



Commonwealth Coordinated Care
Medicare & Medicaid working together for you

The Beneficiary Experience – January 2016

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IN BRIEF

Because the Commonwealth Coordinated Care (CCC) Program represents a new service delivery model, evaluation staff are observing care management activities and conducting interviews with CCC beneficiaries and providers to better understand the experiences and perspectives of consumers. This case study briefly presents the experiences of one CCC enrollee, her service coordinator, service facilitator and community services board (CSB) case manager. Information presented in the case study suggests that the CCC program helps to improve beneficiary quality of care, quality of life and satisfaction.

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- Judy (CCC Beneficiary)

Judy's Story

Judy is 56 years old and has several chronic conditions and physical limitations. She lives in the community and receives Medicaid long-term services and supports (LTSS) through Virginia's Elderly or Disabled with Consumer Direction (EDCD) Waiver, and behavioral health care services through a local community services board (CSB).^{1,2}

Prior to October 2014, Judy received health care services through the Medicare and Medicaid fee-for-service programs, where care is often fragmented and uncoordinated. Recalling her experiences, Judy said, "...I don't recall having people [I] could talk to about things, you know...the service facilitators I had weren't that good...they would come here to get [me] to sign a piece of paper and [then] go out the door...I was going through a really rough time...my leg was infected...I was trying to get a knee [joint replacement]...and the doctors weren't doing much for me." As a result, Judy was ready for a change when she received a letter about the Commonwealth Coordinated Care (CCC) Program, a state initiative designed to improve care for dual eligible beneficiaries by combining their Medicare and Medicaid benefits under a managed care delivery system. "It sounded like something I'd like to try," remarked Judy. However, she was concerned about losing services, so Judy called Anthem Healthkeepers, a CCC health plan, and spoke to a representative who informed her that she wouldn't lose any services.³ Judy said, "the one thing that grabbed my attention was that [the representative] told me right then and there on the phone that we'll take care of you," and after hearing this, she enrolled with Healthkeepers in the CCC Program.⁴

The primary benefit of CCC is care coordination, a collaborative, person-centered process intended to assist beneficiaries with accessing various physical, behavioral and psychosocial services that meet their needs and preferences, while ensuring that information is shared among members of their support networks (e.g., primary and specialty care physicians, other providers, community representatives and family members)⁵. Because dual eligible individuals use services that span the entire health care delivery system, timely communication and team-based care are critical for this

population. Better care coordination can improve quality of care, quality of life and satisfaction by ensuring that the full spectrum of a person's needs are met, decreasing the chance for unfavorable outcomes (e.g., adverse medication interactions, duplicative tests or complicated self-management regimens).⁶

Soon after enrolling in CCC, Jamie (a Healthkeepers' service coordinator) came to Judy's home to conduct a health risk assessment and convene a care team meeting with Jody (a CSB case manager).⁷ Recalling the encounter, Jody said, "I thought it was good...it was very thorough...very much wraparound care...I do mental health and [Jamie] helps with the physical part...so [I thought] it helped meet all of [Judy's] needs..." During the meeting, Jamie learned that Judy was not satisfied with her service facilitator, so Jamie informed her that she could get a new facilitator. Jamie said, "...you have the opportunity to switch...we can find you somebody new...we have options that we can look at." Judy was agreeable so Jamie referred her to Moms in Motion and Marianne became her new service facilitator in the spring of 2015.

Jamie communicates with Judy at least monthly to ensure that her needs are met. During one conversation, Judy expressed interest in getting a blood pressure cuff so Jamie worked with her primary care physician (PCP) to obtain one. During another conversation, Jamie learned that Judy's orthopedic physician was not able to resolve her knee problem so she contacted the specialist and PCP to explore other options. Jamie said, "I reached out to the orthopedist and PCP to see if there was any way to work around it [but]...they can't replace that knee joint...it's a huge frustration for [Judy]...but just having someone that will go behind you and [ask] can we do this helps." Judy agreed, "It does help...[Jamie's] been there for me if I have a problem and it's good to know you've got somebody that's got your back." Judy further added, "I don't think you could ask for a nicer person...[Jamie] goes above and beyond to help people...she makes sure I have what I need...there's options out there that I didn't even know were available that she's helped me with...I think she'd go out of her way for anybody...that's the kind of worker she appears to be."

Jamie also shares information with Marianne and Jody who are key members of Judy's support network. One issue they've worked on is ensuring that Judy has adequate personal care services. Because Judy lives alone and has physical limitations, she's concerned about having to move into a nursing facility if something happens. Jody said, "...going into a nursing facility... would be very detrimental to Judy's mental health...she would deteriorate quickly..." For this reason, Marianne and Jody have shared information with Jamie so she can ensure that Judy receives adequate personal care services at home. Jamie said "...getting input from [Marianne and Jody] assists [me] in making sure [Judy's] in the best health she can be emotionally and physically." Marianne added, "...our job is to go to bat for [Judy] to make sure she gets the services she needs...there's a whole team that comes with [Judy]...she knows that she's got a team that fights for her."



Judy, a CCC beneficiary (sitting) with her care team: Jamie, LTSS service coordinator (center), Marianne, service facilitator (left), and Jody, CSB case manager (right).

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- Jody (CSB Care Manager)"

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When asked how CCC has influenced her quality of care and life, Judy said, “I’m not as anxious about my personal care services as I used to be...my main concern is my health and having enough people who can help me do what I need to do.” Jody agreed, “...I think Judy’s stronger now...more empowered ...she’s going to her [physician] appointments because she knows [Jamie’s] going to be checking up on her so it pushes her to get her medical needs met.” Marianne added, “[Judy’s] more empowered now than she was...I think that’s a tremendous change that I personally have seen in her over the past several months...you know, I’m not often impressed by government activities, but I think [the CCC Program] is one that [DMAS] got right. I think they got it right.”

Judy summed up her experience saying, “I just feel like I have a lot more support than I ever had. I have people now that care about me as a person, not me as a number or just somebody that it’s their job to do this and that. You can tell when a person is really putting their heart into their job or when they’re just doing a job. My experience so far has been outstanding. I couldn’t ask for a better care team and I wouldn’t want to lose them.”

Endnotes

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

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

³CCC health plans must allow beneficiaries to continue receiving all prior authorized services and care from all existing providers (regardless of contract status) with the health plan, for up to 180 days after enrolling in the program. Beneficiaries must also have access to medically necessary services and providers during the entire enrollment process.

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.

⁵*Virginia Commonwealth Coordinated Care Program Memorandum of Understanding*. May, 2013. Available at http://www.dmas.virginia.gov/Content_atchs/altc/altc-icp10.pdf.

⁶Hamblin, A. and Somers, A. *Introduction to Medicaid Care Management Best Practices*, Center for Health Care Strategies, Inc., December 2011. Available at <http://www.chcs.org/resource/introduction-to-medicaid-care-management-best-practices/>.

⁷The health plans have different titles for care coordinators. Anthem Healthkeepers refers to them as LTSS service coordinators, while Humana refers to them as care or transition coordinators. Virginia Premier refers to them as care managers.

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*- Marianne
(service facilitator)*

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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 full benefit Medicare-Medicaid beneficiaries. Known as dual eligibles, these individuals often have substantial acute, behavioral, chronic, primary and LTSS needs. While dual eligibles 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 dual eligibles 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 the program by forming a team composed of agency staff and faculty. The evaluation team is conducting a longitudinal, mixed-methods study 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.