the member's care. BHSA Family Support Coordinators (FSC) offer assistance to guardians during the IACCT process 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.

As part of the high-touch care coordination model for ARTS services, the BHSA continues to engage in frequent care coordination for pregnant women with substance use disorders. As part of the review process for ARTS services, the ARTS Case Manager discusses with the providers the member's prenatal care, Opioid treatment for pregnant women, resources for pregnant and post-partum women and seamless discharge planning. From July 2019 to June 2020, the ARTS coordinators provided this intense care coordination for 16 members in this population.

The BHSA has encountered several challenges in the face of the COVID-19 pandemic, mostly revolving around provider interaction. There are barriers to effective care coordination due to provider unavailability, failing to return calls, and not addressing care coordination feedback during review times. Outreach to ensure member safety and wellbeing continues to be the BHSA's primary goal in the midst of these challenges.

Appendix A: Care Coordination Accomplishments and Success Stories

CCC Plus

A Member recently moved back to Virginia following the death of the spouse and ensuing health issues. The Member currently lives with a formerly estranged family member in a very rural and secluded area. The Member's complex medical history includes congestive heart failure, a history of multiple heart attacks, cardiomyopathy, and insulin dependent diabetes mellitus. The Member shared with the Care Coordinator that "there is nothing more they can do for my heart. I just have to make the best of each day." The Member also stated that depression is a problem due to feeling like a burden and wished there was a way to get out with others. Despite limited resources in the area, the Care Coordinator found a senior day program through the local hospital that offers therapeutic activities and professional counseling for those trying to cope with feelings of isolation, depression and loneliness. The Member could attend these sessions from once a week to daily, with meals and transportation included. The Care Coordinator discussed these options with the Member, who decided that the program could be beneficial. Information was given to the Member who enrolled and attended at least one day a week, prior to the COVID-19 pandemic. The Member was enjoying the interaction and activity and said it "gave me something to look forward to." The Member had hoped to increase attendance, but the pandemic caused the day program to temporarily close.

For the Member, having the opportunity to socialize with others who are dealing with similar life challenges offered an outlet in a therapeutic environment. Once the threat of COVID 19 is contained, the Member looks forward to returning to the senior day program on a regular basis.

Medallion 4.0

A former foster care member, working as a Certified Nursing Assistant, was pregnant with her first child. She has a history of depression and lives alone with little to no family support. She was identified as high-risk pregnancy with multiple emergency room visits. A United Healthcare Care Coordinator, Community Health Worker and First Steps OB Case Worker all engaged the member early in her pregnancy and assisted her with a WIC referral, car seat acquisition, baby supplies, and home delivered meals post-delivery and enrolled her in a prenatal incentive program for coaching and breast-feeding support. The member delivered a healthy full-term baby at 39 weeks. Prenatal and post-partum care milestones have been met. The member now has a PCP, dental care, and pediatrician in place for prevention and wellness. She continues to outreach her UHC Care Coordinator for updates and support.

BHSA

An 11-year-old female member was referred to the Independent Assessment Certification and Coordination Team (IACCT). The member has a history of poor impulse control, disrupted behaviors at home and at school, sexually inappropriate behaviors, self-injury, and property destruction. The member was also diagnosed with a developmental delay. The member is supported by her adoptive mother who was engaged in the IACCT process. The IACCT recommended Psychiatric Residential Treatment Facility (PRTF). The Family Assessment and Planning Team (FAPT) did not recommend PRTF. The Residential Care Manager (RCM) and the Family Support Coordinator (FSC) assisted mother in advocating for additional support in the community. The IACCT team and FAPT were able to work together to help youth and family access services in the community to include additional evaluations. The member and her family were connected with wrap around services in the community, to include an evaluator to complete a psychosexual evaluation. The member was also connected with information on how to access waiver services.

PACE

A PACE participant enrolled after the PACE day center closed due to the COVID-19 pandemic. Prior to enrolling, he lived at home alone and very isolated. He required therapy but his insurance would not cover additional services nor were outpatient services available to him. Due to his isolation at home, he began to decline in both mobility and spirit. The PACE team was able to assess the participant's needs and provide him with therapy in his home. During his assessment, he vocalized that he had quite a few "near misses" (falls). The participant was very pleased with the occupational therapist, and physical therapist, and the physical therapist assistant's response to his needs. The PACE staff quickly developed a treatment plan and secured durable medical supplies to assist the participant. He is progressing very well with his in-home therapy. Each day on his wellness call, he thanks his PACE wellness caller for the wonderful care and support he receives. The participant's near misses are a thing of the past. He looks forward to the social face-to-face benefits of PACE, but for now he is quite satisfied with the alternatives provided.