Implementing Medicaid Reform in Virginia

A summary of planned reforms for review by the Centers for Medicare and Medicaid Services and interested stakeholders

Virginia Department of Medical Assistance Services
August 15, 2013

Executive Summary

As the single-state agency responsible for delivery of the Virginia Medicaid program, the Virginia Department of Medical Assistance Services (DMAS) seeks to transform the Virginia Medicaid program into a cutting-edge payment and delivery system where quality is rewarded and efficiency and cost-effectiveness are paramount. In order to achieve meaningful program reforms, Virginia desires to identify changes needed in authorities granted by the Centers for Medicare and Medicaid Services (CMS). This paper provides background on the Virginia Medicaid program, highlights the overarching goals and program reform strategies, and outlines specific CMS authorities that Virginia needs to move forward with Medicaid reform.

Since the inception of the Virginia Medicaid program in 1969, the Commonwealth has worked diligently to offer coverage for qualifying individuals with disabilities and low-income. The Department currently provides coverage as authorized under Titles XIX and XXI of the Social Security Act (SSA). As of July, 2013, over one million individuals receive coverage through Virginia's Medicaid and Children's Health Insurance programs. There are 938,087 enrollees in programs offered through Title XIX of the SSA and Virginia serves 63,693 children and 1,553 pregnant women through Title XXI.

Virginia's Medicaid program offers health care benefits through several payment and service delivery models, including the fee-for-service (FFS) model and a full-risk capitated managed care model. DMAS also contracts with administrative services organizations to improve administration of certain services and functions provided in FFS. The delivery models are authorized through the Virginia State Plan for Medical Assistance coupled with several different Federal waiver authorities. Virginia has tailored its program to best meet the needs of the Commonwealth by developing §1915(c), §1915(b), and §1115 waivers. The §1915(c) waivers provide authority for the state to provide long term care services and supports (LTSS) to individuals who qualify for institutional level of care in the community, versus in an institution. The §1915(b) wavier provides authority to mandatorily enroll beneficiaries into the MCO program. Virginia's current §1115 waiver allows DMAS to provide services to individuals who would not otherwise be eligible for Medicaid benefits, due to their income level or other disqualifying characteristics.

Most of the individuals who receive services predominantly through the FFS model are receiving LTSS, either through an institution or through one of the six home and community-based services waivers that DMAS operates through §1915(c) waiver authority. In general, but with some exceptions, individuals eligible for the managed care model include children; pregnant women; parents of dependent children; and individuals who are aged, blind or disabled residing in the community and are not receiving Medicare benefits. Often individuals receive services through two or more of the payment and service models simultaneously, as some services are *carved out* of the MCO contracts and provided through FFS, such as non-traditional community behavioral health care services.

Virginia began operating a managed care program in 1996, when the Medallion II managed care program was launched in the Tidewater region of the state. Today, the Medallion II program operates statewide, and DMAS currently contracts with six MCOs that participate in the fully capitated, risk-based, mandatory managed care program. Virginia is also currently in negotiations with a seventh MCO to operate in Northern Virginia. In addition to the Medallion II program, DMAS operates a full-risk managed care program for individuals who receive both Medicaid and Medicare benefits – the Program

for All Inclusive Care (PACE). The PACE program provides all Medicare and Medicaid benefits under one entity anchored by an adult day center. Lastly, DMAS is working towards the implementation of the Commonwealth Coordinated Care program in early 2014, which is a demonstration in partnership with CMS that will serve individuals receiving Medicare and Medicaid under a capitated full-risk MCO model.

Over the past years, Virginia's Medicaid program has received national recognition for a number of its programs; however, overarching reform is needed. Virginia seeks to transform its program to achieve a broader vision of:

(i) **Effective Service Delivery**-Virginia seeks a Medicaid program where costs are predictable, services are coordinated, innovation is rewarded, and provider compensation is based on the quality of the care;

(ii) **Efficient Administration**-DMAS is efficient, streamlined, and user-friendly. Tax payer dollars are used effectively and for their intended purposes; and

(iii) **Significant Beneficiary Engagement**- Beneficiaries take an active role in the quality of their health care and share responsibility for using Medicaid dollars wisely.

In order to remain on the cutting edge of program design, service delivery, and reimbursement, the 2013 Virginia General Assembly directed DMAS through budget language to achieve a number of reforms to the Medicaid program. This language identifies three pathways to continued reform: (1) Advancing reforms currently in progress; (2) Implementing innovations in service delivery, administration, and beneficiary engagement; and (3) Ongoing progress towards expanding coordination of care for long-term services and supports. In full, this directive sets forth an ambitious Medicaid reform agenda, which directs DMAS to expand principles of care management to all geographic areas, populations, and services under programs administered by DMAS.

In order to accomplish a number of the tasks set out before the Department, Virginia must obtain additional authorities from the Centers for Medicare and Medicaid Services. Virginia values its close working relationship with CMS, and the Department has been actively engaged in conversations with CMS on a number of projects on a near daily basis. While CMS continues to support several recent reforms underway in the Commonwealth, DMAS needs expanded flexibility from CMS to ensure that the Commonwealth can implement reforms outlined by the General Assembly in a manner that best meets the needs of Virginia's Medicaid beneficiaries, providers, and the Commonwealth as a whole. Virginia will also continue working with stakeholders to ensure that these reforms address the needs of Virginia's citizens. Between the reforms already in progress and those being pursued in the months and years ahead, DMAS is looking to CMS to specifically fulfill the following requests:

1. **Rapid-Cycle Implementation of Innovative Pilots**

Request for CMS regarding Rapid-Cycle Innovation Pilots: The Department seeks to obtain approval from CMS via an §1115 waiver, or other suggested authority, to implement pilots on an expedited basis. DMAS would like to establish *assurance parameters* and then have the ability to provide an explanation of the proposed pilot to CMS and show how it meets the pre-established parameters. If the pilot meets the assurance parameters as determined through an expedited review process, then CMS would advance approval of the pilot so that it can be implemented within months – instead of the years that it often takes to obtain approval for a program.

2. **Moving to a Value-Driven, Commercial-Like Medicaid Program**

Request for CMS regarding a Commercial-Like Benefit Package: The Department seeks to obtain approval from CMS, either through waiver authority or 'Secretary Approved Coverage,' as described in the Affordable Care Act to modify the existing Medicaid benefit structure to more closely resemble a commercial insurance program; one that citizens purchase through private health insurance. This request will also include approval for a program that uses incentives and disincentives to drive responsible use of the health care system.

3. **Comprehensive Coordination of Long-Term Services and Supports**

Request for CMS regarding Long-Term Services and Support Reforms: The Department seeks to determine the most expeditious way of obtaining authority for a number of programs that will provide comprehensive coordination of Virginia's long-term services and support system.

Vision for Medicaid Reform in Virginia

Purpose

The Virginia Department of Medical Assistance Services (DMAS), the single-state agency responsible for delivery of the Virginia Medicaid program, seeks to transform its Medicaid program into a cutting-edge payment and delivery system where quality is rewarded and efficiency and cost-effectiveness are paramount. To accomplish this, DMAS plans to implement a number of programmatic changes.
This document serves as a concept paper from the Department for review by the Centers for Medicare and Medicaid Services (CMS) and Virginia stakeholders. It provides an overview of Virginia's current delivery system, summarizes the federal authority that Virginia currently has in place, and outlines the reforms that the Commonwealth seeks from the federal government for the Medicaid program.

Overview of the Virginia Medicaid Program

Medicaid is an entitlement program that provides coverage of medical services for certain disabled and low-income individuals as authorized under Title XIX of the Social Security Act. Virginia has participated in the Medicaid program since 1969. Medicaid is financed jointly by the state and federal governments and administered by the states, adhering to guidelines established and approved at the federal level. Federal financial assistance is provided to states in the form of matching dollars, and the federal match rate is based on the state's per capita income. For the majority of the Virginia program, the current federal match rate is 50 percent (the federal minimum), meaning that for every dollar expended in the Medicaid program, 50 cents comes from the federal government and 50 cents comes from the state's general fund. As of July 2013, Virginia serves 938,087 beneficiaries through Title XIX and also serves 63,693 children and 1,553 pregnant women through Title XXI of the Social Security Act, (the Children's Health Insurance Program). The Children's Health Insurance Program (CHIP, formerly the State Children's Health Insurance Program (SCHIP)) was created by the Balanced Budget Act of 1997, which enacted Title XXI of the Social Security Act to help states insure low-income children who are ineligible for Medicaid but cannot afford private insurance. States receive an enhanced federal match (greater than the state's Medicaid match) to provide this coverage. In February 2009, the Children's Health Insurance Program Reauthorization Act of 2009 was approved by Congress. This paper is focused on changes to the Medicaid program; however, appropriate changes would be applicable to the CHIP program as well.

Who is Covered by the Virginia Medicaid Program?

While Medicaid was created to assist people with low-income, coverage is dependent upon individuals meeting additional criteria. Individuals who are eligible for Medicaid primarily fall into particular eligibility categories such as low-income children, pregnant women, the elderly, individuals with disabilities, and parents meeting specific low-income thresholds. Virginia does not provide Medicaid coverage for childless adults who do not otherwise meet the requirements of an aforementioned eligibility category. Within federal guidelines, states set their own income and asset eligibility criteria for Medicaid, which results in a large variation among the states as to who is eligible. In Virginia, income and resource requirements vary by eligibility category.

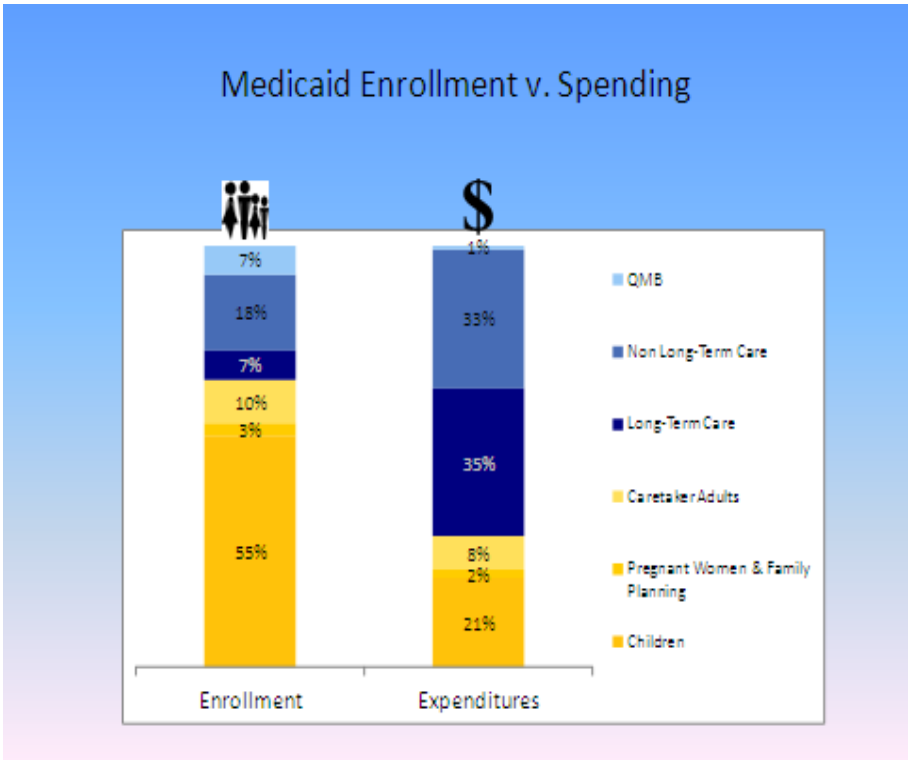
During state fiscal year (FY) 2012 (July 1, 2011 – June 30, 2012) the monthly average number of individuals receiving Medicaid benefits in Virginia was 834,876 individuals with an annual total expenditure of approximately $7.0 billion (approximately 49% from federal funding). Children and adult caregivers make up about 68 percent of the Medicaid beneficiaries, but they account for only 31 percent of Medicaid spending. While a minority in terms of the percent of recipients served (32%), the elderly

and persons with disabilities account for the majority (69 percent) of Medicaid spending, due to their intensive use of acute and long-term services and supports (Figure 1).[1]

The total number of individuals in Virginia who received Medicaid benefits at any time during SFY 2012 was 1,096,470 and was comprised of:

- 604,442 children,
- 195,681 parents or caregivers of children and pregnant women,
- 79,613 elderly individuals, and
- 216,734 individuals with a disability.

Figure 1 – 2012 Enrollment & Expenditures

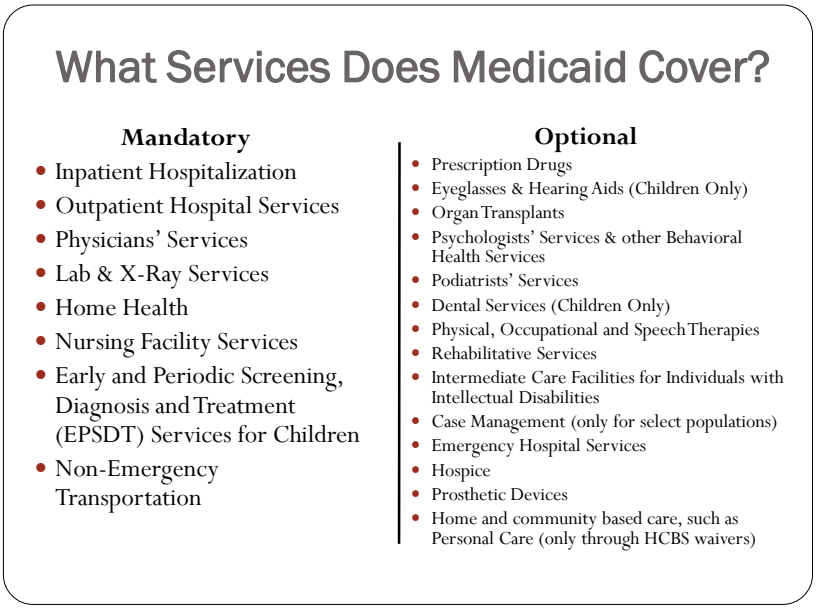


What Services do Medicaid Beneficiaries Receive?

The Virginia Medicaid program covers a broad range of services including all federally mandated services and many services that are provided at the state's option. Nominal cost sharing for some services is permitted under federal law for some of the beneficiaries. The mandated and optional covered services are listed in Figure 2.

[1] "QMB" in Figure 1 refers to a Qualified Medicare Beneficiary.

Figure 2 – Mandatory and Optional Services Covered by Virginia Medicaid



In addition to the mandatory and optional services, certain qualifying Medicaid beneficiaries also receive coverage through home and community-based services (HCBS) "waiver" programs. These waivers provide community-based long-term services and supports as an alternative to institutionalization. The following waiver programs are available to Medicaid beneficiaries who meet the established level of care criteria:

1. Alzheimer's Waiver,
2. Day Support for Persons with Intellectual Disabilities Waiver,
3. Elderly or Disabled with Consumer-Direction Waiver,
4. Intellectual Disabilities Waiver,
5. Technology Assisted Waiver, and
6. Individual and Family Developmental Disabilities Support Waiver.

How are Services Delivered?

Medicaid services are provided to Medicaid beneficiaries through two general delivery models: fee-for-service (FFS) - where providers are reimbursed directly by DMAS for services rendered; and managed care – where DMAS contracts with managed care organizations that pay providers. In managed care, DMAS pays managed care organizations a "per member per month" or "PMPM" fee through a full risk contract to manage the majority of the recipients' care. In July 2013, 32 percent of total Medicaid beneficiaries were enrolled in the fee-for-service program, while 68 percent of total Medicaid beneficiaries were enrolled in managed care.

Fee-for-Service

The majority of individuals receiving services through fee-for-service include most HCBS Waiver participants, individuals residing in facilities (e.g., nursing facility, Intermediate Care Facility for the Intellectually Disabled (ICF/ID), and long-stay hospital), individuals enrolled in both Medicare and

Medicaid,[2] individuals enrolled in another insurance program in addition to Medicaid,[3] and individuals waiting to be assigned to a Managed Care Organization (MCO) (typically a one month period). Individuals receiving services through FFS receive very limited support and coordination of their services. The Department is actively moving away from the FFS delivery system in order to provide a more coordinated delivery system for all beneficiaries.

To improve administration of certain services in delivered through FFS, DMAS often contracts with an administrative services organization (ASO). When contracting with an ASO, DMAS pays the ASO an administrative fee to provide administrative services related to particular health care services (e.g., children's dental services, preauthorization, and provider credentialing), but the service providers are paid on a FFS basis by DMAS.

Capitated Managed Care

Contracted Health Plans: Virginia's managed care program, known as the "Medallion II" program began in 1996 and as of July 1, 2012, is available in all regions of the state. The program is a fully capitated, risk-based, mandatory managed care program and includes children up to age 19, pregnant women, caretaker parents of eligible children and individuals enrolled in the "Aged, Blind, and Disabled" aid categories.

Under Medallion II, DMAS contracts with managed care organizations (MCOs) for the provision of most Medicaid covered services. The contracted MCOs receive a capitated payment from DMAS each month that covers a comprehensive set of services, regardless of how much care is used by the member. Claims for contracted services are paid by the MCO in accordance with Federal and State guidelines and terms established in contracts negotiated between the MCOs and service providers. As of July 1, 2013, MCOs operate in all 134 Virginia localities with enrollment of 696,008 individuals. Currently DMAS contracts with six MCOs: Anthem HealthKeepers Plus, CoventryCares of Virginia, InTotal Health, MajestaCare-A Health Plan of Carilion Clinic, Optima Family Care, and Virginia Premier Health Plan. Virginia is also in negotiations with a seventh MCO, Kaiser, to operate in the Northern Virginia area. Participating Medicaid beneficiaries have a choice between at least two MCOs in each area of the Commonwealth.

MCOs cover the majority of services for individuals enrolled in their program; however, some services for MCO enrollees continue to be covered through the fee-for-service system. These services are referred to as "carved out" services, and in Virginia, include services such as community behavioral health services, early intervention, and dental services for children.

Program for the All-Inclusive Care for the Elderly: An additional managed care delivery option for individuals who receive long-term services and supports paid by both Medicare and Medicaid is the Program for All-Inclusive Care for the Elderly (PACE). PACE is designed to allow Medicaid eligible individuals aged 55 or older, who meet the nursing facility level of care, to access comprehensive coordinated care of both Medical and long-term support services in their homes and communities. There are currently twelve PACE programs serving 904 people across the Commonwealth.

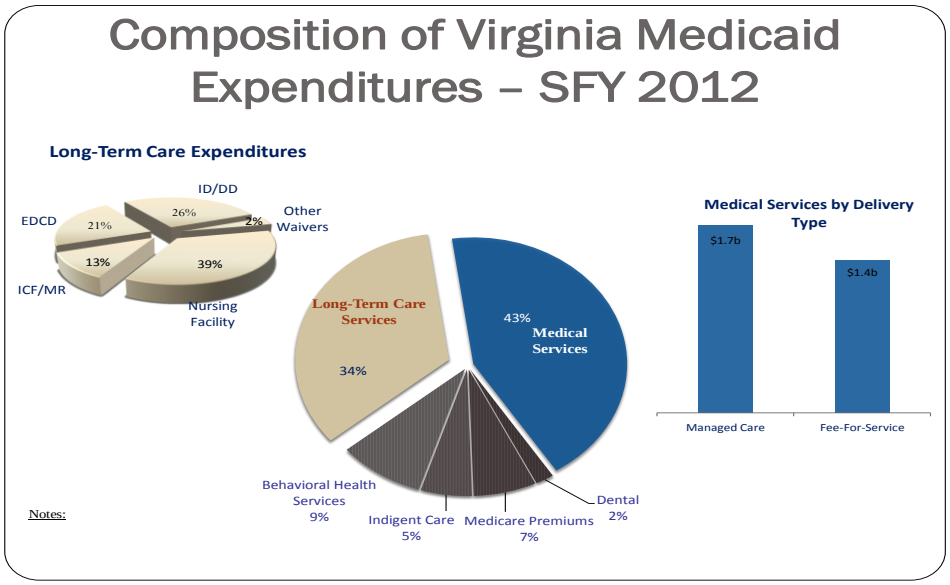
Figure 3 presents the enrollment by delivery system as of June 2013 and Figure 4 presents the composition of medical expenditures for FY 2012.

[2] The majority of medical services for these individuals are covered by Medicare.
[3] Medicaid may provide premium assistance or wrap around services for these beneficiaries.

Figure 3 – June 2013 Enrollment by Delivery System

June 2013 Enrollment	Managed Care	Fee-for-Service	Limited Enrollment[4]	Total
Number	696,008	205,250	102,075	1,003,333

Figure 4 – FY 2012 Medical Expenditures Composition



How Does Virginia Compare to Other States?

Over the past ten years, the average number of people enrolled in the Virginia Medicaid program each month has increased by 70 percent. The overall increase has been driven primarily by economic trends, such as "The Great Recession" of 2008, the growing number of individuals with a disability, as well as a targeted enrollment outreach for children. Despite the enrollment growth, Virginia's eligibility criteria have remained conservative.

Since the program's inception, Virginia Medicaid has had stringent eligibility criteria for those seeking to qualify for coverage. In 2010, Virginia ranked 45th in the nation in terms of the number of Medicaid recipients as a percentage of the total population; in that year, 13% of Virginians were enrolled in the Medicaid program. Compared to other states, Virginia ranked 22nd in terms of Medicaid expenditures per enrollee with an average annual expenditure of $6,012. Based on these and other statistics, Virginia's Medicaid program has long been described as a very lean program with very strict eligibility criteria and modest payment rates for services. From 2008 through 2012, DMAS provider fees for all services grew by 3.4% compared to 4.9% nationwide. In addition, Virginia Medicaid closely monitors the financial performance of its contracted managed care organizations and is one of only 10 states and the District of Columbia that imposes a minimum loss ratio on its contracted plans, in order to ensure the judicious use

[4] Limited enrollment includes individuals enrolled in the Plan First program and Medicare-Medicaid enrollees who are eligible only for partial coverage.

of public funds. In FY 2012, 1.9 % of the total DMAS budget was allocated toward administrative expenses. In comparison to other states, Virginia's rate of growth in expenditures is comparable; however, the absolute level of spending remains low.

Existing Federal Authority for the Virginia Medicaid Program

The Virginia State Plan for Medical Assistance approved by CMS provides federal authority for the Virginia Medicaid program. Federal approval is necessary in order for the state to receive Title XIX federal matching funds. For the majority of the program, Virginia's Federal Medicaid Assistance Percentage (FMAP) is 50% for 2013.

Title XIX requires that Medicaid services must be provided in the same *amount, duration, and scope* to all beneficiaries within a state and meet a number of other requirements. Virginia has tailored its program to best meet the needs of the Commonwealth by developing §1915(c), §1915(b), and §1115 waivers. These waivers are agreements between the state and CMS that CMS will "waive" or not require that the state adhere to the requirements of certain sections of the *Social Security Act*, as long as the state meets other standards and criteria. Section §1915(c) waivers allow states to provide long-term services and supports in community settings as an alternative to institutional settings. Section §1915(b) waivers provide authority for mandatory enrollment in managed care on a statewide basis or in limited geographic areas. Section §1115 waivers provide broad waiver authority at the discretion of the Secretary to approve projects that test policy innovations likely to further the objectives of the Medicaid program. Section §1115 waivers permit states to provide the demonstration population(s) with different health benefits or have different service limitations than are specified in the Medicaid State Plan.

§1915(c) Home- and Community-Based Waivers:

Virginia offers six home- and community-based services (HCBS) waivers to enable individuals to receive long-term services and supports in the community instead of in nursing facilities (§1915(c));

Figure 5 – §1915(c) Home and Community Based Long-Term Services and Supports Waiver

§1915(c) Home- and Community- Based Long-Term Services and Supports Waiver	Number of Enrollees as of June 2013
Day Support Waiver	246
Developmental Disability Waiver	778
Intellectual Disability Waiver	9,138
Alzheimer's Waiver	37
Technology Assisted Waiver	342
Elderly or Disabled with Consumer Direction Waiver	26,231
TOTAL §1915(c) Waiver Enrollment	**36,772**

§1915(b) Waiver to Require Mandatory Participation in Managed Care

Within §1915(b) authority, states have substantial flexibility to tailor their managed care program to best meet the needs of the state. Virginia offers Medallion II, its capitated managed care program, statewide to children, pregnant women, caretaker parents, and individuals meeting requirements as "Aged, Blind, or Disabled." Virginia has worked closely with CMS over the course of the Medallion II program to strengthen the contract obligations and deliverables of the MCO contracts. Significant changes in quality and innovation took effect on July 1, 2013. Highlights of these changes include: (i) enhanced technical guidance to improve reporting, automation of MCO report filing and submission, encounter data, and scoring of MCO's compliance with reporting requirements; (ii) a new quality incentive program where high quality is financially rewarded; (iii) a new Medallion Care System Partnership which encourages development of new payment and delivery models; (iv) improved maternity care requirements; (v) improved chronic disease management for the aged, blind, and disabled; and (vi) improved wellness programs.

§1115 Waiver

On July 31, 2013, Virginia submitted a small §1115 Waiver requesting authority for the state to implement new eligibility rules mandated by the Affordable Care Act (ACA) prior to the official effective date on January 1, 2014. The Department seeks to implement the new eligibly standard, known as the "Modified Adjusted Gross Income" or MAGI, beginning on October 1, 2013. The MAGI eligibility methodology will be used for eligibility determinations for parents of dependent children, children under age 19, and pregnant women, and will base financial eligibility for Medicaid and the Children's Health Insurance Program (FAMIS) on IRS rules. Financial eligibility for some applicants, such as individuals applying for assistance with long-term services and supports, however, will still be assessed using current rules.

Virginia also has an §1115 HIFA waiver for the FAMIS MOMS and FAMIS Select programs. This waiver was renewed in May 2013 for an additional three years. The Department requested a modification in June 2013 to phase out the FAMIS MOMS program starting in January 2014. The Department is waiting for CMS approval. This waiver will remain in effect for FAMIS Select after FAMIS MOMS is phased out.

Reforming Virginia's Medicaid Program

Legislative Directive to Reform Virginia's Medicaid Program

Virginia's Medicaid program strives to deliver high-quality, cost-effective care and has received national recognition for a number of its programs. In order to remain a national leader, the Department must consistently strive to strengthen and refine the program. To bolster the culture of continuous improvement, the 2013 Virginia General Assembly directed DMAS through budget language to achieve a number of reforms to the Medicaid program. This language outlines three phases: (1) Advance reforms currently in progress, (2) Implement innovations in service delivery, administration, and beneficiary engagement, and (3) Move forward with coordination of long-term services and supports. In full, this directive sets forth an ambitious Medicaid reform agenda, which directs DMAS to expand principles of care management to all geographic areas, populations, and services under programs administered by DMAS.

The Commonwealth's Medicaid reform agenda emphasizes the implementation of comprehensive, value-driven, market based reforms that improve quality of care and contain spending growth. As mentioned above, the reform plan lays out a 3-phased approach to accomplish Medicaid reform and establishes a Medicaid Innovation and Reform Commission (MIRC) to assess progress made. The process included an opportunity for public comment and stakeholder input.

Phase 1: Advance Reforms Currently in Progress

- Implement a 3-year Medicare and Medicaid Enrollee (dual eligible) Financial Alignment Demonstration;
- Transition all children in Foster Care into managed care;
- Enhance program integrity and fraud preventions; and
- Implement a new eligibility and enrollment information system for Medicaid and other social services.

Phase 2: Implement Innovations in Service Delivery, Administration, and Beneficiary Engagement

- Develop commercial-like benefit packages for Medicaid populations[5];
- Implement reasonable limitations on non-essential benefits such as non-emergency medical transportation (NEMT);
- Promote patient responsibility through reasonable cost sharing and active engagement in health and wellness activities to improve health and control cost;
- Simplify the administration of Medicaid through any necessary waivers and/or State Plan authorization under Title XIX or XXI of the Social Security Act; and
- Outline parameters and metrics to provide maximum flexibility and expedite the development and implementation of pilot programs that test innovative models which: (1) leverage innovations and variations in regional delivery systems; (2) link payment and reimbursement to quality and cost containment outcomes; or (3) encourage innovations that improve service quality and yield cost savings to the Commonwealth.

Phase 3: Move Forward with Coordination of Long-Term Services and Supports

- Seek reforms to include all remaining non-coordinated Medicaid populations and services, including facility-based and home and community-based services, in cost-effective, managed and coordinated delivery systems.

Vision for Reform

The three phases of reform, as directed by the General Assembly, are program and population specific; however, they directly fit within the Department's broader vision of Medicaid reform which includes:

> (i) Effective service delivery-*Virginia seeks a Medicaid program where costs are predictable, services are coordinated, innovation is rewarded, and provider compensation is based on the quality of the care*;

[5] Community behavioral health services and non-emergency transportation (i.e., rides to medical appointments) are currently covered by Medicaid and would continue to be included in the new Medicaid benefit package for the current population.

(ii) Efficient administration-*DMAS is efficient, streamlined, and user-friendly. Tax payer dollars are used effectively and for their intended purposes;* and

(iii) Significant beneficiary engagement- *Beneficiaries take an active role in the quality of their health care and share responsibility for using Medicaid dollars wisely*.

To achieve this vision and meet the directives of the General Assembly, DMAS seeks broader flexibility from CMS in structuring programs. The Department plans to continue work with stakeholders and CMS to hone this plan prior to the January 2014 General Assembly session.

Working with CMS to Implement Reforms in Virginia

Virginia appreciates its close working relationship with CMS and the Department is actively engaged in conversations with CMS on a number of projects on a near daily basis. Subsequently, CMS has and continues to support several significant, recent reforms undertaken by Virginia. These reforms include:

- Medicare-Medicaid Enrollee (dual eligible) Financial Alignment Demonstration;
- Significant reforms to the Department's contracts with its managed care organizations; and
- Fast tracking reviews of eligibility and enrollment changes.

For example, in response to State concerns, CMS policy now allows for a 90% match rate on new Eligibility and Enrollment systems and will allow a 75% administrative match on eligibility functions. Additionally, CMS and Virginia staff have participated in calls to discuss additional reforms included in budget language for which the Department is moving forward. This paper is in response to those calls.

The Department has implemented a number of the reforms that are allowed within existing federal authority, and is seeking expanded flexibility from CMS to ensure that the Commonwealth can implement the reforms outlined by the General Assembly in a manner that best meets the needs of Virginia's Medicaid beneficiaries and the Commonwealth. A number of these reforms will likely require changes to the Department's current authority with CMS. The following is a discussion of select reforms and specific requests for obtaining authority from CMS to implement these reforms.

Phase 1: Reforms Already in Progress

The Department has an unprecedented number of significant reforms currently under way. Many of these reforms are outlined in Phase One of the budget language. Highlights of the Phase One reforms are discussed below.

- *Commonwealth Coordinated Care:* DMAS has made significant strides in implementing a coordinated, integrated model of care for dual eligible individuals via the Medicare – Medicaid Financial Alignment Demonstration (FAD). Virginia was the sixth state to sign a Memorandum of Understanding with CMS which signifies Virginia's formal acceptance into the FAD. The FAD is an opportunity authorized by the ACA to integrate covered Medicare and Medicaid benefits under one system of coordinated care using a full-risk capitated model operated jointly by the state and CMS. Over the past eighteen months, DMAS held regular meetings with the Medicare Medicaid Advisory Committee, (appointed by the Secretary of Health and Human Services), and other important stakeholders, and finalized the design and name of the Demonstration. *Commonwealth Coordinated Care* (CCC) is a voluntary program which will serve up to approximately 78,000 dually-eligible elderly and disabled individuals in five regions of the Commonwealth: Central Virginia, Tidewater, Northern Virginia, Charlottesville/West and

the Roanoke regions. The CCC will be phased in on a regional basis over the first twelve months of the Demonstration, starting with the Central Virginia and Tidewater regions. Eligible individuals will be notified of the opportunity to enroll during December 2013 and the first opportunity for enrollment is targeted for February 1, 2014. The remaining three regions will be phased in later in the 2014, with the first enrollment opportunity targeted for August 2014. CCC will operate through December 2017, in order to allow for three years of operation after full implementation.

Over the past 18 months, DMAS worked with CMS to develop the terms and conditions under which the CCC will operate, including:

- who will be eligible to enroll;
- covered benefits;
- the method of enrollment and the enrollment timeline;
- requirements and timeframes for participating plans to perform important functions, such as indentifying vulnerable enrollees, performing health risk assessments, form Integrated Care Teams, and develop individual care plans;
- beneficiary protections, including an ombudsman program and requirements for ensuring the continuity of care;
- quality and performance outcome measures that are tied to reimbursement and other monitoring infrastructure;
- savings expectations;
- a partially integrated appeals processes; and,
- other necessary operational details.

In April 2013, DMAS released a request for proposal (RFP) to solicit proposals for health plans to operate in CCC. Proposals were received on May 15, 2013. DMAS is currently in negotiations with plans and is developing, with CMS, a plan to determine readiness for program participation.

Request for CMS regarding the Medicare Medicaid Enrollee Financial Alignment Demonstration: The Department has a signed Memorandum of Understanding and an approved §1932(a) State Plan Amendment with CMS. Additional required authority includes an amendment to the §1915(c) Elderly or Disabled with Consumer Direction Waiver at the time of the next scheduled extension application. CMS and the state are moving forward with this amendment and no additional action is requested at this time.

- *Behavioral Health Services Administrator:* The Department is implementing a new non-risk care coordination model for behavioral health and substance abuse services for eligible Medicaid and FAMIS beneficiaries. A contracted behavioral health services administrator (BHSA) will operate as an ASO and implement and administer this new model for covered services beginning in December 2013. Covered services include non-traditional behavioral health services such as

community-based mental health services (i.e. intensive in-home services, mental health support services). Covered services also include traditional behavioral health services (i.e. inpatient psychiatric hospitalization, outpatient therapy services) for members not enrolled in the Medallion II, CCC or PACE programs. The BHSA contract includes a centralized call center for member and provider assistance, service authorizations, management of the behavioral health provider network, and claim payments.

Request for CMS regarding the Behavioral Health Services Administrator*:* The Department has authority for this implementation; therefore, no action is requested at this time.

- *Foster Care*: Historically, children in foster care have been excluded from managed care for a variety of reasons, including the mobility of the population. But as managed care became operational statewide on July 1, 2012, the ability to provide continuity of coordinated care for somewhat more transient populations, such as children receiving foster care, is now possible.

  Implementation of a foster care pilot in the City of Richmond was completed in SFY 2012. As of May 2013, two hundred and twelve (212) children receiving foster care were enrolled in managed care and receiving additional services, such as a 24-hour nurse hotline, toll-free member helpline, and disease management programs.

  Item 307.DDD of the 2013 Appropriations Act builds on the City of Richmond pilot and authorizes DMAS to expand managed care to children in foster care and adoption assistance on a regional basis. Preparations are underway to expand managed care to the Central, Tidewater and Northern Virginia managed care regions beginning in September 1, 2013, with completion by the end of calendar year 2014. The local Departments of Social Services are identifying children in foster care and adoption assistance via the Medical Management Information System. Training sessions on Medicaid managed care in expansion regions have been conducted for foster care and adoptive parents.

Request for CMS regarding Foster Care*:* The Department has authority for this implementation; therefore, no special action is requested at this time.

- *Enhanced Program Integrity:* DMAS has consistently achieved results while fulfilling its mission to protect the integrity of Virginia's Medicaid program and the health and welfare of its beneficiaries. During FY 2011 and FY 2012, DMAS program integrity efforts identified over $61 million in improper expenditures and prevented the payment of more than $363 million in potential improper expenditures. In addition, the Department expanded fraud identification and prosecution, making 145 referrals of potential fraud, and continually improving coordination with the Office of the Attorney General's Medicaid Fraud Control Unit (MFCU). DMAS also works with contracted MCOs to enhance program integrity within their organizations. In July 2013, the Department amended the Medallion II contract to require provider audits within the MCO networks. The Department also worked with MCOs to determine the circumstances and procedures for suspension of provider payments resulting from audits by DMAS of MCO providers. Lastly, the Department is moving forward on program integrity initiatives that will augment current practices through the use of new contractors and innovative analytical modeling.

Request for CMS regarding Enhanced Program Integrity*:* The Department has authority for this implementation; therefore, no special action is requested at this time.

Phase Two Reforms:

Phase two of the budget language directs the Department to become a quality-driven, rapid responder to innovation. To achieve this, the Department seeks to implement a commercial-like benefit package for Medicaid beneficiaries and establish pre-set parameters through which pilot programs can be developed quickly. These mandates will require a number of authority changes for Virginia. The following discussion of Phase two reforms includes highlights from the budget language and specific requests of CMS.

Moving to a Value-Driven, Commercial-Like Medicaid Program: The Commonwealth has elected not to expand its Medicaid program. If the General Assembly decides to expand eligibility in the future, it will be imperative for the Department to base coverage of the expansion population on a value-driven, commercial-like insurance package. This will better prepare beneficiaries for transition from the Medicaid expansion group to the health insurance Marketplace, and ensure that costs for the expansion will be contained for the state and federal governments.

To mitigate the cost of future growth in the Medicaid program, the Department seeks to align the Medicaid service benefit package with Virginia's selected essential health benefit package. These reforms would initially impact the current Medicaid population, but would have even greater impact with an expansion population, if mandated. Specifically, DMAS hopes to: (1) use incentives and disincentives to that reward the responsible use of the health care system; (2) shape the service benefit package to more closely resemble services that citizens receive through private health insurance; and (3) update payment and reimbursement processes to reward high quality and effective delivery of care. The Department believes it has authority to implement the third option through current §1915(b) waiver authority; however, changes in authority are needed for the first two reforms.

- Incenting the Responsible Use of the Health Care System: The Department seeks the ability to apply maximum allowable cost sharing for certain adults with income over 100% FPL (per §1916A and July 5, 2013, final rules) included in the Medicaid Expansion population, if mandated. The Department also seeks to achieve optimal utilization and deter improper utilization of the delivery system through tools such as issuing prepaid debit cards for copayments of frequently misused services. In this example, at the end of the year, the beneficiary could keep any remaining balance on the debit card that was not used to access care. For this scenario, the Department would need approval from CMS to allow federal matching funds for this use and the ability to exclude the remaining card balance from countable income during a Medicaid eligibility determination.

- Commercial-like Benefits*:* Virginia does not have authority to move forward with an expansion, hence, it is not mandatory that Virginia adopt the Federal Rules on Alternative

Benefit Packages at this time.[6] However, Virginia remains interested in revising the Medallion II MCO and FFS benefit packages to mirror Virginia's Essential Health Benefit package. Although the two benefit packages are very similar, tightening service limits on select services may be required to bring the Medicaid benefits more in line with commercial benefits. The revised Medicaid benefit package, however, would still include community behavioral health services, non-emergency transportation, and the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit for children; despite that these services are not traditionally covered by commercial providers.

- Paying Based on Quality of Care*:* The Department shall move away from fee-for-service toward a payment and reimbursement processes that rewards quality and effective care delivery. A first step toward achieving this directive is the implementation of a quality incentive program with the contracted Medallion II managed care plans that rewards plans for meeting quality targets and withholds a portion of the capitation payment if the plan does not meet the established targets. This program went into effect in July 2013. The FY 2014 contract will establish the baseline targets, and the first withhold will take place in FY 2015.

  The Department is also encouraging health plans to reward direct service providers for meeting quality targets or providing a bundled payment to select providers. Through the Medallion Care System Partnership, a new arrangement with the Medallion II MCOs, plans are financially incented to improve health outcomes by increasing participation in integrated provider health care delivery systems. The goal is to improve health outcomes for Medicaid members through MCO partnerships with providers that are tied to gain and/or risk sharing, performance-based incentives, and achievement of other Commonwealth-approved quality targets.

Request for CMS regarding a Commercial-Like Benefit Package: The Department seeks to obtain approval from CMS, either through waiver authority or 'Secretary Approved Coverage,' as described in the Affordable Care Act, to modify the existing Medicaid benefit structure to more closely resemble a commercial insurance program that citizens purchase through private health insurance. This request will also include approval for a program that uses incentives and disincentives to drive responsible use of the health care system.

- *Rapid-Cycle Implementation of Innovative Pilots:* Due to an unprecedented level of interest in health care and delivery system innovation, in addition to overall system reform, the Department seeks approval to implement smaller pilot programs that test reforms on a rapid-cycle basis. The Department needs the ability to respond to and implement improvements to the program on a rapid basis in order to take advantage of opportunities within the Virginia delivery system. The normal time it takes to implement new programs is anywhere from18-24 months; this timeframe is not feasible when there is significant momentum and federal funding at stake.

[6] Based on rules issued in July for the new adult population; "Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearings and Appeals Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment." CMS-2334-F, Issued on July 5, 2013. Accessed at: https://federalregister.gov/a/2013-16271

The Department seeks to work with CMS to establish a process that allows Virginia to maximize flexibility and expedite the implementation of pilot programs that test models that: (1) leverage innovations and variations in regional delivery systems; (2) link payment and reimbursement to quality and cost containment outcomes; and (3) encourage innovations that improve service quality, coordinate care, and yield cost savings to the Commonwealth. The Department envisions these pilots being tested within the current Medicaid population and an expansion population, if the expansion is mandated by the Governor and legislature.

Specifically, the Department would like to work with CMS to develop static "assurance" parameters that facilitate federal approval for pilot programs that meet these parameters within an expedited 30 – 60 day time frame. The Department would work with CMS to develop assurance parameters that would ensure beneficiary safeguards and guarantee quality, access to providers, and cost effectiveness of each pilot. Potential assurance parameters are included in Figure 6 below. In exchange for meeting the established assurance parameters, the Department would be allowed to waive select sections of the Social Security Act. Potential sections that may require waiver are outlined below.

Innovation pilots that would be eligible for the expedited assurance parameter approval process would generate from several sources. First, the development of these parameters will position the Department to develop and participate in multi-payer pilots. Second, if awarded in Virginia, the Department seeks the ability to test new payment and service delivery models granted through the Center for Medicare and Medicaid Innovation (CMMI). The application process for the Health Care Innovation Award Round Two application is being coordinated by the Virginia Center for Health Innovation (VCHI). If awarded, these pilots would be developed to provide better health, better health care, and lower costs through improved quality for: (1) children with complex medical conditions; (2) at-risk adolescents; (3) high-risk obstetrics patients; (4) adults with behavioral health needs; and (5) adults with complex chronic conditions. Establishing assurance parameters would allow Virginia to be poised and ready to implement any pilots coordinated by VCHI or awarded by CMMI.

Addressing these populations is important for several reasons. The first four populations are major cost drivers for Virginia's Medicaid and CHIP programs. The fifth group includes uninsured adults and a number of individuals eligible for Medicare and Medicaid, therefore at this time; it is more important to private payers and Medicare. However, if the Governor and Virginia General Assembly elect to expand the Medicaid program, improving care for individuals with complex chronic conditions will become even more critical to Virginia's Medicaid program. New payment models will incent value, incorporate quality metrics, and shared risk, but specifics will vary depending on the population to be served, scope of services provided, and specific providers and health plans engaged in their care.

Lastly, the Department has been approached by several regional health systems that seek to test options beyond traditional health plans including programs: (1) to address the specific needs of "super utilizers," (2) leverage tight, high performing provider networks, and (3) expand telehealth to a wide range of providers and specialists in both urban and rural areas.

Figure 6 – Potential Assurance Parameters

CMS and DMAS Assurance	Parameter	Description
Beneficiary Safeguards	Stakeholder Engagement	Structure for engaging stakeholders regularly in the development and implementation of new programs.
	Outreach and Marketing	Pilots must adhere to all existing Medallion II limitations on marketing and outreach.
	Appeals	Participants in pilots must be allowed to appeal denied services simultaneously to both the pilot program and through the DMAS beneficiary appeals process.
	Beneficiary Safety	Sentinel events must be reported
	Continuity of Care	Beneficiaries continue to have access to medically necessary items, services, prescription drugs, and medical, behavioral health and any LTSS providers during the pilot enrollment transition period.
	Enrollment assistance and options counseling	Beneficiaries will be provided enrollment assistance and options counseling to help them make a decision about whether enrolling in the pilot would best meet their needs.
	Person-Centered care	Covered benefits are provided to Beneficiaries in a manner that is sensitive to the Beneficiary's functional and cognitive needs, language and culture, allows for involvement of the beneficiary and caregivers (if applicable), and is in a care setting appropriate to the beneficiary's needs and preferences.
	Beneficiary Communications	Materials will be required to be accessible and understandable to beneficiaries and their caregivers.
	Beneficiary Participation on Governing and Advisory Boards	Pilots must establish an independent beneficiary advisory committee and a process for that committee to provide input to the governing board.
Amount, Duration, and Scope of Services	Enhanced benefits	Pilots may offer different value added services, enhanced coordination, or other cost-effective alternative benefits that are not provided to all Medicaid beneficiaries; however, pilots will not be allowed to offer services that are less than what are provided through contracted MCOs.

Freedom of Choice	Limited Provider Networks	Network Adequacy: Pilots may use PACE network adequacy standards as the basis for limited provider networks. Access Standards: Distance: At least one provider for primary care and the 5 most prevalent specialties within 30 minutes drive time in urban areas and 60 minutes drive time in rural areas. Wait: No more than 1 month wait for specialty visits. No more than 2 weeks wait for non-urgent primary care visits. Emergency: out of network emergency services must be covered
Quality	All pilots will track and report all Core Quality Measures and identify and track 3 population-specific quality measures. The Department will also explore requiring quality measures that will be included in health plans participating in the Federally Facilitated Marketplace. All pilots must include a quality improvement program.	**1. Core Quality Measures** **Examples may include:** 1. All-cause hospital readmissions (NCQA/HEDIS) 2. Medication Reconciliation After Discharge from Inpatient Facility (NCQA/HEDIS) 3. Controlling blood pressure (NCQA/HEDIS) 4. Getting Appointments and Care Quickly (AHRQ/CAHPS) 5. Access to Primary Care Doctor Visits (HEDIS) 6. Follow-up After Hospitalization for Mental Illness (NCQA/HEDIS) **2. Population-Specific Quality Measures:** To be established for several targeted populations for example, measures for pregnant women and children: 1. Smoking cessation rates (and drugs) 2. Earlier access to prenatal care (second trimester) 3. Birth weight 4. Preterm delivery
Cost Effectiveness	All pilots will be developed with an expectation of cost savings, compared to what would have been spent without the program.	All pilots will be expected to achieve at least 2% overall cost savings (trended and adjusted from the base period) for the focus population by the end of the demonstration period.
Length of Pilot	Maximum length of pilots	Pilots will have a maximum length of 48 months
Evaluation	All pilots must include a plan for an external, independent evaluation.	Evaluation must include: • Quality outcomes • Cost effectiveness • Beneficiary safeguards • Beneficiary satisfaction Plans for the evaluation must be approved by the Department.
Payment	Allowable payment strategies	Risk-Based and bundled payments will be allowed.

Projects such as the ones discussed in this section do not meet all of the assurances typically required by CMS. In order to implement the pilots described above, and other pilots that Virginia

may wish to consider DMAS would need a waiver of certain sections of Title XIX of the Social Security Act. The following sections of act that may need to be waived, and the reasons why a waiver would be required to implement the pilots follow.

Potential Waiver Requests for Innovation Pilot Programs

A. Statewideness/Uniformity Section 1902(a)(1) 42 CFR 431.50

a. To the extent necessary to allow for enhanced services in specific regions of the state in order to test whether value added services, enhanced coordination, or cost-effective alternative benefits to beneficiaries results in improved quality and cost savings.

B. Amount, Duration and Scope of Services Section 1902(a)(10)(B) 42 CFR 400 Subpart B

a. To the extent necessary to enable the Commonwealth to permit managed care plans to offer different value added services, enhanced coordination, or cost-effective alternative benefits to beneficiaries in Medallion II.
b. To the extent necessary to enable the Commonwealth to contract with select delivery systems to offer different value added services or cost-effective alternative benefits to enrollees not participating in Medallion II.

C. Member Rewards Section 1902(a)(10)(C)(i)

a. To the extent necessary to enable the Commonwealth to exclude funds provided through member reward programs from income and resource tests established under State and Federal law for purposes of establishing Medicaid eligibility.

D. Freedom of Choice Section 1902(a)(23) 42 CFR 431.51

a. To enable the Commonwealth to require participants to receive benefits through certain providers.

E. Cost Sharing Sections 1902(a)(14) and 1916 42 CFR 447.51-447.56

a. To permit the Commonwealth to impose a copayment for non-emergency use of the emergency room on populations with household incomes above 100% of the federal poverty level that is in excess of the amount permitted pursuant to section 1916A of the Act.
b. To explore waiving cost sharing requirements on existing adult populations when the end result is no out of pocket payments

Request for CMS regarding Rapid-Cycle Innovation Pilots: The Department seeks to obtain approval from CMS via an §1115 waiver, or other suggested authority, to implement pilots on an expedited basis. DMAS would like to establish assurance parameters and then have the ability to provide an explanation of the proposed pilot to CMS and show how it meets the pre-established assurance parameters. If the pilot meets the parameters as determined through an expedited review process, then CMS would advance approval of the pilot so that it can be implemented within months – instead of the years that it often takes to obtain approval for a pilot program.

Phase Three Reforms: Coordination of Long-Term Services and Supports

Developing a coordinated delivery system for Virginia's long-term services and supports is a top priority for the Commonwealth. ***Significant and ongoing stakeholder work will be necessary to ensure that this***

reform effectively meets the needs of beneficiaries, their support systems, and providers. These reforms include:

- Implementation of the Commonwealth Coordinated Care Program (Virginia's Medicare-Medicaid Enrollee Demonstration);
- Reform and consolidation of the §1915(c) waivers for individuals with Intellectual and Developmental Disabilities;
- Transitioning HCBS Waiver enrollees into managed care for their medical services; and subsequently, over time, transitioning all HCBS Waiver and LTSS facility-based services into a coordinated delivery system (that would include medical, behavioral health, and LTSS).

The Commonwealth also seeks to develop PACE-like programs for individuals with ID/DD so that they can receive coordinated care with the additional benefit of congregate daytime activities. Figure 7 below outlines the implementation phases of this effort.

Further, the Commonwealth seeks to expand funding and coverage for transition and housing services for individuals transitioning into the community from state facilities (per the Department of Justice settlement) and nursing facilities. The Commonwealth also seeks flexibility to offer home modifications *prior* to individuals leaving facilities; enhanced funding could build on services covered by the Money Follows the Person (MFP) program and include stipends for housing and coverage of assisted living. MFP is time limited, and federal restrictions on qualified residences (maximum of four beds) do not allow enough flexibility for the state. Many individuals are prohibited from making the transition to the community, due to the fact that transition services and environmental modifications to housing cannot be made *prior* to discharge from a facility.

Figure 7 - Virginia's Timeline for Providing Coordinated Care to All LTSS Participants

Time-frame	Population	Number of Beneficiaries Impacted (as of June 2013)	Services	Description	Geographic Regions
January 2014	**Medicare-Medicaid Enrollees**	78,000	All Medicare and Medicaid medical, behavioral health, and long-term services and supports, including nursing home and services that are provided through the EDCD Waiver	Implementation of the Commonwealth Coordinated Care program. This is part of the CMS Financial Alignment Demonstration. (Coordinated Care Phase I)	Richmond, Tidewater, Northern Virginia, Charlottesville, Roanoke
July 2014	**ID/DD/ Day Support Waiver Enrollees** (only individuals residing the community)	10,162	ID/DD/Day Support1915(c) Waiver Services	Implement redesign of the ID/DD/Day Support HCBS waivers New program will likely (i) transition the program from a diagnosis based model to a needs-based	Statewide

Time-frame	Population	Number of Beneficiaries Impacted (as of June 2013)	Services	Description	Geographic Regions
				program and (ii) expand residential support options Maintain Waiver Services in Fee-For-Services. The current §1915(c) ID waiver renewal is due in July 2014.	
October 2014	**HCBS waiver enrollees**	23,038[7]	Medical services through managed care	All HCBS waiver participants who are not currently enrolled in a coordinated delivery system will move to managed care for their medical services and traditional behavioral health services. Community behavioral health services covered through the BHSA will remain in the BHSA. This will not include nursing home residents.	Statewide
July 2015	**Individuals with ID and DD**	100-400	Program for All Inclusive Care for the Elderly (PACE) sites or PACE-like sites for individuals with Intellectual and Developmental Disabilities	PACE or PACE-like sites as an alternative to waiver participation for individuals with ID/DD	Could focus in regions where training centers are closing: Northern Virginia, Central, Southside, Southeastern, and Southwestern Virginia.
July 2016	• **EDCD** • **Alzheimer's** • **Tech Waiver** • **Nursing home** • **Hospice**	48,298	• Behavioral Health Services • Long-Term Services (Medical services will have	Coordinated Care for LTSS Phase II: Add behavioral health and long-term services and supports for	Statewide

[7] 36,772total waiver enrollment – 10,217 (EDCD that will be in CCC) – 3,517 (ALTC enrollment) = 23,038

Time-frame	Population	Number of Beneficiaries Impacted (as of June 2013)	Services	Description	Geographic Regions
	• **MFP (pending Congressional reauthorization)**		been added in October 2014)	individuals enrolled in the following programs (Medical services were already transitioned into coordinated care) • EDCD • Alzheimer's • Tech Waiver • Nursing home • Hospice • MFP	
July 2016	**ID/DD/Day Support Enrollees**	11,331	Behavioral health, ID/DD/Day Support Services and ICF-IDs* into coordinated care *This does not include moving IMDs (e.g., freestanding psych, residential treatment centers, and state psych hospitals)	Coordinated Care for LTSS Phase III: Move ID/DD/Day Support waiver services from Fee-For-Service into coordinated delivery systems	Statewide
January 2018	**Statewide Commonwealth Coordinated Care expansion**	TBD	All LTSS, medical, and behavioral health services and Medicare Services	Geographically expand the Commonwealth Coordinated Care program for Medicare-Medicaid Enrollees statewide and include coverage for children who are Medicare-Medicaid enrollees (pending Congressional authorization of the CMS Financial Alignment Demonstration)	Statewide

Request for CMS regarding Long-Term Services and Supports Reforms: The Department and CMS need to determine the most expeditious way of obtaining authority for the Phase 3 reforms. The Department would like to mandatorily enroll individuals into the new coordinated system of care.

Next Steps for Virginia

Virginia seeks to work with CMS over the next several months to develop a plan for obtaining authority for the reforms included herein and have a plan developed by mid-fall, in preparation for the upcoming

legislative session beginning in January 2014. The Department looks forward to continued input from stakeholders about this plan and throughout this process.