COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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November 1, 2015

MEMORANDUM

TO: The Honorable Terence R. McAuliffe
Governor of Virginia

The Honorable Charles J. Colgan
Co-Chairman, Senate Finance Committee

The Honorable Walter A. Stosch
Co-Chairman, Senate Finance Committee

The Honorable S. Chris Jones
Chairman, House Appropriations Committee

Daniel S. Timberlake
Director, Virginia Department of Planning and Budget

FROM: Cynthia B. Jones CBJ/dn
Director, Virginia Department of Medical Assistance Services

SUBJECT: Report on Implementation Progress of the Financial Alignment Demonstration Waiver (Duals)

The 2015 Appropriation Act, Item 301 HHH(2) requires:

> *The department shall report by November 1 of each year to the Governor, the Chairmen of the House Appropriations and Senate Finance Committees, and the Director, Department of Planning and Budget detailing implementation progress of the financial alignment demonstration waiver. This report shall include, but is not limited to, costs of implementation, projected cost savings, number of individuals enrolled, and any other implementation issues that arise.*

Should you have any questions or need additional information, please feel free to contact me at (804) 786-8099.

CBJ/

Enclosure

pc: The Honorable William A. Hazel, Jr., MD, Secretary of Health and Human Resources

Department of Medical Assistance Services

Annual Report to the General Assembly

Report on Implementation Progress of the Financial Alignment Demonstration Waiver (Duals)

November 2015

Report Mandate

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Background

Nationally, and in the Commonwealth of Virginia, dual eligible individuals have the most complex health care needs of any Medicaid or Medicare members, including multiple chronic health conditions, behavioral health needs, and disabling conditions. Even though beneficiaries enrolled in Medicaid and Medicare comprise 15 percent of the Medicaid population, they account for 39 percent of Medicaid expenditures. In Virginia, individuals who are eligible for both programs were initially excluded from participating in Medicaid managed care programs and received care dictated by conflicting state and federal rules and separate funding streams, resulting in fragmented and poorly coordinated care. Therefore, addressing quality and costs for these individuals has been a priority in the Commonwealth.

In October of 2011, DMAS submitted a letter of intent to the Centers for Medicare and Medicaid Services (CMS) that indicated the Commonwealth's desire to pursue an

opportunity authorized by the Patient Protection and Affordable Care Act to integrate Medicare and Medicaid benefits under one system of coordinated care using a full-risk capitated model. The Commonwealth Coordinated Care (CCC) program was granted final authority by the 2014 General Assembly. This directive came under the umbrella of a series of Medicaid reforms intended to reduce costs and increase quality of care. It was the first program of its kind to align the administrative and financial components of the federal Medicare program and the state administered Medicaid program.

To operationalize CCC, the Department of Medical Assistance Services (DMAS) underwent a competitive procurement process and selected three of Virginia's Medicaid Medicare health plans (MMPs) to help meet the following CCC program goals:

Goal 1: Provide high-quality, person centered care.

Goal 2: Reduce fragmentation.

Goal 3: Improve the health and lives of enrolled individuals.

Goal 4: Reduce the need for avoidable services, such as hospitalization and emergency room use.

Goal 5: Encourage individual participation in treatment decisions and support the goal of providing treatment in the least restrictive, most integrated setting.

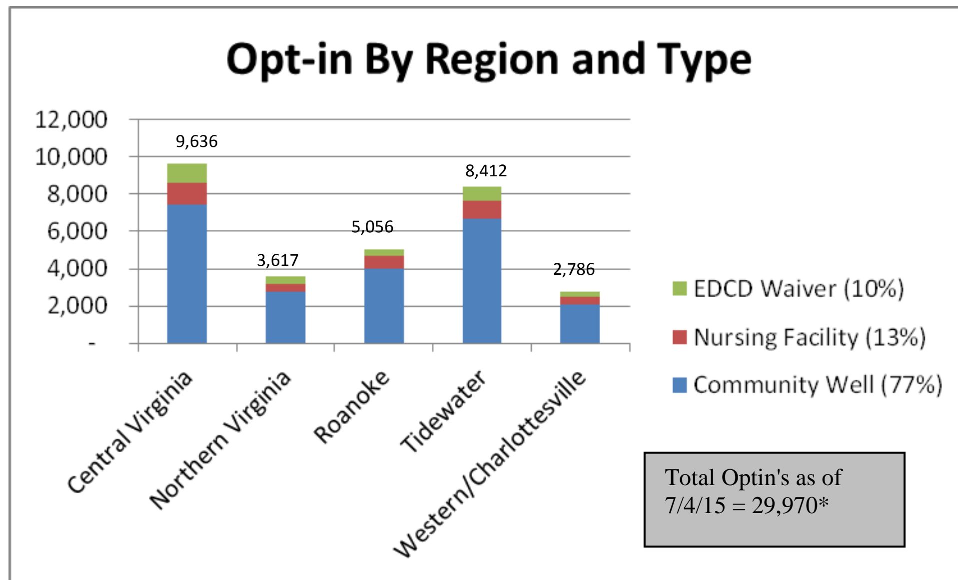
Since its implementation in March 2014, DMAS and the MMPs have made significant strides in operationalizing a coordinated, integrated model of care for dual eligible individuals. The CCC's goals have helped to drive business practices and improvements despite continued challenges. The progress and achievements made in the last year would have not been possible without the exemplary work of the stakeholders, DMAS staff, providers, and participating MMPs.

CCC Enrollment Figures

As of July 1, 2015, we estimate the total CCC eligible population to be 66,469. Of that total, 29,507 have been enrolled in CCC, 28,208 have elected to remain in their current fee-for-service health benefit and 8,608 are currently undecided. Using these enrollment figures, 42.4 percent of eligible beneficiaries are electing to opt-out of CCC. DMAS staff has developed an Enrollment Dashboard, which is updated monthly and contains detailed enrollment information (http://www.dmas.virginia.gov/Content_pgs/altc-stkhld.aspx). We have included some of the tables and charts from the dashboard below:

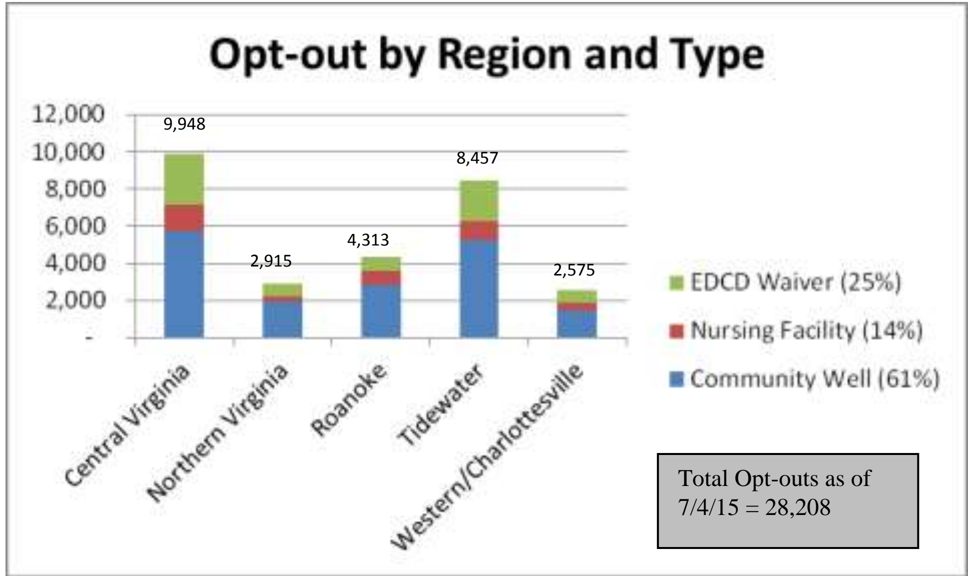
ENROLLMENT DATA:

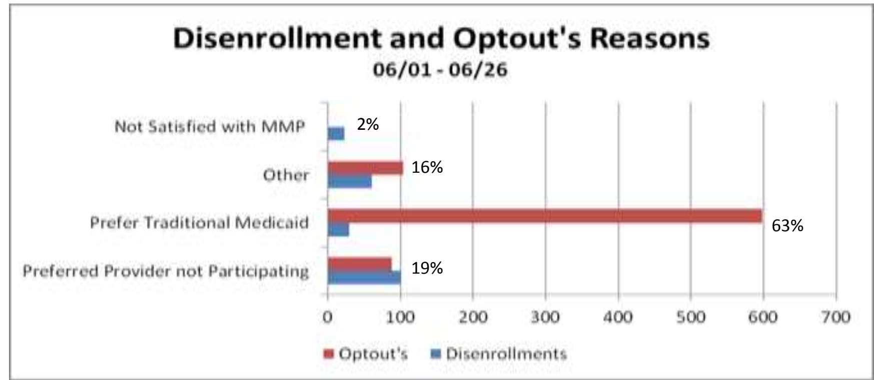
As of July 1, 2015:



* Total "Opt-ins" include prospective enrollment for August and September. As of July 4 there are a total of 2,036 prospective enrollments for those months.

CCC Enrollment By Plan and Region						
	Central Virginia	**Northern Virginia**	**Roanoke**	**Tide Water**	**Western/ Charlottesville**	**Grand Total**
Virginia Premier	2,663	59	1,213	1,487	710	**6,132**
Anthem HealthKeepers	3,689	1,825	1,810	3,771	1,235	**12,330**
Humana	3,284	1,733	2,033	3,154	841	**11,045**
Total	**9,636**	**3,617**	**5,056**	**8,412**	**2,786**	**29,507**





Implementation Progress

Since the beginning of FY 2015, DMAS, in consultation with the CCC Advisory Committee, other important stakeholders, CMS and members of the State Administration, have made progress operating the CCC program. Some of the accomplishments achieved by DMAS under this initiative include:

1. Completed auto-enrollment process and began service coverage in all five CCC regions,

2. Initiated joint CMS and DMAS Contract Monitoring Team meetings to oversee the Medicare-Medicaid Plans (MMPs) contract compliance and their effectiveness in provision of services,

3. Conducted comprehensive beneficiary, provider, and advocate education and outreach initiatives,
4. Continued IT Systems coordination and monitoring,
5. Began gathering and analyzing quantitative and qualitative quality measures required by CMS and DMAS in order to determine the success of the program,
6. Conducted program evaluation interviews, focus groups and surveys with stakeholders (e.g., MMP staff, providers, enrollees and their caregivers) in order to gauge satisfaction and overall success of the program. This is done in consultation and conjunction with George Mason University staff, and
7. Implemented Behavioral Health Home initiative.

Enrollment and Network Adequacy

Beneficiaries were enrolled into CCC using a regional phase-in method beginning with Tidewater on July 1, 2014, and concluding with Northern Virginia on November 1, 2014. Following the completion of the regional phased-in enrollment process, DMAS begin to enroll newly eligible beneficiaries across the demonstration area on a monthly basis. Prospective enrollees receive notification of their eligibility and their ability to select a health plan or opt-out both 60 and 30 days prior to the first day their coverage is scheduled to begin with the health plan.. The first newly eligible beneficiaries began receiving services on December 1, 2014.

Because CCC is a pilot program, we limited the design to include 103 localities across five regions of the Commonwealth. In order to automatically enroll eligible beneficiaries, an MMP is required to meet CMS and DMAS network adequacy standards, which are measured on a locality by locality basis. As of July 1, 2015, seven localities (e.g., Fairfax, Fauquier, Henry, Harrisonburg, Manassas Park and Martinsville counties and Fairfax City,) have one MMP meeting network standards and one locality (e.g., Mecklenburg County) has zero MMPs meeting standards. Beneficiaries residing within a locality with only one MMP meeting standards are given the option to opt-in to CCC. For beneficiaries residing in a locality with zero MMPs meeting standards, they are prohibited from participating in the demonstration.

"At first I was scared about changing my mom's health coverage options- then I realized how much easier it would be for my mom and me to get to appointments, stay on track with her care and receive additional support when we needed it. It is actually just great to have a person to call, who cares."

- CCC Beneficiary's Care Taker

Contract Monitoring

Over the past year, the focus of the CMS and DMAS staff has shifted from enrollment to operations. With that change in emphasis, the importance and responsibility of the Contract Monitoring Team (CMT) expanded. CMT consists of DMAS and CMS management and operations staff who are charged with monitoring the MMPs to guarantee compliance with all aspects of the CCC contract. To aid them in this task, CMT has developed and applied several tools including: bi-weekly and ad hoc conference calls with the MMPs, enrollment and operational dashboards, technical site visits and formal audits. (The bi-weekly conference calls were initially weekly but were reduced due to declining need. In the future, the calls will move to monthly.) While most of the CMTs interactions with the MMPs are designed to identify and resolve areas of concern before they become problematic, this is also the venue where CMS and DMAS can impose sanctions if necessary.

The CMT dashboard, along with the MMP conference calls, have been one of the most effective tools for identifying potential areas of concern and pathways to resolving them. When the program began, the dashboard focused on enrollment, MMP staffing sufficiency, IT systems compliance and outreach to newly enrolled beneficiaries. As the program has matured, the dashboards shifted to focus on operational aspects of the program such as the completion of Health Risk Assessments (HRA) and Plans of Care (POC) by subpopulations, the number and status of appeals and grievances, member ER visits, hospitalizations and length of hospital stay, claims processing and MMP call center activity.

MMP dashboards are submitted prior to biweekly conference calls in order to allow CMT members to analyze the data and identify potential areas of concern. If a member of CMT identifies an instance of noncompliance with the contract, the MMPs are given the opportunity to respond and if necessary resolve the issue. If the issue is not resolved in a timely manner, the MMP becomes subject to sanctions such as a notice of noncompliance issued by CMS and DMAS. Depending on the nature of the notice, a notice of noncompliance can levy civil money penalties, suspension of marketing and enrollment until the issue has been corrected and ultimately expulsion as a Medicare plan. The CCC CMT has issued three notices of noncompliance, all of which were resolved in an expeditious manner. CMS has issued another six notices to the MMPs for their Medicare Part D and marketing guideline compliance.

Education and Training

The MMPs and DMAS have demonstrated an unprecedented standard for stakeholder engagement, provider education and internal staff training. The efforts have garnered national recognition and have been praised for creating a “culture of cooperation” as

stated in the 2015 Kaiser Health Foundation Report on CCC. As one of the first states to successfully implement the CCC program, Virginia's state administrators have been asked to lend the lessons learned with other states undergoing duals demonstration projects. Virginia was a leader in overcoming implementation challenges that other states have been unsuccessful at resolving. Additionally, CCC has fostered a unique model of collaboration between MMPs that has proven invaluable to the program and its stakeholder engagement efforts.

CCC education and training efforts have shifted focus throughout FY 2015 from town hall meetings to provide general stakeholder education to targeted training and educational discussions on specific operational issues. Additionally, CCC staff made themselves available for training and education upon request by stakeholder groups. This year CCC staff and leadership presented to over 40 groups of beneficiaries, provider, community advocates, and other stakeholders locally, across the Commonwealth and nationwide.

DMAS and MMP staff held beneficiary and provider calls throughout FY 2015 though the frequency of the calls has reduced from weekly to monthly due to a corresponding decrease in questions and comments from the participants. The reduction in questions and comments is due to the introduction of care coordinators as the main point of contact for both providers and beneficiaries. Also, the presence of MMP staff on the calls served as a means of communication between the MMPs and stakeholders. One new educational initiative from this year is the publication of a monthly stakeholder newsletter, which can be found here: http://www.dmas.virginia.gov/Content_pgs/altc-stkhld.aspx. These newsletters serve as a way for DMAS to provide CCC-related information to a large audience. Currently, this letter is distributed to 350 stakeholders each month.

One of the targeted training initiatives focused on Department of Social Services (DSS) eligibility workers. Eligibility workers often become the main point of contact for beneficiaries on Medicaid programs. It came to the attention of CCC staff that some DSS Eligibility Workers were not fully aware of the CCC program and in some cases provided incorrect information to prospective and current enrollees. In limited cases, this caused the enrollee to opt-out of the program. To address this issue, CCC staff held education events at local and regional DSS offices for eligibility workers and their supervisors. CCC staff previously provided education and training to DSS through DSS Broadcasts, quarterly DMAS webinars, regional leadership training, and eligibility worker association meetings, but feedback indicated this education was not passed along to the eligibility staff. Additionally, CCC staff provided education and training to the Virginia Benefit Program Organization (BPRO), a professional organization that supports benefit program staff.

Another targeted training was conducted by CCC staff for the MMP care coordinators. From our evaluation and outreach efforts, CCC staff heard from providers and beneficiaries that there were gaps knowledge among the MMP care coordinators, for example, around the Long Term Services and Supports (LTSS) initiative and transition services. To address this issue CCC staff initiated two education and training strategies: hold bi-weekly calls for all MMP care coordinators and conduct onsite training with the care coordinators.

The bi-weekly calls began on April 3, 2015. DMAS staff provides education on specific topics related to LTSS, consumer direction, Money Follows the Person, hospice and other issues as needed. DMAS staff conducts testing/polling of the care coordinators knowledge and provide for a Question and Answer period that encourages care coordinators to share best practices. These calls average 145-175 participants per call and have been praised by the care coordinators.

"I learn so much from our peer-to-peer calls- resources in the community I haven't heard of, better ways to do transitions of care….I have never been a part of something like this before- but there is so much value in connecting with all these people. I truly feel like we are getting somewhere and working together to get there…"

-Care Coordinator

The care coordinator onsite trainings are new as of May 2015 and educational topics thus far have focused on provider relations, proper completion of Health Risk Assessment, Plans of Care and Interdisciplinary Care teams, LTSS, Consumer Direction, EDCD Waiver Services and general knowledge of the CCC philosophy of care. As part of these training sessions, care coordinators are given pre and post-tests to gauge their understanding of the program before and after the training. The average pre-test scores across the plans for the first training were 69.6% correct and the average post test scores were 80.3%. A second round of trainings was held in June 2015. CCC staff will hold a third round of trainings in the late summer or fall of this calendar year. As with the twice monthly calls, the participants have provided positive feedback and generally feel that it's been tremendously helpful. One training attendee wrote on their evaluation form, "I have a PhD in education so I can recognize a well-planned and executed training."

Quality Monitoring

CCC has a robust Quality Monitoring Program which has been designed to ensure that beneficiaries are receiving high quality health care. To facilitate the monitoring program, CMS and DMAS staff implemented a Quality Infrastructure Plan in FY 2015. This plan

established and designated specific quality monitoring tasks and initiatives as well as the structure under which they will be addressed. These efforts resulted in the creation of several Quality Monitoring workgroups and committees including but not limited to: CMS and DMAS Quality Management Committee, CMS and DMAS Quality Monitoring with the MMPs, DMAS Quality Learning Collaborative with external stakeholders, and MMP Member Advisory Committees.

One example of how these groups help ensure that high quality health care is being provided is from the CMS and DMAS Quality Monitoring group. This group meets with the MMPs bi-weekly to review a series of quality assurance measures, such as: health risk assessment, plan of care, interdisciplinary care team completion rate; claims and authorization timely processing rate; as well as grievances and appeals resolutions. This process provides the MMPs with feedback and the opportunity to improve upon their processes in a timely manner.

An additional aspect of the CCC Quality Program requires MMPs to conduct quality improvement projects focusing on member care management and cardiovascular disease. MMPs are provided incentives by DMAS to meet performance benchmarks to earn back a portion of capitation payment that are withheld through the CCC Quality Withhold Program. Quality improvement activities are monitored via ongoing meetings with the MMPs by CCC staff. Furthermore, DMAS has contracted with Health Services Advisory Group as our external quality review organization to conduct third party auditing on the MMPs' operation system, performance measures reporting, performance improvement projects and encounter data reporting. Member and external stakeholders have provided input to the quality measures and initiatives via the CCC Quality Learning Collaborative and MMP Member Advisory Committee.

To promote transparency and educate stakeholders on the effectiveness of CCC, DMAS staff created a series of CCC Quality Monitoring Dashboards. The first of these dashboards focuses on Care Management and can be found here: http://www.dmas.virginia.gov/Content_pgs/ccc-qm.aspx. Each dashboard requires CMS review and approval prior to publication. New and updated dashboards will be added as they are approved.

Evaluation Program

Because the CCC Program represents a new care delivery model in Virginia, DMAS partnered with George Mason University (GMU) to evaluate the program by forming a team composed of agency staff and GMU faculty. DMAS staff is responsible for the

qualitative component of the evaluation, while GMU faculty is responsible for the quantitative component. 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. To assess the overall impact of the CCC Program on various costs, quality, and utilization outcomes over time, the DMAS/GMU 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. Major evaluation activities completed over the past year include:

- Observed approximately 60 hours of care management activities to collect first-hand information on how services are being provided to both LTSS and community well (CCC enrollees that reside in the community and are not enrolled in the EDCD Waiver) enrollees;

- Conducted roughly 26 interviews of LTSS and behavioral health provider staff to collect information on their experiences with the CCC Program;

- Partnered with the Virginia Association of Centers for Independent Living, the Virginia Association of Area Agencies on Aging, and the Virginia Association of Community Services Boards to organize a series of focus groups and/or interviews with enrollees and/or family members/caregivers to gain insight into how end users are experiencing the CCC Program;

- Presented on the evaluation at five CCC stakeholder advisory committee meetings, three CCC evaluation advisory committee meetings, and several national conferences;

- Completed an evaluation report in April 2014 that provided preliminary findings based on initial fieldwork activities and another report in March 2015 that examined DMAS' implementation of the CCC Program; and

- Surveyed random samples of LTSS enrollees and dual eligible beneficiaries who declined enrollment to examine their level of satisfaction with current health care services as well as their understanding of the CCC Program.

The CCC evaluation is scheduled to run through December 2017 and information is being posted online as it becomes available.

In order to share our evaluation findings with stakeholders and the general public we have created a CCC Evaluation webpage which can be found here: http://www.dmas.virginia.gov/Content_pgs/ccc-eval.aspx. For specific information on our evaluation findings please see the "Notes from the Field" documents and the various presentations. Additionally, Department evaluation staff are in the process of completing a brief case study on one beneficiaries experience in CCC. Her story will be posted on the Evaluation webpage once it is finalized.

Behavioral Health Homes

Integrating behavioral and medical health in chronic care populations is of particular interest to the Commonwealth. Not only does it serve to enhance the overall quality of life for the beneficiary, it has been shown to garner impactful cost savings when behavioral health and medical care are coordinated effectively. A 2014 CMS report on co-occurring behavioral and medical conditions found that 41% of dual eligibles had a mental health and chronic condition diagnosis and were roughly double the Per Member Per Month (PMPM) rate than those beneficiaries with no behavioral health diagnosis. Key findings and subsequent recommendations from a variety of sources suggest that integrating behavioral health into primary care for these beneficiaries is the solution to curbing the cost and improving physical health care outcomes for these individuals.

In response to the growing evidence, DMAS implemented a Behavioral Health Home (BHH) pilot within the CCC program. As part of the three-way (CMS, DMAS and MMP) contract, the MMPs are required to work with community partners to develop BHHs for CCC enrollees with serious and persistent mental illness (SPMI). The goal of the pilot is to provide beneficiaries with a comprehensive behavioral health management program that integrates physical and behavioral health services and has access to staff and resources to improve health care delivery, including the ability to rapidly respond to acute episodes for enrollees. Enrollment into the BHHs began in May of 2015.

The CCC MMPs and Community Services Boards/Behavioral Health Authority (CSB/BHA) have been collaborating to develop BHHs within the CCC Regions, resulting in thirteen BHHs across the five CCC regions. Two of the CSBs/BHAs have developed a "blended" BHH where they have contracted with each of the MMPs and implemented one BHH; one of these is in Central Virginia and the other is in Tidewater. Enrollment into the BHHs began in April of 2015. As of July 1, 2016, there were 229 CCC beneficiaries with SPMI enrolled in a BHH.

Early in the rollout of CCC, the MMP Behavioral Health representatives and the Virginia Association for Community Services Boards (VACSB) developed a Steering Committee to plan and address behavioral health issues across the CCC project. In late spring, the

Steering Committee added the BHH program as part of their focus. While there is active care coordination and service plan development by the Interdisciplinary Care Team (ICT) and it is generally believed that the BHHs are progressing, there have been some concerns raised. Notably, the MMPs and CSBs have voiced concern over the challenges they face when CCC beneficiaries "opt out" of an MMP or change MMPs frequently as this makes care coordination, service authorization and claims processing difficult. Additionally, it has been a challenge across the MMPs to ensure that the primary care physician is attending the ICT meetings; but each plan is strategizing how to address that need. Each of the MMPs has identified patient education best practices; some conducted solely by the MMP and some in partnership with the CSBs. One MMP is developing a patient education "tool kit" specifically for the BHH target population.

Moving forward, the CCC MMPs will provide DMAS with a written summary of BHH activities twice a month. DMAS anticipates having a more involved role monitoring this component of the demonstration with the addition of staff with expertise in behavioral health on the CCC team

Implementation Challenges

The Financial Alignment Initiative (i.e., Dual Eligible project) is unique in representing the first program to truly integrate the Medicaid and Medicare programs. As these initiatives were implemented in the Commonwealth and throughout the country, certain challenges arose. While none of the challenges discussed below is insurmountable, documenting them will ultimately help with broader implementation of similar projects in the future.

Enrollment Volatility

One of the unique features of the CCC program is the voluntary nature of enrollment. The ability of enrolled and eligible enrollees to continually opt in and out of the program has proved to be exceedingly complex to manage for providers, DMAS and MMPs. Despite it being seen as a benefit for beneficiaries, it has proved to be confusing to them as well. For the providers and MMPs, the challenges arise when attempting to submit and process service authorizations and claims, as well as trying to coordinate care for beneficiaries as they move between MMPs and fee-for-service. For DMAS the complications arise when DMAS has an individual enrolled and CMS may not; this causes DMAS to have to align this enrollment each month. Finally, beneficiaries get confused because a letter is generated every time the beneficiary's enrollment status changes, in accordance with federal regulations. In some instances, beneficiaries opt in and out or switch MMPs multiple times in one day.

DMAS has shared these concerns with CMS and will continue to work on ways to refine the process to minimize the impact on providers, MMPs and beneficiaries.

Enrollment Systems

The coordination of the CMS and DMAS IT systems continues to be particularly complex. By early FY 2015, the enrollment errors created due to systems communication errors numbered in the thousands. To combat this problem, DMAS added a part-time staff member to assist in resolving the back-log of systems enrollment errors and to identify and resolve new issues as needed. By December of FY 2015, the back-log had been corrected. To aid in the identification of new systems issues, DMAS established a process for reviewing all enrollment actions on a daily basis. This approach has greatly limited the number of issues and minimized impact. CMS and DMAS are currently working on a process where DMAS staff can have authority in CMS' system to correct errors within their records. This will significantly reduce the time it takes to resolve issues thereby lessening the impact on the beneficiaries.

Claims Processing

Early in FY 2015, it was learned that each MMP experienced system errors related to proper payment to nursing facilities. Specifically, the MMPs had difficulty applying patient pay adjustments against Medicaid billing, thus facilities were overpaid by utilizing the unadjusted Medicaid rate. Next, with resource utilization groups (RUG) based billing, each MMP applied the RUG rate incorrectly which caused claims to be paid improperly or go unpaid all together. At one point it was estimated there were over $12 million in outstanding claims for the latter.

To address these issues DMAS, the MMPs and representatives from the nursing facility industry, including VHCA, and the Virginia Association of Health Plans (VAHP), established a workgroup with the goal of continuing the progress toward a more efficient and consistent billing process under CCC so that all the MMPs can begin to meet the 14 day payment requirement contained in their contract with DMAS and CMS.

To date the MMPs have corrected the issues related to improperly applying the RUG rate. MMPs are now beginning to address the over payments due to incorrectly applying the patient pay adjustments. Additionally, they produced helpful training materials, held regularly scheduled calls and continued on-site troubleshooting as needed. Furthermore, through the VHCA/VAHP Claims Workgroup, the MMPs standardized certain billing processes and forms. It is expected that these changes will resolve many of the unique issues that nursing facilities have experienced since implementation of the CCC program; however, it is critical that both parties continue to collaborate for the remainder of the demonstration.

Care Coordination

The success of CCC depends on the ability of the care coordinators to work effectively with beneficiaries, their caregivers and the providers. As the program became operational, DMAS identified areas of improvement to better enable care coordinators to work effectively with beneficiaries, their caregivers and the providers. In many cases, it was noted that there was a need for better understanding of consumer direction, accessing community services and transitions of care. To ensure care coordinators from all three MMPs were receiving uniform messaging and education, DMAS initiated bi-weekly calls the state. The calls and the training are discussed more fully in the Education and Training section of this report.

Additionally, DMAS, VHCA, the MMPs and recently VAHP have developed an ongoing Care Coordination workgroup to collaborate on common areas of concern. Though some nursing facility providers have reported positive feedback and noted that the MMP care coordinators have been helpful to their residents, others are less clear about the roles and responsibilities of care coordination and how this function fits into their own organizational structures. Some have voiced general concerns regarding the care coordinator's involvement in care planning, service facilitation and transitions of care. One of the primary goals of the workgroup is to further define the role of the care coordinator and what is necessary for this specific population across all three MMPs.

This workgroup, along with the claims processing workgroup discussed in the previous section, will work to produce helpful educational materials, identify best practices and processes, identify policy barriers and find efficiencies and collaborative solutions that will help providers on the ground, operating in and around the CCC program. Through these collaborative efforts, the groups hope to improve communication and overall cohesiveness between providers, health plans, the agency - and most importantly, the CCC beneficiaries and their families.

Appropriations and Expenditures

The 2013 Appropriations Act provided administrative funding for State Fiscal Year's 2014 and 2015 to assist with the implementation costs of CCC. The approved amounts, reflected in table below, cover costs to:

- hire necessary personnel to implement and oversee the program (program analyst, quality analyst, and supervisor);
- support contract modifications for the Commonwealth's Medicaid External Quality Review Organization, as required by federal regulations for Medicaid managed care systems;

- cover implementation and initial operating costs for the enrollment broker; and
- cover actuary expenses to develop rates for the MMPs.

CCC APPROPRIATION		
FY 14		
GF	NGF	Total
$650,784	$1,850,891	$2,501,675
FY 15		
GF	NGF	Total
$1,208,568	$2,408,675	$3,617,243
Total to Date		
GF	NGF	Total
$1,859,352	$4,259,566	$6,118,918

Additional total funding of $1,115,564 ($557,564 GF and $557,564 NGF) was requested during the 2014 General Assembly Session. The request was approved and is reflected in the FY 2015 appropriation. The increase is provided to support contract modifications that cover:

- Increased costs for implementation and initial operating costs for the enrollment broker; and increased costs to cover actuary expenses to develop rates for the MMPs, and

- Support contract modifications to cover the addition of LTC/Acute and Expedited Enrollment for the enrollment broker contact.

Projected Cost Savings

As a requirement of CCC, Medicaid payments to MMPs are based on estimates of what would have been spent in absence of the CCC Program, less a savings adjustment of one (1), two (2), and four (4) percent in years one (1), two (2) and three (3), respectively.

Current projected savings estimates show a net savings of $2.5 million in FY 2015 and $4.3 million in FY 2016. These figures are based off the reduction in the capitated payment amounts as described above and the anticipated savings in reduced service needs of the enrollees due to a more robust care coordination model. The FY 15 projections are restricted because the provision of services had just begun for a limited segment of enrollees at the time this report was written and the total enrollees have been fewer than anticipated.

The table below shows the projected savings by state fiscal year using the formula described in the first paragraph. The column labeled "Cost Without CCC" reflects the projected total Medicaid costs for dual eligible beneficiaries if CCC was not an option,

while the column labeled "Cost With CCC" reflects the projected total Medicaid costs for dual eligible beneficiaries now that CCC is available and operating.

CCC ANTICIPATED SAVINGS			
	COST WITHOUT CCC	COST WITH CCC	NET SAVINGS
FY 15	$249,777,127	$247,279,356	($2,497,771)
FY 16	$309,903,752	$305,524,631	($4,378,621)

Beneficiary Success Stories

It is important to recall why this program was created – to streamline and improve the health outcomes and care coordination for individuals who must navigate the Medicare and Medicaid systems. The examples below of CCC beneficiaries are important reminders of why, despite the challenges associated with adjustment to the CCC Program, the person-centered model of integrated service delivery can make a significant difference in a beneficiary's life.

Success Story One: This particular case describes an EDCD (Elderly Disabled Consumer Directed) waiver who is living in her own home with attendant care services. She has Alzheimer's disease, congestive heart failure, aphasia, and is incontinent. The member's daughter is the member's primary caregiver and stays with the member when there is no attendant present. This story exemplifies excellent care coordination and success in keeping the beneficiary in her home, where her family feels she is best served

When the care coordinator first met with the member and her daughter to complete the care assessment, the care coordinator noticed that the daughter was distressed from the strain of providing care for so much of the time. She learned that the burden of being the primary caretaker with little relief was pushing the daughter to consider nursing home placement. The care coordinator discussed the various options for care with the daughter, and completed the Task/Hour Guide assessment. Those results indicated that the member's condition warranted an increase in hours. The care coordinator explained that to the daughter, and facilitated the approval of the increased hours.

Once the increased hours were implemented, the Care Manager monitored the situation closely. The member's daughter said that she was so relieved to have the additional assistance and care for her mother that she felt she could continue caring for her mother at home after all. The daughter shared that she really appreciated knowing that she has

some support now that her mother is in the CCC program, and that the care coordinator is available to help the family whenever they need her.

The intervention from the MMP care coordinator and the coordination of care provided was instrumental in enabling the member to remain in the home, and giving the daughter the support she needed to remain the primary caretaker.

-DMAS Stakeholder Update, October 2014

Success Story Two: The second case story demonstrates the true nature of person-centered care. Care coordinators are trained to identify needs, address the comprehensive aspects of health and develop a personalized plan of care accordingly. Because of their close interaction and relationship with the beneficiary, care coordinators are poised to support members in a way that is unique to managed care programs for the long term care population. In this example, the care coordinator identifies behavioral health needs, socioeconomic barriers to care (transportation), and value-added benefits that could help increase the member's quality of life.

"During the Health Risk Assessment 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."

-DMAS, 'Notes from the Field,' March 2015

Summary

Virginia's Medicare-Medicaid beneficiaries face a set of unique challenges and barriers, to include multiple chronic health conditions, co-occurring behavioral health needs and physical disabilities. As noted in the opening of this report, these individuals have the most complex and costly health care needs of any Medicare or Medicaid members. The primary aim of the CCC program is to improve the quality of life for these vulnerable individuals and their families. In order to better serve these individuals and reduce costs, the CCC program aims to: reduce fragmentation; provide high-quality and coordinated care; improve the health and lives of enrolled individuals; reduce the need for avoidable

services, such as hospitalization and emergency room use; encourage individual participation in treatment decisions; and support the goal of providing treatment in the least restrictive, most integrated setting.

The CCC program is predicated on the person-centered mission and has demonstrated impressive results under challenging circumstances. The success stories noted above demonstrate how CCC is working to achieve the goals for all 29,507 enrollees. By aiding beneficiaries in accessing critical medication, additional covered services and utilizing existing community resources CCC will reduce the need for more intensive and avoidable services and be able to keep beneficiaries in their own homes longer and safer.

There is still much work ahead. This report summarizes the implementation challenges, including coordination of the Medicare and Medicaid IT systems, provider payment errors and uniform implementation of care coordination principles and best practices. In part these challenges have led to some of the 28,208 opt-outs. The Department has been working diligently with our stakeholders to ensure the current challenges are overcome in an efficient manner and potential future challenges are avoided altogether.

These experiences have provided the state and MMPs the knowledge to make appropriate changes to systems and processes to adapt to the complexities of the dual population. For the remainder of this demonstration, it is anticipated the knowledge gained will lead to significant improvement in the health care and lives of the CCC enrollees.