



Commonwealth Coordinated Care
Medicare & Medicaid working together for you

The Beneficiary Experience – June 2016

By Gerald A. Craver, PhD

Virginia Department of Medical Assistance Services

600 East Broad Street

Richmond, VA 23219 • (804) 786-7933 • <http://www.dmas.virginia.gov/>

IN BRIEF

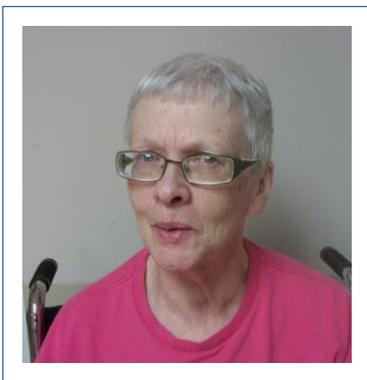
As part of the ongoing review of the CCC Program, evaluation staff are observing care management activities and conducting interviews with individuals, providers, and care coordinators to better understand what the program looks and feels like from the perspective of individuals who are directly involved in it. This brief document is the third in a series of short case studies that examine the CCC Program from such perspectives. Collectively, these case studies suggest that CCC care coordination activities are improving individuals' quality of care, quality of life, and satisfaction.

Coral's Story

Coral is 71 years old and has lived in a nursing facility since 2013 when she suffered a massive stroke that left her severely impaired.^{1,2,3} Prior to that, she was fully independent, worked for a local community service organization, and was fluent in five languages. Because Coral receives both Medicare and Medicaid benefits, she was passively enrolled with Humana in the Commonwealth Coordinated Care (CCC) Program in October 2014.⁴ Like many individuals who receive these benefits, Coral received care through the traditional fee-for-service (FFS) Medicare and Medicaid programs prior to enrolling in CCC. While traditional programs have existed for several decades, the care that individuals receive through them is often fragmented and uncoordinated.⁵

The CCC Program is intended to address these issues by combining and coordinating individuals' Medicare and Medicaid benefits through a managed care delivery system. Once enrolled, individuals are assigned to a care coordinator (usually a nurse) who is responsible for coordinating services that meet their health and social needs.⁶ To accomplish this, the coordinators perform various activities including assessing individuals to identify gaps in care and developing care plans that address their needs and preferences; building relationships with individuals and advocating for their rights; facilitating communication among providers and between individuals and providers; and helping individuals and providers adjust to a new managed care environment.⁷ Through these activities, coordinators can improve quality of care and life for individuals while also helping them to become more involved in directing their own care.

Soon after enrolling in the CCC Program, Coral met Jennifer, her Humana care coordinator, at the nursing facility where she resides. Because Coral's power of attorney (POA) receives her mail, she wasn't aware of being passively enrolled in CCC. According to Jennifer, "I came [to her room]...and said, you've been enrolled, and she said I don't know anything about it...so I explained the [CCC] program [and] told her that she needed an extra advocate...I said you need somebody else to help fight for you...and she agreed to give it a shot..." While at the nursing facility, Jennifer introduced herself to Chelle (short for Michelle), one of the facility's unit nurse managers, and told her that they would be working together to coordinate Coral's care. During the conversation, she also mentioned that Coral had



Coral, an individual receiving both Medicare and Medicaid benefits, resides in a nursing facility and has participated with Humana in the CCC Program for over a year.

access to dental coverage and other benefits not covered under FFS Medicare and Medicaid.⁸ After hearing this, Chelle said Coral had several teeth that were bothering her, so Jennifer arranged for Coral to visit a dentist in Humana's CCC provider network.⁹ Jennifer said "...I let [Chelle] know about the extra benefits which we've used...it's a good thing." Chelle agreed, "Yes it is...it's a good thing...those were benefits [Coral] didn't have before..."

Because Coral is in a nursing facility, Jennifer visits her frequently. Sometimes during these visits, Jennifer participates in meetings with Chelle and other staff so they can coordinate Coral's care. Depending on the meeting topic, Coral will participate. For example, when the POA wanted to make changes to Coral's care that didn't reflect her preferences, Jennifer and Chelle convened a meeting to discuss it in more detail. Recalling the meeting, Chelle said "Coral got to hear [the POA's] viewpoint, our viewpoint, and she got to [express] her viewpoint...it was a very productive meeting...Coral's been very clear about maintaining her independence and making her own decisions..." Jennifer agreed, "...it was one of the most productive meetings I've seen for clearing up communication barriers...[the meeting] was important...we're advocating for Coral [and] we made sure the POA understood that Coral gets to make her own decisions....so he understands this now and is okay with her care..." Chelle added that afterwards, "It looked like a weight had been lifted off [Coral's] shoulders...I think she was really nervous about the meeting..." Coral agreed, "I know...I know...thank you...thank you."

A few months later, Coral needed surgery so nursing facility staff referred her to a specialist who in turn referred her to another specialist. After the visits, Chelle submitted an authorization request for the surgical procedure to Humana; however, it was denied so she contacted Jennifer for assistance. Jennifer researched the denial and found out that Humana's referral process was not followed. Jennifer said, "...[staff] didn't understand that the referrals hadn't been made properly...they are used to calling up colleagues and saying, hey can you see this person, they don't understand that there's a process that has to be followed." After learning this, Jennifer worked to get the referrals processed correctly and Chelle resubmitted the request to Humana, which was approved this time. Describing her experience, Chelle said, "Jennifer helped with getting Coral's surgery [processed], she gave me some information and was very informative...we didn't know what had happened...[CCC] is a new program...but now we know the referral process...this will never happen again." Jennifer agreed and said, "...Chelle's been great to work with...it's been a learning opportunity for all of us..."

When asked to describe what it's like to work with a care coordinator in a nursing facility, Chelle said "I know there is one more person that can advocate for [individuals] and that can help me determine what is the best [care] route or the best doctor [for them] who works with Humana CCC...having a care coordinator around helps me figure out what I need to do to get them the best care outside of here." Coral simply said, "I made a new friend...thank you."



Jennifer, a Humana care coordinator (left), with Chelle, a nursing facility nurse manager (right). Jennifer and Chelle work together to coordinate care for Coral.

"I came [to her room]...and said, you've been enrolled, and she said I don't know anything about it...so I explained the [CCC] program [and] told her that she needed an extra advocate...I said you need somebody else to help fight for you...and she agreed to give it a shot..."

- Jennifer (Humana Care Coordinator)

"I know there is one more person that can advocate for [individuals] and that can help me determine what is the best [care] route or the best doctor [for them] who works with Humana CCC...having a care coordinator around helps me figure out what I need to do to get them the best care outside of here."

- Chelle (Nurse Manager)

Endnotes

¹Informed consent was obtained from all participants prior to data collection.

²The information in this case study was collected through approximately two hours of observations and interviews with the participants.

³Due to the stroke, Coral requires assistance with her physical mobility and verbal communication.

⁴Individuals can select which of the three participating health plans (Anthem Healthkeepers, Humana, or Virginia Premier) they want to participate with when enrolling in CCC, based on the health plan's availability in their locality.

⁵Meyer, H. (2012). The coming experiments in integrating and coordinating care for 'dual eligibles'. *Health Affairs*, 31(6): 1151-1155.

⁶*Virginia Commonwealth Coordinated Care Program Memorandum of Understanding*. (2013). Available at http://www.dmas.virginia.gov/Content_atchs/altc/altc-icp10.pdf.

⁷The CCC evaluation team identified these activities by observing care management activities.

⁸Depending on which health plan beneficiaries enroll with, they have access to additional benefits such as eye exams/glasses, hearing exams/aids, dental services, over-the-counter pharmacy supplies, and meal assistance.

⁹During one interview, a nursing facility social worker reported that it can be difficult for nursing facilities to obtain dental care for residents.

CCC PROGRAM AND EVALUATION OVERVIEW

On March 1, 2014, the Virginia Department of Medical Assistance Services (DMAS) implemented the CCC Program in select regions across the state to improve care for individuals receiving full Medicare and Medicaid benefits. These individuals often have substantial acute, primary, behavioral, chronic, and LTSS needs. While they have access to a range of services, most are not coordinated because they are provided through fragmented fee-for-service programs. CCC seeks to improve care for individuals by coordinating the delivery of all health and social services they are eligible to receive under a managed care delivery system. Because CCC represents a new care delivery model, DMAS partnered with George Mason University to evaluate it by forming a team composed of agency staff and faculty. The evaluation team is conducting a longitudinal mixed-method evaluation to examine the effects of the CCC Program over time from multiple perspectives. For additional information, please contact Gerald Craver at gerald.craver@dmas.virginia.gov or see http://www.dmas.virginia.gov/Content_pgs/ccc-eval.aspx.