Foster Care Program

Annual Report

Lifetime Changes, One Child at a Time

FY 2015 Annual Report

Department of Medical Assistance Services

Program Accomplishments

- Virginia is the only state to offer multiple health plan options through six (6) different Managed Care Organizations
- **95%** of foster care youth in all of the transitioning regions (Tidewater, Central, Northern, Charlottesville, Halifax, Roanoke and Southwest) have seen a physician within the first year of managed care enrollment
- The Department successfully moved over 4,600 foster care youth and 5,900 adoption assistance youth into managed care through a unified transition in regional phases to minimize disruption to coverage for this special population
- The Department of Medical Assistance Services, the Virginia Department of Social Services (VDSS), Local Departments of Social Services (LDSS) and the six Medicaid Managed Care Organizations (MCOs) worked collaboratively to ensure a smooth and seamless transition of this population from the fee-for-service delivery system
- The six Medicaid Managed Care Organizations designated foster care liaisons as points of contacts to help resolve issues

- Trainings were conducted for local Social Service agencies, foster and adoptive parents, child placing agencies and group homes
- VDSS Foster Care Manual was updated to include health care responsibilities of local agencies and parents
- Issues handled expeditiously by staff at DMAS and MCOs
- Extremely low pregnancy rates for foster care girls ages 10-19 for calendar years 2014 and 2015
- Collaboration between Department of Behavioral Health and Developmental Services (DBHDS) to look at Trauma Informed Care
- Manually moved 112 foster care children from MajestaCare in November 2014 due to MCO exit from Virginia without any problems

Executive Summary

The Department of Medical Assistance Services transitioned 300 foster care children into managed care in 2011 with legislative support from the Governor and General Assembly. The pilot was successful, and in 2012, the General Assembly endorsed the inclusion of children placed in foster care and those receiving adoption assistance into managed care. The goal of the expansion process was to provide improved access to preventive and coordinated health care.

Preparation to ensure a seamless transition began in 2012 and focused on three major areas: system changes at DMAS and LDSS allowed for proper identification and location of the children; targeted outreach to local DSS staff, child placement agencies, foster care and adoptive parents; and extensive trainings and communications. In addition, the Department hired a staff member with subject matter expertise to manage and monitor the program.

The process would not have been successful without local permanency and eligibility staff members across the state. Their dedication towards this special population was unprecedented; their commitment; unmatched; and because of this, over 10,000 foster care and adoption assistance children were enrolled into managed care. Collaborative efforts took place with the Managed Care Organizations, (Anthem, Coventry Cares, INTotal, Kaiser Permanente, MajestaCare, (November 2014 exit) Optima and Virginia Premier,) and the enrollment broker (Maximus).

The program experienced huge successes and accomplishments in 2014, most notably, the transition of 4,600 foster care and 5,900 adoption assistance youth into managed care between September 2013 and June 2014. Unlike other states that offer Medicaid coverage through Fee-For-Service or one (1) managed care health plan, Virginia is the only state to offer health plan enrollment through six (6) different Managed Care Organizations.

This annual report provides an overview of the structure and impact of the transformed foster care program on the population it serves.

Creation of the Special Population's Unit

Shifting the foster care and adoptive youth into managed care was a delicate process. The task of converting this special population into managed care was being handled by various staff members within the Department. Although the Department's staff was committed to this special project, staff still had to manage their other job duties outside of the scope of the project.

The Department saw the need to create a Special Population's Unit within the Health Care Services Division. This unit's main objective was to focus on some of Virginia's most vulnerable Medicaid members. With the establishment of the Special Population's Unit, the Department created the agency's first Foster Care and Adoption Assistance Coordinator position. The Foster Care and Adoption Assistance Coordinator was hired in January 2014. By the time of the hiring of the FCAA Coordinator, foster care members in three regions (Tidewater, Central and Northern) had already transitioned into Managed Care.

Fortunately for the Department, the FCAA Coordinator was previously a supervisor at one of the local DSS agencies that had already gone through the transition process. During this process, while serving in the supervisory role, the FCAA Coordinator was responsible for moving over 250 foster care and adoption assistance youth. Collaboration between the eligibility and permanency staff was a daily task to ensure that demographic information was correct in the system. This was vital in ensuring that these youth were placed in the correct MCO on the appointed date. The Coordinator had subject matter expertise regarding the conversion which proved to be a benefit for the Department.

Starting in March of 2014, the FCAA Coordinator oversaw the next phase of shifting the remaining foster care and adoption assistance youth into managed care. The remaining regions (Charlottesville, Halifax, Roanoke and Southwest) transitioned from March 1, 2014 through June 1, 2014. The final phases of the crossover were extremely successful with over 90% of this special population being enrolled into managed care. Much of the success was in part due to the strong relationships forged between the FCAA Coordinator with local and state staff, along with the MCOs. It was important for the FCAA coordinator to maintain great working relationships with the above mentioned individuals to ensure that one of Virginia's most vulnerable populations changed to managed care without any interruptions to their health care.

Program Purpose and Description

Howard Schultz said it best; "When you're surrounded by people who share a passionate commitment around a common purpose, anything is possible." There are so many people who share an immeasurable commitment to foster care children. Judges, guardian ad litem (GAL), staff at local social service agencies, staff members across state agencies, advocacy groups, and foster parents. Without the safety net of passionate individuals, moving foster care children into managed care would not have been possible. Foster care children were placed into managed care to receive the absolute best care. Placing them into managed care was done with a purpose.

Enrolling foster care children into managed care allows this special needs population increased access to care and specialized services, one-on-one case management services and completion of health risk assessments. Managed care affords the opportunity for foster care and adoption assistance youth to receive quality care from credentialed providers.

Conversion Process

By June 1, 2014, the process of converting foster care children into managed care was complete. Much effort was put forth by the Department, VDSS, LDSS and the MCOs to place these children into managed care. The move occurred in regional phases beginning with the Tidewater area in September 2013 and concluding with the Southwest region on June 1, 2014.

More than 70 statewide trainings were conducted by the Departments FCAA Coordinator during the initial period. Representatives from the six managed care organizations participated in these trainings as well. During the trainings, the local permanency and eligibility staff had the opportunity to learn about managed care and the MCOs in detail, before the foster care population transitioned into managed care.

The trainings proved to be very beneficial for local DSS staff members, the MCOs and the Department. Local agencies provided feedback to the Department and the MCOs about foster care and adoption assistance members which led to program improvements and sharing of best practices.

During the shift, the local Departments of Social Services were assured that the Department was a responsive and helpful partner.

Follow Up Trainings

Although the conversion went seamlessly, it was very important to follow up with each region at their one year anniversary of having foster care children enrolled in managed care. Follow up meetings occurred statewide, involving the permanency and eligibility workers who provide specific case management for the foster care population. The meetings allowed the workers to provide feedback to the Department and the MCOs to discuss any issues they encountered during the process. Overall, the meetings have been exceptionally favorable; staff members have been positively candid which has allowed for growth and improvement within the foster care program. In addition to the follow-up meetings, post implementation calls were conducted sixty (60) days after each region went live. The calls allowed local eligibility and permanency supervisors and staff the opportunity to give the Department initial feedback about the enrollment process. This feedback allowed the Department to make adjustments to the process plan.

Forged Relationships

Oftentimes working in silos is far too common in the professional realm. Fortunately, the Department, VDSS, LDSS and the MCOs have all worked impeccably with each other. In order for this special population to receive the best health care, all parties had to work collaboratively. It was important to have a united force and set the standard for managed care enrollment for foster care and adoptive members. Without great working relationships, none of this outstanding work would have been possible.

As part of maintaining relationships, the FCAA Coordinator attended Virginia's Benefit Programs Organization (BPRO) meetings at Petersburg DSS. The main focus of BPRO is to improve the quality of eligibility practices and develop effective methods in working with the public. The meetings were held quarterly and included benefit and permanency staff that were responsible for foster care and adoption cases. Information sharing incorporated new or updated policy changes, updates to program guidance manuals, system changes that effect eligibility and an overview of federal guidelines. These meetings also allowed local DSS staff to get feedback from state consultants and program managers.

In an effort to continue building relationships with outside agencies, the FCAA Coordinator held trainings with the state's Licensing Child Placement Agencies (LCPAs). LCPAs serve a vital role in the community and like local DSS agencies, are responsible for finding placements for foster care children. A major goal for LCPAs is to find permanent placements for foster care children from infancy until 18 years old. Majority of the children LCPAs place are in the custody of various local social service departments.

The Real Work Begins

After the transition, there was a misperception that once this population was enrolled into managed care, the work was complete; however, the work had only just begun.

The MCOs are required to complete health risk assessments (HRAs) within 60 days of member assignment to their health plan. In addition to this requirement, ongoing outreach for these members occurs. The Department developed a pay for performance program incentive that will assess MCO performance measures across six quality measures; three HEDIS measures and three administrative measures. One of the administrative measures is designed to assess the percentage of foster care children who received an assessment in the required timeframe.

Some may speculate whether managed care works for one of Virginia's most vulnerable populations. There is great news! Data demonstrates the successes of placing foster care and adoptive children into managed care. It is working.

What Does the Data Show?

As soon as all regions transitioned into managed care, concluding with the Southwest region in June 2014, the Department began collecting data on primary care physician visits for foster care members in the MCOs and Medicaid fee-for-service delivery systems.

Primary Care Physician Visits

Managed Care	
Region	% Seen By a Physician
Tidewater	95%
Central	92%
Northern	98%
Charlottesville	94%
Halifax	92%
Roanoke	97%
Southwest	97%

As of the writing of this report, all seven regions have foster care members that have been enrolled in managed care for an entire year. On average, data shows that 95% of the foster care youth have seen a physician within the first year of managed care enrollment.

For comparison purposes, the Department also looked at physician visit rates for foster care children who were in Medicaid fee-for-service for the same period of time. Some reasons that foster care children remain in fee-for-service include:

- Residential treatment placement
- Nursing home placement
- Out-of-state placement
- Enrolled in private health insurance
- Hospitalization

Medicaid Fee-for-Service	
Region	% Seen by a Physician
Tidewater	97%
Central	100%
Northern	80%
Charlottesville	93%
Halifax	83%
Roanoke	94%
Southwest	94%

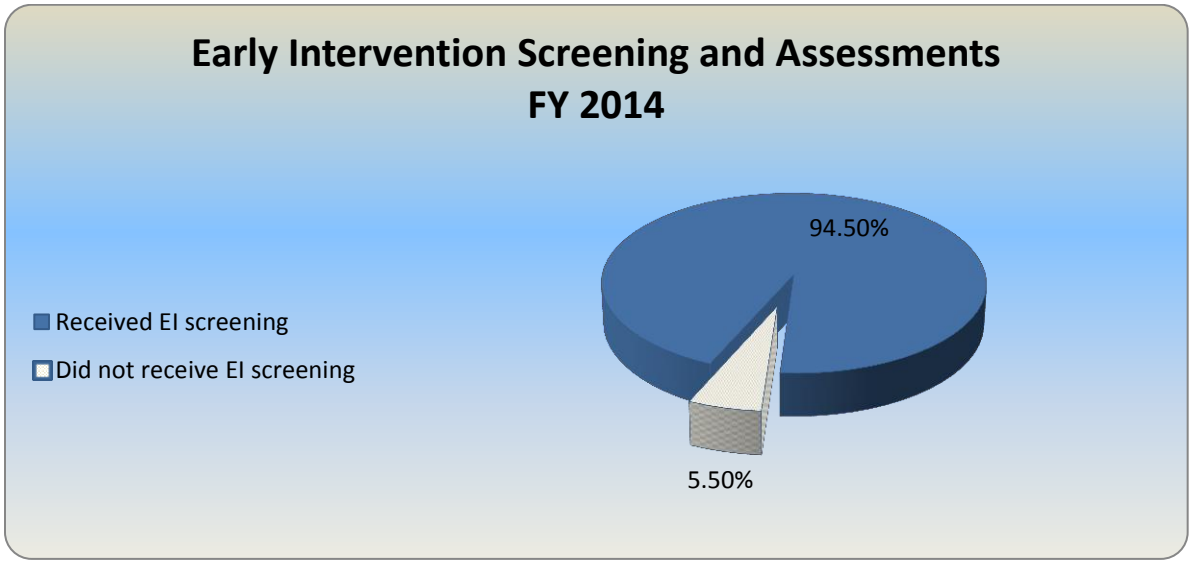
On average, data shows that 91% of the foster care youth have seen a physician while being enrolled into Medicaid fee-for-service.

Nearly 90% of foster care children are enrolled into managed care but it was important to monitor physician visits for foster care children that remained in Medicaid fee-for-service. It is the goal of the Department to ensure that all foster care members receive proper care across both delivery systems. For the children who had not seen a physician within the first year of managed care enrollment, the Foster Care Coordinator reached out to the local Departments of Social Services. Because the relationship between the Foster Care Coordinator and the local agencies remain strong, the dissemination of information was well received. Local workers informed the foster parents to take their children to the physician and provided an update to the Department once the child was seen by a provider.

Early Intervention Screenings and Assessments

"Early intervention services are developmental supports and services that are performed in natural environments, including home and community based settings in which children without disabilities participate, to the maximum extent possible. Services are designed to meet the developmental needs of an infant or toddler with a developmental delay and the needs of the family related to enhancing the child's development, as identified by the Individualized Family Service Plan (IFSP) team, in any one or more of the following areas: physical development, cognitive development, communication development, social or emotional development, and adaptive development." www.dbhds.virginia.gov

Data was collected for all foster care members ages 0-3 (452 total members) to review Early Intervention developmental screenings and assessments for calendar year 2014. The goal was to identify any foster care child who may be eligible for Early Intervention but had not received an Early Intervention screening. Data showed that of the 452 children, 427 (94.5%) were screened and assessed for Early Intervention services. The remaining 25 (5.5%) children had not received a screening or assessment for Early Intervention services. Although Early Intervention stands as a carve out service which Medicaid fee-for-service covers, the managed care plans were made aware of the members who had not received a screening or assessment. As a proactive measure, the Department also reached out to local DSS agencies to inform them of early intervention services and the importance of foster care children receiving those services, if deemed necessary.



Residential Treatment Centers

A Residential Treatment center is a " 24-hour, supervised, medically necessary, out-of-home program designed to provide necessary support and address mental health, behavioral, substance abuse, cognitive, or training needs of a child or adolescent in order to prevent or minimize the need for more intensive inpatient treatment."
www.virginiamedicaid.dmas.virginia.gov

One major goal for the foster care program was to monitor foster care children placed in residential treatment centers. Data was collected on foster care children who were admitted to residential centers during calendar year 2014 to see how many foster care children were entering residential facilities while in FFS, how many foster care youth were in an MCO prior to entering the facility and if so, how many of those youth were assigned to their previous MCO after discharge from the facility.

Data showed there were 387 foster care children who were placed in a residential center during calendar year 2014. Of those, 97 (25%) of the foster care youth were solely receiving services through Medicaid fee-for-service prior to entering the center. The remaining 290 (75%) received services under an MCO prior to entering the center.

The Department is currently developing a discharge planning process to notify MCOs when a foster care member is admitted to and discharged from a RTC to facilitate continuity of care.

Pregnancy Rates Amongst Foster Care Girls

Data was reviewed between calendar years 2014 and 2015 for pregnancy rates amongst foster care girls. Of the 732 foster care girls, data showed that thirty-two (32) or 4.4% of these girls between the ages of 10-19 were pregnant in 2014. In 2015, data showed that there were 657 girls between the ages of 10-19. Of the 657, forty (40) or 6% of these girls were pregnant.

For each pregnant foster care member, their managed care health plan assigned the girls to specific case managers.

Calendar Year	Overall number of foster care girls	# Pregnant foster care girls	% of pregnant foster care girls
2014	732	32	4.4%
2015	657	40	6%

Foster Care Fast Facts

The foster care fast fact sheet was created to provide a quick recap of data pulled for foster care members specifically. The fact sheet includes monthly enrollment numbers, regional physician visits, pregnancy data, Early Intervention screenings and assessments and residential placement data. The fact sheet is shared with the Departments management team and state officials. It is also shared with staff at various trainings that include local DSS agencies and licensed child placement agencies. As new data is retrieved on various matters within the program, the fast facts sheet will be updated accordingly and distributed.

Health Care Dashboards

As a result of the Foster Care Fast Facts sheet, the Division of Health Care Services (HCS) saw a need for dashboards that focus solely on foster care and adoption assistance members. For the latter part of 2015, the Systems and Reporting unit within HCS worked on the creation of dashboards for this special population. The dashboards include fee-for-service (FFS) professional claims and MCO professional encounters for targeted reporting dates. All aspects of health care services are reviewed for this population. Data is also compared to the SSI and general population to look at trends amongst each population. It is the goal of the Department to complete a semi-annual report of all findings.

The Benefits of Managed Care

Care Management

DMAS continuously monitors the care received by this population. Case management services are offered through the MCOs for members who have more complex healthcare needs, such as behavioral or therapeutic diagnosis. Designated MCO foster care liaisons have proven to be an enormous benefit for the program. These designated liaisons primarily resolve billing and claims issues, clarify MCO responsibility and resolve urgent matters.

The MCOs also have outreach teams that have direct contact with foster parents and children during face-to-face home visits and are likely to complete the contractually mandated health risk assessments for this special population. Outreach staff also monitors the care of foster care children and make the Department aware of issues that range from incorrect addresses, incorrect telephone numbers and out-of-state placements.

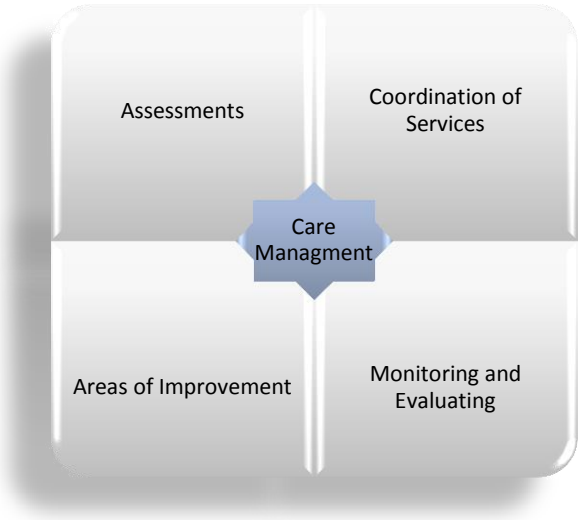
In addition to case management services, the Department's FCAA Coordinator manages a separate foster care email inbox where inquiries are received from local social service agencies and foster and adoptive parents. Most issues are resolved within 48 hours of receipt. For more complex cases, interdisciplinary teams are formed to review the cases. Each member is treated carefully, because neither member nor case is the same. It is important to provide the best care outcomes for each member.

Contract Changes

During calendar year 2015, changes were made to the 2015-2016 Medallion 3.0 managed care contract that positively impacted the foster care program. The managed care organizations are required to complete health risk assessments for all foster care children. This allows the MCOs to collect pertinent health care information and offer additional services for children who may have more specific health care needs, assign case managers to help parents navigate the health care system, and provide additional resources for its members.

MCO Care Management Meetings

At the start of the first quarter in 2016, the FCAA Coordinator will once again incorporate quarterly care management meetings with the MCOs foster care liaisons, outreach workers and case managers. The meetings will be held with this designated group because these are the front line workers who understand the complexities of this population. The meetings will serve as an opportunity to brainstorm, discuss programmatic issues, discuss areas of improvement, and offer solutions for problems that the MCOs encounter.



Exit of MajestaCare

In August 2014, MajestaCare notified the Department it would be exiting Virginia Medicaid on November 30, 2014. The exit of MajestaCare affected 112 foster care members from 29 DSS localities in the Roanoke and Southwest regions. An exit plan was developed to move all foster care children into a new health plan by November 18, 2014.

Unlike the regular Medicaid population, only social workers can make changes in enrollment for foster care members. Notifications were sent to the affected social service agencies on a weekly basis with status updates.

Although change is a forever constant for social service agencies, the local agencies responded favorably to this and all foster care members were moved to a new plan by November 18, 2014. The Department did not receive any complaints in regards to the change and there were no disruptions in services for the affected foster care members.

On The Horizon

Program Charter

A working program charter was created to improve the efficiency and effectiveness of strategies, policies, and procedures to positively impact foster care members. The charter provides an overview of the program mission, vision and future goals. The program charter serves as an aide to accomplish established goals within the program.

Health Services Advisory Group

The Department contracted with an external quality review organization, Health Services Advisory Group (HSAG), to conduct a focus study that will deliver qualitative and quantitative measures in the summer of 2016 about foster care children receiving services through the managed care organizations.

Department of Behavioral Health and Developmental Services

Staff members from the Department have teamed up with the Department of Behavioral Health and Developmental Services (DBHDS) and VDSS to look at aspects of Trauma Informed Care for foster care youth. Trauma Informed Care, “is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives.” www.dbhds.virginia.gov

Pilot Program with Local DSS Agency in Central Region

Starting in 2016, the FCAA Coordinator will partner with a local DSS agency in the Central region to develop a collaborative process to ensure that foster care children are seen by a physician within thirty (30) days of initial foster care placement. The purpose of the pilot is to improve the efficiency and effectiveness in ensuring that foster care members are seen by a physician within a timely manner. During the pilot process, we will discuss the project plan, define barriers that the agency encounters when trying to schedule an appointment within 30 days, and discuss best practices and areas of improvement. It is the goal of the Department to provide additional resources for the agency and parents to assist them in navigating the health care system.

Webinars

In 2016, training webinars will be developed for foster and adoptive parents and local DSS staff. The webinars will serve as a training tool to explain Medicaid and Managed Care in detail. The webinars will provide information that explains the benefits of managed care, what services Medicaid and Managed Care offer, and tools to navigate the health care system. Health care responsibilities of the DSS agency and parents and the process of selecting an MCO will also be explained in the training webinars. The webinars will be a great resource for new and existing DSS workers and foster and adoptive parents.

Foster Care Agreement and Manual

During the fourth quarter of 2015, the FCAA Coordinator worked on contract revisions for VDSS's Child and Family Services Manual Foster Care section and Virginia's Permanent Foster Care Agreement. The proposed changes for both documents will include a health care and medical responsibilities section. Other sections will include instructions on how to use the Medicaid and Managed Care insurance card, MCO assignment process, placement changes and how that effects the MCO assignment. Additional revisions will include foster parent(s) and service worker responsibility in ensuring that the child receives an annual visit with their primary care physician in accordance to the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) guidelines. Additionally, the foster parent(s) and service worker will ensure that the child receives any necessary ongoing medical, dental, vision and behavioral health care as applicable to the child's needs. There will also be an inclusion of Early Intervention screenings and assessments requirement section for children ages 0-3. It is the goal of the Department to submit all changes by the first quarter of 2016.

Three Branch and Child Welfare Advisory Committee

There are many key stakeholders with interest in the foster care population, in particular, the Three Branch Institute. The Three Branch Institute was a state-driven committee that measured and sought to improve the social and emotional well-being of children in foster care, including behavioral and mental health, physical health, and the usage of psychotropic medications The Three Brach Institute partnered with the National Conference of State Legislatures (NCSL), the National Governors Association, Casey Family Programs, the National Center for State Courts, and the National Council for Juvenile and Family Court Judges. http://www.ncsl.org The assemblage of Three Branch consist of legislative, executive and judicial branch representation. The goal of Three Branch is to engage the three branches, local DSS agencies, and community advocacy groups to improve the overall well-being for foster care youth. Virginia was one of seven (7) states selected through a competitive RFP to participate in the Three Branch Institute during 2013-2014.

Although the grant that funded the Three Branch Institute ended in 2014, the vision and effort continues through the Child Welfare Advisory Committee (CWAC). The activities of the CWAC help to ensure that all child welfare activities are child-centered, family- focused and community-based. CWAC formed four (4) subcommittees (Child Protective Services, Permanency, Prevention, and Quality Improvement) that will focus on the enhancement of permanency for Virginia's foster care youth. The subcommittees will address issues such as barriers for prevention programs, barriers to adoption, sex trafficking and safety measures.

Learning Collaborative

As a continued work from the Three Branch Institute, Virginia developed a Learning Collaborative series that will look at a variety of topics within the foster care population. The Learning Collaborative will operationalize practice models at local DSS agencies and develop data and measures related to psychotropic medication monitoring. Some areas of interest include determining the percentage of foster care children being prescribed psychotropic medication, how many are taking multiple medications, and how many foster care children are under the age of six (6) that are taking these medications. Since this is a complex matter, many stakeholders are vested in this area of interest. Some stakeholders include VDSS, DMAS, Community Services Board (CSB) providers, DBHDS, Behavioral Health Providers, Office of Comprehensive Services and the Virginia Department of Education. Research will continue on this staple through 2016.

Positivity Corner

Over the course of the year, the foster care program received much praise from the Three Branch Committee, CWAC, VDSS and local social service agencies. Foster parents also commended the Department and the MCOs for the increased care that is rendered for their foster care children. Although the transition was a significant undertaking, the results have been positively enormous. It is the Department's goal to change a lifetime, one foster care child at a time.

Remarks from Director of Knowledge Management of Casey Family Programs

"This is really great work; I hope you all are justifiably proud of the monumental work this represents and the integrity with which you're moving forward."

Remarks from an adoptive parent

"You are such a life saver. My son would not have been able to get his prescriptions without the help of DMAS and his health insurance plan."

Feedback from Local DSS agencies

"We were very pleased with the process. Since (we) Richmond City were the pilot agency for the transition in 2012, we've had 2 years to get adjusted. We have been thoroughly pleased with the MCO representation during the initial training and follow-up visits." – Central regional response

"The transition went smoother than expected."- Central regional response

"Since the transition, we have found that there are more providers available for the foster care youth." – Central regional response

"The process was great. There were enough trainings, webinars and information sharing which made the transition process go smoothly" – Halifax regional response

"This was a new process. For the foster parents and the agency it was not necessarily a hard change. It was a process that had to be done, so we did it." –Charlottesville regional response

"The transition went smoother than we thought. We have been impressed with the additional services offered for foster care youth. We also like how case managers are assigned to more complex cases and how the case managers are able to assist parents with scheduling appointments, finding providers, etc." – Northern regional response