

Commonwealth Coordinated Care
Medicare & Medicaid working together for you

Virginia Advisory Committee*

Creating a Coordinated Delivery System for Medicare-Medicaid Enrollees

July 17, 2014 from 1:00 to 3:00 pm
Conference Room 7A&B, DMAS
600 East Broad Street
Richmond, VA 23219

Meeting 6

I. Welcome and Introductions	Cindi Jones Director, Virginia Department of Medical Assistance Services (DMAS)	1:00 pm
II. National Updates	Lindsay Barnette Technical Director, Medicare- Medicaid Coordination Office CMS	1:10 pm
III. Virginia Updates	Tammy Whitlock Director, Division of Integrated Care and Behavioral Services, DMAS	1:20 pm
IV. Committee Member Focus Session 1: <i>Outreach, Education, Collaboration with VICAP and Ombudsman</i>	Sarah Broughton CCC Outreach & Education Coordinator, DMAS	1:30 pm
V. Committee Member Focus Session 2: <i>Medicare-Medicaid Plans Discuss Care Coordination and Provider Outreach</i>	Representatives from Anthem Healthkeepers, Humana, & Virginia Premier	1:40 pm
VI. Committee Member Focus Session 3: <i>Quality Update</i>	Fuwei Guo, MPH Integrated Care Quality Analyst Office of Coordinated Care, DMAS	2:20pm
VI. Committee Member Focus Session 4: <i>Evaluation Update</i>	Gerald Craver, PhD Senior Research Analyst Policy and Research Division, DMAS	2:35 pm
VII. Wrap Up and Next Steps	Cindi Jones	2:50 pm

*The Department will not hold a public comment period during this meeting; however, stakeholder input is very important to the Department and the Advisory Committee. If you have follow up questions or comments that you would like discussed during a future meeting, please submit them to CCC@dmas.virginia.gov.



Advisory Committee Members

1. Alzheimer's Association (Carter Harrison)
2. Medical Society of Virginia (Mike Jurgensen)
3. Self-Advocate (Joan Manley)
4. State Long Term Care Ombudsman (Joani Latimer)
5. Virginia AARP (Bill Kallio)
6. Virginia Adult Day Services Association (Lory Phillipop)
7. Virginia Association for Home Care and Hospice (Marci Tetterton)
8. Virginia Association of Area Agencies on Aging (Courtney Tierney)
9. Virginia Association of Centers for Independent Living (Maureen Hollowell)
10. Virginia Association of Community Services Boards (Mary Anne Burgeron)
11. Virginia Association of Health Plans (Doug Gray/Laura Lee Viergever)
12. Virginia Health Care Association (Hobart Harvey/Steve Morrisette)
13. Virginia Hospital and Health Care Association (Chris Bailey)
14. Virginia Poverty Law Center (Jill Hanken)
15. Arc of Virginia - Jamie Liban



VIRGINIA UPDATE



Commonwealth Coordinated Care
Medicare & Medicaid working together for you

Tammy Whitlock, Director
Division of Integrated Care & Behavioral Services

Virginia Update for Advisory Committee
July 17, 2014

Overview

- **Enrollment**
- **MAXIMUS**
- **Networks**
- **Systems**



Virginia Enrollment

CCC Enrollments By Plan and Optouts- July 12,2014			
Optins			
MMP NAME	Active	7/1 Passive	Total
VaPremier	380	1950	2330
HealthKeepers	1387	3067	4454
Humana	890	3495	4385
Total Optins	2657	8512	11169
Total Optouts			10217

Virginia Enrollment

CCC Member Participation By Region - July 12, 2014

CCC Region	Active Opt-ins	Opt-outs	Total dual population
Central Virginia	1189	3105	24327
Northern Virginia	170	531	16653
Roanoke	234	615	12771
Tide Water	908	5639	18098
Western/Charlottesville	156	322	6747
Total Members	2657	10212	78597



Virginia Enrollment

PASSIVE Enrollments by Waiver Ind by MMP- July 12, 2014					
MMP	1- ICF	2- SNF	9- EDCD	Other	Grand Total
Va Premier	433	96	1027	4543	6099
Healthkeepers	1015	178	1128	5711	8032
Humana	1179	164	1513	6515	9371
Grand Total	2627	438	3668	16769	23502



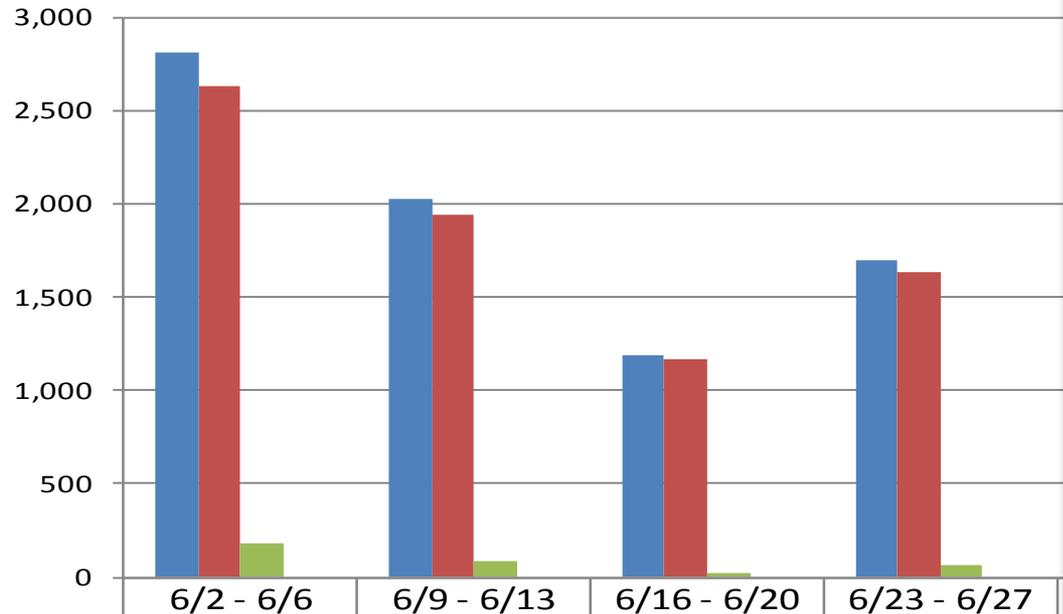
MAXIMUS

MAXIMUS met all contract standards in the month of June. Listed below are the contract standards of promptness;

- Standard - Must answer at least 95 percent of all incoming calls within 3 rings. This standard is achieved by using an Automated Call Distribution System (ACD). Actual: One hundred percent of calls are answered by the ACD within one ring.
- Standard: No more than 3 calls per operator shall be in the queue at any time. Actual: Our Calls in Queue per Operator Report shows that there was no occasion when there was more than three calls in queue per operator for the month of June.
- Standard: The average wait time for an ESR to answer the call is 60 seconds. Actual: In June, the average speed of answer was 60 seconds.
- Standard: The rate of abandoned calls cannot exceed 10 percent in any one week. Actual: The week of June 2nd, the abandonment rate was 6.37 percent. This was the highest weekly abandonment rate in the month of June. The week with the lowest abandonment rate was the week of June 16th. The abandonment rate was 1.93 percent that week.

MAXIMUS

June Weekly Call Volumes and Abandonment Rates



■ Calls Received	2,808	2,025	1,192	1,698
■ Calls Answered	2,629	1,943	1,169	1,630
■ Calls Abandoned	179	82	23	68
Percentage Abandoned	6.37%	4.05%	1.93%	4.00%

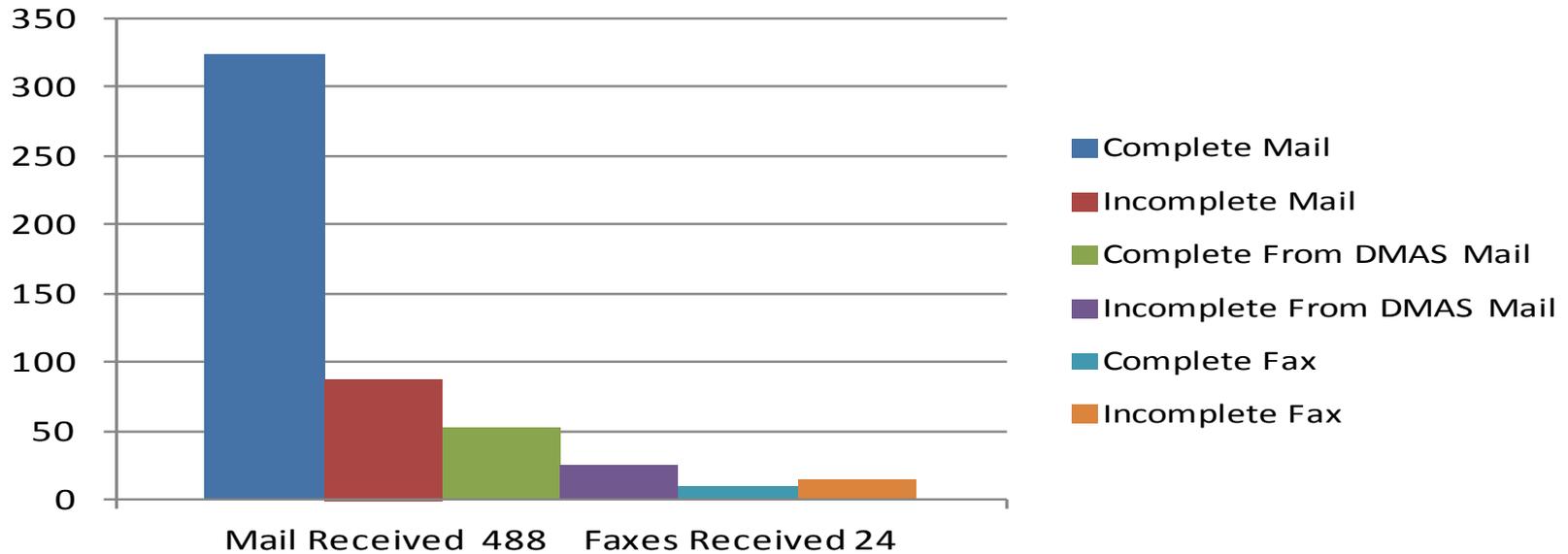
MAXIMUS

June Language line report

	Number of Calls	Percentage
KOREAN	6	26.1%
MANDARIN	5	21.7%
VIETNAMESE	4	17.4%
RUSSIAN	2	8.7%
SPANISH	2	8.7%
FARSI	1	4.3%
HINDI	1	4.3%
MONGOLIAN	1	4.3%
TAGALOG	1	4.3%
	23	100.0%

MAXIMUS

Mail and Fax Activity June 2014



Networks

- Additional localities available in the Central Virginia region
 - HealthKeepers- now passing in Fredericksburg City, Spotsylvania and Stafford
 - VA Premier- now passing in Prince Edward
- NOVA automatic assignment Nov. 1 allows MMPs to continue to expand networks in that area and increase provider diversity and beneficiary choice

Networks

For the remaining counties that will begin getting 60 day letters August 1st (Western and Roanoke regions), the list below will NOT be included in passive assignment at this time as there is only 1 approved MMP;

- Western
 - Harrisonburg City
 - Staunton City
- Roanoke
 - Henry
 - Martinsville City
 - Radford City
 - Wythe

Systems

- Intelligent Assignment
 - System retested before Central VA automatic assignments
- Part D re-enrollment upon discharge is now an automated process
- Working with CMS to continue to automate beneficiary decisions
- Encounter data



Commonwealth Coordinated Care
Medicare & Medicaid working together for you

Outreach Update

CCC Advisory Committee
July 17, 2014

Sarah Broughton
Outreach & Education Coordinator



Provider Involvement

Monday Provider Calls (LTSS)		Friday Provider Calls	
Adult Day Services	1:30-2p Conference Line 866-842-5779 Conference code 7143869205	Hospitals and Medical Practices	11-11:30am Conference Line 866-842-5779 Conference code 8047864114
Personal Care, Home Health & Service Facilitators	2-2:30p Conference Line 866-842-5779 Conference code 8047864114	Behavioral Health	11:30am-12pm Conference Line 866-842-5779 Conference code 8047864114
Nursing Facilities	2:30-3p Conference Line 866-842-5779 Conference code 7143869205		

Ongoing Association Meetings!



Educational Resources

Providers

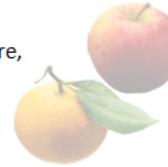
- Provider Resource Guide
- Calls
- Medicaid Memos
- Website

Beneficiaries

- 10 Key Points Guide
- Calls
- Townhalls
- By Request

10 Key Points about Commonwealth Coordinated Care

1 Commonwealth Coordinated Care (CCC) is an enhancement: Medicare & Medicaid were never built to work together, creating gaps and overlaps in your care; therefore, Virginia is offering CCC to blend Medicare and Medicaid. With CCC **you keep your Medicare & Medicaid** benefits with the added benefit of **Care Coordination**.



2 When it comes to your healthcare, **choice** is important. That is why with CCC you are not locked in when you choose a CCC health plan. You can even choose to “opt-out” of CCC completely. There is no “open enrollment.” You can opt-in or change your CCC plan at any time.



3 To qualify for CCC you must be 21 & older and receiving Medicare Parts A, B, & D and receiving FULL Medicaid benefits. In addition to individuals living in the community, CCC is also available to individuals receiving the Elderly & Disabled with Consumer Direction (EDCD) Waiver and those living in nursing facilities. You must live in a CCC region to participate. For a list of CCC localities visit the DMAS website at http://www.dmas.virginia.gov/Content_atchs/altc/altc-anst6.pdf



4 Some individuals are exempt from CCC, including: Individuals receiving any other Home and Community Based Waiver, those receiving hospice, or those with other comprehensive insurance. To find out if you are eligible for CCC, you can contact the enrollment broker, MAXIMUS at 1-855-889-5243.



5 **Care Coordination** is the primary benefit of CCC. If you enroll in CCC, a care manager from your plan will get to know you and work with you to achieve your health goals. The Care Manager will coordinate your appointments and services. There is no cost for this benefit and Care Coordination is currently not available under traditional Medicare and Medicaid benefits.



Link text with image



Department of Medical Assistance Services

Search DMAS Site GO

- Home
- Administration and Business
- Behavioral Health Services
- Client Services
- Commonwealth Coordinated Care
- Learning Network
- Long Term Care & Waiver Services
- Managed Care
- Maternal and Child Health
- Pharmacy Services
- Provider Services
- Service Authorization
- Search Services

INFORMATION FOR MEDICARE AND MEDICAID ENROLEES



INFORMATION LINKS

- ◆ [Commonwealth Coordinated Care Fact Sheet](#)
- ◆ [Commonwealth Coordinated Care Regions](#)
- ◆ [Commonwealth Coordinated Care Enrollment Timeline](#)
- ◆ [Demo Map](#)
- ◆ [FAQs For Enrollees](#)
- ◆ [Initial Opt-In Letter to Beneficiaries](#)
- ◆ [Tidewater 60 Day Letter to Beneficiaries](#)
- ◆ [Tidewater Comparison Chart-English](#)
- ◆ [Central Virginia Comparison Chart-English](#)
- ◆ [Charlottesville Comparison Chart-English](#)
- ◆ [Northern Virginia Comparison Chart-English](#)
- ◆ [Roanoke Comparison Chart-English](#)
- ◆ [Tidewater Comparison Chart-Spanish](#)
- ◆ [Central Virginia Comparison Chart-Spanish](#)
- ◆ [Charlottesville Comparison Chart-Spanish](#)
- ◆ [Northern Virginia Comparison Chart-Spanish](#)
- ◆ [Roanoke Comparison Chart-Spanish](#)
- ◆ [10 Key Points about CCC: Enrollee Townhall Presentation](#)

On the Web:
Beneficiaries



Department of Medical Assistance Services

Search DMAS Site

- Home
- Administration and Business
- Behavioral Health Services
- Client Services
- Commonwealth Coordinated Care
- Learning Network
- Long Term Care & Waiver Services
- Managed Care
- Maternal and Child Health
- Pharmacy Services
- Provider Services
- Service Authorization
- Search Services

INFORMATION FOR SERVICE PROVIDERS



INFORMATION LINKS

- ◆ [Medicaid Memo: Beneficiary Choice in Health Care Decisions](#)
- ◆ [Awarded Plans Contact Information](#)
- ◆ [Service Provider & Comparison Chart](#)
- ◆ [Key Points about CCC: Provider Townhall Presentation](#)
- ◆ [Nursing Facility CCC Authorization Process](#)
- ◆ [Sample CCC Insurance Card](#)
- ◆ [Verifying CCC Enrollment Information](#)
- ◆ [Healthkeepers Provider Quick Reference](#)
- ◆ [Humana Provider Quick Reference](#)
- ◆ [Virginia Premier Provider Quick Reference](#)

UPCOMING EVENTS

- ◆ [Provider Calls](#)
- ◆ [Newport News Provider Townhall Flyer](#)

On the Web:
Providers

**Coming
together is a
beginning;
keeping
together is
progress;
working
together is
success.**

-Henry Ford



Care Coordination



Anthem HealthKeepers
Offered by HealthKeepers, Inc.

Care Coordination

- Each member has a Care Manager who provides “*member-centered*” care management functions to all enrollees.
- Our goals focus to ensure members are educated on available services and community resources and assist in development of self-management skills to effectively access these services while *honoring member choice*.



Functions of the Care Manager

- **Monitors functional and health status and assists in seamless transfer of care across specialties and different level of care settings.**
- **Ensures that health care providers participate in decision making with respect to treatment options.**
- **Connects with services to promote community living in order to prevent premature or unnecessary NF placement.**
- **Coordinates with social service agencies including CSBs, social services, and local health departments**



Care Coordination: Interdisciplinary Care Team (ICT)

- Our team of professionals collaborate, either in person or through other means, with members to develop and implement a plan of care that holistically supports their medical, behavioral, LTSS and social needs.
- ICTs may include physicians, physician's assistants, LTSS providers, nurses, specialists, pharmacists, behavioral health (BH) providers and/or social workers appropriate for the member's medical diagnosis and health condition, comorbidities and community support needs.
- ICTs employ both medical and social models of care.



Humana Gold Plus Integrated, A Commonwealth Coordinated Care Plan

Humana Gold Plus Integrated H3480-001
(Medicare-Medicaid Plan)

Lynn Eggleton
Scott Parker
Dr. PK Gupta

July 17, 2014



Humana

Serving more than 12 million Members across the country, Humana delivers primary care, specialty care and occupational healthcare services through a network of more than 300 wholly owned medical centers and clinics and more than 2,300 contracted providers.

Helping people achieve lifelong well-being

- **Founded in 1961**
- **Long term commitment to serving the frail, elderly, disabled and the chronically ill**
- **5M Medicare Advantage and Part D Members**
- **550K Dually Eligible Medicare-Medicaid Members**
- **18 Years Medicaid Experience**

Humana's Values

- Thrive Together
- Cultivate Uniqueness
- Pioneer Simplicity
- Inspire Health
- Rethink Routine

Humana Beacon Partnership

Humana has partnered with Beacon to provide a fully integrated medical behavioral health model of care for Members in the Commonwealth Coordinated Care (CCC) program featuring :

- A member-centric approach, that positions the Member and supports caregivers as the leaders of the plan of care
- A holistic framework addressing physical, functional, behavioral, cognitive, environmental, financial and social needs
- Access to a multidisciplinary care team
- Flexibility, coordination and individualization of service delivery by telephone and in person
- Connections to community based and LTSS services

A Typical Care Coordination Story

- Member A.S. is a 44 year old CCC member who was identified as SMI through the DMAS Medical Transition File.
- The member has a history of Bipolar II disorder and PTSD as well as painful endometriosis and uncontrolled diabetes.
- The Member is receiving Targeted Case Management (TCM) services through a Community Services Board (CSB).
- The BH care manager facilitated the comprehensive and behavioral health assessment in collaboration with the care team and the TCM from the CSB.
- During this process, the BH care manager discovered several gaps in this Member's medical care, the primary issue being that the Member had not seen her PCP for over 8 months due to transportation issues and a change in the PCP's participation with the Member's prior health plan.
- The Member revealed that she was extremely anxious and in a great deal of pain due to her medical condition and that her plan was to go to the emergency room for care to help deal with her pain because she felt like she had no other options.
- The Member expressed hopelessness related to receiving care for her pain and her ability to get to her medical appointments.

A Typical Care Coordination Story (continued)

- Following the comprehensive medical and behavioral health assessments, the clinician connected the member and the BH care manager to a customer service representative to find a PCP near the member's home.
- The new PCP was able to schedule an appointment to see the member the next day, with transportation arranged by the BH care manager.
- There was excellent coordination and responsiveness from Logisticare.
- The PCP selected is two blocks from the Member's home and in walking distance.
- The Member and her TCM both report the Member is happy with her new doctor and has already kept a follow-up appointment to help her begin to manage her medical conditions.
- The BH care manager will continue to work with the Member's community based TCM as well as the Humana medical care team to ensure her care plan addresses all of her needs and that all available supports are in place.

The Care Management Team

- **Medical Director-** Provides consultative clinical oversight of clinical operations.
- **LTSS Transition Coordinators** – Conducts thorough face-to-face assessment of the Member and develops the Member-centric plan of care initially and with any change in condition.
- **LTSS Care Coordinators** – Responsible for ongoing care management of the Member. Reviews and updates the established Plan of Care, supporting the Member in meeting their goals. Leads the ICT , advocates for the Member. Collaborates with peers on Member’s admissions, transition and discharge planning.
- **CW Care Managers**– Provide care management for the Community Well Members (i.e. non LTSS) telephonically. Conducts assessments, develops the Plan of Care. Leads the ICT , including referrals for a Field Care Manager home visit, when face-to face support is needed.
- **BH Care Managers** – Provide behavioral health care management, as either primary or in a care consultative role for both the LTSS and CW members.

Interdisciplinary Care Team

Coordination and Continuity of Care

The Interdisciplinary Care Team (ICT) supports a holistic, coordinated and individualized Member experience as enrollees move along their life and health continuum



At the center of the ICT model are the persons who serve at the core and most closely interact with one another: the Member and caregiver, the Care Manager and the service providers.

The Interdisciplinary Care Team facilitates coordination of a full range of services and interventions such as:

- **Member education, self care management and informed healthcare decision making/ consumer direction**
- **Access and connections to community resources**
- **Reinforcement and coordination of provider treatment and medication plan(s)**
- **Preventive screenings, chronic condition management and wellness support**
- **Care coordination and care transitions**
- **Appropriate advanced illness and end of life planning**

VA Premier CompleteCare

a Commonwealth Coordinated Care Plan

Virginia Premier CompleteCare (Medicare-Medicaid Plan)
July 17, 2014

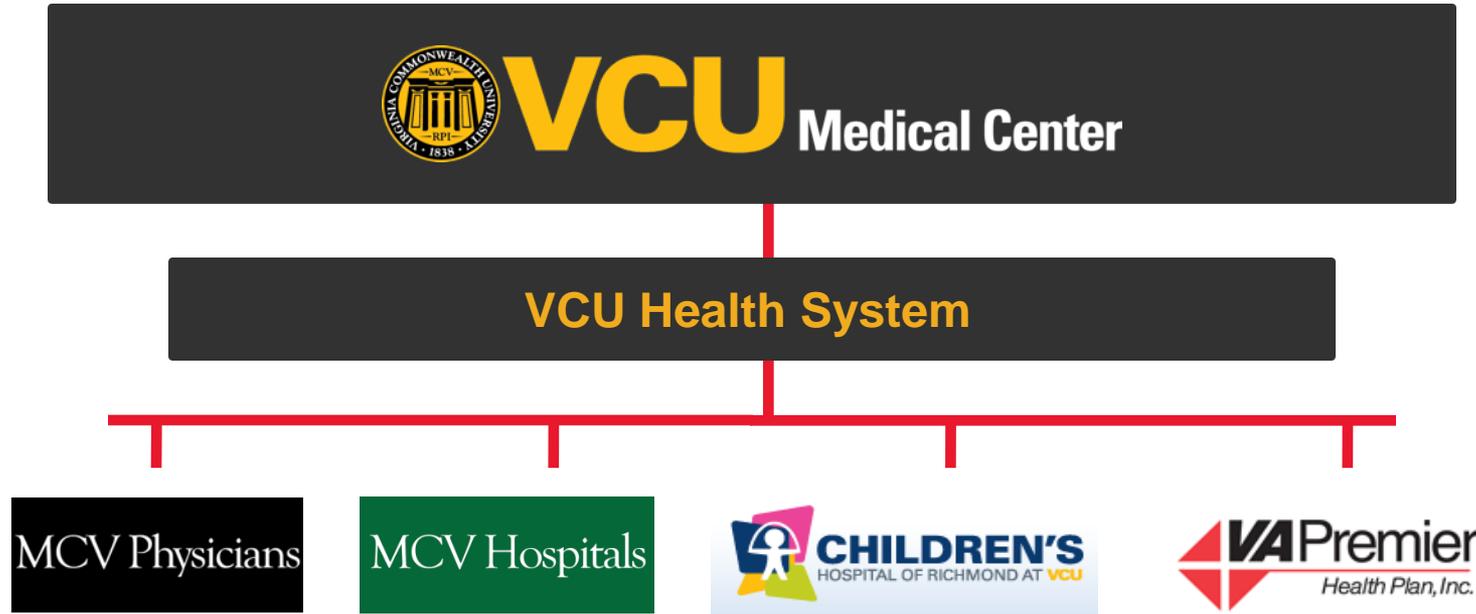
Linda Hines, Vice President Health Services

Rick Gordon, Director Long Term Services & Support

Timothy Hart, Director Claims Operations

Patricia Suffern, Program Manager & CompleteCare Compliance Officer





What Sets Us Apart?

The Basics

- We are the **#1 Medicaid Health Plan** in Virginia for six consecutive years, from **2008 - 2014**.*
- Ranked #38 in 2013 - 2014 by NCQA of Best Medicaid Health Plans in the United States.
- **Not-For-Profit** Health Plan
- Company owned transportation service
- The first and only **university-based** Managed Care Organization in Virginia

** NCQA's Medicaid Health Insurance Plan Rankings, 2013-2014*

Care Management Success

VAPremier
CompleteCare



Care Management Structure

Care Management Teams Per Region

(Tidewater, Central Virginia, Roanoke, Charlottesville)

3-5 Care Management Teams Per Region

(Determined by number of members, geography and composition of membership)

Team Composition

Team Lead – Level III Care Managers

Level III, II & I Care Managers

Patient Care Coordinators, Medical Outreach, Social Workers & Health Educators

Care Management Approach **VA Premier CompleteCare**



Community Well

- HRA completed by Member Engagement Representative
- Level I Care Manager completes POC, ICT and on-going monitoring

EDCD

- Level III Care Manager performs face-face assessment
- Completes POC, ICT and monthly contact

Nursing Facility

- Level II & III Care Manager performs face-face assessment, interacts with Nursing facility staff
- Coordinates POC, ICT with Nursing Facility, quarterly contact

Our Call Centers

Member Services

- 1-855-338-6467

Claims Customer Service

- 1-855-338-6467

Organizational Determinations

- 1-888-251-3063

Provider Services

- 1-855-338-6467

Case Management

- 1-855-338-6467

Engagement & Interaction

- Provider Calls
- Mailings
- Site Visits and Recruitment
- Town Halls
- Association Meetings and Presentations
- Provider In-Services
- Provider Education Meetings
- Weekly Provider DMAS Calls
- MTR Follow Up

- Provider Resource Guides
- Website
 - <https://www.vapremier.com/providers/provider-resources>
 - Provider Services: 1-855-338-6467
- FAQs
- CompleteCare Provider Point of Contact –
 - Rick Gordon, Director of Long Term Services & Support
rgordon@vapremier.com OR 804-819-5151 Ext. 55075
- DMAS Link and Memos
- Training Sessions – Now a coordinated effort on the part of all 3 MMPs, Same Day, Same Location
- CCC Training- Learning Management System, Providers Login With NPI to Complete Required Training
- LTSS In-Services

How do We Reach Non-Par Providers?

- DMAS Medical Transition Report
 - Used To Identify Non Par Providers
 - Triggers Two Mechanisms For Outreach
 - Medical Management (Care Managers) – Provide Authorizations and Explain 180 Day Continuity of Care
 - Network Development – Reach out to discuss CCC, Requirements for Claims and Reimbursement, Provide contracts for review and consideration
- Non- Par Education and Outreach
 - Once identified, we utilize all means previously mentioned to communicate valuable information

- **3 Ways To submit Claims**
 - **Provider Portal** – API/NPI Direct Data Entry
 - <https://www.payertransactions.com/vpcc>
 - **Clearinghouses**
 - Partnering with two of the largest clearinghouses in the industry
Availity and RelayHealth
 - **Paper Claims** – Claims Created Electronically and Dropped to Paper
- **Claims Paid to Contracted (PAR) & Non-Contracted (Non Par)**
 - At a minimum we need a W-9 on file to pay Non-Par Claims
 - We use the MTR and the Authorizations Process to Identify Non-Par Providers and communicate requirements via letter

- Our Claims Department is committed to providing you with the highest level of service possible. Our goal is to pay claims appropriately and timely to ensure that your claims billing & payment experience is a success.
- Providers can submit claims using the following options:
 - Submission via the Provider portal.
 - Electronic Claims Submission (EDI) Submission
 - Paper claims submission

So....How are we doing so far?

Claims Average Days To Payment

Total Claims Paid: 551

**Average Turn
Around Time (Days)**

Behavioral Health Medicaid Claims	3.80
Long Term Care Claims	6.69
Nursing Facility Claims	6.50
Outpatient Facility Claims	12.08
Inpatient Facility Claims	14.00
Professional Claims	7.02
Year To Date	7.22

Provider Claims Support

Our Customer Service Team is available to assist you with any claims related issue you may be having.

Please call us at (1) 855 338-6467

CCC Quality Updates

- ▶ CCC Quality Main Components
- ▶ CCC Key Quality Updates

CCC Advisory Committee
July 17, 2014

Fuwei Guo, MPH
Integrated Care Quality Analyst

Quality Definition

“Quality is the degree to which health services for the individuals and population increase the likelihood of desired health outcomes and are consistent with the current professional knowledge.”

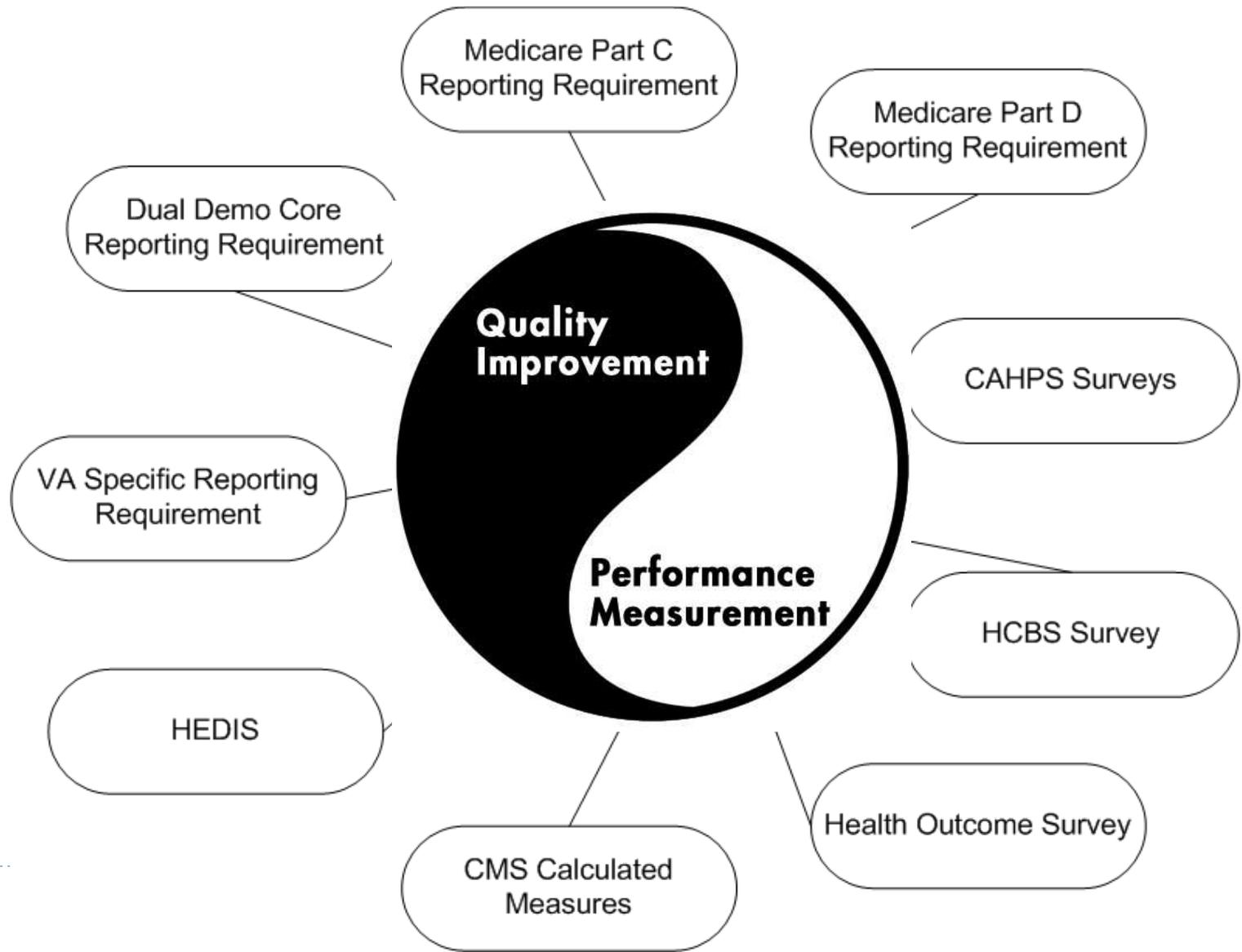
-----Institute of Medicine (IOM)

Quality Statement

Quality Statement (Vision)

“To ensure that Medicare-Medicaid Enrollees enrolled in CCC receive efficient, high quality person-centered care and services every time.”

Quality Measure and Improvement



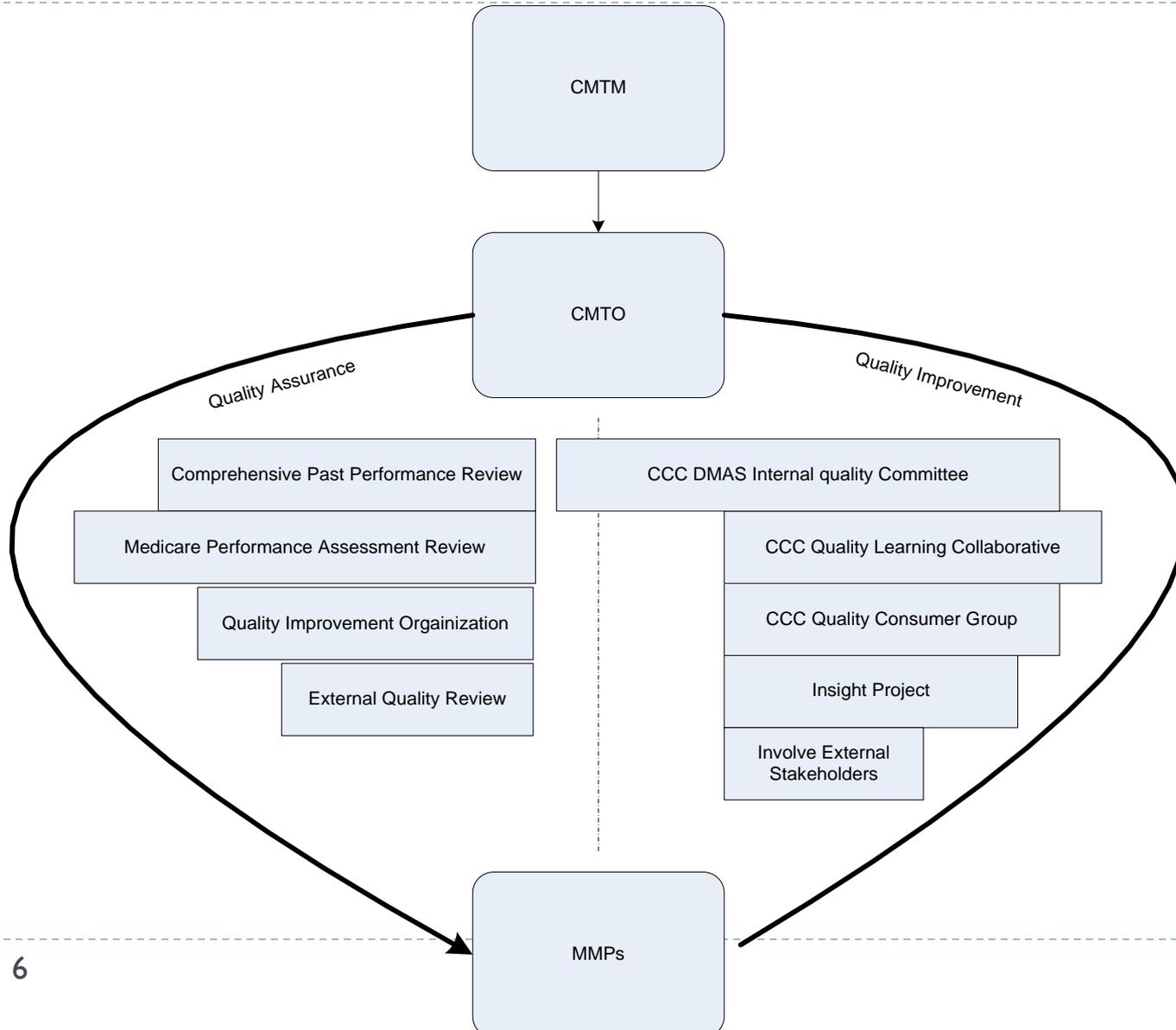
Quality Infrastructure

Our approach:

Blend Medicare and Medicaid quality addressing both quality assurances and quality improvement.

	<i>Quality Assurance</i>	<i>Quality Improvement</i>
Motivation	Measuring compliance with standards	Continuously improving processes
Attitude	Required, defensive	Chosen, proactive
Focus	Outliers: “ <i>bad apples</i> ” Individuals	Processes Systems
Responsibility	Few	All

Quality Infrastructure



Key CCC Quality Updates

- ▶ Created CCC Quality Infrastructure
- ▶ QM Strategy Development Plan and CY2014 QM Plan
- ▶ Reporting Requirements and Withhold Methodology
- ▶ Monthly MMP quality monitoring meeting
- ▶ EQRO scope and PI requirements
- ▶ Future CCC Quality Learning Collaborative



Commonwealth Coordinated Care Program Evaluation Update

Stakeholder Advisory Committee
July 17, 2014

Gerald A. Craver, PhD



Overview

- **Evaluation Advisory Committee**
- **Evaluation Scope Update**
- **Major Evaluation Activities**
- **Center for Culturally Responsive Evaluation and Assessment**
- **Next Steps**
- **Questions, Comments, or Concerns**

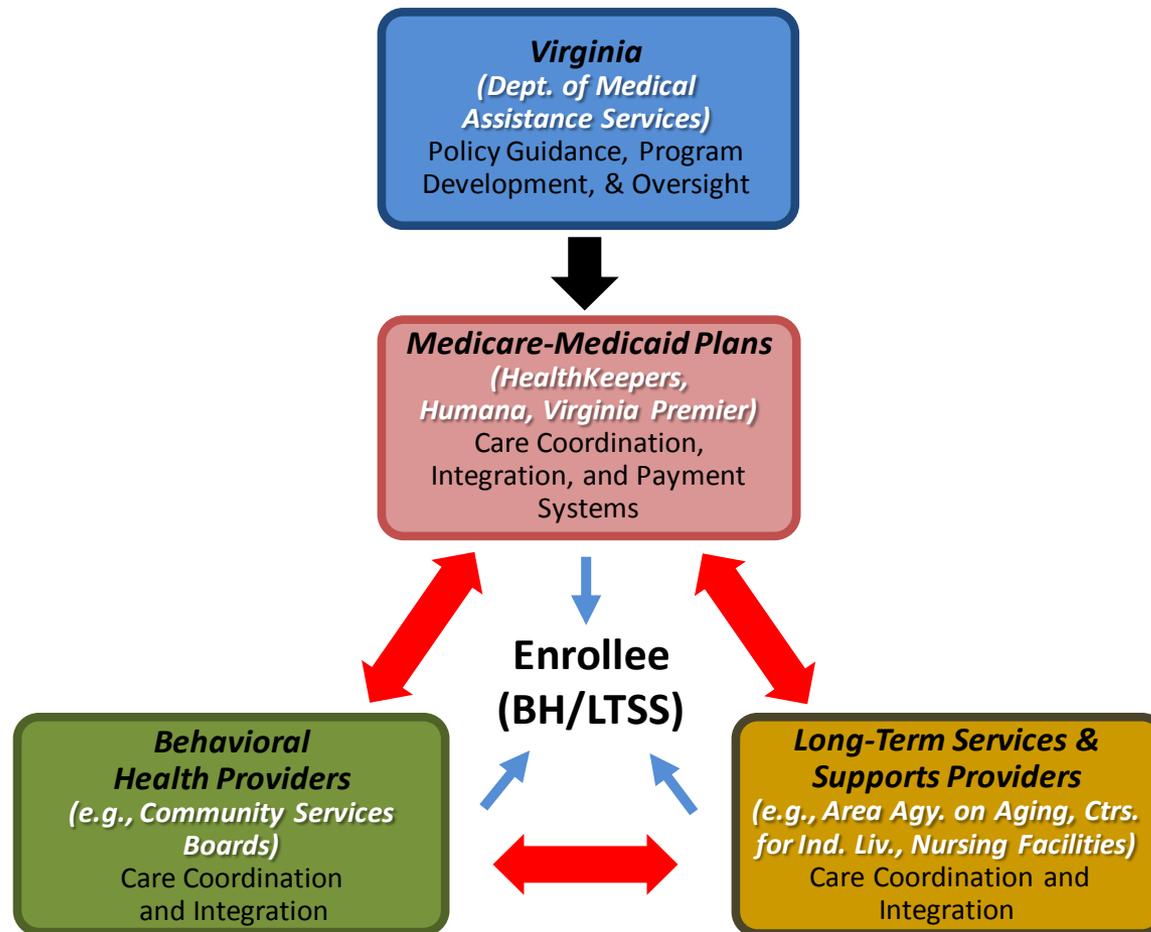


Evaluation Advisory Committee Update

- Committee consists of 12 members representing the aging, physical disability, nursing facility, ID/DD, hospital, and health plan communities
 - Currently, no enrollee representation
- Met May 22 to review drafts of the first evaluation report and enrollee survey questionnaire
 - Feedback was provided on improving the report and questionnaire



Evaluation Scope Update





Major Evaluation Activities To Date

- DMAS/Mason biweekly team meetings
- Interviews (DMAS, Providers, MMPs), site visits (AAA, AD, CSB, Townhalls), and observations (MMP Care Management Activities) to collect data and develop in-depth understanding of the CCC Program
- Enrollee Survey Questionnaire and First Evaluation Report
- Evaluation website:
http://www.dmas.virginia.gov/Content_pgs/ccc-eval.aspx



Enrollee Focus Groups

- Planning a series of focus groups to learn about enrollee care and service experiences leading up to the CCC Program and experiences during the enrollment process
 - VACIL: Fredericksburg, Hampton, Norfolk, Richmond, and Manassas (TBD)
 - VACSB: Locations (TBD)
- MMPs will sponsor focus groups (e.g., transportation, interpreter services)



Care Management (CM) Case Study

- In June, staff observed an EDCD enrollee's visit to a gastroenterology office. The enrollee was accompanied by her care manager (CM) and personal care assistant. Upon arrival, the enrollee was informed that her PCP had not submitted a referral. The CM contacted the PCP for a referral so the enrollee could see the specialist. Afterwards, the CM reported that if she had not been present, the enrollee most likely would not have met with the specialist. She said events such as these discourage people from receiving medical care.*



CM Case Study (Continued)

- *The CM also reported that the PCP had changed some of the enrollee's prescriptions, which the specialist was not aware of. As a result, the CM provided the specialist with a new list of prescriptions. The CM said information exchange between physicians is important because it "prevents people from having 50 different meds."*



Notes from the Field Overview

- Purpose is to serve as a formal record of data collection activities and findings, and to promote transparency in the evaluation process through wide dissemination
- Objective is to describe and understand CCC Program and assess its effect on enrollees and various program outcomes through a series of short reports
- Content and format are flexible and will change to meet the needs of various stakeholders



CCC Enrollee Telephone Survey Overview

- Survey CCC enrollees who are also EDCD Waiver participants and receiving consumer-directed or agency-directed personal care services
 - Administered as a 30 minute telephone survey approximately six months after enrollment
- Questions cover medical care, personal care, demographics, and health status
 - Includes questions from existing surveys and look-back questions to compare to previous experience



Center for Culturally Responsive Evaluation and Assessment (CREA)/University of Illinois at Urbana-Champaign

- CREA promotes social policy making through program evaluations that are not only methodologically rigorous but also culturally and contextually defensible
- Annual Conference, Sept. 18 – 20, 2014
 - *Evaluating the Commonwealth Coordinated Care Program: Virginia Medicaid's Approach to Culturally Responsive Evaluation*
accepted for presentation
 - September 19 at 3:45 pm (CST)



Next Steps

- Complete 2nd *Notes from the Field* focusing on describing/assessing DMAS' implementation of the CCC Program
- Work with VACIL and VACSB to develop criteria/processes for conducting enrollee focus groups
- Work with MMPs to plan interviews/observations of care management staff and activities (with particular emphasis on HRAs and ICTs)
- Begin quarterly data submission to RTI (August) and host site visit (September)



Questions, Comments, or Concerns

- What are your questions, comments, or concerns?
- For more information on the evaluation, please contact Gerald Craver (gerald.craver@dmas.virginia.gov)
- ***THANK YOU!!!***