

Commonwealth Coordinated Care
Medicare & Medicaid working together for you

Virginia Advisory Committee*

Creating a Coordinated Delivery System for Medicare-Medicaid Enrollees

April 15, 2015 from 1:00 to 3:00 pm
Conference Room 7A&B, DMAS
600 East Broad Street
Richmond, VA 23219

Meeting 8

I. Welcome and Introductions	Cindi Jones Director, Virginia Department of Medical Assistance Services (DMAS)	1:00 pm
II. Virginia Updates	Tammy Whitlock Director, Division of Integrated Care and Behavioral Services, DMAS Jason Rachel, PhD Supervisor CCC Operations, DMAS	1:05 pm
III. Committee Member Focus Session 1: <i>Quality Dashboard</i>	Fuwei Guo, MPH Integrated Care Quality Analyst Office of Coordinated Care, DMAS	1:20 pm
IV. Committee Member Focus Session 2: <i>Evaluation Update</i>	Gerald Craver, PhD Senior Research Analyst Policy and Research Division, DMAS	1:35pm
V. Committee Member Focus Session 3: <i>Improving Outcomes for Complex and Costly Individuals: VCUHS Center for Advanced Health Management</i>	Peter Boling, M.D. VCU Health System Center for Advanced Health Management (CAHM)	1:45 pm
VI. Committee Member Focus Session 4: <i>Medicare-Medicaid Plans Update: Innovative Partnerships and Behavioral Health Homes</i>	Representatives from Anthem Healthkeepers, Humana, & Virginia Premier	2:00 pm
VIII. Wrap Up and Next Steps	Cindi Jones	2:55 pm

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

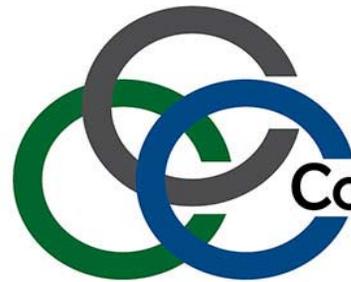


Advisory Committee Members

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



VIRGINIA UPDATE



Commonwealth Coordinated Care
Medicare & Medicaid working together for you

Tammy Whitlock, Director: Division of Integrated Care & Behavioral Services

Jason Rachel, PhD : Supervisor of CCC Operations

Virginia Update for CCC Advisory Committee

April 15, 2015

Annual Letter



- Reminder to beneficiaries about the opportunity to access care coordination
- Letter mailed to beneficiary 12 months after recorded opt-out decision
 - Notifies beneficiary of choice & ability to opt-in
 - Includes success stories and program highlights
 - Offers resources for questions





DMAS Supportive & Contract Monitoring Activities

- Training with Care Coordinators
 - Topics include information in the following areas:
 - EDCD Waiver
 - Nursing Facility
 - Contract Requirements & More
 - Currently holding monthly calls for the Care Coordinators for Q&A on various topics
- Annual on-site and technical visits
- Observations, HRAs, POCs, ICTs, etc.

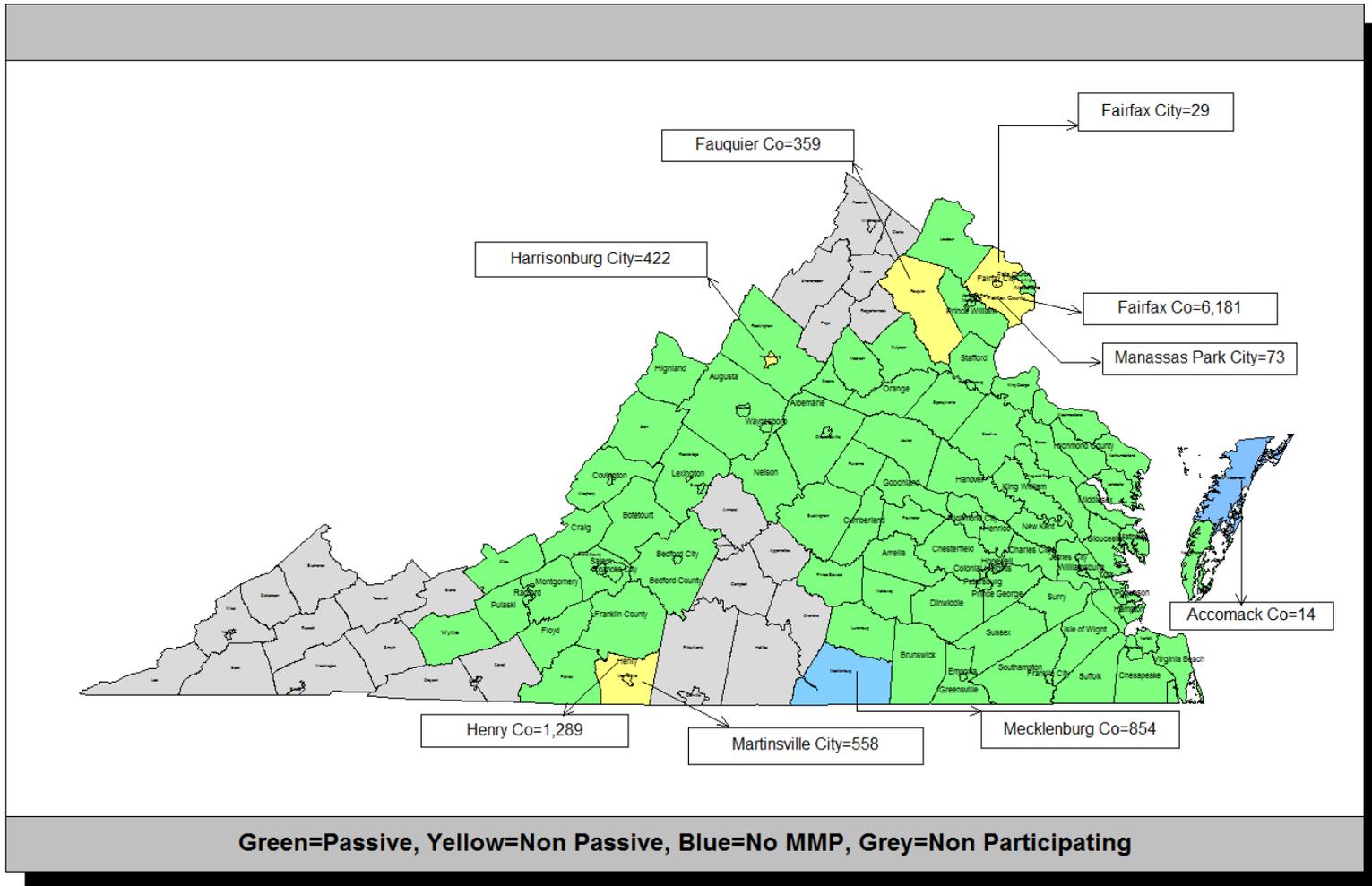
Network Updates

- Anthem Healthkeepers now approved to offer services in: Alexandria, Arlington, Falls Church, Loudoun and Wythe.
- Humana is now approved to offer services in Waynesboro and Staunton.
- Beneficiaries have begun opting in to these areas

Localities Starting CCC Automatic Enrollment: Coverage Effective July 1, 2015		
Charlottesville Region	Roanoke Region	Northern VA Region
City of Staunton	Wythe	Alexandria City
		Arlington
		Falls Church City
		Loudoun



Automatic Assignment Localities: April 2015



Single MMP Population Count

GeoAccess

Enrollment, Age, and Preliminary 90-day Assessment Completion in Capitated Financial Alignment Model

State	FAD Name	FAD Start date	Number of MMPs (as of 1/30/15)	Total enrollment as of January 2015*	% of enrollees under age 65	% of enrollees age 65+	Preliminary % of members with assessment completed within 90 days (through Nov 2014)**
CA	Cal MediConnect	April 2014	9	139,604	31%	69%	74%
IL	Medicare-Medicaid Alignment Initiative	March 2014	8	68,212	46%	54%	76%
MA	One Care	October 2013	3	17,876	99%***	1%***	60%
Ohio	MyCare Ohio	May 2014	5	77,147	49%	51%	58%
VA	CCC	April 2014	3	28,288	52%	48%	92%
Sum			28	331,452	44%	56%	73%

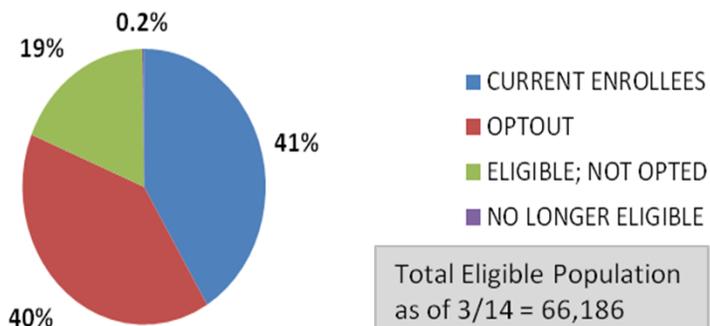
<http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FAIEnrollmentHRAJan2015.pdf>



Commonwealth Coordinated Care Monthly Enrollment Dashboard

Through 4/06/2015

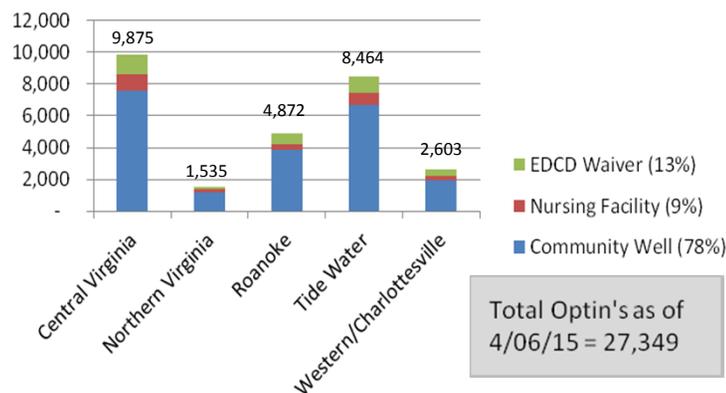
CURRENT ENROLLMENT STATUS OF TOTAL ELIGIBLE POPULATION



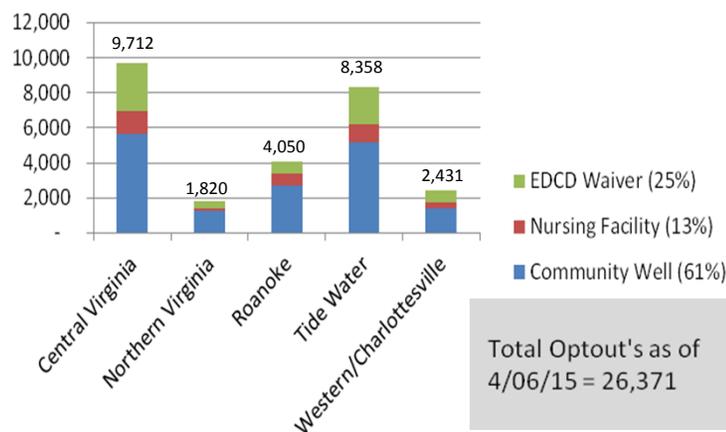
Total Eligible Population
as of 3/14 = 66,186

CURRENT ENROLLEES = All Active and Automatic Enrollments as of 4/06/15; **OPTOUT** = All potential enrollees that elected to not participate as of 4/06/15; **ELIGIBLE; NOT OPTED** = Potential enrollees that have not decided as of 4/06/15; **NO LONGER ELIGIBLE** = All potential enrollees that lost CCC eligibility because they lost Medicaid eligibility, moved out of the demonstration area, or because they now participate in some other exempt program or are in an exempt facility.

Optin By Region and Type



Optout by Region and Type



Enrollment Reporting

CCC OVERALL MONTHLY ENROLLMENT STATISTICS - REPORT DATA DATE - 2/07/2015						
CCC ELIGIBLE POPULATION						
Sum of MEMBER_CNT	CCC_REGION					
WAIVER_IND	Central Virginia	Northern Virginia	Roanoke	Tide Water	Western/Charlottesville	Grand Total
CW	15146	10961	8588	13783	4267	52745
EDCD	3810	2234	1802	2969	1075	11890
NF	2999	1355	1998	2348	1026	9726
Grand Total	21955	14550	12388	19100	6368	74361

CCC MONTHLY ENROLLMENT STATISTICS - REPORT DATA DATE - 3/10/2015						
CCC ELIGIBLE POPULATION						
Sum of MEMBER_CNT	CCC_REGION					
WAIVER_IND	Central Virginia	Northern Virginia	Roanoke	Tide Water	Western/Charlottesville	Grand Total
CW	13308	9248	7771	11989	3840	46156
EDCD	3741	2156	1747	2917	1047	11608
NF	2612	1182	1731	2029	868	8422
Grand Total	19661	12586	11249	16935	5755	66186

Lost Eligibility Reporting - Feb

CCC VOIDED MEMBERS						
(Enrolled But Lost Eligibility Before Active Plan Begin Date)						
	Central	Northern Virginia	Roanoke	Tidewater	Charlottesville	Total
Grand Total	532	658	269	550	143	2152

CCC LOST ELIGIBILITY MEMBERS						
(Reasons = Lost Medicare Or Medicaid , Death , Excluded)						
	Central	Northern Virginia	Roanoke	Tidewater	Charlottesville	Total
Grand Total	1040	743	649	668	285	3385

CCC EXEMPT						
(CCC_IND = D, ES,H,N,S,X)						
	Central	Northern Virginia	Roanoke	Tidewater	Charlottesville	Grand Total
Grand Total	395	980	358	258	165	2156



Lost Eligibility Reporting - March

CCC MEMBERS LOST ELIGIBILITY AFTER ENROLLING						
	Central	Northern Virginia	Roanoke	Tidewater	Charlottesville	Grand Total
Grand Total	37	15	27	27	17	123

CCC MEMBERS LOST ELIGIBILITY AFTER PASSIVE ASSIGNMENT						
	Central	Northern Virginia	Roanoke	Tidewater	Charlottesville	Grand Total
Grand Total	1	4	5	4	6	20

CCC MEMBERS LOST ELIGIBILITY BEFORE PASSIVE ASSIGNMENT						
	Central	Northern Virginia	Roanoke	Tidewater	Charlottesville	Grand Total
Grand Total	1	1	0	1	0	3



Department of Medical Assistance Services



Commonwealth Coordinated Care Program Evaluation Update

Stakeholder Advisory Committee
April 15, 2015

Gerald A. Craver, PhD





Care Management Dashboard

- *Review of New Care Management Performance Dashboard*
 - *Soon be available online:*
http://www.dmas.virginia.gov/Content_pgs/cc-c-qm.aspx



Department of Medical Assistance Services



CCC Quality Update

Stakeholder Advisory Committee
April 15, 2015

Fuwei Guo, CCC Quality Analyst





Overview

- **CY 2014 Care Coordination Observations**
- **CY 2014 LTSS Enrollee Focus Groups**
- **New Evaluation Report - *Notes from the Field* (March 2015)**
- **LTSS Beneficiary Surveys**
- **Next Steps**
- **Questions, Comments, or Concerns**



Observations in CCC Evaluation

- Purpose is to observe delivery of CCC services by care coordinators to develop a more holistic understanding of the program
- Data collection consists of note taking while observing care coordinators interacting with enrollees with LTSS and/or BH needs, family members, and providers
 - Supplemented with unstructured interviews of care coordinators and reviews of the technical/non-technical literature on care coordination



Summary of CCC Observation Activity (CY 2014)

- Conducted 11 observations between June and December 2014, representing 20 care coordinator – enrollee and/or family member/provider encounters
 - Observations of EDCD, Nursing Facility, & Community Well enrollees in the Tidewater & Central CCC Demonstration Regions
- In total, the observations lasted approximately 16.5 hours and generated 62 pages of typed notes for analysis



Overview of HRA Observations

Type	Health Risk Assessment (HRA)
EDCD Waiver	<p><u>Site: Enrollee Home Visit (N=3)</u></p> <ul style="list-style-type: none"> • Meetings Lasted 1 to 2.5 hours/enrollee • Care Coordinator Established Rapport with Enrollees, Families, & Caregivers & Identified Enrollee Needs & Goals for Care Plan • Care Coordinator Exchanged Information & Educated Participants about Health/Social Services & Enhanced Benefits • Coordinators Indicated Follow Up with Physicians/Service Facilitators
Nursing Facility	<p><u>Site: Facility Room Visit (N=11)</u></p> <ul style="list-style-type: none"> • Most Meetings Lasted around 5 minutes/enrollee • Enrollees Already Receiving 24/7 Care by Nursing Facility Staff • Care Coordinators Engaged Family Members through Verbal Permission & Had Limited Dialogue with Enrollees • Coordinators Obtained Information from Nursing & Social Work Staff on Enrollee Medication, Hospitalizations, & Height/Weight Records
Community Well	<p><u>Site: Clinic Examination Room (N=2)</u></p> <ul style="list-style-type: none"> • Meetings Lasted Approximately 30 minutes/enrollee • Care Coordinator & Provider Staff Conducted Team Assessments during Follow-Up Appointments & Engaged Enrollees in Dialogue about Preventive Care & Educating about Health/Social Services



Overview of ICT Observations

Type	Interdisciplinary Care Team (ICT)
<p>EDCD Waiver</p>	<p><u>Site: Physician Office (N=1)</u></p> <ul style="list-style-type: none"> • Meeting Lasted Approximately 15 Minutes & Involved Coordinator, Enrollee, & Specialist Physician • Coordinator Exhibited Rapport & Dialogue with Enrollee & Exchanged Information with Physician (<i>Reconciling Medication</i>)
<p>Nursing Facility</p>	<p><u>Site: Facility Conference Room (N=2)</u></p> <ul style="list-style-type: none"> • Meetings Lasted less than 10 minutes/enrollee & Involved Nursing/Social Work Staff Exchanging Limited Information with Coordinator on Lab Tests, Vaccines, and Health Needs • Meetings did not include Enrollees, Families, or Physicians • Apparent Limited Involvement of Coordinator in Care Planning
<p>Community Well</p>	<p><u>Site: Clinic Conference Room (N=1)</u></p> <ul style="list-style-type: none"> • Meeting Lasted Approximately 30 minutes/enrollee • Care Coordinator, Care Manager, & Social Worker worked with Enrollee to Resolve Housing Issue & Exchanged Information with Enrollee on Health/Social Services, & Care Plan • Care Coordinator, Care Manager, and Social Worker Indicated Follow up with Enrollee on Housing Issue



Focus Group Study Overview

- Purpose is to examine the early implementation of the CCC Program by soliciting accounts of experiences from beneficiaries with LTSS/BH needs and to identify areas for program improvement
- Partnered with VaCIL to recruit beneficiaries meeting certain criteria (receiving services from CILs assisting with project, enrolled in CCC for 3 months, and have experience working with a care coordinator, etc.)



Questions, Participants, and Analysis

- Questions covered CCC enrollment, program experience, care coordination, and areas for improvement
- 4 focus groups (2 in Tidewater and 2 in Central Region) consisting of 21 participants (15 beneficiaries and 6 family members/caregivers)
- Discussions audio recorded and transcribed verbatim generating 311 pages of transcripts for analysis



CCC Experience Themes Reported by Participants

- Learning About CCC Through a Confusing Landscape (*beneficiary experience*)
- Providers and Family Members Influencing Enrollment Decisions (*beneficiary experience*)
- LTSS Beneficiaries Recognizing CCC Value (*beneficiary experience*)
- Promoting CCC to Better Meet LTSS Beneficiary Needs (*program improvement*)
- Engaging in More Person-Centered Service Delivery (*program improvement*)



Notes from the Field (March 2015)

- Next evaluation report reviews activities that DMAS performed to implement the CCC Program as well as some of the main implementation successes achieved during CY 2014
 - Includes challenges encountered during implementation, the strategies used for overcoming them, and case studies illustrating delivery of care coordination services to beneficiaries
- Currently being reviewed by DMAS staff and will be posted online when finalized



CCC Enrollee Telephone Surveys

- Currently surveying EDCD Waiver participants enrolled in CCC Program to collect information on their medical care, personal care, demographics, and health status
- Also surveying EDCD Waiver participants who declined enrollment in CCC Program to collect information on DMAS enrollment materials, reasons for declining CCC participation, demographics, and health status



Next Steps

- Continue working with VaCIL and V4A to schedule additional focus groups with LTSS enrollees
- Continue interviewing BH/LTSS providers and observing MMP care coordination activities across demonstration regions in both institutional and community settings
- Complete CCC enrollee surveys by early summer and submit findings by September 30th
- Meet with evaluation advisory committee on June 10th



Questions, Comments, or Concerns

- **THANK YOU!**
- For additional information on the CCC Evaluation, please contact:
 - **Gerald Craver**
gerald.craver@dmas.virginia.gov
804-786-1754
 - Or visit the **CCC Evaluation website**
http://www.dmas.virginia.gov/Content_pgs/ccc-eval.aspx

Improving Outcomes for Complex, Costly Individuals:

VCUHS Center for Advanced Health Management

Peter A. Boling, MD
Professor and Chair
Division of Geriatric Medicine
Virginia Commonwealth University
April 15, 2015

Principles

- Define “population” and needs
- Deliver health care and social support that is
 - truly patient-centered
 - coordinated
 - affordable
- Evidence-based care delivery
- Align funding with care + support models
- Value: Quality / Cost
 - Costs accurately risk-adjusted for specific populations
 - Quality measures: specific to care setting & population
 - Measures accurate, burden bearable

Quality: Structure, Process, Outcome

Social Support System

Health Care System

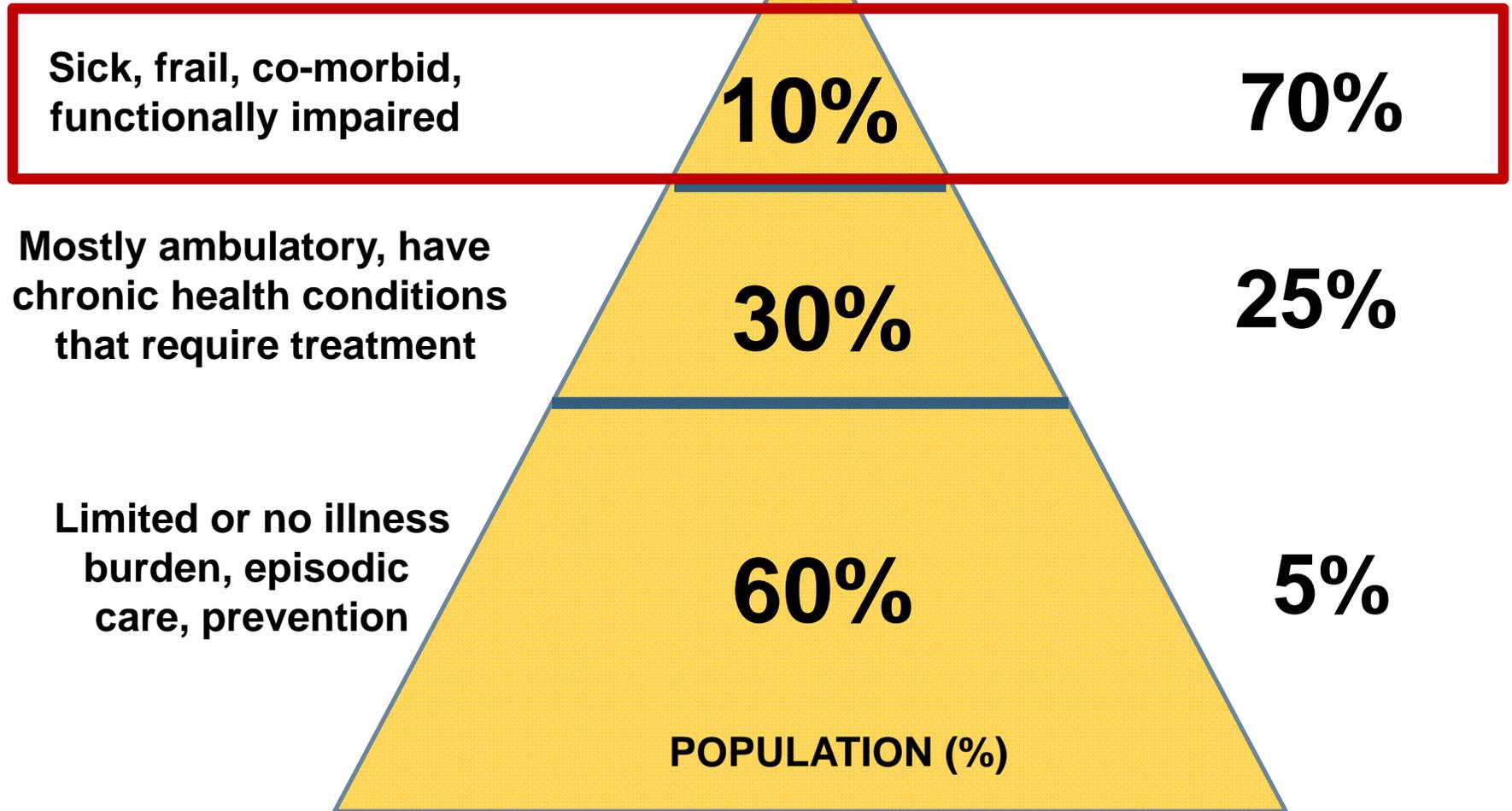
- Engaged patient and family
- Defined preferences and goals
- Delivery system care processes

- Patient experience of care
 - Clinical results
 - Costs

Population Needs + Resource Use

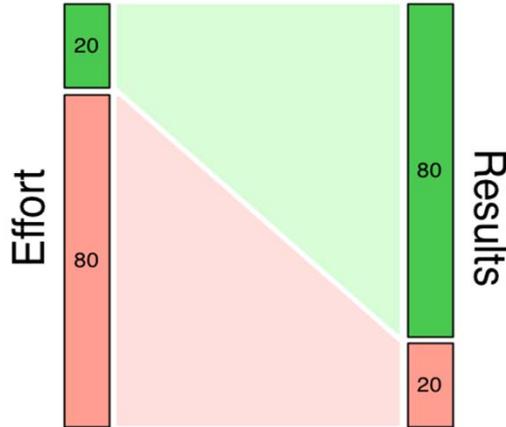
NEEDS

COSTS (%)



The 80-20 Rule

"For many events, roughly 80% of the effects come from 20% of the causes." - Pareto



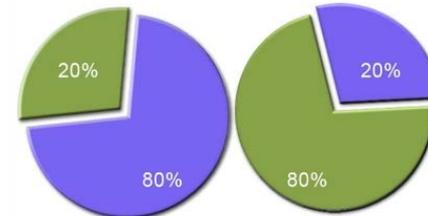
Therefore 20% of the effort produces 80% of the results but the last 20% of the results consumes 80% of the effort.

www.EndlesslyCurious.com

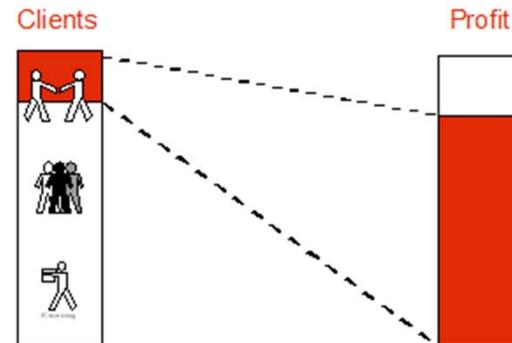


80-20 Rule – The Pareto Principle

Pareto Principle



20% of the input (time, resources, effort) accounts for 80% of the output (results, rewards)

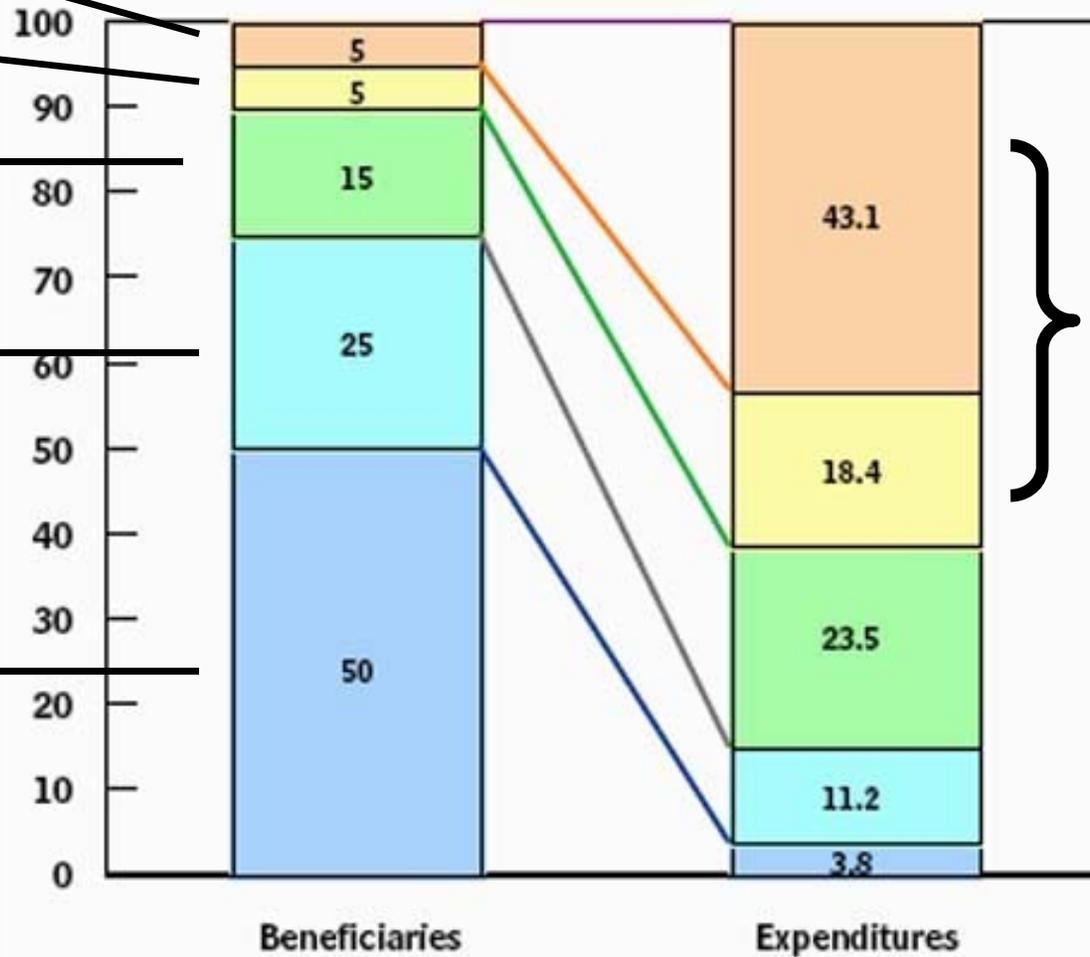


The top 20% of your clients
Generate 80% of your profit

Concentration of Total Annual Medicare Expenditures Among Beneficiaries, 2001

2005 \$\$
 \$63,000
 \$27,000
 \$11,000
 \$3,000
 \$550

(Percent)



TARGET !

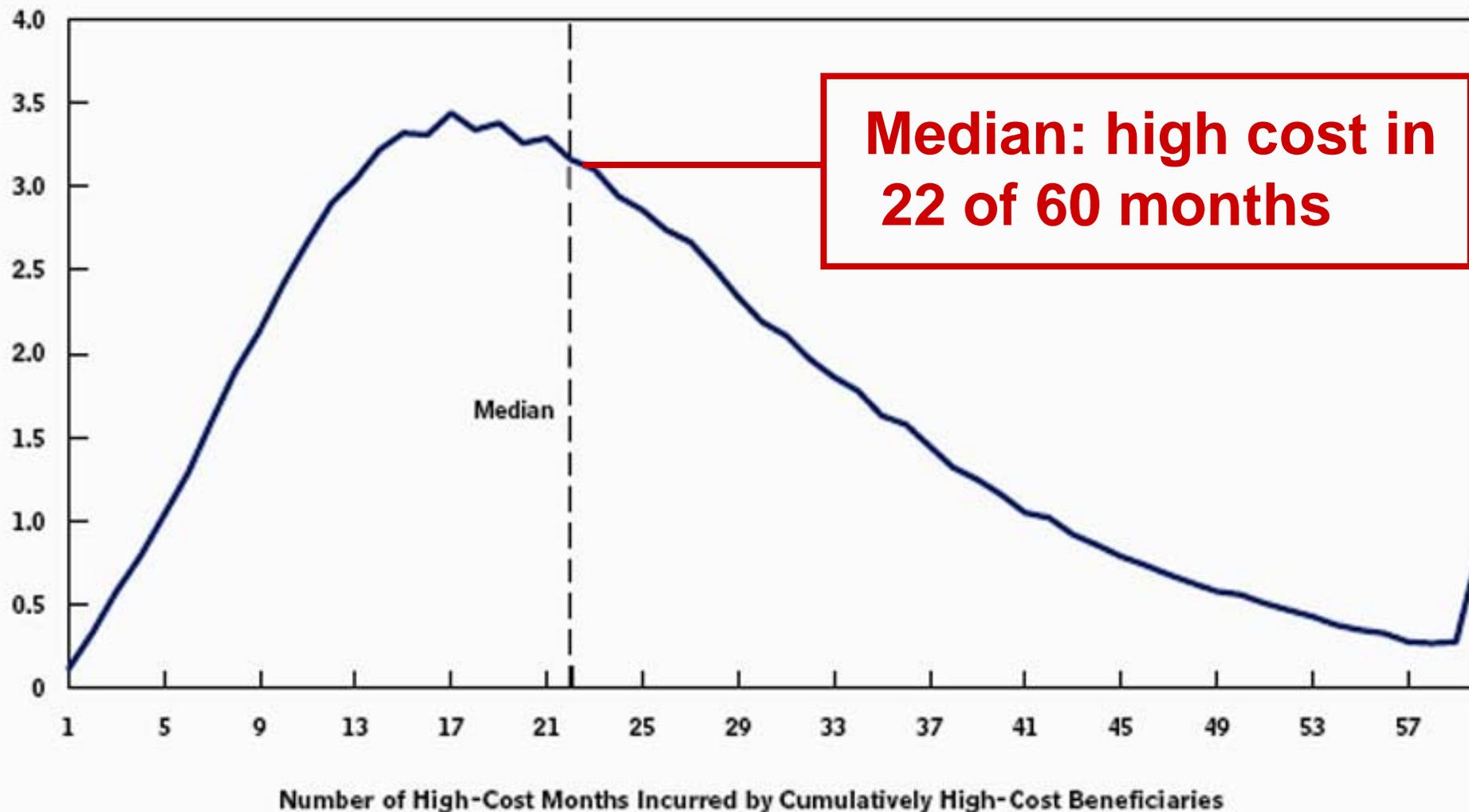
Source: Congressional Budget Office based on data from the Centers for Medicare and Medicaid Services.

Index year high cost individuals, 5 year look back

Figure 4.

Distribution of High-Cost Months Over the 1997-2001 Period

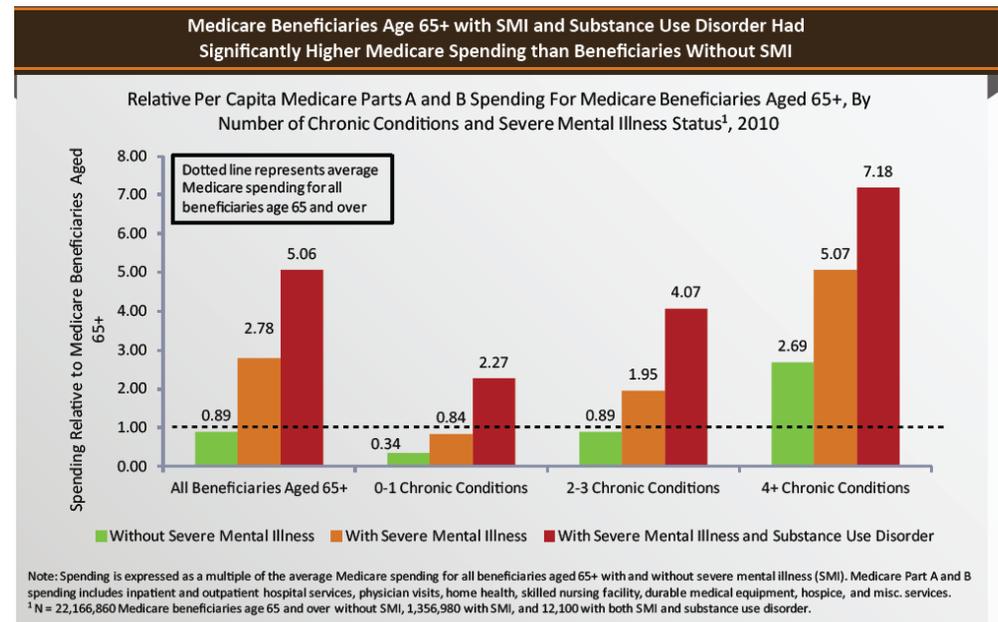
(Percentage of beneficiaries in the top 25 percent)



Source: CBO May 2005 report

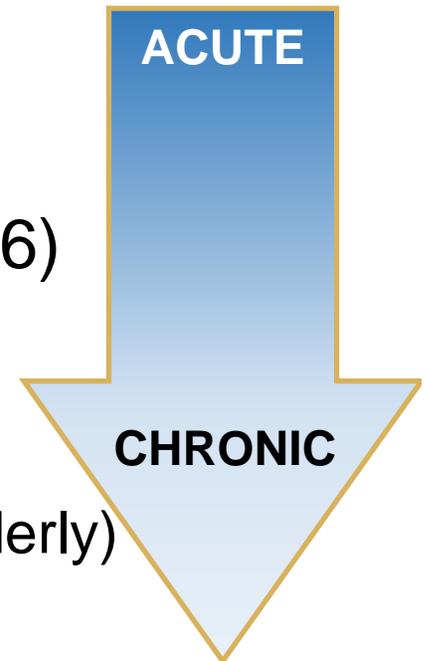
Population of Interest

- Advanced chronic illness burden
- Multiple disease states usually
- High service use, cost
- Poor coordination
- Reduced mobility
- Psych co-morbidities
 - Chemical dependency



Models with savings (15% + in red)

- **Hospital at Home**
- **Transitional care** - 6 weeks, post-acute
 - **Coleman, Naylor**, CCTP (ACA section 3026)
- **GRACE** (consultative via home visits)
- Risk contracts
 - P.A.C.E. (Program for All-Inclusive Care of the Elderly)
 - Special Needs Programs (SNP)
- **Home-based primary care**
 - Veterans Affairs (VA) Home-Based Primary Care (HBPC)
 - Non-VA home-centered primary care
 - Independence at Home (ACA 3024) – natl. demo in process



Office-based care, examples, lessons

- Mass General Hospital CMS demonstration
- VCU: VCC and Complex Care Clinic
- Lessons
 - Targeting
 - high cost, complex patients
 - patients without access to regular ambulatory care
 - Right team and right care model
 - Expertise and experience
 - Data

Selected references, successful models

- Hospital at home (Ann Intern Med. 2005 Dec 6;143(11):798-808)
- Naylor transitional care (JAMA 1999; 281:613–620.)
- Coleman transitional care (Arch Intern Med 2006; 166:1822–1828)
- GRACE - Counsell (JAMA. 2007 Dec 12;298(22):2623-33.)
- PACE (J Gerontol A Biol Sci Med Sci. 2010 July;65(7):721–726)
- Office-based Care – Mass General and VCU
 - McCall N, Cromwell J, Urato M, Bott D. Evaluation of Medicare care management for high cost beneficiaries (CMHCB) Demonstration: Massachusetts General Hospital and Massachusetts General Physicians Organization. Final Report. 2010; RTI Project Number 0207964.025.000.001)
 - Health Affairs (Millwood) 2012 Feb;31(2):350-9
 - Academic Medicine 2013 Dec;88(12):1855-61.

House Calls (home-based primary care or HBPC)

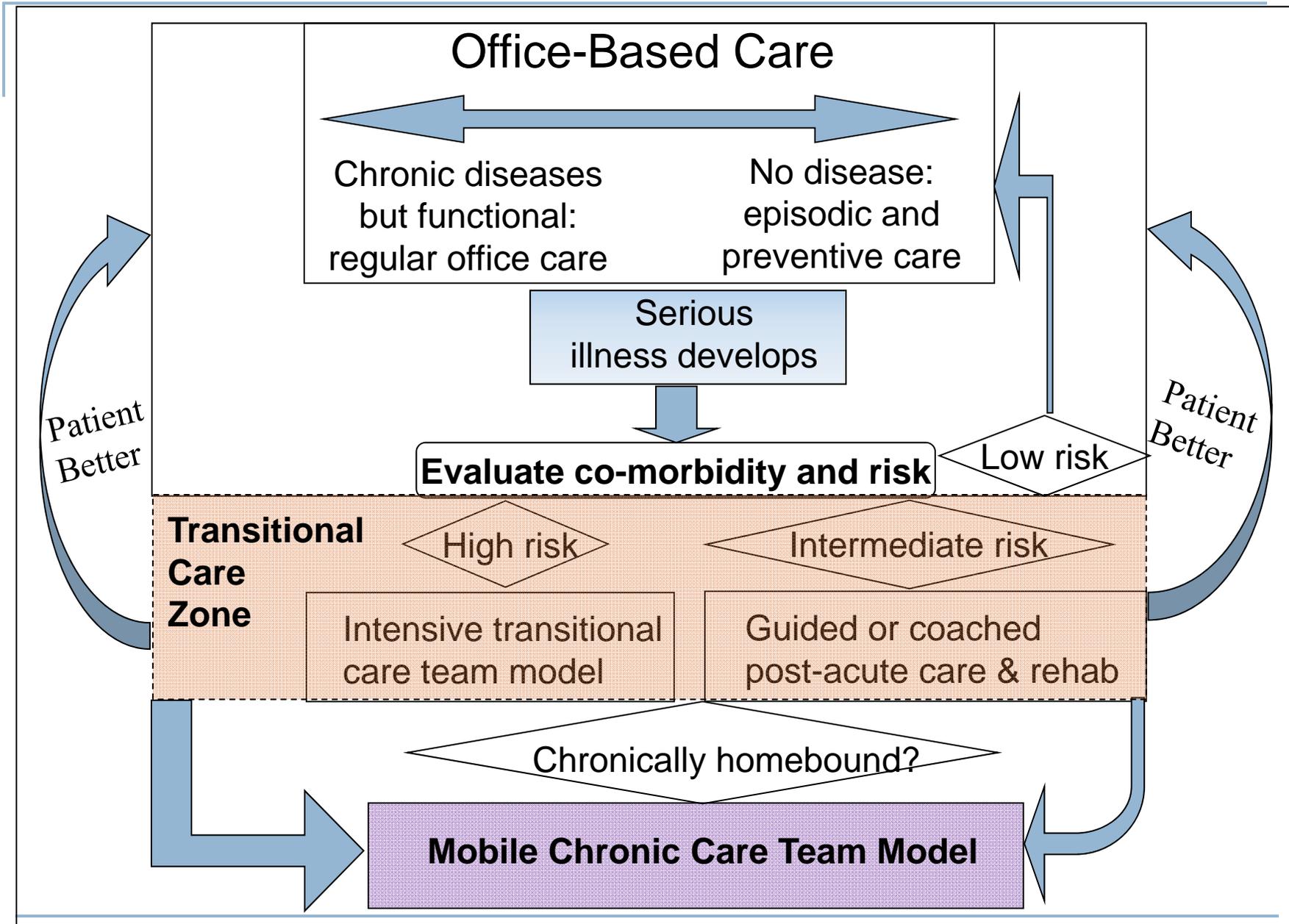
- Veterans Affairs HBPC (J Am Geriatr Soc 62:1954–1961, 2014.)
- Non-VA HBPC (J Am Geriatr Soc. 2014 Oct;62(10):1825-31)

Strategies unproven for complex care

- Care coordination separate from primary care
 - Medicare Coordinated Care demo, others
 - Telemedicine without strong clinical response team
- Standard PCMH models, with a few exceptions
 - Guided Care, Physician Group Practice demo, much of the published PCMH evaluation data
- Many ACO and MCO care models
 - Do not employ advanced health homes

Why Home-based Health Care ?

- Immobile patients (and families) prefer
- ***Much*** better information for provider
- More timely, accessible when sick
- Less bricks + mortar, lower overhead cost
- Avoids risks associated with hospitals
- Reduces discontinuity
- Saves money: hospital, ED, nursing home



“Doing Well By Doing Good”

Doing Well by Doing Good: The Chronic Disease Medical Home

IT'S TIME FOR NEW IDEAS



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(312)775-4217

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Please take six minutes to view

“[Doing Well by Doing Good: The Chronic Disease Medical Home](#),”

an easy-to-view synopsis of our research that has members taking action following UHC’s Member Board of Directors meeting on January 28-30, 2015.

TRADITIONAL
PCP PRACTICE

CHRONIC DISEASE
MEDICAL HOME

2,000	PATIENTS PER PHYSICIAN	300
1	VISITS PER YEAR	5
90	PATIENTS PER WEEK	30
20 MIN.	AVG. TIME WITH PATIENT	60 MIN.
\$500,000	ANNUAL FEE REVENUE	\$250,000



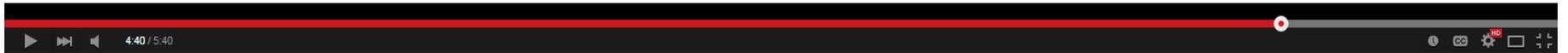
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1,000 CHRONICALLY ILL PATIENTS



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MEDICAL HOME INVESTMENTS

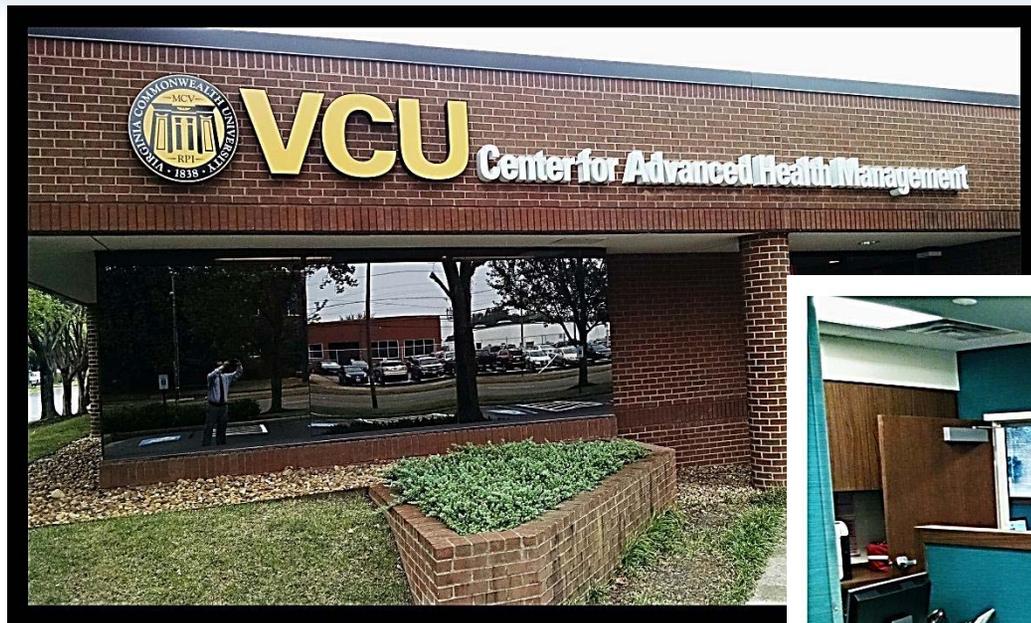
SYSTEMIC SAVINGS



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VCU Center for Advanced Health Management



VIRGINIA COMMONWEALTH UNIVERSITY
Medical Center | Center for Advanced Health Management

VCU Medical Center
Virginia Commonwealth University

VCU School of Medicine

VCU Center for Advanced Health Management



House
Calls Team

Nursing
Home Team

Psych
Team

Inpatient
Consult Team

- Physicians
- Nurse practitioners
- LCSWs
- Pharmacist
- Psych NP / Psychiatrist
- RNs + LPNs
- Care partners
- Clerical and admin
- Data analyst

Clinic Team

MCO Case
Managers

Pharmacy
Consultant

Telemedicine

Story # 7 – Complex Medication Management

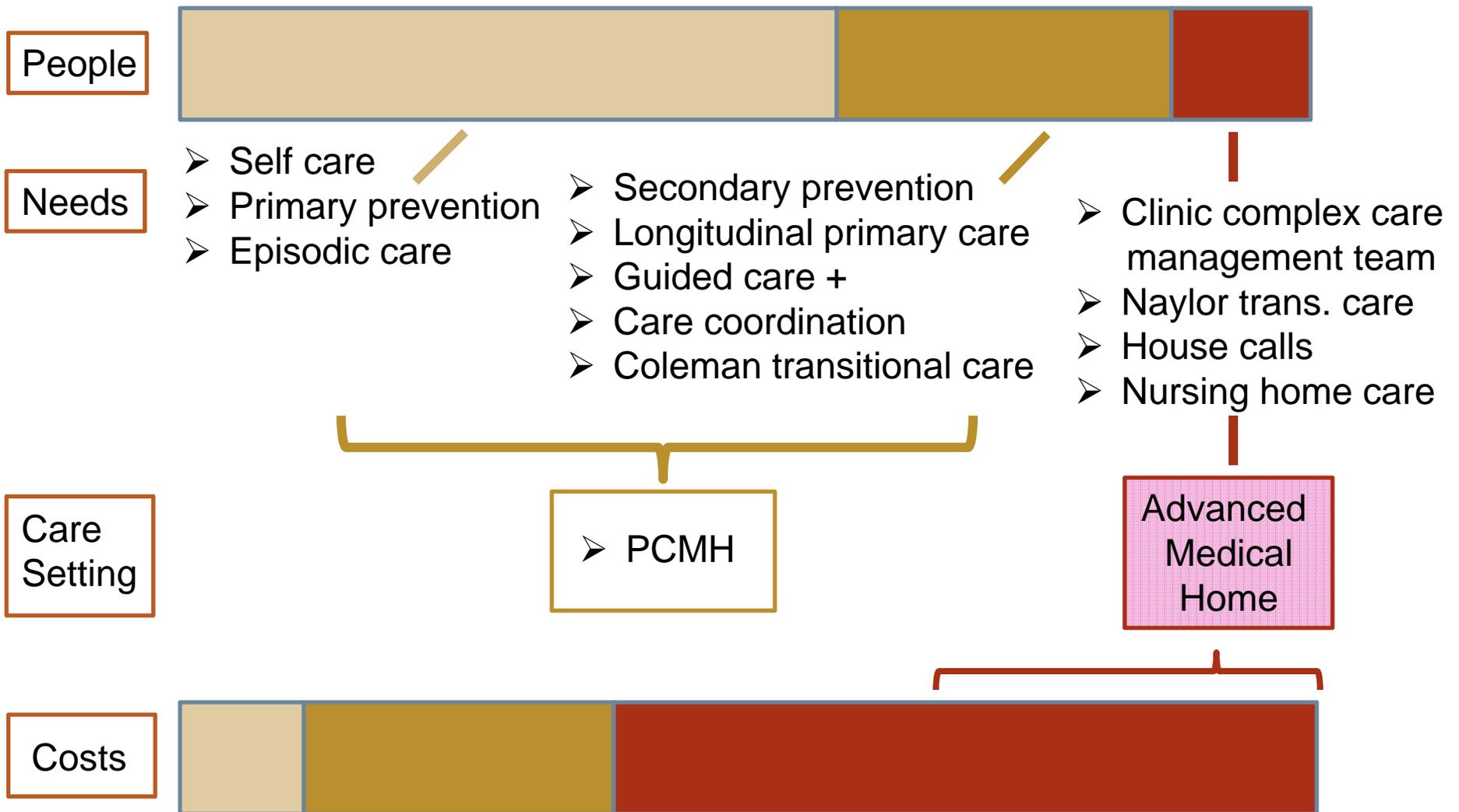
- ❑ A new patient with complex medical history seen at CAHM, reported medication noncompliance due to confusion
- ❑ At 1 week f/u visit, patient brought **75 medication bottles**, including benzodiazepine and narcotics
- ❑ Reduced to 11 medications
- ❑ Regular f/u continues



Value, Quality, Relativity

- “Standards of care”
- Statins
 - 3% absolute risk reduction
 - 800 / 24,000 benefit
 - No proven benefit in old-old
- Drug-eluting stents
- AICDs
- Hospitalists
- And so on.....
- **Complex team care costs money, but...**
- **Done well, coordinated well, targeted well -**
 - **better for patients**
 - **better for providers**
 - **saves money overall**
 - **better for society**

Payment: Match to Model



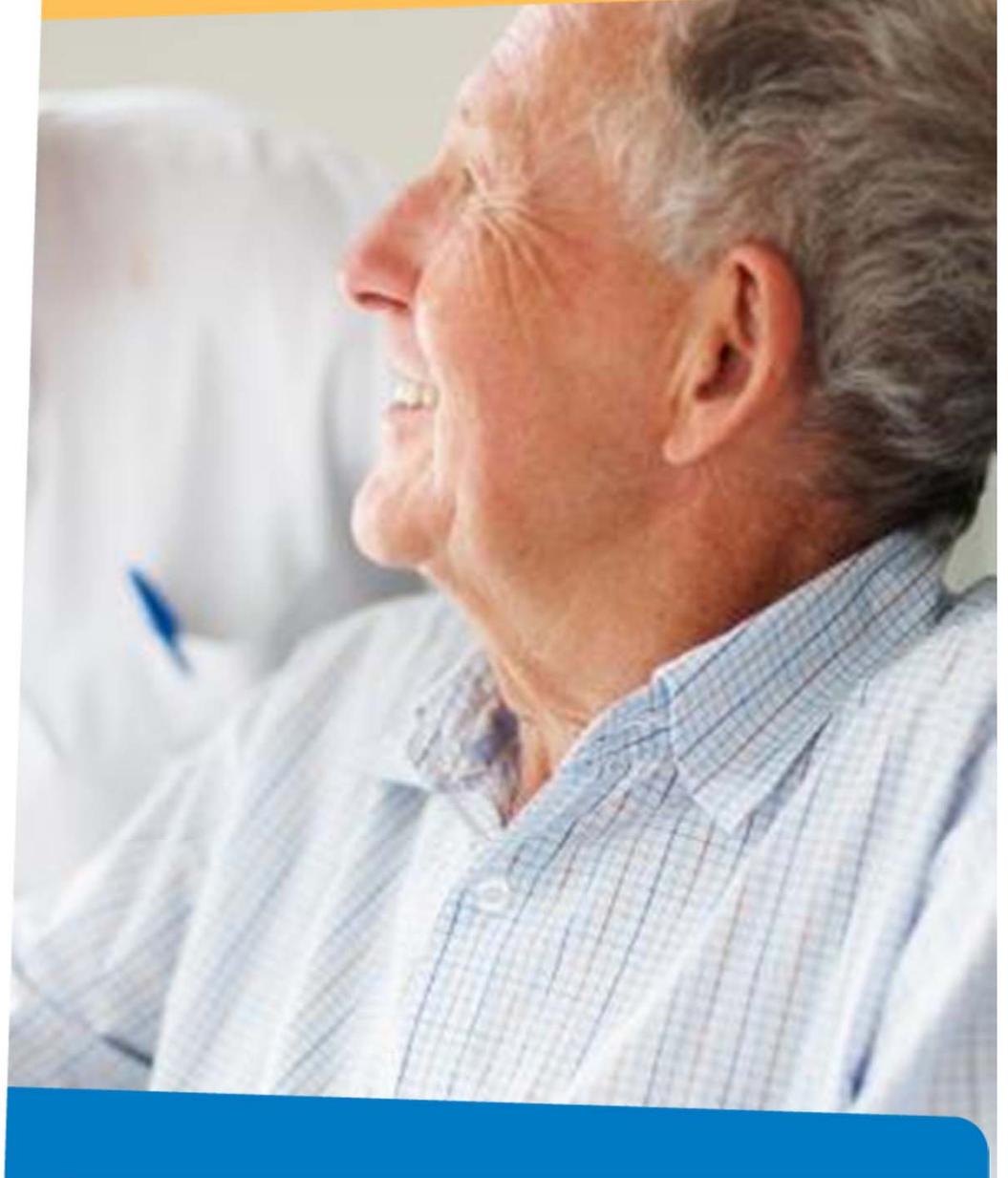


Anthem HealthKeepers
Offered by HealthKeepers, Inc.

Anthem HealthKeepers Medicaid-Medicare Plan (MMP)



Commonwealth Coordinated Care
Medicare & Medicaid working together for you



Behavioral Health Health Homes - Overview

- Purpose: Caring for Members with severe mental illness and co-morbid medical conditions that are often left undiagnosed/untreated.
- Structure: Behavioral health and medical providers delivering integrated case management service in a community based setting; a dedicated Anthem behavioral health care manager assigned to each participating CSB as a primary point of contact
- Current Status:
 - 11 CSBs are participating in Tidewater, Central and Western demonstration areas
 - 93 Members receiving services through the health home program

BH Health Homes - Opportunities

- Expanding program in 2015
 - Additional CSBs joining program: 1 in Tidewater, 2 in Northern VA and 3 in Western
 - Additional training onsite with CSB staff re: medical conditions, best practices for integration of care, Member 360 application
- Automating processes for assignment, billing and reporting
 - Identifying members not seen at CSB, but reside in catchment area and/or have private providers
 - Using invoicing to track encounters and bill; researching codes for claims and quarterly encounter reports
 - Building member assignment in accordance with CSB capacity/resources which varies by CSB
 - Maximizing data available to track members due to opt out or eligibility loss/re-enrollment, lag in billing

BH Health Homes - Success in the Central Region

- Richmond Behavioral Health Authority (RBHA) has a TCM CM who manages the BH Health Home members and provides monitoring, counseling, education, problem solving, transportation
- PCP & NP onsite for services and consultation with CM regarding management of medical conditions
- Most BH Health Home members utilize onsite services which makes care coordination amongst all providers easier, more effective and allows for “warm transfers”
- Positive relationship and ongoing communication via email, phone and in person with Anthem MMP CM who can utilize medical directors and medical CMs as needed to provide additional support, education, resources.

Provider Collaborations

- Health Systems and Provider Groups
 - Shared Savings and Full Risk Arrangements in place and/or in discussions with several providers in Tidewater, Roanoke, Central, Northern demonstration areas
 - Program implementation triggered by assigned membership thresholds
 - Program success requires both financial and quality of care achievements
- Post Acute Care Providers
 - Collaboration agreement with broad network of high quality long term care providers across all demonstration areas. Shared Savings opportunities and focus on member experience and quality of care.
- Just over 1/3 of Anthem's membership is being or will be served by end of Q2 2015 in some part through a provider collaboration

Stakeholder Engagement and Community Outreach

- Close collaboration between Anthem HealthKeepers and DMAS has allowed, through targeted outreach to members and providers, for education and assistance with individual needs
- Continued Commitment to education of providers and MMP members through targeted community meetings and partner events
- Community Outreach Representatives are stationed regionally to enhance member to community resource utilization and focus on members' needs
- Grassroots engagement has been launched with non-profit organizations who support MMP members through quality of life enhancements.
- The establishment of strong Key Stakeholder relationships between outreach and CILs, AAAs, Food Banks, etc. has allowed Community Outreach to develop a Member Outreach Advisory Board which provides feedback from all regions on the performance of the MMP.

Humana Gold Plus Integrated, A Commonwealth Coordinated Care Plan

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

CCC Stakeholder
Advisory Committee
April 15, 2015



Enhanced Care Coordination – ECC

- **Enhanced Care Coordination (ECC)** is an integrated medical, social and behavioral health care service that was designed to meet the needs of dual eligible individuals who have a serious mental illness (SMI) and/or intellectual disability (ID) and serious and chronic medical issues.
- Person-centered principals of care aimed at assisting the individual to actively manage health and medical issues by performing seven core functions :
 - ◆Assessing
 - ◆Planning
 - ◆Linking and Coordination
 - ◆Supportive Services
 - ◆Monitoring
 - ◆Reassessing/Revising the Individualized Care Plan
 - ◆Evaluating
- Designed to meet the needs of CCC individuals with SMI and/or ID who possess one or more of these serious and chronic medical conditions:
 - Hypertension
 - Asthma
 - Diabetes
 - Cancer
 - Hypercholesterolemia
 - Heart Disease/CAD/CHF
 - Arthritis
 - COPD
 - Obesity

Enhanced Care Coordination – ECC

- The effectiveness of ECC in general will be evaluated through outcome measures that may include, but are not limited to the following:
 - Improved access to and appropriate use of primary and specialty medical care
 - Reduced use of hospital emergency rooms to treat non-urgent medical conditions
 - Reduced hospital admissions rates
 - Reduced lengths of stay during hospital admissions
 - Streamlined prescription practices and pharmaceutical access
 - Reduction in high-risk behavior (e.g., sexually transmitted diseases, smoking, substance use)
 - Reduction in baseline indicators for chronic conditions (e.g., hypertension, diabetes)
 - Improved consumer satisfaction

Enhanced Care Coordination – ECC

- First of two pilot programs set to begin May 1 with Richmond Behavioral Health Authority (RBHA)
- Manager, Provider Partnerships in place
- Program coordination details are being finalized internally and with RBHA
- Referral Training in the use of our web based tool scheduled
- Member stratification underway for identifying initial enrollees
- Communication lines and key contacts established

Innovative Partnerships

- Bay Aging
 - Current AAA Managed Membership: 340
 - Current AAA Staff: 1 FT Program Manager, 5 FTE, 2 PTE
 - Service Area - All of Tidewater, + ten (10) localities in Central VA (Franklin City, Westmoreland, Northumberland, Richmond County, Lancaster, Essex, Middlesex, King & Queen, King William, & Southampton)
 - Weekly management and Team meetings / Quarterly Leadership Meetings
 - Inclusion in Weekly training calls / Monthly Staff Meeting / Educational offerings
 - UTC Outreach Initiative (effective April 2015)
- Chronic Disease Self-Management (ER Utilization Study)
 - DARS Led Planning May 2015



VA Premier CompleteCare

a Commonwealth Coordinated Care Plan

Virginia Premier CompleteCare (Medicare-Medicaid Plan)
Commonwealth Coordinated Care
Advisory Meeting



Agenda

- Virginia Premier CompleteCare
- Enhanced Care Coordination
- Magellan
- Ally Align
- CAHM
- Medical Home
- Contacts



Enhanced Care Coordination ECC



- Integrates primary, acute, behavioral health and long-term services and supports for Medicare-Medicaid enrollees
- Improve care coordination for Dual Eligible Beneficiaries.



CompleteCare and ECC

- VPCCC has committed to Pilot ECC Program
- 2 Sites
 - Hampton Newport News
 - Richmond Behavioral Health Authority
- Evaluate Program in 1 Year
- Utilize VACSB/ MMP program evaluation tools and criteria
- Managed and Authorized Internally



ECC Target outcomes

- Reduced use of hospital emergency rooms for non-urgent care.
- Reduced hospital admission rates.
- Reduced hospital readmission rates.
- Reduced inpatient lengths of stay.
- Increased community tenure between hospital admissions.
- Initiation of active discharge planning within 1 business day of a hospital admission.
- Active outreach and provision of ECC services within 1 business day following a hospital discharge.
- Increased adherence to prescribed medications.
- Increased access to primary and specialty medical care.
- Increased engagement in behavioral health and substance abuse treatment services, as needed.
- Improved functional status.
- Increased involvement in recovery-oriented services/supports.



Medical Home

- Establishment of Patient Centered Medical Home in Roanoke to enhance access to primary care physicians and improve health outcomes.
- Incorporates behavioral health care into services provided.
- Innovative care model to address medical, psychosocial and community service needs.
- Provide home visits.
- Embedded Care Management



- Partnership with VCU's Center for Advanced Health Management that was specifically designed for the complex needs of Central Virginia's under-served elderly population.
- Staff includes physicians specializing in geriatrics, social workers and a psychiatric nurse practitioner. Provider also services nursing home Members and visits to patients' homes.



Partnership with AllyAlign to enhance care for Virginia Premier Members

- **Medication Therapy** – Evaluation of pharmacy utilization per enrollee. (Ex. An enrollee is diagnosed with high blood pressure but takes no high blood pressure medication).
- **Top 5 Chronic Diseases** – Analyze the top 5 chronic diseases per facility and develop plans to prevent our enrollees from acquiring those diseases.
- **Enhanced Care Services** – Root cause analysis for hospital admissions and the creation of mitigation strategies to prevent unnecessary acute care admissions.



Virginia Premier CompleteCare has Partnered with Magellan Health Services!

- Partnership with Magellan to provide services for our Members with behavioral health care needs.
- **Behavioral health** and **substance abuse** service authorizations handled by Magellan Healthcare, Inc.



Magellan Behavioral Health Services



- Authorization request forms are available on the Virginia Premier CompleteCare website www.vapremier.com/providers/complecare-overview/provider-forms-library

for the following services:

Mental Health Skill Building
Psychosocial Rehabilitation
Intensive Community Treatment

These forms should be faxed directly to Magellan at **1-866-354-8758**.

- Please call Magellan at **1-800-424-4971** for all other behavioral health or substance abuse service authorizations.
- More information about Magellan can be found on our website at: <https://www.vapremier.com/providers/complecare-overview/behavioral-health-services>



Contact Information

Our Call Centers

Member Services

- 1-855-338-6467

Claims Customer Service

- 1-855-338-6467

Organizational Determinations

- 1-888-251-3063

Provider Services

- 1-855-338-6467

Case Management

- 1-855-338-6467

Thank You!



Thank you!
Virginia Premier CompleteCare

