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Evaluating Commonwealth Coordinated Care: The Experiences of Individuals Dually Eligible for Medicare and Medicaid

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Case Study

Evaluating Common-wealth Coordinated Care: The Experiences of Individuals Dually Eligible for Medicare and Medicaid

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Objectives

1. To understand Virginia's rationale for implementing the Commonwealth Coordinated Care Program and its approach to evaluating it.
2. To provide a framework for examining the health care experiences of individuals with behavioral health and/or long-term service and support needs who are enrolled in the Commonwealth Coordinated Care Program.
3. To inform policy on future options for improving the quality and health care experiences of similar groups of individuals in Virginia

and other states.

Background

In the United States, approximately 10.2 million older adults and others with disabilities are dually eligible for both Medicare and Medicaid benefits (Medicaid and CHIP Payment and Access Commission [MACPAC], 2015). They represent some of the nation's most vulnerable citizens because of their complex mix of medical needs, including acute, primary, behavioral, chronic, and long-term services and supports (LTSS). Although dual eligible individuals have access to a wide range of health and social services, these benefits are generally not well coordinated because they are provided primarily through the traditional fee-for-service (FFS) Medicare and Medicaid programs. The lack of coordination is further complicated by the fact that Medicare and Medicaid operate independently of each other, resulting in conflicting coverage and payment policies, fragmented service delivery systems, and incentives for provider cost shifting. By hindering efforts to improve access and care coordination for dual eligi-

ble individuals, this environment promotes unnecessarily high costs and less than optimal patient care and quality of life (Centers for Medicare and Medicaid Services [CMS], 2011).

In response, the federal and state governments are pursuing a number of strategies to improve the quality and delivery of care for this population. One such strategy authorized under the 2010 Patient Protection and Affordable Care Act and administered by CMS is the Financial Alignment Demonstration (FAD), which is testing two new payment reform and service delivery models at the state level: capitation and managed FFS (CMS, 2011). Capitation is a payment arrangement for health care service providers such as physicians or nurse practitioners that pays a set amount for each enrolled person assigned to them, for a given period of time, whether or not that person seeks care. Under the capitated payment model, CMS and 10 states have contracted with over 60 managed care plans to coordinate care for dual eligible individuals, while under the managed FFS model, two states are using their existing infra-

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structures to provide individuals with enhanced care coordination (CMS, 2011; MACPAC, 2015; Kaiser Commission on Medicaid and the Uninsured, 2016). Regardless of which model states test, the demonstrations seek to improve quality, access, and health care experiences for dual eligible individuals, while reducing Medicare and Medicaid costs by providing them with services that are more coordinated and person-centered (CMS, 2013).

As part of the FAD initiative, CMS contracted with RTI International to evaluate the demonstrations at the national and state levels. The national evaluation includes site visits to participating states; interviews and focus groups with program staff, stakeholders, and dual eligible individuals; analyses of quality, utilization, and cost outcomes; and calculation of savings attributable to the state demonstrations. While RTI is responsible for the federal evaluation, participating states have the option to evaluate their own demonstrations.

Commonwealth Coordinated Care (CCC)

Virginia implemented its financial alignment demonstration, The Commonwealth Coordinated Care (CCC) Program, on March 1, 2014 for approximately 78,600 dual eligible individuals ages 21 and older who receive full Medicare and Medicaid benefits and reside in one of five geographic regions of the state designated for the program. A unique feature of the CCC Program is that it represents the first time that Virginia has enrolled dual eligible individuals with behavioral

health (BH) and/or LTSS needs in a managed care program.

The CCC Program is a capitated model, implemented through a three-way contract among CMS, DMAS, and three managed care plans (Anthem Healthkeepers, Humana, and Virginia Premier), to operate what are called Medicare – Medicaid Plans (MMPs). Initially, the state sent letters to dual eligible individuals encouraging them to select an MMP and actively enroll in CCC. Individuals who did not choose to opt-out of the program were assigned to an MMP and automatically enrolled. (Regardless of how individuals enrolled, CCC participation is entirely voluntary and individuals can disenroll or change MMPs at any time.) Under the terms of the three-way contract, the MMPs provide participants with one membership card (to replace separate Medicare and Medicaid cards), access to a 24-hour nurse call line; and coverage for standard Medicare and Medicaid benefits, as well as additional benefits not typically covered in the FFS programs, such as dental, hearing, and vision services. To ensure that individuals receive appropriate care, the program provides a number of protections, including continuous quality monitoring, continuity of care requirements, a unified appeals and grievances process, and state long-term care ombudsman services, in accord with CMS principles.

These benefits are intended to improve quality, access, and health care experiences for enrolled individuals; but the key benefit of CCC is enhanced care coordination where the MMPs provide individuals with a care coordinator (usually

a registered nurse) who is responsible for coordinating various services that meet the person's health and social needs. Coordinators perform several activities to accomplish this, including evaluating individuals to identify gaps in care; developing care plans that address their specific needs and preferences; teaching individuals self-management skills; building relationships with individuals through periodic contact and advocating for their rights when needed; facilitating communication among providers and between individuals and providers; and helping providers and individuals adjust to a new managed care environment (Craver, 2016a).

As of May 2016, approximately 29,374 individuals were enrolled in the CCC Program. Most (23,360, or 80%) were automatically enrolled, while the remainder (6,014, or 20%) voluntarily enrolled. The distribution of individuals was as follows: 12,441 individuals (42%) were with Anthem Healthkeepers, 10,730 (37%) with Humana, and 6,203 (21%) with Virginia Premier. (Additional information on CCC is available online at: www.dmas.virginia.gov/Content/pgs/alte-enrl.aspx.)

CCC Evaluation

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

ble for the qualitative component. To ensure that both components support each other, the DMAS/Mason evaluation team has met periodically to exchange information since the spring of 2014.

To meet the informational requirements of DMAS management and other stakeholders, the evaluation is examining the program at the beneficiary and population levels. MMP care coordination for individuals with BH and/or LTSS needs is a particular focus for two reasons: 1) care coordination is the CCC Program's hallmark and 2) the program represents the first time that Virginia is enrolling individuals with these needs into a managed care delivery system. (Of the 29,374 enrolled individuals, approximately 21% had BH needs, while 24% had LTSS needs.) As part of the CCC evaluation, DMAS recruited and facilitated an advisory committee to assist the evaluation team with understanding the unique needs and concerns of individuals in the target subpopulations. While having similar research goals as RTI's national evaluation, the DMAS/Mason evaluation is specific to Virginia and includes the use of methods and data that RTI is not using; these include surveys of dual eligible individuals and intensive fieldwork involving observations, interviews, and focus groups.

Quantitative Findings

For the quantitative component, Mason faculty members are surveying individuals over time to examine changes in quality of care, access, and health care satisfaction and experiences. Later phases of the evaluation will be supplemented

with Medicaid claims data to examine whether the CCC Program resulted in more appropriate utilization, improved quality, and lower costs at the state population level. Thus far, Mason faculty members have surveyed approximately 1,000 enrolled individuals who were receiving LTSS through DMAS' Elderly or Disabled with Consumer Direction (EDCD) Waiver; 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 (Cuellar, Gimm, & Gressenz, 2015). Currently, Mason faculty are compiling results of a survey of individuals in the EDCD Waiver who disenrolled, and are also preparing to survey enrolled individuals with BH needs.

Qualitative Findings

For the qualitative component, DMAS staff members are observing care coordination activities and conducting interviews to understand what the program looks like from the perspective of the dual eligible individuals who are directly involved in it. Since June 2014, DMAS staff members have observed 171 hours of care coordination activities and interviewed 72 individuals (56 who enrolled and 16

who disenrolled) in both group and individual settings across the MMPs and demonstration regions. Staff are also interviewing care coordinators and providers as part of this process.

Staff members have identified several themes that allow for a more in-depth understanding of individual health care experiences. Examples include *Acquiring 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 Meaningful Relationships* (defined as how individuals develop and experience relationships with key individuals as part of their CCC engagement); and *Coordinating Care by Building Associations* (defined as how care coordinators work with providers to support enrolled individuals). The case summaries that follow illustrate these themes by providing insight into how two individuals (the first, an EDCD Waiver participant, and the second, an EDCD Waiver participant who also receives services from a local Community Services Board) initially perceived the CCC Program, became engaged in the program, and experienced meaningful relationships with their coordinators and others involved in their care. The case summaries also provide insight into how MMP care coordinators work with providers to support enrolled individuals.

Case Study 1

Cynthia is 58 years old with several

chronic conditions. In March 2014, she received a letter informing her that the state was implementing a new program for dual eligible individuals that would combine their Medicare and Medicaid benefits under one health plan. Recalling that, Cynthia said, “I [received] a letter saying I had the option to enroll or stay the way I was and I liked the idea of Medicare and Medicaid being together...so I enroll[ed].” Because Cynthia was already in Humana’s Medicare Advantage Plan, she was familiar with Humana and selected it as her MMP. Cynthia’s enrollment decision was also influenced by the fact that most of her providers were in Humana’s network. As Cynthia remarked, “I like to [stay] with people who know me...whether it’s the pharmacy or the doctor...”

Soon after enrolling, Carol, a Humana care coordinator, started working with Cynthia. “I like my coordinator, she’s always in touch...she and I not only talk [on the phone], but she sees me [in my home],” said Cynthia. When asked about how Carol assists her, Cynthia said, “[Carol] tells me about things that are available, like Silver Sneakers [an exercise program]... she helps me when I do my...[pharmacy] orders...she answers my questions...like when I had to find a dermatologist [and] if I have any problems [with providers or services], she straightens it out.” When Cynthia started having mobility issues, Carol ordered a personal emergency response system pendant in case she fell and injured herself. Because Cynthia is in the EDCD Waiver, Carol works with Wendy (a home health agency nurse) to support her at home.

Wendy started working with Cynthia in the spring of 2014, and likes the CCC Program because she has a contact person, “I can call [Carol] and I know [my concerns] will be taken care of.” This doesn’t usually happen with Wendy’s FFS members because their case workers change frequently. When comparing her relationships with Carol and Wendy to relationships with other health-care staff before enrolling in the CCC Program, Cynthia said, “...we have a good relationship...they can tell when something’s going on with me whether I say so or not...this is better...I like the one-on-one [contact]...” (Craver, Behrens, & Broughton, 2015).

Case Study 2

Judy is 56 years old and has several chronic conditions and physical limitations. She receives LTSS through the EDCD Waiver and BH services through a local Community Services Board (CSB). In October 2014, she received a letter from the state informing her about a new program to improve care for dual eligible individuals. “It sounded like something I’d like to try,” said Judy, so she enrolled with Anthem Healthkeepers in the CCC Program. Soon afterward, Jamie, a care coordinator, came to Judy’s home to discuss the program with her and Helen, a CSB case manager. Recalling the encounter, Helen said, “I thought [the program] was very good...I do mental health and [Jamie] helps with the physical part...so [I thought] it [would] help meet all of [Judy’s] needs...” During the meeting, Jamie learned that Judy was not satisfied with her service facilitator, so Jamie informed her that she could choose a new

facilitator. Jamie said, “...you have the opportunity to switch...we can find you somebody new...we have options that we can look at.” Judy was agreeable, so Jamie referred her to a local provider and Marianne became her new service facilitator. (Service facilitators support individuals in the EDCD Waiver by developing and monitoring care plans, providing management training assistance, and completing ongoing review activities as required for their consumer directed personal care and respite services.)

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

When asked how the CCC Program has influenced her quality of care and life, Judy said, “I’m not as anx-

ious about my personal care services as I used to be...I have a lot more support than I ever had...I have people now that care about me as a person, not me as a number or just somebody that it's their job to do this and that. You can tell when a person is really putting their heart into their job or when they're just doing a job. My experience so far has been outstanding. I couldn't ask for a better care team and I wouldn't want to lose them" (Craver, 2016b).

Managed Long-Term Services and Supports

As a four-year demonstration, the CCC Program is scheduled to expire on December 31, 2017, at which time enrolled individuals will transition to a new statewide managed care initiative, known as Managed Long-Term Services and Supports (MLTSS), that will serve approximately 212,000 individuals with complex care needs, including behavioral health, through an integrated managed care delivery system. Building on the CCC Program, MLTSS will focus on improving quality, access, and health care experiences for enrolled individuals, while reducing costs through coordinated, person-centered services. However, MLTSS will differ in that it will incorporate lessons learned from implementing the CCC Program, namely, strengthen requirements for MMP staffing, training, and care coordination activities; use a simplified, two-way contract between the state and participating health plans instead of a three-way contract; require mandatory enrollment for all eligible individuals throughout the state; and require health plans to

operate (or obtain approval to operate) as Medicare Dual Special Needs Plans. MLTSS is scheduled for implementation in July 2017. (Additional information on the program is available online at: www.dmas.virginia.gov/Content/pgs/mltss-home.aspx.)

Conclusion

Virginia implemented the CCC Program to both improve the quality of health care experiences of dual eligible individuals and reduce Medicare and Medicaid costs. To measure the impact of the program, the DMAS/Mason evaluation team is employing a mixed-method, longitudinal study design. We believe that using this analytic approach can strengthen findings by allowing the evaluators to assess the program's effectiveness from multiple perspectives at different time points. Virginia's approach to evaluating the CCC Program has received national recognition as a best practice, and, therefore, can provide a framework that other states could use to evaluate similar health care initiatives for complex populations.

To date, the evaluation findings suggest that the CCC Program is improving quality and health care experiences for enrolled individuals. Of course, additional research is needed to draw conclusions about the program's long-term effects on utilization and costs. Nevertheless, as a major public health care reform initiative implemented under the Affordable Care Act for some of the state's most vulnerable citizens, the evaluation findings presented in this case study are important for several reasons. First, the findings

can be used for monitoring purposes to ensure that the CCC Program is achieving its objectives. Second, the findings can help inform the development of MLTSS, a new program that will replace CCC and focus on care coordination for dual eligible individuals and others with similar complex care needs. Third, because the dual eligible population will most likely increase in coming years with the aging of America, the evaluation findings can help to inform the development of future programs in Virginia and elsewhere that intend to improve care for this vulnerable population.

Study Questions

1. How is Virginia evaluating the CCC Program and what do evaluation findings thus far indicate?
2. How can one use CCC evaluation findings to develop future programs for similar groups of individuals?
3. Why did Virginia implement the CCC Program and what will happen to the program after it expires in December 2017?

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