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December 1, 2016

**MEMORANDUM**

**TO:** The Honorable Terence R. McAuliffe
Governor of Virginia

The Honorable Thomas K. Norment, Jr.
Co-Chairman, Senate Finance Committee

The Honorable Emmett W. Hanger, Jr.
Co-Chairman, Senate Finance Committee

The Honorable S. Chris Jones
Chairman, House Appropriations Committee

Daniel Timberlake
Director, Department of Planning a d Budget

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

SUBJECT: Quarterly Report on Progress of the Financial Alignment Demonstration for Medicare-Medicaid Enrollees (1st Quarter – State Fiscal Year 2017)

The 2016 Appropriation Act, Item 306 AAAA and ZZ(2) requires a quarterly report on the implementation of the Commonwealth Coordinated Care program, including information on program enrollment, the ability of Medicare and Medicaid Managed Care Plans to ensure a robust provider network, resolution of provider concerns regarding the cost and technical difficulties in participating in the program, quality of care, and progress in resolving issues related to federal Medicare requirements which impede the efficient and effective delivery of care.

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

*ADMINISTERING MEDICAID AND THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM IN VIRGINIA*

***DMAS' mission is to provide a system of high quality and cost effective health care services to qualifying Virginians and their families.***

The Medicaid program, signed into law by President Lyndon B. Johnson on July 30, 1965, celebrated its 50th year in 2015.

Medicaid is a joint federal and state program authorized under Title XIX of the Social Security Act that provides health and long-term care coverage for specific groups of Virginians with low incomes. In Virginia, Medicaid is administered by the Department of Medical Assistance Services (DMAS) and is jointly funded by Virginia and the federal government. Virginia's federal matching rate, known as the Federal Medical Assistance Percentage (FMAP) is generally 50%, so Virginia receives $1 of federal matching funds for every $1 Virginia spends on Medicaid.

Medicaid is primarily available to children in families with low-income, pregnant women, elderly, individuals with disabilities, and parents below strict income limits.

DMAS also administers Virginia's Children's Health Insurance Program (CHIP) known as FAMIS. FAMIS covers children and pregnant women in families earning too much to qualify for Medicaid but too little to afford private insurance.

All states must follow federal Medicaid/CHIP guidelines regarding who is covered, but set their own income and asset eligibility criteria. Virginia's eligibility criteria are among the strictest in the nation.

VIRGINIA'S MEDICAID PROGRAM
DMAS
INNOVATION · QUALITY · VALUE

## Report to the General Assembly

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

Commonwealth Coordinated Care
Medicare & Medicaid working together for you

**November 2016**

**Report Mandate**: The 2016 Appropriation Act, Item 306 ZZ(2) and AAAA(1) requires:
ZZ(2) The department shall include in the fall quarterly report required in paragraph AAAA. of this Item an annual update that details the implementation progress of the financial alignment demonstration. This update shall include, but is not limited to, costs of implementation, projected cost savings, number of individuals enrolled, and any other implementation issues that arise.

AAAA(1) The Department of Medical Assistance Services (DMAS) shall provide quarterly reports beginning on July 1, 2015, to the Governor, Director, Department of Planning and Budget and Chairmen of the House Appropriations and Senate Finance Committees on the implementation of the Commonwealth Coordinated Care program, including information on program enrollment, the ability of Medicare and Medicaid Managed Care Plans to ensure a robust provider network, resolution of provider concerns regarding the cost and technical difficulties in participating in the program, quality of care, and progress in resolving issues related to federal Medicare requirements which impede the efficient and effective delivery of care.

## Background

Nationally, and in the Commonwealth of Virginia, Medicare-Medicaid enrollees have extremely complex health care needs, including multiple chronic health conditions, behavioral health needs, and disabling conditions. Even though beneficiaries enrolled in both 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.

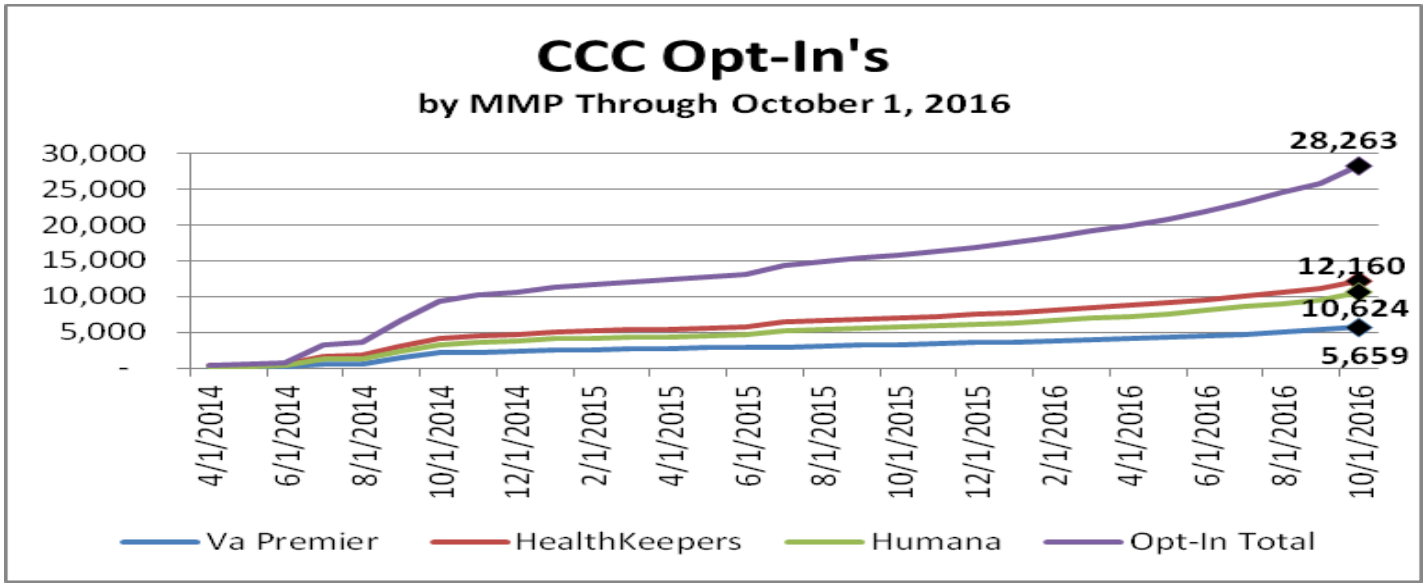
To operationalize CCC, the Department of Medical Assistance Services (DMAS) underwent a competitive procurement process and selected three Medicaid Medicare health plans (MMPs) to help meet the following CCC program goals:

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.

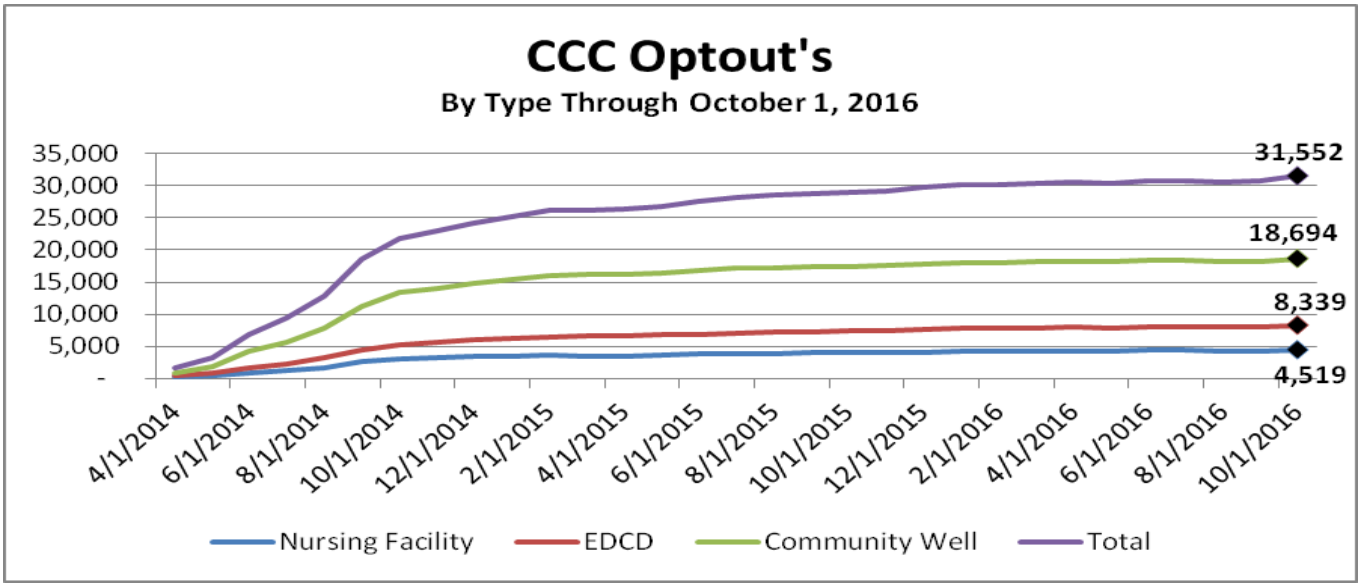
Since its implementation in March 2014, DMAS and the MMPs have made significant strides in operationalizing a coordinated, integrated model of care for dual eligible individuals. The CCC's goals have helped to drive business practices and improvements despite continued challenges. The progress and achievements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

## CCC ENROLLMENT FIGURES

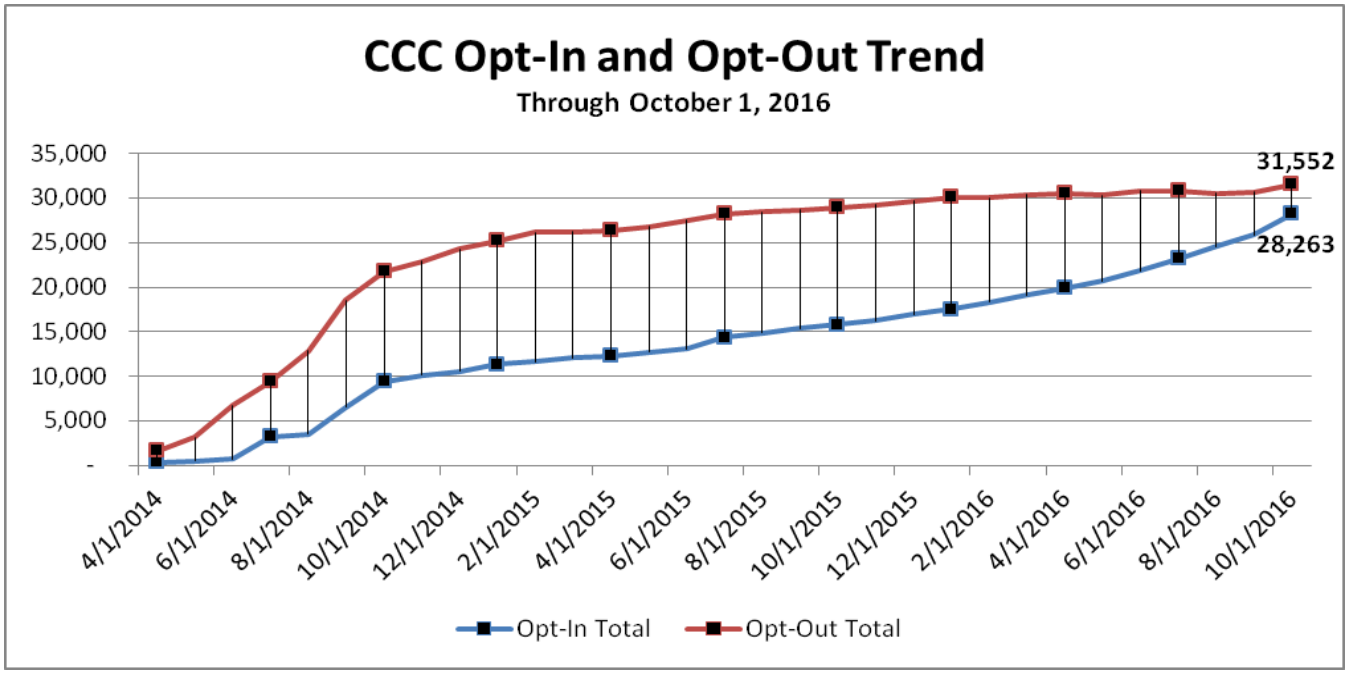
The number of individuals electing to opt in to CCC continued to trend upward in the first quarter of FY 2017. There are currently 28,263 total CCC enrollees compared to 27,034 from the last quarter of FY 2016. Of the total current enrollees, 12,160 (43%) are enrolled with Anthem; 10,624 (37%) are enrolled with Humana; and 5,659 (20%) are with Virginia Premier. The distribution of enrollees between the MMPs is largely, though not exclusively, due to the size of the MMPs provider networks. Since Anthem and Humana meet network adequacy requirements in more localities, they receive more enrollees through the automated intelligent assignment process, which uses an algorithm to assign enrollees to a specific health plan based on previous Medicare managed care enrollment and historic utilization.




The number individuals eligible for CCC who opt out and dis-enroll from CCC also continued to rise to 31,552 in the first quarter of FY 2017 from 30,830 in the last quarter of FY 2016. However, the overall rate of opt-outs and dis-enrollments is slower than the rise in individuals electing to opt in. The majority (59%) of opt-outs come from the community well (not living in a nursing facility and not on the EDCD waiver) population. DMAS and CCC continue to work toward reducing the number of opt-outs and dis-enrollments through outreach and education efforts, as well as through efforts aimed at reducing waiting periods for the enrollee's first contact with the MMP Care Coordination staff. A more detailed explanation of DMAS' outreach efforts can be found in this report under "Education and Outreach."




The slowing of opt-out rates, combined with continuing increase in enrollments, has resulted in a decreased gap between the number of opt-outs and opt-ins. Of those who have acted, 53% have opted out of CCC and 47% have opted in, as compared to 55% opting out and 45% opting in from just six months ago. These figures, however, do not account for the 8,355, or 12% of the total CCC eligible population, individuals eligible for CCC that live in a single MMP locality and therefore do not have to opt-in or out. As the Department moves forward with the transition to the Managed Long Term Services and Supports program (called Commonwealth Coordinated Care Plus or CCC+) education and outreach efforts will continue in anticipation of reducing the gap even further.




## 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, has 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 the Behavioral Health Home initiative.

## ENROLMENT AND NETWORK ADEQUACY

There were two significant changes to the provider networks in FY 2016. First, Mecklenburg County was added for "opt-in only" beginning June 1, 2016. This meant that only one health plan met network adequacy requirements in that locality. As a result of this change, individuals eligible for CCC must now affirm that they want to opt in to CCC and cannot be passively assigned. Second, Fauquier County was added for "passive assignment" beginning July 1, 2016. This means that at least two health plans have met network adequacy in that locality. As a result, individuals eligible for CCC who reside in Fauquier were passively assigned to one of the health plans using the automated intelligent assignment process on July 1, 2016. Individuals passively assigned have 60 days to opt out of CCC prior to their service begin date if they wish to dis-enroll.

## CONTRACT MONITORING

The CMS and DMAS Contract Monitoring Team (CMT) continued to focus on services to members and ongoing operations. The CMT consists of DMAS and CMS management and operations staff who are charged with monitoring the MMPs to guarantee their compliance with all aspects of the CCC contract. The CMT decreased the frequency of contract monitoring calls with each MMP from bi-weekly to monthly, with ad hoc calls as needed.

The CMT dashboard was revised to incorporate reporting of reassessment and Plan of Care (POC) revision data, in addition to information related to initial Health Risk Assessments (HRA) and POC by subpopulations, the number and status of appeals and grievances, member emergency room visits, hospitalizations and length of hospital stays, claims processing and MMP call center activity.

MMP dashboards are submitted prior to monthly 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.

"Secret Shopper" calls were made to each MMP's customer service line, requesting information regarding the plan's ability to address non-English speaking members' needs and the accuracy of general program information.

DMAS staff conducted on-site reviews of each MMP during August and September 2016. The results are being compiled and reports are being finalized. Areas of review included staff qualifications, compliance with appeal and grievance requirements, Elderly or Disabled with Consumer Direction enrollments, contact attempts for difficult to reach members (identified as Unable to Contact) and ongoing care coordination activities.

## 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 dual demonstration program, Virginia's state administrators have been asked to share the lessons learned with other states undergoing dual demonstration projects. Virginia is also 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 continued to place an emphasis on general stakeholder education, targeted training, and educational discussions on specific operational issues. Additionally, CCC staff made themselves available for training and education upon request by stakeholder groups. The number of requests for presentations decreased, as interest in the new Managed Long Term Supports and Services (MLTSS) program increased.

The beneficiary and provider calls held by DMAS and MMP staff were eliminated after discussions with stakeholders. It was agreed that there was no longer a need for regular calls and that if needed in the future, they could be re-started. There have been no requests by stakeholders to resume these calls.

Fauquier County became newly eligible for automatic enrollment of eligible individuals with an effective date of July 1, 2016 into Humana or Anthem Healthkeepers MMP. A town hall for providers and beneficiaries/advocates was held in May 2016 with presentations by DMAS, Humana, Anthem and representatives from the Department of Aging and Rehabilitative Services to discuss the Virginia Insurance Counseling Assistance Program (VICAP) and Ombudsman information. Similar town halls for providers and beneficiaries were held in September 2016 in Martinsville and South Hill when Henry County, Martinsville, and Mecklenburg County became available for automatic enrollment with Humana or Anthem.

Another targeted training was conducted by CCC staff for the MMP care coordinators in March 2016. Training included evidence-based care transition strategies, inclusive of hospital discharges and follow-up (Coleman Model), care coordination strategies for different subpopulations, and Nursing Facility discharge planning.

Monthly care coordinator calls continued throughout 2016, with topics related to Behavioral Health services, LTSS, EDCD enrollment and NF admission/discharge notification to DMAS. DMAS staff provides education on specific topics and provides for a question and answer period that encourages care coordinators to share best practices. These calls average 125-160 participants per call and have been praised by the care coordinators.

Planning for future education and training opportunities is in progress. DMAS continue to work with providers and beneficiaries to understand the benefits of CCC and the effects of transitioning to the new MLTSS program, Commonwealth Coordinated Care PLUS (CCC Plus).

## QUALITY MONITORING

Over the past year the focus of the program has made a natural shift from enrollment and systems related issues to ensuring that the health care provided through the CCC MMP's meets the standards set forth in the three-way contract and the expectations of the CCC members and stakeholders. To meet this objective, DMAS, in partnership with CMS and the MMP's, set up a robust quality monitoring program. The subsections that follow are summaries of only a few of the activities undertaken over the past year. For more detailed information on the quality monitoring activities you can visit the CCC Quality Monitoring webpage.

### *Member Advisory Committee*

Working together CMS, DMAS and the MMP's have developed a robust quality monitoring infrastructure. One part of this infrastructure includes numerous committees that meet on a routine basis to provide the MMP's oversight and direction in implementing their health care quality monitoring programs. One such committee is the MMP's Member Advisory Committee. While CMS and DMAS also have standing quality committees with the MMPs and the MMPs have internal quality committees, it was important to involve the CCC enrollees in order to capture their voice and allow them the opportunity to guide us in improving the quality of care provided through this program.

The three-way contract between CMS, DMAS and MMPs requires each MMP to establish and maintain active Member Advisory Committees; however, the structure and governance of this committee is largely left to the MMP and the participating enrollees. During CY2016, these committees have matured to the point where now most of the committees are chaired by enrollees and frequently there are as many as 40 to 50 enrollees participating. Each MMP's Member Advisory Committee meets on a quarterly basis rotating between the CCC demonstration regions. Agenda items typically include member health benefits (covered and flexible services), health education and gathering member suggestions, listening to and resolving member questions and complaints, and collecting feedback on certain quality projects.

Through these committees DMAS has found that the CCC enrollees who participate become empowered and are generally more satisfied with their health plan because it allows members to provide direct feedback to MMPs on quality improvement projects that impact the quality of their health care. At the same time, the participating enrollees provide valuable member input and insights to help design and implement quality improvement projects and activities. One example of how enrollee participation aided the MMPs can be seen in the development and administration of the MMP annual member satisfaction and quality of life survey. Each MMP drafted their own survey, but before issuing them they consulted their Member Advisory Committees to ensure its efficacy. What they discovered was that the survey was too long and that then needed to limit the length to fewer than two pages and no more than 20 questions. The MMPs incorporated the suggestions knowing more members will complete the survey which will ultimately lead to more meaningful results.

***EQRO Work and Result***

In CY 2015, the DMAS External Quality Review Organization (EQRO) contractor, Health Services Advisory Group (HSAG), conducted an operations system review audit on each of the three MMPs. The subsequent reports were finalized at the end of CY 2015 and deficiencies were identified which each MMP is required to respond to with a Corrective Action Plan (CAP). The CAP's were reviewed and approved in March of 2016 and are currently being monitored by the CMT. As of October of 2016, all three MMPs' CAPs have been fully implemented. CMT will continue to monitor the MMP's progress in resolving these and other issues.

In addition to the operations system review, HSAG also conducted validation of the three MMP's performance measures. The primary objective of the performance measure validation process is to evaluate the accuracy of the performance measure data collected by the MMPs and to determine the extent to which the specific performance measures calculated by the MMP (or on behalf of the MMP) followed the specifications established by CMS and DMAS. The HSAG review included measures pertaining to timeliness of initial assessments of enrollees, development of plans of care with the required documentation and timeliness in adjudicating claims. The validation process included, but was not limited to, an off and on-site review of: the MMPs' IT system capacity, source code validation and supporting documentation review. The report from this process was finalized in early September 2015 and all three MMPs passed the validation audit without any further action required.

Finally, HSAG conducted a validation review of the MMP's Quality Improvement Projects (QIP). The QIP is part of the MMP's overall quality management strategy and is designed to achieve measurable improvement in specific MMP processes and outcomes of care. Early in the CCC program CMS and DMAS determined that the MMP's QIP will focus on improving member care management and prevention of cardiovascular disease. While DMAS staff monitors the implementation of the QIP through quarterly reports and meeting, HSAG's review ensures that the MMP's QIP are conducted in methodologically sound manner, meet all state and federal requirements and evaluate the implementation of the QIP itself. This validation process allows DMAS and our stakeholders to confirm that any reported outcomes are valid. The subsequent report shows that QIPs for each MMP were methodologically sound and achieved meaningful improvement.

***Performance Measures and Result***

One of the highlights of this year's Quality Program is that we now have more performance measure data from CY2014 and CY2015 to compare with the data being reported in CY2016. Performance measures for CCC can be generally

separated into three categories: Engagement Measures, Process Measures and Outcome Measures. It is by design that these categories follow the same basic path as an enrollee as they move through the program.

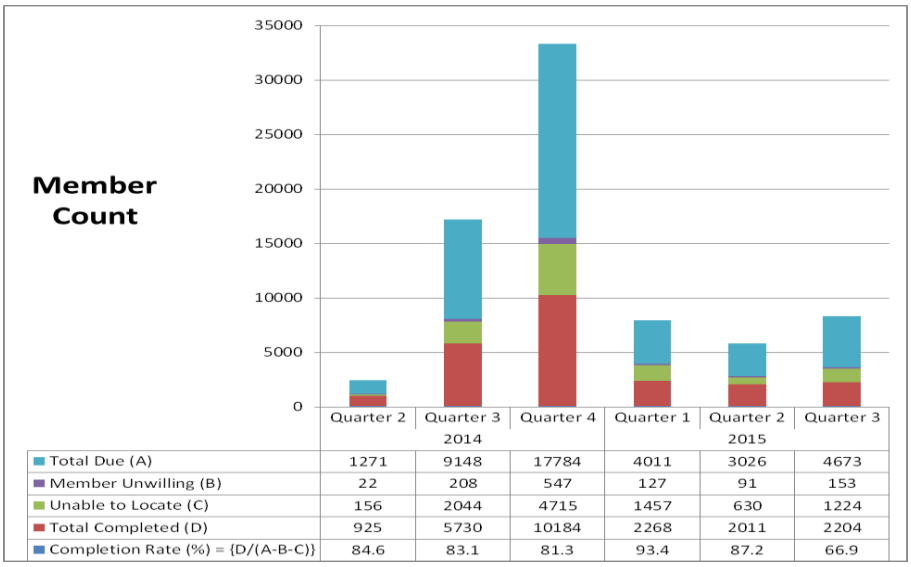

As illustrated above, these categories can be viewed as steps that every enrollee will follow as they move through CCC. First, the enrollee is engaged in services by the MMP that works with the enrollee to complete a health risk assessment (HRA) of the enrollee's health care needs and to develop a Plan of Care (POC). CMS, DMAS and the MMPs monitor the completion of the HRAs and POCs to ensure they are completed in a timely manner and are completed accurately. Next, DMAS uses numerous process measures to ensure members are receiving high quality care and making good progress in meeting the goals identified in his/her POC. Finally, at the end of the continuum are outcome measures that DMAS tracks to ensure CCC members have better quality of life and health care experiences. In the paragraphs that follow we have pulled out one measure from each of the three categories discussed above and will describe them in greater detail to provide a better understanding of the type of measures DMAS is capturing and analyzing.

***Engagement***

Across all three MMP's there are roughly 230 care managers assisting our members to navigate the complex health care system through care coordination, member education, and member advocacy. One of the care managers' first tasks when someone enrolls in CCC is to complete the member's HRA. An HRA is a comprehensive assessment of an enrollee's medical, psychosocial, cognitive, and functional status in order to determine their medical, behavioral health, LTSS, and social needs. For the first year of the demonstration (which encompasses both CY 2014 and CY 2015) the MMPs were required to complete the HRA with the member within 60 days for "vulnerable" populations (*e.g.*, EDCD enrollees, persons with Serious Mental Illness, I/DD, Individuals with complex or multiple chronic conditions, etc.), and 90 days for all others.

As illustrated in the table below, 82.8 percent of the CCC program's enrollees' initial HRA's were completed within the required timeframes. (CCC began in Quarter 2 of 2014). Based on CMS published national dual demonstration data, as of the end of quarter 3 of 2015, Virginia's CCC program ranked #3 among all State's participating in the financial alignment demonstration for initial HRA completion rate.

***Member's Initial HRA Completion***



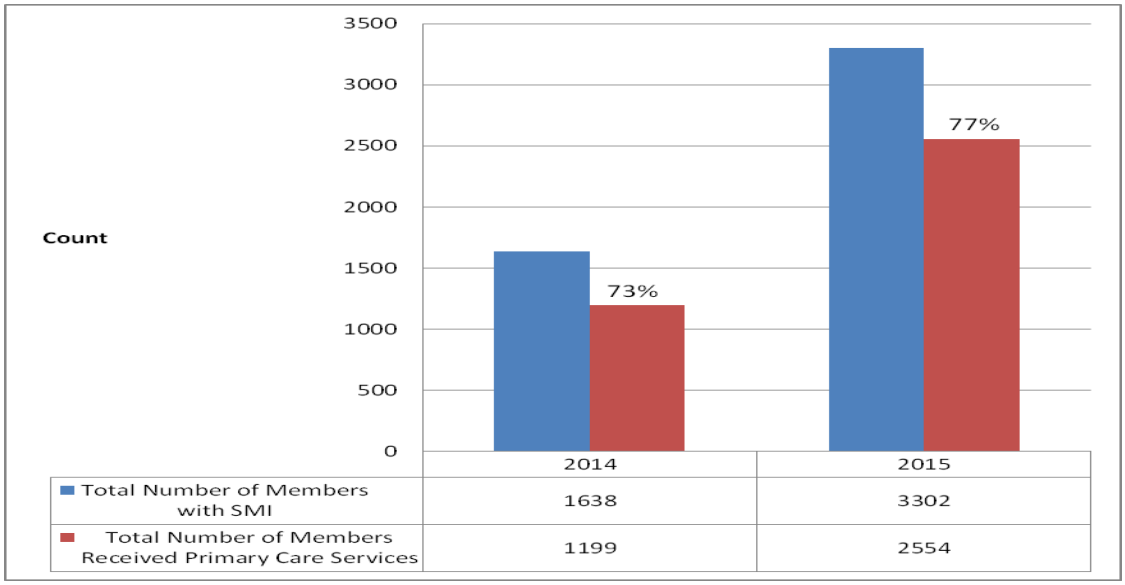

| | Quarter 2 2014 | Quarter 3 2014 | Quarter 4 2014 | Quarter 1 2015 | Quarter 2 2015 | Quarter 3 2015 |
|---|---|---|---|---|---|---|
| Total Due (A) | 1271 | 9148 | 17784 | 4011 | 3026 | 4673 |
| Member Unwilling (B) | 22 | 208 | 547 | 127 | 91 | 153 |
| Unable to Locate (C) | 156 | 2044 | 4715 | 1457 | 630 | 1224 |
| Total Completed (D) | 925 | 5730 | 10184 | 2268 | 2011 | 2204 |
| Completion Rate (%) = {D/(A-B-C)} | 84.6 | 83.1 | 81.3 | 93.4 | 87.2 | 66.9 |

*Source: CCC Performance Database as of September 2016*

***Process Measure***

After the initial engagement, numerous process measures were utilized to ensure members are receiving high quality care and making good progress meeting the goals identified in his/her POC. One such measure is utilization of annual Primary Care Provider (PCP) visits. Annual PCP visits are a key component of member access to preventative care services as regular PCP visits facilitate timely diagnosis of illness and prevent costly emergency department visits and hospitalizations. For members with more complex health conditions, regular PCP visit is even more valuable. As illustrated below, for CCC members with severe mental illness (SMI), CCC has increased annual PCP visit rate from 73% in CY2014 to 77% in CY2015.

*Members with Severe Mental Illness (SMI) Received Annual Primary Care Services*




| | 2014 | 2015 |
|---|---|---|
| Total Number of Members with SMI | 1638 | 3302 |
| Total Number of Members Received Primary Care Services | 1199 | 2554 |

*Source: CCC Performance Database as of September 2016*

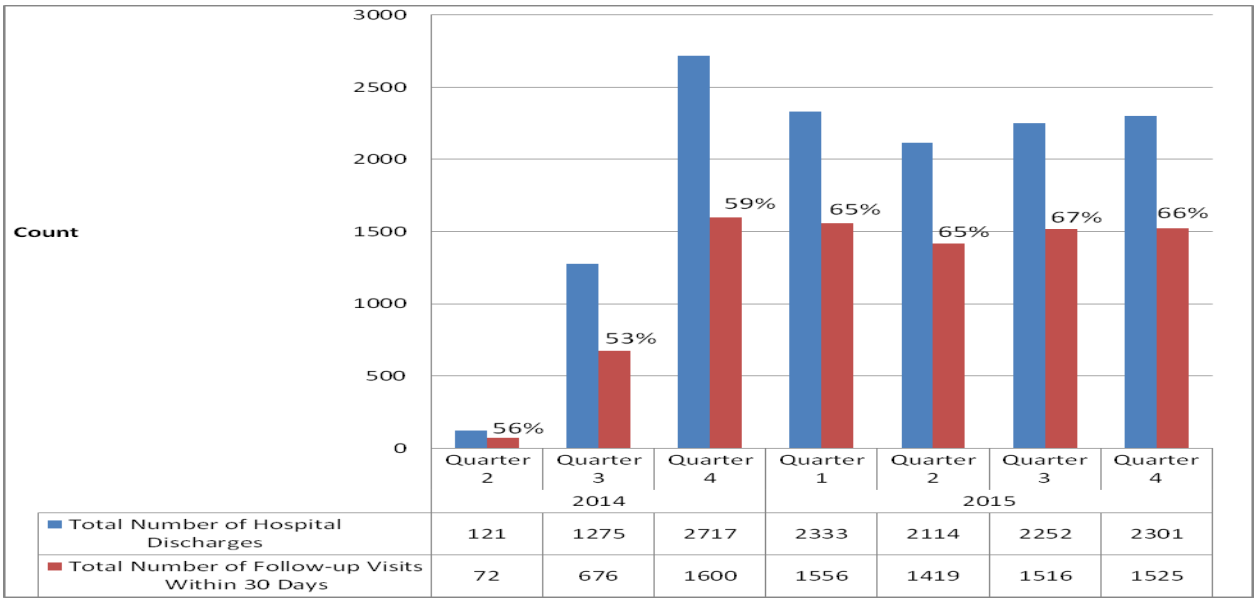
***Outcome Measure***

Ultimately, the purpose of CCC is to create better health outcomes for enrolled Virginians. One way CCC aims to do this is through intervention and assistance by care managers as an enrollee transitions from one care setting to another. A transition from one care setting to another, such as from a hospital to home, is one of the most vulnerable times for an enrollee and, if done improperly, can create gaps in the continuity of their care that can lead to readmission to the hospital, creating greater costs and less desirable health outcomes for the enrollee.

> ***"If I had to put a number on the whole Medicaid/Medicare insurance, as far as making [my] quality of life better, I would have to give it a 10. Because it has evolved so much now that it's enough even in the medical stance and getting you [out of] the house and helping you not to sit in the house wasting away. … When I was no longer able to walk, I had to depend on the Muscular Dystrophy Foundation to help me get a lot of my stuff. Now Medicaid [MMP} helps me get it or Medicare helps me get it. You have somebody to talk to now. They call you, like I say, once a month, make sure everything's all right, make sure the quality of life is still there, if there's [anything] they can do to help."***
>
> *– CCC enrollee*

With the guidance of CMS and DMAS, the MMPs developed and implemented care transition policies and procedures that require intensive care management during these transition periods. As a result each MMP has policies in place that require the enrollee's PCP to be notified of any transition in care setting and that a follow-up appointment with the PCP be scheduled. This allows the PCP to monitor the recovery process, engage any necessary intervention and work with the enrollee's interdisciplinary care team members to update member's POC. One of the measures used to demonstrate improvement in member care transition is the rate of PCP follow-up visits within 30 days of hospital discharges. As illustrated below, the MMPs have increased the rate of PCP follow-up visits over the course of the program.

*PCP Follow-up Visits within 30 Days of Hospital Discharge*




| | Quarter 2 | Quarter 3 | Quarter 4 | Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 |
|---|---|---|---|---|---|---|---|
| | 2014 | | | 2015 | | | |
| Total Number of Hospital Discharges | 121 | 1275 | 2717 | 2333 | 2114 | 2252 | 2301 |
| Total Number of Follow-up Visits Within 30 Days | 72 | 676 | 1600 | 1556 | 1419 | 1516 | 1525 |

*Source: CCC Performance Database as of September 2016*

***Member Surveys and Result***

To understand the enrollee experience in CCC, particularly with the quality of the health care they receive and the impact the program has had on their overall quality of life, the MMP's are required to conduct two sets of surveys: The Consumer Assessment of Healthcare Providers and Systems (CAHPS), and the CCC Merged Member Experience and Quality of Life Survey (Merged Survey). The CAHPS survey is a standard survey process required for most Medicare Advantage product lines, while the Merged Survey is a creation of DMAS and the MMPs based upon recognized survey tools that have been customized to fit the CCC program.

The CAHPS survey exhibits the member experience across several dimensions of care including, but not limited to: Getting Needed Care, Getting Appointments and Care Quickly, Doctors Who Communicate Well, Customer Services, Care Coordination and Getting Needed Prescription Drugs. Beginning early 2015, surveys were sent to a sample of CCC enrollees with at least six months of continuous enrollment. The results were then aggregated and compared to other State's participating in the Financial Alignment Demonstration. Given the variation in demonstration start dates and enrollment phase-ins, MMPs in different states were at various points of implementation when the CAHPS surveys were conducted. As a result, the 2015 findings provide a very early look at enrollee satisfaction. The results for CCC are encouraging; with CCC coming in no lower than #3 across the survey domains and typically surpassing the national average.

The results from the Merged Survey were similarly encouraging. The Merged Survey for CY 2015 was designed to test the enrollees' satisfaction with the assistance they've received from their care managers/care coordinators and if they feel they have better control over their health since joining CCC. The first surveys were sent in September of 2015 with the final report being submitted to DMAS on January 31, 2016. The survey results demonstrate that 86% of enrollees confirm they received a satisfactory level of assistance from the MMP care managers, 87% rate their care management services as good or better and 81% feel they have better control of their health since they joined CCC as a direct result of the care management services they received.

DMAS and the MMPs have reviewed the results of both surveys and have developed strategies to improve upon the results. Both the CAHPS and the Merged Survey are scheduled to be conducted again in 2016 and we look forward to seeing how these strategies have worked.

**To promote transparency and educate stakeholders on the effectiveness of CCC, DMAS staff created a webpage specific to CCC Quality Monitoring activities. This webpage is updated as more information becomes available and can be found here: http://www.dmas.virginia.gov/Content_pgs/ccc-qm.aspx.**

## EVALUATION PROGRAM

Because the CCC Program represents a major state reform initiative, DMAS partnered with George Mason University (Mason) to evaluate its impact using both quantitative and qualitative components. Mason faculty members are responsible for the quantitative component, while DMAS staff members are responsible for the qualitative component.

For the quantitative component, Mason faculty members are surveying individuals to examine changes in quality of care, access, and health care satisfaction and experiences. Thus far, they have surveyed approximately 1,000 enrolled individuals with long term service and support needs (LTSS); 516 individuals responded, representing a 52% response rate. In terms of the experiences of dual eligible individuals, the survey results indicate that the CCC Program is successful and has engendered a high level of satisfaction. In particular, 96% of the 516 individuals responding reported being very satisfied with their care coordinators; 91% reported that the enrollment process was easy to understand; and 74% reported no change in their health care services since enrolling, while 19% reported some improvement in their services since

enrolling. Currently, Mason faculty members are compiling results of a survey of individuals with LTSS needs who opted out of the CCC Program.

For the qualitative component, DMAS staff are observing care coordination activities and conducting participant interviews to understand what the program looks like from the perspective of the dual eligible individuals who are directly involved. Since June 2014, DMAS staff observed over 180 hours of care coordination activities and interviewed more than 80 individuals (including care coordinators and LTSS providers) in both group and individual settings across the Medicare-Medicaid Plans and demonstration regions. Staff identified several themes that allow for a more in-depth understanding of individual health care experiences. Examples include Developing Perspectives on CCC (defined as how individuals initially viewed the CCC Program and how their perceptions may vary over time); Engaging in CCC (defined as how individuals became involved in the program and how their involvement may change over time); Experiencing Relationships/Attachments (defined as how individuals develop and experience relationships with key individuals as part of their CCC engagement); Collaborating through Associations (defined as how care coordinators work with providers to support enrolled individuals), and Meeting Beneficiary Needs (defined as how the CCC Program can meet beneficiary needs by offering more resources).

The CCC Evaluation ended on September 30, 2016 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 beneficiary's experience in CCC. Her story will be posted on the DMAS Evaluation webpage once it is finalized.**

## BEHAVIORAL HEALTH HOMES

Integrating behavioral and medical health in chronic care populations continues to be of particular interest to the Commonwealth. Not only does it serve to enhance the overall quality of life for the member, it has been shown to create significant 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.

The CCC MMPs and the Community Services Boards/Behavioral Health Authority (CSB/BHA) have been collaborating to develop BHHs within each CCC Region, resulting in nineteen BHHs across the five CCC regions. 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. This total does not reflect the total number of members who have been served in BHHs, simply the number enrolled at the time. The opportunity for the CCC members to opt in and opt out of the MMPs and the BHH pilots made tracking the total number of members served since inception of the project very difficult.

Early in the rollout of CCC, the MMP Behavioral Health representatives and the Virginia Association of Community Services Boards (VACSB) developed a Steering Committee to plan and address behavioral health issues across the CCC project. In late spring of 2015, the Steering Committee added the BHH program as part of their focus. This Steering Committee has continued to meet via monthly conference calls. 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. In addition, the MMPs, VACSB and DMAS have revised the twice a month written summary and beginning in August 2016, the MMPs now submit a monthly report to DMAS about the BHH activities. All parties agreed that the report would include the following outcome measures:

| CCC BHH Outcome Measures |
|---|
| # Individuals having PCP Visits |
| # Individuals with ER Visits-Medical |
| #Individuals with ER Visits-BH related |
| #Individuals with inpatient admissions-medical |
| #Individuals with inpatient admissions-BH related |
| # Individuals with follow up appointments within 7 days of inpatient discharge-medical |
| # Individuals with follow up appointments within 7 days of inpatient discharge-BH |

Moving forward, the CCC MMPs and DMAS intend to continue to discuss these measures. Thus far, there appears to be some miscommunication between the MMP behavioral health representatives and the MMP staff who run the data as the report results at times differ from the verbal reporting of the MMP representatives. All parties are eager to achieve consistent reporting. An additional component being discussed is the need for a culture change within the community service delivery system regarding the concept of integrated care and the impact that has on day-to-day operations at the provider level. The Virginia service delivery system is fragmented and providers are not accustomed to close collaboration across disciplines. This is an ongoing topic for the CCC BHH Steering Committee.

## IMPLEMENTATION CHALLENGES

The CCC program is unique in representing the first program to truly integrate the Medicaid and Medicare programs. Now completing the second project year, the Commonwealth has moved from an implementation stage to a monitoring and refining stage for this initiative. Moving into the monitoring stage for the CCC Program, the Commonwealth has identified several areas of opportunities to refine and improve the operations of the program, as well as the enrollee experience.

**Enrollment Volatility**

One of the unique features of the CCC program is the voluntary nature of enrollment. The ability of enrolled and eligible members to opt in and out of the program on a monthly basis has proved to be exceedingly complex to manage for providers, DMAS and the MMPs. While the voluntary aspect of enrollment optimizes enrollee choice and offers certain enrollee protections, this "churning" of enrollees can result in disruptions in care. For the providers and MMPs, the challenges arise when attempting to submit and process service authorizations and claims, as well as efforts to coordinate care for beneficiaries as they move between MMPs and fee-for-service. For members, confusion arises because federal law requires that a letter be generated every time the member's enrollment status changes. In some instances, beneficiaries opt in and out or switch MMPs multiple times in one day. DMAS shared these concerns with CMS and will continue to work on ways to refine the process to minimize the impact on providers, MMPs and members.

**Enrollment Systems**

Despite the complexity in the coordination of the CMS and DMAS IT systems, improvements were made during the past year. To reduce enrollment discrepancies between the State and Federal enrollment systems, CCC increased the daily oversight of all enrollment transaction by hiring an additional part-time staff person. In addition, system enhancements were made to MMIS to automate several of the unsolicited enrollment transactions from the Federal system that historically caused enrollment discrepancies. This refinement not only reduced the number of enrollment discrepancies, it also reduced the need for staff resources.

**Care Coordination**

The success of CCC depends on the ability of the care coordinators to work effectively with members, their caregivers and the providers. As the program became operational, DMAS identified areas of improvement to better enable care coordinators to work effectively with members, 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 continued monthly calls with the MMPs' care coordination staff.

## 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 the costs associated with actuarial services required 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 |
| **FY 16** | | |
| GF | NGF | Total |
| $1,819,523 | $3,019,630 | $4,839,153 |
| **Total All Years** | | |
| GF | NGF | Total |
| $3,678,875 | $7,279,196 | $10,958,071 |

Additional total funding was requested and approved during the 2014 General Assembly Session of $1,115,564 ($557,564 GF and $557,564 NGF) for 2015 and $1,221,910 ($610,955 GF and $610,995 NGF) for 2016. This action is reflected in the FY 2015 and FY 2016 appropriation table values and was 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.

## 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.

Total net savings arising from the CCC program were $2.5 million GF in FY 2015 and $4.4 million GF in FY 2016. These figures are based upon the reduction in the capitated payment amounts as described above and the savings in reduced service needs of the enrollees due to a more robust care coordination model.

The table below shows the savings by state fiscal year using the formula described in the first paragraph. The column labeled “Cost Without CCC” reflects the total Medicaid costs for dual eligible beneficiaries if CCC were not an option, while the column labeled “Cost With CCC” reflects the total Medicaid costs for dual eligible beneficiaries now that CCC is available and operating.

**CCC SAVINGS**

| | COST WITHOUT CCC | COST WITH CCC | NET SAVINGS |
|---|---|---|---|
| **FY 2015** | $249,777,127 | $247,279,356 | **(2,497,771)** |
| **FY 2016** | $309,903,252 | $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 recipient who is living in his own home with attendant care services. He has anxiety, depression, COPD and is $O_2$ dependent. This story illustrates the excellent care coordination and the improvement of a member's mental and physical health seen in the CCC program.

*The care manager met face-to-face with the member and determined that much of his anxiety was related to the large Oxygen tank he was using. This tank was not portable and therefore the member felt he was unable to leave his home. After meeting with the member and hearing his concerns about the large, immobile tank, the care coordinator arranged for the member to have a portable oxygen tank that could easily be carried outside the home. The member praised his care coordinator and stated that he "loved the care that he received and the dedication she displayed in getting him his portable tank." The member stated this tank made such a difference in his life because he now had the ability to spend time with family and friends, with the result of improved overall physical and mental health.*

*As a result, the member's ER visits and hospitalizations decreased, with the member having no admissions for months at a time. He continues to enjoy his improved quality of life.*

Success Story Two: This member is a 53 year-old male with history of remote CVA (a condition caused by stroke), obesity, arthritis, and schizophrenia. The member moved to Virginia Beach in October 2015 and was living in a group home. The member was experiencing increased psychiatric stress due to living in group home and had five recent hospital admissions. Over the course of the year, he had total 14 hospital admissions (mostly psychiatric in nature), 30 ER visits and 83 office visits.

*After meeting with the member, the care manager (CM) coordinated with in-house team to ensure that the member had a case worker for skill building. This CM then collaborated with that case worker to implement a Plan of Care that focused on scheduling an initial appointment with a PCP to address medical health problems; linking to Virginia Beach CSB for intake appointment, coordinating with CSB case manager and psychiatrist, resuming monthly injections of the appropriate psychiatric medications and referral to PACT team as needed.*

*This CM also taught the member to call the Health Plan nursing advice line for any minor health issues before going to the emergency department. The CM made certain that member knew to call the crisis hot line for behavioral health needs. CM worked with the member on the importance of medication compliance. Also, the CM referred the member to a social worker and coordinated with them in finding stable housing.*

*Since the intervention with the CM the member is working with a case manager, talk therapist and psychiatrist from the Virginia Beach CSB. He has also been regularly attending appointments with his new PCP. He has moved out the group home and into his own apartment in February 2016. He stated that he is at peace and happier living alone. He did have to change his CSB case manager due to the change in location, but the member stated the new case manager is as good as the other.*

*This year the member had 3 admissions to date with only 1 after the move to his new apartment. This is a significant and measurable improvement over last year's metrics and further supports the important role of collaborative care management with the ICT both as to health outcomes and budgetary savings.*

## SUMMARY

Virginia's Medicare-Medicaid beneficiaries face a set of unique challenges and barriers, which 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 objectives are 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 these goals for all 28,550 members. By aiding beneficiaries in accessing critical medication, additional essential covered services and utilizing existing community resources, CCC is reducing the need for more intensive and avoidable services and keeping beneficiaries in their own homes longer and more safely.

These experiences have provided DMAS and MMPs the information required to make appropriate changes to systems and processes in order to adapt to the complexities of the dual population. For the remainder of this demonstration, it is anticipated that the knowledge gained thus far will continue to produce significant improvements in the health care and lives of the CCC enrollees.

With CCC scheduled to sunset on December 31, 2017 DMAS is using lessons learned from this program to plan for the transition to CCC+. CCC has afforded DMAS invaluable experience, and DMAS and looks forward to building on this to ensure that CCC+ is also a success. CCC+ will expand upon the principles of coordinated care, statewide operation, and service to individuals with complex care needs across the full continuum of care. All individuals eligible for CCC (whether opting in or opting out) will transition to CCC+ on January 1, 2018. CMS and DMAS have begun working towards the coordination of a successful transition of CCC-eligible members into CCC+.

Even though CCC will end in just over one year there is still much work ahead. This report has provided a summary of the implementation challenges faced in the coordination of the Medicare and Medicaid IT systems, provider payment issues and the uniform implementation of care coordination principles. The Department continues to work diligently with stakeholders to address current challenges and provide the best care possible as the program moves from a demonstration project to an permanent, integral component of Virginia Medicaid.