



Notes from the Field – March 2015

On March 1, 2014, the Virginia Department of Medical Assistance Services (DMAS) implemented the Commonwealth Coordinated Care (CCC) Program, a capitated four-year financial alignment demonstration authorized under the Affordable Care Act, to improve care for Medicare-Medicaid beneficiaries. Known as dual eligibles, these individuals often have substantial acute, behavioral, chronic, primary, and long-term service and support (LTSS) needs. While dual eligibles have access to a range of services, most benefits are uncoordinated because they are provided through fragmented fee-for-service (FFS) programs. The lack of coordination is further complicated because the Medicare and Medicaid programs operate independently of each another, resulting in conflicting coverage and payment policies. By hindering care coordination efforts, this environment promotes unnecessarily high costs and poor patient care and satisfaction.

The CCC Program seeks to address these issues by coordinating the delivery of all health and social services for dual eligibles under a managed care delivery system. Because the CCC Program represents a new care delivery model in Virginia, DMAS partnered with George Mason University (Mason) to evaluate the program by forming a team composed of agency staff and Mason faculty. (The members of the evaluation team are listed in Appendix A.)¹ To assess the overall impact of the CCC Program on various cost, quality, and utilization outcomes over time, the DMAS/Mason evaluation team structured its activities around examining CCC implementation at the state-level; care coordination and payment systems at the Medicare-Medicaid Plan (MMP) level; and demographic, enrollment, and satisfaction patterns at the enrollee level. The main focal areas of the evaluation are presented in Figure 1.

As part of its activities, the DMAS/Mason evaluation team is providing agency management and other stakeholders with periodic updates on the program's performance through a series of short reports. The present report represents the second in the series and examines Virginia's early implementation of the CCC Program. The document also includes an update on the evaluation team's current activities and concludes with a summary of key findings.²

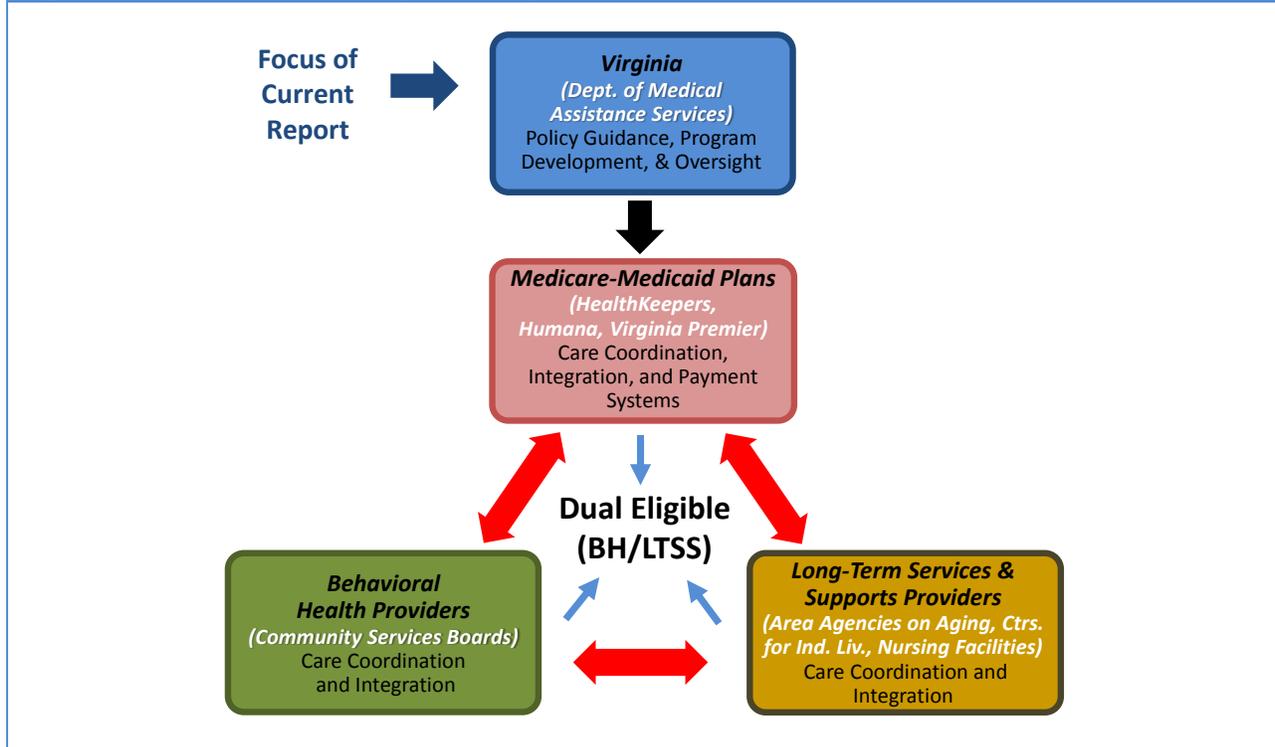
Virginia's Implementation of the CCC Program (CY 2011 – CY 2014)

Successfully implementing financial alignment demonstrations requires states to engage in a substantial amount of designing and planning activities. This report reviews the major activities that DMAS performed to implement the CCC Program as well as some of the agency's main implementation successes that were achieved during Calendar Year (CY) 2014. Because Medicare and Medicaid are

¹ In addition, DMAS formed an advisory committee to assist the evaluation team with understanding the unique needs and concerns of the various organizations and dual eligible subpopulations involved in the CCC Program. The advisory committee members are listed in Appendix B.

² The first report along with additional information on the evaluation is available online at: www.dmas.virginia.gov/Content_pgs/ccc-eval.aspx.

Figure 1. CCC Evaluation Scope and Report Focus



governed by distinct sets of policies and procedures, states can still encounter various challenges that complicate implementation even after carefully preparing for the demonstrations. As a result, this report also reviews the challenges that DMAS encountered during the program’s first operational year and the strategies that were used for overcoming them. Because care coordination is a hallmark of the CCC Program, several short case studies are also included illustrating the delivery of this service.

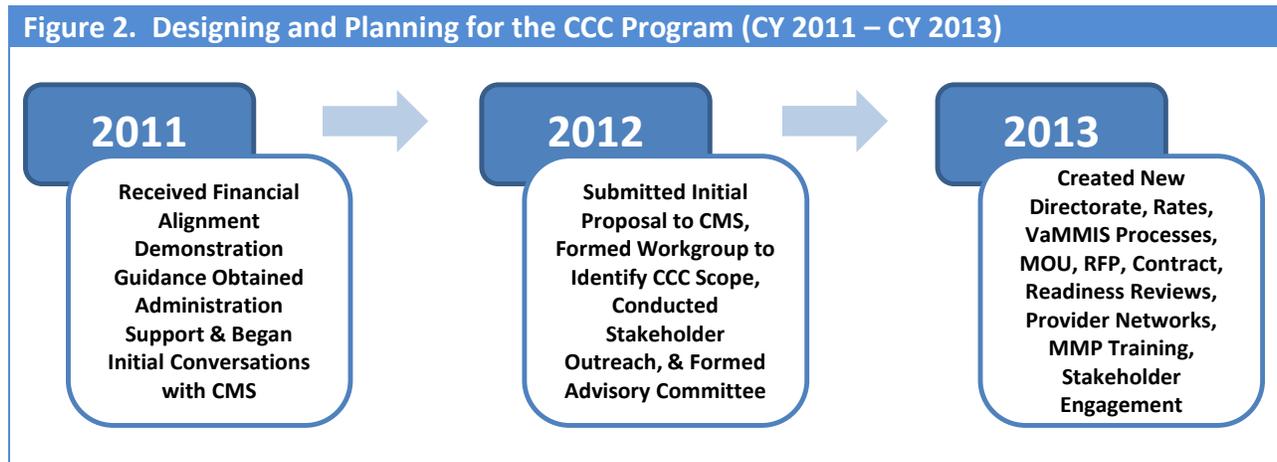
Designing and Planning for the CCC Program (CY 2011 to CY 2013). Initial work on the CCC Program began when the Centers for Medicare and Medicaid Services (CMS) issued preliminary guidance on the Medicare-Medicaid financial alignment demonstration project in July 2011. The guidance outlined two payment and service delivery models that CMS intended to test and directed interested states to submit letters of intent by October 1, 2011 in order to implement their demonstrations by the end of 2012.³ DMAS was well positioned to test the capitated financial alignment model having implemented managed care in the mid-1990s and several limited care coordination/integration programs in the mid-

³ The financial alignment demonstrations are intended to test two new payment and service delivery models for full benefit Medicare-Medicaid beneficiaries: capitation and managed FFS. Under the first model, CMS and the states contract with health plans to coordinate and improve patient care for beneficiaries, while under the second model, states use their existing FFS infrastructures to provide beneficiaries with enhanced care management services.



2000s (e.g., the Program for All Inclusive Care for the Elderly and the Acute and Long-Term Care Program). After determining which model it planned to implement, DMAS obtained state administration support and submitted its letter of intent to CMS by the deadline.

After submitting its letter of intent, DMAS was directed to develop a proposal by June 2012 outlining its vision for the CCC Program. Because most state Medicaid agencies proposed implementing the demonstrations in either 2013 or 2014, DMAS was allowed to proceed with a February 1, 2014 implementation date.^{4,5} (The date was subsequently moved to March 1 to allow the agency additional time to prepare for the program.) Designing and planning for the CCC Program began in earnest after DMAS' proposal was submitted to CMS. Some of the major activities performed during this time included conducting stakeholder education and outreach; developing blended Medicare-Medicaid reimbursement rates; revising the Virginia Medicaid Management Information System (VaMMIS) to process CCC eligibility and payment information; creating a new directorate within DMAS to administer the CCC Program; developing a request for proposals (RFP) to select MMPs for the demonstration; entering into a memorandum of understanding (MOU) with CMS that described the program and signified DMAS' acceptance into the financial alignment demonstration; conducting readiness reviews to ensure that the three MMPs selected through the RFP process met all the requirements for the demonstration; and executing the three-way contracts between CMS, DMAS, and the MMPs. A summary of the major implementation activities by calendar year is presented in Figure 2. Because of the project's complexity and scope, over 70 DMAS staff members across 14 divisions and administrative units were involved in performing these activities.



⁴ Of the states submitting demonstration proposals to CMS in the summer of 2012, two proposed implementing their demonstrations in 2012, while 13 proposed implementing in 2013 and 11 proposed implementing in 2014. DMAS requested a January 1, 2014 implementation date in its 2012 proposal to CMS; however, the MOU that the agency signed with CMS in May 2013 directed it to proceed with a February 1 implementation date.

⁵ The decision to postpone implementation was also influenced by stakeholders in Virginia expressing concerns over whether the CCC Program would be ready prior to 2014.



Major CCC Program Implementation Successes (CY 2014). A number of state-level successes were achieved during the program's first year of operation. One of the most important successes was the enrollment of approximately 25,000 beneficiaries into the CCC Program. Another success was that most of these individuals began accessing services through the MMPs soon after their enrollment. For example, approximately 16,800 health risk assessments (HRAs) were performed between March and October 2014 to identify beneficiaries' health and social needs and over 225,000 provider claims were processed for services rendered to CCC enrollees during that time.

Another success was the agency's education and outreach activities. In CY 2014, DMAS conducted 14 town hall meetings around the state to educate providers, beneficiaries, family members, and caregivers about the CCC Program, and facilitated 184 weekly conference calls (representing approximately 92 hours of dialogue) between the MMPs and various providers and 80 conference calls (representing approximately 40 hours of dialogue) between the MMPs and beneficiaries and their advocates. In addition, the agency coordinated the development of several ad hoc workgroups between the MMPs and various provider groups and associations to improve service delivery for CCC enrollees with BH and/or LTSS needs. Additional state-level CCC implementation successes achieved in CY 2014 are presented in Appendix C.

CCC Program Implementation Challenges and Strategies for Overcoming Them (CY 2014). Despite the successes achieved during the CCC Program's first year, DMAS still encountered certain enrollment, systems, and programmatic issues that complicated implementation and delayed service delivery in some instances. In order to continue implementing the program as seamlessly as possible, the agency developed strategies for overcoming these obstacles. For example, a challenge that arose soon after the CCC Program was implemented involved processing disenrollment requests. Participation in CCC is voluntary and beneficiaries may disenroll at any time by calling Maximus (the state enrollment facilitator), Medicare, or a Medicare Advantage Prescription Drug Plan (PDP). CCC disenrollment requests received by Maximus are processed through VaMMIS, while requests received by Medicare or a PDP are processed through the Medicare Advantage and Prescription Drug (MARx) System. Because CMS was unable to reconcile disenrollments between MARx and VaMMIS, DMAS considered individuals who disenrolled through Medicare or a PDP as still eligible for enrollment. Thus, many beneficiaries who disenrolled through one of the federal entities were reenrolled into CCC. To address this issue, DMAS worked with Maximus to develop an automated process to reconcile disenrollments between MARx and VaMMIS, and it also requested that Medicare transfer beneficiaries calling to disenroll to Maximus to reduce discrepancies between the two systems.

Another implementation issue involved the agency's intelligent assignment (IA) methodology, which is used to automatically assign beneficiaries to an MMP based on their previous provider relationships and enrollment in Medicare managed care.⁶ Due to a system's error in the IA methodology, roughly 1,100

⁶ Beneficiaries who opted into CCC during the voluntarily enrollment period were allowed to select their MMPs. However, all beneficiaries (regardless of whether they opted into CCC or were automatically enrolled) are allowed to change MMPs or even disenroll from CCC at any time.



beneficiaries in the Tidewater demonstration region were incorrectly assigned to an MMP (these individuals represented less than 8% of the region's 14,000 beneficiaries). To resolve this issue, DMAS delayed automatic enrollment for these individuals until the late summer of 2014 to give them additional time to consider their options, and it postponed automatic enrollment in the Central demonstration region until September 1, 2014 to allow for enough time to correct the error.⁷ Additional information on the enrollment, systems, and programmatic implementation challenges encountered during CY 2014 and the strategies used to address them are presented in Appendices D, E, and F, respectively.

Care Coordination Case Studies. Care coordination is the primary benefit that dual eligibles receive after enrolling in CCC. Care coordination is provided by care coordinators who serve as the beneficiaries' single point of contact from the MMPs. Care coordinators typically perform a variety of roles. For example, coordinators work with beneficiaries and/or family members to identify beneficiary health and social needs through health risk assessments (HRAs), develop and maintain plans of care (POCs) that support beneficiaries in achieving their health goals, convene and lead interdisciplinary care teams (ICTs) composed of various health care professionals to assist beneficiaries with implementing their POCs, and arrange services for beneficiaries when transitioning between care settings (e.g., transitioning from institutional to community settings).

Care coordination for enrollees with BH and/or LTSS needs is a particular focus of the evaluation. As a result, the following case studies illustrate how care coordinators are assisting beneficiaries with these needs. A common theme across these examples is improving care through communication and relationship building.

During the HRA for Ms. M, a 65 yr. old LTSS enrollee recovering from basil carcinoma surgery, the care coordinator noted that she was feeling guilty about her condition. The coordinator asked Ms. M if she wanted to speak to a counselor. Ms. M declined initially, but later contacted the care coordinator who generated a counseling referral so she could obtain assistance. During a follow-up visit with the coordinator, Ms. M stated that while the counseling was helping, she was encountering difficulty arranging transportation to attend the sessions. Upon hearing this, the coordinator confirmed that transportation is available through the CCC Program for counseling appointments and provided Ms. M with contact information to schedule this service. During the visit, Ms. M also expressed interest in using other CCC benefits (e.g., gym membership and a \$35 over the counter drug benefit) offered by the MMP, which the coordinator helped to arrange.

⁷ While beneficiaries in the Central region could not be automatically assigned to one of the MMPs prior to September 1, 2014, they could still select an MMP and voluntarily enroll in CCC prior to September.



* * *

Mr. G, a 45 year old LTSS enrollee with diabetes and severe paralysis, cannot walk or use a wheelchair. Prior to enrolling in CCC, Mr. G had high A1C levels due to difficulty taking insulin for his diabetes. He received an insulin pump through Medicare, but was later informed that the pump was no longer covered under his benefits. During the HRA, the care coordinator determined that the insulin pump was critical to Mr. G's health so she helped him appeal CMS' decision. The appeal was successful and Mr. G began using the pump to take insulin. Since then, his A1C levels have decreased. Mr. G informed his coordinator that, "I don't ever want to go back to Medicare and Medicaid. They would never do this stuff for me."

* * *

The care coordinator for Ms. B, a 63 year old LTSS enrollee with heart disease, accompanied her on an appointment to see a cardiologist. Upon arrival, Ms. B was informed that she could not see the cardiologist because her primary care physician (PCP) had not submitted a referral. Upon hearing this, the coordinator contacted the PCP to request a referral and Ms. B was allowed to see the specialist. During the visit, the coordinator informed the cardiologist that Ms. B's PCP had changed some of her prescriptions, which the specialist was not aware of. As a result, the coordinator provided the cardiologist with a new list of prescriptions. According to the coordinator, communication between physicians is important and can "prevent people from having 50 different meds."

* * *

During an ICT for Ms. T, the care coordinator observed that her mother was experiencing "burnout." Ms. T is an LTSS enrollee with an intellectual disability and her mother is the main caregiver. After the ICT, the coordinator contacted Ms. T's social worker regarding her mother's condition. The social worker subsequently arranged for Ms. T and her mother to meet with staff at a local community service board for additional assistance. The mother was very appreciative and told the coordinator, "No one has ever really helped me before. Thanks so much!"

* * *



During the HRA for Ms. C, an LTSS enrollee, the care coordinator observed that her prescription bottle for thyroid medication was empty and that she was not authorized to receive any refills. Ms. C had recently undergone thyroid surgery and the medication was essential to her health. While talking to Ms. C about the medication, the coordinator learned that she had also missed an appointment with her PCP following the surgery so she never received the prescription. The coordinator subsequently called the PCP to schedule an appointment for Ms. C. During the HRA, the coordinator also learned that while Ms. C was receiving personal care services three times a week, she had experienced several recent falls as well as increased weakness and confusion. As a result, the coordinator contacted Ms. C's personal care provider to recommend an increase in her personal care hours. The provider agreed to increase Ms. C's hours to better meet her needs. In addition, the coordinator arranged for Ms. C to receive an in-home Personal Emergency Response System to contact caregivers/providers if she falls and injures herself in the future.

Current Evaluation Activities

The DMAS/Mason evaluation team is currently conducting both qualitative and quantitative data collection activities. For example, the team is working with the Virginia Association of Area Agencies on Aging to schedule a second round of focus groups with LTSS enrollees to learn about their experiences during the CCC Program's second year and it is also interviewing BH and LTSS providers to examine their perceptions of the CCC Program.⁸ The team is also continuing to observe care coordination activities for CCC enrollees across the demonstration regions in both institutional and community settings.⁹ In addition, the evaluation team is surveying LTSS enrollees as well as beneficiaries who declined enrollment to examine their level of satisfaction with health services as well as their understanding of the CCC Program. Finally, the team is planning to meet with the evaluation advisory committee on June 10, 2015 to report on its activities to date.

Summary Findings

The current review identified a number of key findings about DMAS' implementation of the CCC Program. The review found that designing and planning for the CCC Program required considerable time and resources. Activities started approximately three years prior to the program's implementation

⁸ During CY 2014, the evaluation team worked with the Virginia Association of Centers for Independent Living to schedule a round of focus groups with LTSS enrollees. Findings from these focus groups are available online at: www.dmas.virginia.gov/Content_pgs/ccc-eval.aspx.

⁹ Findings from the team's CY 2014 observations of care coordination activities are also available online at the above website.



in March 2014. The review also found that beginning these activities in advance allowed the agency to achieve a number of implementation successes during the CCC Program's first year including the delivery of care coordination services (a hallmark of the program) to dual eligible beneficiaries with BH and/or LTSS needs. However, the review found that the agency still encountered some enrollment, systems, and programmatic issues that complicated implementation despite the amount of effort that was spent preparing for the CCC Program. By providing insights into Virginia's early implementation of the CCC Program, this report may be useful to other states that are performing similar integrated care initiatives for dual eligible beneficiaries.



Appendix A

CCC Evaluation Team

Department of Medical Assistance Services

Gerald Craver, PhD*
(Policy and Research Division)

Meredith Lee, MPH*
(Policy and Research Division)

Matthew Behrens, MPA
(Division of Integrated Care and Behavioral Services)

Sarah Broughton, MSW*
(Division of Integrated Care and Behavioral Services)

Fuwei Guo, MPH
(Division of Integrated Care and Behavioral Services)

Elizabeth Smith, RN
(Division of Integrated Care and Behavioral Services)

George Mason University

Alison Cuellar, PhD
(Department of Health Administration and Policy)

Gilbert Gimm, PhD
(Department of Health Administration and Policy)

*Staff contributing to this report.

Note: Emily Carr, Manager of the Coordinated Care Unit at DMAS, also contributed to this report.



Appendix B

CCC Evaluation Advisory Committee

Jack Brandt

Self-Advocate Disability Policy Specialist
Virginia Commonwealth University
Partnership for People with Disabilities

Sheryl Garland

Vice President
Health Policy and Community Relations
Virginia Commonwealth University
Health System

Debbie Burcham

Executive Director
Chesterfield Community Services Board

Maureen Hollowell

Director of Advocacy and Services
Independence Center, Inc.

Emily Carr

Manager, Coordinated Care Unit
Virginia Department of Medical Assistance Services

Linda Redmond, PhD

Research, Policy and Program Manager
Virginia Board for People with Disabilities

Parthy Dinora, PhD

Director of Research, Evaluation, and Program
Development
Virginia Commonwealth University
Partnership for People with Disabilities

E. Ayn Welleford, MSG, PhD, AGHEF

Chair & Associate Professor
Department of Gerontology
Virginia Commonwealth University

Laura Lee O. Viergever

Director of Policy
Virginia Association of Health Plans

Jamie Liban

Executive Director
The Arc of Virginia

Nakia Speller

Supportive Services Unit Manager
Prince William Area Agency on Aging

Debra Grant

Community Advocate

Steve Ford

Senior Vice President for Policy and
Reimbursement
Virginia Health Care Association



Appendix C

Major CCC Program Implementation Successes (CY 2014)

Success	Description of Implementation Success
CCC Program Implementation & Enrollment	CCC was implemented on March 1, 2014 as a voluntary program for full-benefit dual eligible beneficiaries (≥ 21 yrs. of age) residing in one of the 103 participating localities (representing about 77.4 % of all Virginia localities.) For beneficiaries residing in Tidewater/Central Virginia, enrollment began on March 1, 2014, with services starting on April 1. Enrollment for beneficiaries residing in Northern Virginia and the Charlottesville and Roanoke areas began on May 1, 2014, with services starting on June 1, 2014. Two options exist for enrolling beneficiaries into CCC. Under the first option, beneficiaries may proactively enroll by contacting Maximus (the state enrollment facilitator), while under the second option, dual eligibles are automatically enrolled through an intelligent assignment algorithm. (Individuals who enroll in CCC may disenroll at any time.) As of January 16, 2015, 24,844 beneficiaries were enrolled in CCC.
Blended Medicare-Medicaid Payment Methodology	The CCC Program is based on a capitated financial alignment model that involves the development of a three-way contract between CMS, the state, and three Medicare-Medicaid Plans (MMPs). Under this model, the MMPs receive blended Medicare-Medicaid payments in return for managing and coordinating all health and social services that enrollees are entitled to receive. DMAS worked with its actuarial contractor and CMS to develop capitation rates based on estimates of what Medicare and Medicaid would have paid on behalf of the enrollees absent the CCC Program, with an agreed upon savings percentage subsequently applied. Under the blended methodology, CMS and DMAS each make monthly payments to the MMPs for their components of the capitated rate. The MMPs receive three monthly payments for each enrollee: one amount from CMS reflecting Medicare Parts A and B coverage, a second amount from CMS reflecting Medicare Part D coverage and a third amount from DMAS reflecting Medicaid coverage. Additional information of the blended payment methodology is available online at: www.dmas.virginia.gov/content_pgs/capitation.aspx .
Electronic Processing of Provider Claims	Prior to CCC, full benefit dual eligible beneficiaries received most (if not all) of their acute, behavioral health (BH), pharmacy, primary care, and long-term services and supports (LTSS) through the fee-for-service system. As a result, providers that cared for these beneficiaries were accustomed to submitting claims through the existing Medicare and/or Medicaid systems. However, this structure changed with the advent of CCC because all health and social services for full benefit duals in the demonstration areas are now provided through an integrated managed care delivery system. Because the MMPs did not have experience authorizing and paying for many BH/LTSS services that are typically provided to full benefit dual eligible beneficiaries, some observers were concerned about the plans' ability to correctly process these claims in a timely manner. To address this, DMAS, the MMPs, and various stakeholders collaborated to ensure that structures were developed to correctly process claims electronically. Between March and October 2014, the MMPs processed over 225,000 claims for BH/LTSS services provided to CCC enrollees. (By May, 2015, the MMPs had processed over 350,000 BH/LTSS claims.)
Health Risk Assessment and Personalized Plans of Care	The Memorandum of Understanding (MOU) between DMAS and CMS defines the health risk assessment (HRA) as a comprehensive assessment that is performed to identify a beneficiary's medical, psychosocial, cognitive, and functional status in order to determine his/her health and social needs. The MOU also defines the plan of care (POC) as a plan based on the HRA that is primarily directed by the beneficiary and/or family member(s), with the assistance of an Interdisciplinary Care Team composed of various health care professionals to meet the beneficiary's medical, health, behavioral, LTSS, and social needs. As such, the HRA and POC are essential for providing effective integrated care for dual eligibles and are core elements of the CCC Program. Between March and October 2014, the MMP care managers completed 16,804 HRAs and 14,261 POCs for beneficiaries. In addition, the MMPs also had a 92% completion rate for HRAs during CY 2014.

(Continued on next page)



Commonwealth Coordinated Care
Medicare & Medicaid working together for you

Success	Description of Implementation Success
Town Hall Meetings, Newsletter, and Presentations	During CY 2014, staff from DMAS, the MMPs, and the Virginia Insurance Counseling and Assistance Program (VICAP) conducted a total of 14 town hall meetings around the state to educate providers, Medicare-Medicaid beneficiaries, family members, and/or caregivers about the CCC Program. The town hall meetings consisted of demonstration overviews, a VICAP overview, MMP presentations, and a question/answer session. DMAS staff also prepared and emailed 12 monthly newsletters that included updates on the CCC program, evaluation, education and outreach, and quality monitoring activities. The newsletters are posted on the DMAS website. In addition, staff from DMAS and VICAP offered a variety of education and outreach activities as needed to beneficiaries in nursing facilities, assisted living facilities, and independent living senior housing complexes families during the calendar year.
Stakeholder Advisory Committee	In an effort to engage stakeholders in policy development and program oversight, DMAS engaged stakeholders in a series of meetings in 2012 and formally convened a stakeholder advisory committee composed of 18 members representing self-advocates and their families, senior, behavioral health, disability, physician, home health, health plan, nursing facility, and hospital communities. Individuals serving on the committee are appointed by the Virginia Secretary of Health and Human Services. The committee meets on a quarterly basis and the meetings are open to the public. During the meetings, staff from DMAS and the MMPs present on the progress of the CCC Program (including successes achieved and challenges encountered), and any upcoming CCC events and activities that stakeholders need to be aware of. Since November 2013, the CCC Stakeholder Advisory Committee has met eight times. Minutes from the advisory committee meetings are available on the DMAS website at www.dmas.virginia.gov/Content_pgs/mmfa.aspx .
Stakeholder Conference Calls	To facilitate information exchange on CCC, DMAS hosts weekly stakeholder conference calls with the MMPs and CMS. These calls are separated into provider calls (i.e., adult day care, behavioral health, hospitals and medical practices, nursing facilities, personal care, home health and service facilitators) and beneficiary calls. The conference calls feature CCC updates and opportunities for stakeholders to ask DMAS and MMP staff questions about the program. Examples of changes made to the CCC Program as a result of the information exchange that occurs during the calls include a new service authorization request time frame for continuity of care authorizations upon return to FFS from 30 to 60 calendar days from the date of CCC disenrollment and a provider reference guide. Since March 2014, staff from DMAS and the MMPs facilitated 184 provider conference calls (approximately 92 hours) and 80 conference calls for beneficiaries and their advocates (approximately 40 hours). During the conference calls, DMAS staff prepare “question and answer” logs that are sent to individuals on the agency’s CCC email distribution list after the calls are completed. A schedule of the conference calls is available on the DMAS website at www.dmas.virginia.gov/Content_atchs/altc/ProviderCalls.pdf .
DMAS/MMP/ Stakeholder Workgroups	DMAS and the MMPs formed workgroups with several provider organizations and associations to align processes on various topics for long-term care and behavioral health (BH) providers (e.g., standardized authorization forms, claims processing, staff contacts, care coordination flow, communication lines, and evaluation metrics). By forming the workgroups, DMAS and the MMPs opened communication with these organizations which helped facilitate providing BH and LTSS services to CCC enrollees. The workgroups have met periodically since they were started in early 2014.
Collaborative Working Environment to Support CCC Program	The emphasis DMAS placed on promoting communication during the development and implementation of the CCC Program allowed the MMPs to support one another by collaborating to provide education instead of requiring providers to attend separate training sessions. Providers benefit from the collaborative effort and the MMPs benefit by pooling resources for venues, travel, and reducing unnecessary duplicative efforts.
Evaluation Team and Advisory Committee	Because CCC represents a new approach to providing care in Virginia, DMAS partnered with George Mason University (Mason) to evaluate the program using both qualitative and quantitative data collection and analysis procedures. (This state-level evaluation is in addition to the evaluation being conducted by CMS on the dual demonstration states.) DMAS staff are responsible for the qualitative component of the evaluation, while Mason faculty are responsible for the quantitative component.

(Continued on next page)



Success	Description of Implementation Success
	<p>As part of the evaluation, DMAS created an evaluation advisory committee to assist the evaluators with understanding the unique needs and concerns of the various organizations and dual eligible subpopulations involved in the program. The advisory committee is composed of 13 members representing the aging, behavioral health, disability, enrollee, nursing facility, and state government communities. The evaluation team interacts with the advisory committee members on an ad hoc basis based on the members' particular areas of expertise (e.g., partnering with members representing Centers for Independent Living or Area Agencies on Aging to recruit enrollees for focus group) and with the full committee on an annual basis. (The committee has met twice since it was formed in the summer of 2013.) Information from the evaluation is available online at: www.dmas.virginia.gov/Content_pgs/ccc-eval.aspx.</p>
<p>Quality Monitoring & Learning Collaborative</p>	<p>The overall goal of the CCC Program is to provide dual eligible beneficiaries with high-quality, person-centered services that meet their medical and social needs through a coordinated and integrated managed care delivery system. To ensure that this goal is met, the MMPs are responsible for reporting on over 100 separate quality measures to DMAS and CMS. As part of this process, DMAS formed an internal quality committee that benchmarked the Virginia-specific quality withhold performance measures, developed MMP quality management plan expectations, and finalized the process for ensuring EDCD waiver assurance compliance. DMAS and the MMPs collaborated to form the CCC Quality Learning Collaborative, which is a group of stakeholders and beneficiaries who meet to discuss issues related to CCC quality improvement and monitoring. To date, the learning collaborative has met twice since the summer of 2014. In addition, DMAS developed a database to support the systematic collection and analysis of quality measurement data from the MMPs.</p>
<p>Contract Monitoring and Implementation Oversight</p>	<p>To ensure that the MMPs adhere to the requirements of the three-way contract, DMAS and CMS created a joint contract monitoring team composed of staff who are knowledgeable about the full range of services and supports (particularly BH and LTSS) that are utilized by the target population. DMAS/CMS team meets on a weekly basis with each MMP to discuss/coordinate activities such as monitoring compliance with reporting requirements, periodic service audits, and grievances and appeals data. DMAS staff who serve on the contract monitoring team also provide agency management with weekly updates on CCC implementation that include enrollment numbers, systems issues, network adequacy, and MMP activities.</p>
<p>Core Competency Training and Capacity-Building Activities for MMPs</p>	<p>To ensure the MMPS maintain a strong understanding of the LTC and BH needs of dual eligible beneficiaries, DMAS initiated a series of training and capacity-building activities to improve core competencies that covered topics such as patient pay, Medicare rate setting, home and community based waivers, consumer direction and fiscal agent role, BH and LTSS services in Virginia Medicaid, CCC enrollment and disenrollment, advanced care planning, managing protected health information, marketing, billing codes, and managing beneficiary transfers between health plans. Approximately 20 training sessions were held between CY 2013 and CY 2014.</p>
<p>Virginia Insurance Counseling Program (VICAP) and the State Long Term Care (LTC) Ombudsman</p>	<p>As part of its efforts to educate beneficiaries about the CCC Program and to ensure that their rights are protected, DMAS partnered with VICAP and the LTC Ombudsman. Under this partnership, VICAP is responsible for providing beneficiaries (and their families) with unbiased educational information about their options for participating in the CCC Program, while the LTC Ombudsman is responsible for protecting their beneficiary rights, investigating complaints, empowering beneficiaries to resolve health care problems, and assisting with appeals and grievances. During CY 2014, VICAP participated in 45 presentations on the CCC Program, while the LTC Ombudsman reviewed 69 complaint cases from beneficiaries or their advocates.</p>



Appendix D

CCC Enrollment Challenges and Strategies for Overcoming Them (CY 2014)

Challenge	Description of Challenge	Strategy for Overcoming
Medicare Processed CCC Disenrollment Requests	Beneficiaries can opt-out of CCC by calling Maximus, 1-800-Medicare, or a Medicare Advantage Prescription Drug Plan (PDP). Requests received by Maximus (a DMAS subcontractor) are processed through the VaMMIS ¹ , while requests received by 1-800-Medicare or a PDP (which are federal entities) are processed through MARx ² . Because CMS is unable to reconcile disenrollments between MARx and VaMMIS, DMAS viewed individuals disenrolling through a federal entity as eligible for enrollment. Thus, many who disenrolled through a federal entity were reenrolled into CCC.	DMAS worked with Maximus to develop an automated process to reconcile disenrollments between MARx and MMIS. In addition, DMAS requested that CMS require 1-800-Medicare to transfer beneficiaries who call to disenroll to Maximus to reduce discrepancies. Currently the state and enrollment facilitator are discussing the best way to address this issue with CMS.
Employer Sponsored Health Insurance (ESHI)	Beneficiaries with ESHI will lose this coverage permanently if they enroll in CCC. DMAS received guidance on ESHI prior to CCC implementation; however, it was unclear how CMS planned to communicate this information with DMAS. As a result, DMAS did not develop an automated system to identify these individuals to ensure that they are not automatically enrolled into CCC.	Because DMAS and the MMPs are unable to identify ESHI beneficiaries, CMS sends a file to the agency containing a list of these individuals so they can be manually excluded from automatic enrollment.
Enrollment Churning	To protect beneficiary choice, individuals are not locked into CCC participation or MMP assignment for set periods. Thus, individuals may switch between CCC participation and/or MMP assignment as often as they wish. While protecting choice is important, it creates certain enrollment and continuity of care challenges. For example, one challenge involves reconciling individuals' actual enrollment status between the state and federal systems when they are allowed to make multiple changes daily. A second challenge is that some individuals may become confused about their actual enrollment status by making multiple changes during a set time period. Finally, a third challenge involves allowing beneficiaries to enroll (or switch MMPs) during the last five days of a month. Due to the state-federal file transfer process, individuals enrolling during this time will not receive CCC services until about 30 days after enrollment.	DMAS and the MMPs have discussed with CMS the challenges and confusion for beneficiaries surrounding this requirement. Currently, CMS has not developed a solution. DMAS has also worked with Maximus to update scripting when an individual calls to make enrollment changes multiple times in a day to advise of their previous calls and counseling options with the Ombudsman and VICAP offices. In response to these enrollment challenges, DMAS initiated weekly enrollment meetings with each of the MMPs to discuss and review enrollment discrepancies. These meetings are an open forum for enrollment specialists from DMAS and the MMP to also have an open dialogue regarding enrollment processes and systems.

¹Virginia Medicaid Management Information System (VaMMIS)

²Medicare Advantage and Prescription Drug (MARx) System



Appendix E

CCC System Challenges and Strategies for Overcoming Them (CY 2014)

Challenge	Description of Challenge	Strategy for Overcoming
Intelligent Assignment	DMAS uses intelligent assignment methodology to assign beneficiaries to MMPs based on their previous Medicare managed care enrollment and historical utilization of certain providers. Some Tidewater beneficiaries (less than 8% of the 14,000 beneficiaries in Tidewater) were incorrectly assigned due to a systems error. Of those, the majority needed to be reassigned to correctly match them to their current Medicare Advantage health plan. These individuals received a notice of change with a CCC effective date of July 1. Approximately 2% of CCC eligible beneficiaries in Tidewater needed reassignment based on their nursing facility and/or adult day care center participation. These individuals received a notice of change with an effective date of August 1 to provide additional time for beneficiaries to make a decision.	DMAS worked with Xerox and CMS to correct this issue and moved automated coverage for Central Virginia to September 1, 2014 to allow for additional testing to prevent this issue from occurring in the future.
Enrollee Cancellation/Disenrollment Programming	Prior to implementation, CMS did not have a systems testing environment to allow for end-to-end testing of the enrollment/disenrollment data exchanges performed between CMS, DMAS, and the MMPs. Because the enrollment system has specific transaction codes that designate whether beneficiaries cancelled (or declined) CCC enrollment or disenrolled after participating, failing to test data exchanges has resulted in numerous difficulties correctly processing enrollments/disenrollments in a timely manner.	As information and formatting became available from CMS during go live, DMAS worked with Xerox (DMAS' fiscal agent) to develop an automated process to address this issue and with Maximus (DMAS' enrollment facilitator) to implement the process at front end system entry.
Daily Enrollment Review	As part of the above issue, DMAS developed a database to screen rejection codes and required state action/transaction codes manually in order to reconcile them between MMIS and MARx.	DMAS is continuing to perform this process manually on a daily basis until automated systems are developed.
Medicare Claims and Encounter Data	To assign beneficiaries to appropriate providers and to monitor quality improvement, DMAS and the MMPs need access to Medicare claims and encounter data. Because this information was not provided during the program's initial implementation stage, the MMPs encountered difficulty ensuring continuity of care for CCC beneficiaries. Moreover, CMS is requiring DMAS to go through Palmetto (an insurance contractor) to receive the MMPs' Medicaid encounter data, but not Medicare encounter data which has caused delays in monitoring quality improvement.	CMS worked with the MMPs to develop an agreement to exchange Medicare claims data. DMAS continuing to work with CMS and its contractor, Palmetto, to obtain Medicare encounter data to date.



Appendix F

CCC Program Challenges and Strategies for Overcoming Them (CY 2014)

Issue	Description of Challenge	Strategy for Overcoming
Returned Mail	When CCC became operational, the state sent enrollment letters to beneficiaries; however, many were returned because of incorrect addresses due to: 1) beneficiaries moving and not reporting new addresses to local DSS ¹ offices and/or 2) local offices failing to update the new address information when reported. Per existing procedures, if correct addresses are not located for beneficiaries, DSS will cancel Medicaid coverage.	Enrollment letters are now mailed with a return address for the respective local DSS offices. If beneficiary addresses are incorrect, the mail is returned directly to these offices for processing.
Continuity of Care and Service Authorizations	To ensure continuity of care, the MMPs must honor all service authorizations that beneficiaries have until the authorizations end or 180 days after CCC enrollment, whichever is sooner. To assist the MMPs, DMAS provided weekly medical transition reports indicating which enrollees have authorizations requiring reauthorization. However, the reports did not contain service authorizations that enrollees received from FFS providers prior to their actual enrollment in CCC.	To address this, DMAS developed a new service authorization report that it submits to the MMPs at the end of each month containing all authorizations generated on individuals by fee-for-service providers prior to their effective CCC enrollment date.
Protecting Beneficiary Choice	Some providers that do not want to contract with the MMPs are encouraging CCC beneficiaries to opt-out, which violates beneficiary choice and federal regulations.	DMAS is educating providers through town hall meetings, stakeholder monthly newsletters, and Medicaid provider memos. However, this issue has not been resolved entirely because some providers continue to encourage CCC enrollees to opt-out.
Provider Network Advocacy	The MMPs are required to maintain adequate provider networks to ensure beneficiaries have access to appropriate health/social services. To date, the MMPs have not met network adequacy standards for Mecklenburg County and additional localities in the Western, Charlottesville and Northern Virginia demonstration regions.	Network development is an ongoing process and DMAS and CMS are both monitoring the MMPs' progress toward this requirement. In addition, the Medicare network adequacy standards are based on the entire population, not just those eligible for CCC. CMS is currently reviewing this issue and further guidance is expected this year.
General Confusion about CCC Program	CCC involves coordinating the delivery of all primary, preventive, acute, behavioral, and long-term services and supports for approximately 73,465 beneficiaries under a managed care delivery system. A unique feature of CCC is that this arrangement has never been done before by managed care plans in Virginia. As a result, some beneficiaries and providers are not participating due to the newness of the program and comfort with the existing care delivery model.	Over a year prior to implementation and ongoing, DMAS developed avenues to educate dual eligibles and providers about the benefits of CCC in addition to strategizing with other states to implement additional outreach activities to increase awareness and understanding of the program. A robust outreach plan was developed prior to launch and continues to develop throughout implementation as new strategies are identified.

¹Department of Social Services

(Continued on next page)



Commonwealth Coordinated Care
Medicare & Medicaid working together for you

Challenge	Description of Challenge	Strategy for Overcoming
Satisfaction with Current Medicare-Medicaid Services	Because CCC participation is voluntary, beneficiaries are allowed to opt out and return to their original Medicare/Medicaid coverage. While beneficiaries do not have to justify their decisions, DMAS directed Maximus to ask their reasons for disenrolling when calling to identify areas where improvements can be made to better meet the needs of beneficiaries. Many have reported that they are not interested in participating in CCC because they do not like change or because they are satisfied with their current services.	DMAS and the MMPs are working to promote the CCC Program to beneficiaries and advocates through town hall meetings, stakeholder monthly newsletter, and weekly conference calls as many have beneficiaries do not currently have access to the full range of benefits provided through CCC in addition to care coordination.
Beneficiary CCC Notification Letters	To notify beneficiaries about CCC enrollment, CMS and DMAS developed three letter templates for DMAS to use. As part of this process, a beneficiary advisory workgroup was formed to review the templates to ensure reading levels and clarity appropriate for the target population. The letters were sent to beneficiaries approximately 90-, 60-, and 30-days prior to their enrollment dates. While the letters were intended to inform beneficiaries about CCC enrollment or disenrollment procedures and to educate them on the different MMP options available, many found them confusing and the opt-out process difficult to understand and navigate.	Advocates and enrollees have alerted DMAS to their concerns about the user-friendliness of the CCC notification letters and the agency has relayed this information to CMS. DMAS continues to collect this feedback for future implementation.