



VDA WEEKLY E-MAILING

July 15, 2014

Table of Contents

[ACL News & Information](#)

[NASUAD Weekly Update](#)

[DOJ and HHS Call for Action to Address Abuse of Older Americans](#)

[Person-Centered Planning and Self-Direction: HHS Issues New Guidance](#)

[Coordinated Dementia Care Article](#)

[Commonwealth Coordinated Care](#)

ACL News & Information

Here is a link to news & information from the Administration for Community Living (ACL):

<http://www.acl.gov/NewsRoom/NewsInfo/Index.aspx>

NASUAD Weekly Update

Here is a link to the weekly National Association of States United for Aging and Disabilities (NASUAD) update where you can sign up or view the current and archived editions:

<http://www.nasuad.org/newsroom/friday-update>

DOJ and HHS Call for Action to Address Abuse of Older Americans

Cecily Slasor, Administrative Support

July 9, 2014 Elder Justice Roadmap outlines critical path to combating problem

Today, leaders in the fight against elder abuse announced a framework for tackling the highest priority challenges to elder abuse prevention and prosecution, and called on all Americans to take a stand against the serious societal problem of elder abuse, neglect and financial exploitation.

Note: The web links in this document may change over time. DARS-VDA does not attempt to refresh the links once the week has passed. However, this document is maintained on the web for a period of time as a reference. Some links may require registration.

1610 Forest Avenue • Suite 100 • Henrico, VA 23229

Office 804.662.9333 • Toll free 800.552.3402 • TTY users dial 711 • Fax 804.662.9354



Supported by the Department of Justice (DOJ) and the Department of Health and Human Services (HHS), the Elder Justice Roadmap was developed by harnessing the expertise of hundreds of public and private stakeholders from across the country and by gathering their input. The goal of these expert summits was to identify the most critical priorities and concrete opportunities for greater public and private investment and engagement in elder abuse issues. The [Elder Justice Roadmap](#), being published today, reflects the knowledge and perspectives of these experts in the field and will be considered by the Elder Justice Coordinating Council and others in developing their own strategic plans to prevent and combat elder abuse. [Read more.](#)

[BACK TO TOP](#)

Person-Centered Planning and Self-Direction: HHS Issues New Guidance on Implementing Section 2402(a) of the Affordable Care Act

*By Sharon Lewis, Principal Deputy Administrator of ACL and Senior Advisor on Disability Policy, HHS
Cecily Slasor, Administrative Support*

On June 6, 2014, the Secretary of Health and Human Services issued important guidance on person-centered planning and self-direction for implementing Section 2402(a) of the [Affordable Care Act](#). This provision of the law requires the Secretary to ensure all states develop systems for delivery of home and community-based services and supports (HCBS) that are designed to respond to the changing needs of beneficiaries, maximize independence, support self-direction, and achieve a more consistent and coordinated approach to the administration of policies and procedures across programs providing HCBS.

This new information will help states, agencies, providers, people with disabilities, families, and other stakeholders to encourage the development of systems and services that are person-centered and maximize self-direction. That, in turn, will empower people who receive long-term supports and services (LTSS) to reach their goals and achieve a better quality of life. [Read more.](#)

Coordinated Dementia Care Article

Charlotte Arbogast, MSG, Dementia Services Coordinator

Check out the lead article from the VCU School of Allied Health's Alumni Magazine (Spring/Summer 2014) entitled "A portrait of coordinated care: Examining how each allied health profession touches the lives of those with dementia." The article even features our own

Commissioner Rothrock! The article reviews how the different professions within the SAHP, from PT and OT to gerontology, clinical lab sciences and others, provide quality services to individuals



with dementia and their caregivers. It's a great summary of what a quality, holistic assessment should look like. Enjoy! The entire magazine can be found at: http://wp.vcu.edu/sahp/wp-content/uploads/sites/3224/2014/06/SAHP_Mag_Spring2014.pdf.

Commonwealth Coordinated Care

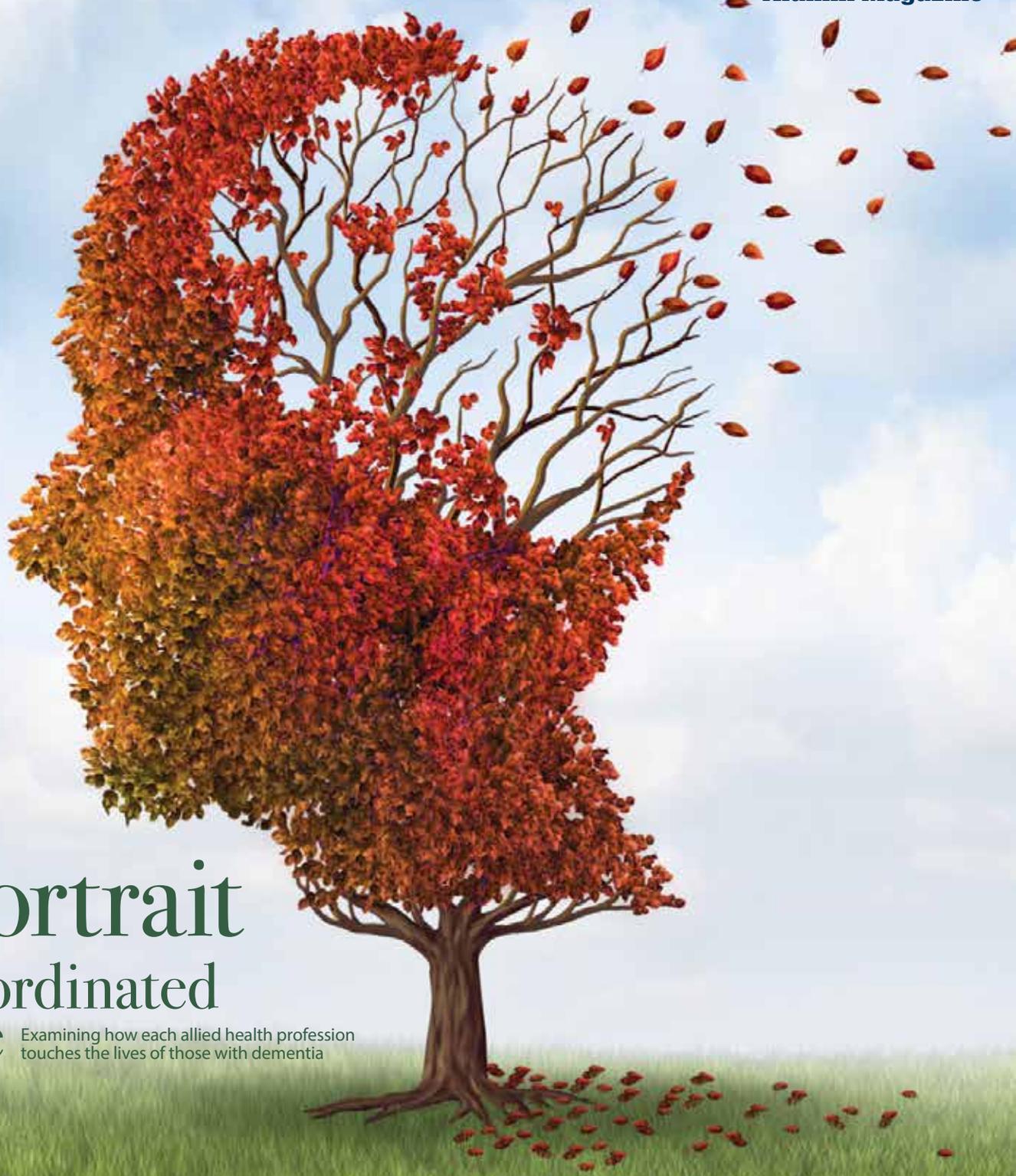
James A. Rothrock, Commissioner

Please see the two attachments on Commonwealth Coordinated Care (CCC). We want to get the information out that CCC is an enhancement that *blends* Medicare and Medicaid. Consumers will benefit from care coordination and other features of this initiative. Please share this information with your staff so we can support this effort. Thank you.

VCU Allied Health

SPRING 2014

Alumni Magazine



A portrait of coordinated care

Examining how each allied health profession touches the lives of those with dementia

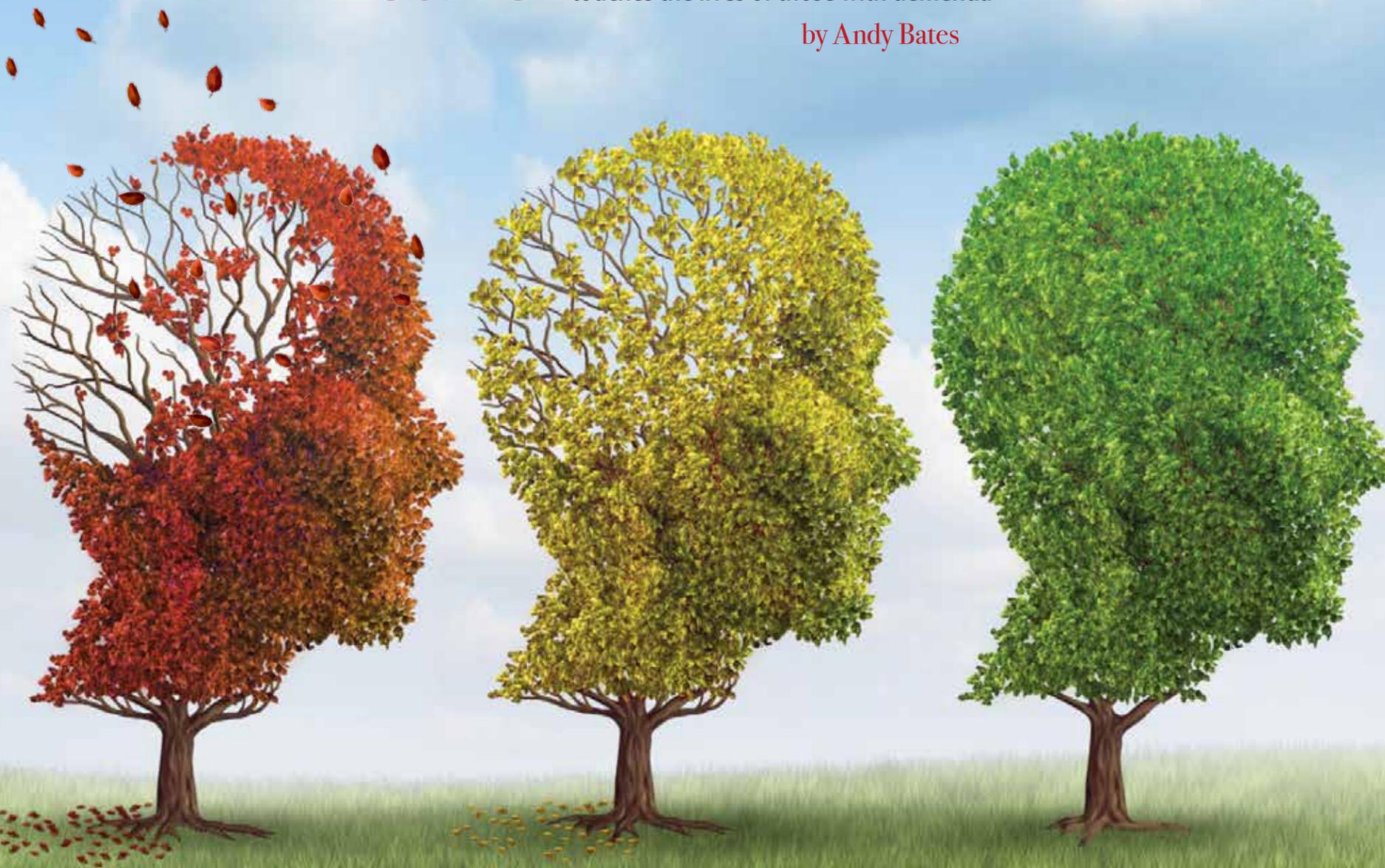


VCU School of
Allied Health Professions

A portrait of coordinated care

Examining how each allied health profession touches the lives of those with dementia

by Andy Bates



By the time you reach the end of this sentence, someone in the world will have been diagnosed with dementia. In fact, the World Health Organization estimates that the number of new dementia cases each year totals nearly 7.7 million, which equates to a diagnosis every four seconds.

Numbers, however, can only tell part of a story. The fact that WHO projects the population of people living with dementia to double every 20 years — reaching 65.7 million by 2030 and 115.4 million by 2050 — certainly provides a sense of scope, but it fails to portray the equally rising number of people taking on the responsibilities of caregiving, or the increased demand for skilled professionals throughout the health care system.

Despite such far-reaching implications, a diagnosis of dementia remains so deeply personal at its core because it impacts the organ we've trusted most in our lives to guide us. Such a diagnosis can leave people feeling helpless, afraid, angry, even ashamed. At every stage of progression, though, you'll find an allied health professional there to help diagnose, educate, guide and care — not only for the people fighting these conditions, but also for the loved ones fighting alongside them.

Perception vs. reality

"There's this assumption that everybody gets dementia as they get older, that it's a normal part of aging, and that's really not true," says E. Ayn Welleford, Ph.D. (M.S. '93/G; Ph.D. '98), chair of the Department of Gerontology in the Virginia Commonwealth University School of Allied Health Professions.

That assumption, Welleford adds, can often lead people to see signs of dementia (such as forgetting one's car keys or not immediately being able to recall a name) where there really aren't any. Or, conversely, people may dismiss actual warning signs of dementia (such as not being able to engage in the processes of planning and acting out a day's activities, or extreme forgetfulness) as just being part of the typical aging process.

When symptoms are interpreted improperly, dementia runs the risk of becoming a catch-all diagnosis, Welleford says, when there are so many other possible explana-

tions for the cognitive impairments a person may be presenting. For example, based on the answers a person may give on a mental status exam, what might initially appear to be dementia may sometimes be more indicative of depression. Similarly, since common health complications like urinary tract infections or medication interactions can cause symptoms, Welleford's department, as well as the Virginia Center on Aging at VCU and its Virginia Geriatric Education Center, can help to infuse a more intimate knowledge of the aging process through continuing education and training. That way, health care providers and staff at places like adult day care centers can better recognize and differentiate the symptoms of dementia to aid proper diagnosis.

Enlisting the work of clinical laboratory scientists early in the diagnosis process is also important, says William Korzun, Ph.D., DABCC, MT(ASCP) (Ph.D. '88), associate professor in the VCU Department of Clinical Laboratory Sciences.

"A physician often will order clinical laboratory tests for liver, kidney and thyroid function, because defects in those organs can lead to dementia-like symptoms," Korzun says. "Likewise, vitamin B12 and folic acid deficiencies, as well as other anemias, have been associated with dementia symptoms, and if you treat those conditions, then the dementia recedes."

Such tests have established reference ranges, and any results that fall out of those ranges could raise red flags to a physician, Korzun says. However, in the event that such tests fail to rule out other causes of the symptoms being presented, a physician may also request a series of brain imaging tests, which would fall under the purview of the radiologic technologist.

"With CT and MRI, we can look at different structures of the brain to see if there is a tumor or a stroke, and we can also look at the functioning of the brain to see if there is any lack of blood flow to an area or an infarction that may be causing these symptoms," says Rebecca Keith, RT(R)(CT)(ARRT), assistant professor and clinical coordinator of radiography in the VCU Department of

“This can be a very devastating diagnosis for many people and their families to accept, because they know their lives are going to change in so many ways,”

— KATHY BERRY, (B.S. '78; M.S. '93/PC; CERT. '04/G), CHAPLAIN

Radiation Sciences. “Very often we’re looking at the temporal lobes, the middle areas of the brain, because a lot of times with dementia, these areas can appear shrunken or atrophied, and that can clue us in, too.”

Even with a sound diagnosis, there’s no cure for dementia and only one guarantee: The symptoms will worsen and become more debilitating over time. Diagnosis, then, becomes the starting point for an individualized, holistic care plan aimed at maintaining function and quality of life for as long as possible, and that plan invariably involves a wide range of allied health professionals throughout the process.

Tailoring strategies

“This can be a very devastating diagnosis for many people and their families to accept, because they know their lives are going to change in so many ways,” says Kathy Berry, (B.S. '78; M.S. '93/PC; Cert. '04/G), who serves as a chaplain dedicated specifically to memory support at Westminster Canterbury in Richmond, Va. “Also, when you’ve seen one person with dementia, you’ve seen

one person with dementia. It affects individuals so uniquely, and that provides a challenge for anyone interacting with people with dementia.”

Part of that challenge rests in assessing each individual’s ability to function on a daily basis, and while occupational and physical therapists are enlisted to perform such an assessment, oftentimes it’s the family caregiver who can provide the most insight. However, how can medical professionals be sure that the information a caregiver provides is accurate?

That’s a question Catherine Verrier Piersol, Ph.D. (Ph.D. '13/HRS), examined closely during her time as a student in the Ph.D. in Health Related Sciences program, which has also helped inform her current work as clinical director of Jefferson Elder Care in the Thomas Jefferson University School of Health Professions in Philadelphia.

A portion of this research involved developing a tool to measure caregivers’ abilities to accurately assess a patient’s functional capacity, which Piersol says can guide “targeted intervention planning and teach caregivers strategies for maximizing a patient’s participation in daily activities, while also ensuring safety” — a process that often involves physical and occupational therapists working in tandem.

Alzheimer’s disease, dementia and related conditions — What are they?

According to the Centers for Disease Control and Prevention, dementia is a term used to describe a group of cognitive disorders marked by memory impairment and difficulty in the domains of language, motor activity, object recognition and executive function (the ability to plan, organize and abstract). Dementia typically impacts the lives of older adults and is not classified as a disease but rather as a group of symptoms that affect the mental and physical tasks listed above.

Alzheimer’s disease is the most common cause of dementia symptoms and is marked by the progression of those symptoms, as well as brain-cell death. In addition to Alzheimer’s disease, there are several other conditions that are characterized by

dementia symptoms. These include Huntington’s disease, Parkinson’s disease and Creutzfeldt-Jakob disease.

The Department of Gerontology manages a webinar series, funded through the Virginia Center on Aging’s Geriatric Training and Education Initiative, titled “The Other Dementias: Virtual Training and Active Learning on Non-Alzheimer’s Dementias” to help health care providers throughout the state learn to better differentiate the symptoms and trajectories of these conditions. That way, they can tailor treatment plans even further and develop best practices moving forward.

Learn more and view the webinars at alzpossible.org.

As with any elderly individual, there is going to be a decline in physical function for people with dementia. However, there are unique physical challenges that dementia presents above and beyond the typical aging process, according to Sheryl Finucane, PT, Ph.D. (Ph.D. '91), assistant professor and coordinator of graduate education in the VCU Department of Physical Therapy.

“There tends to be a higher frequency of falls, some of which can be attributed to typical declines in general balance and muscle strength,” Finucane says. “But there is evidence that there are declines in gait associated with dementia, which can also lead to a fall. On top of that, a person with cognitive impairment may have difficulty identifying risk factors in their environment, they may not self-assess their own physical limitations as well as they used to, and they also may lose the ability to assess the risks around them.”

A physical therapist, then, will work with an individual on an exercise or activity regimen to help improve the balance, muscle strength and mobility needed to navigate his environment safely, which can be as minimal as going from a sitting to standing position 10 times a day, to light-weight or resistance-band exercises.

Meanwhile, an occupational therapist can work to modify an environment. Things like adding adaptive equipment such as grab bars in a bathroom can go a long way toward mitigating safety risks, as can working to reduce clutter, loose wires on a floor or ripples in a carpet, says Jodi Teitelman, Ph.D. (M.S. '78; Ph.D. '83; Cert. '83/G), associate professor in VCU’s Department of Occupational Therapy. As the disease progresses, more modifications might be needed to avoid other dangerous risk factors, including wandering, which can entail adding stop signs to doors or other ways to distract a person from their initial urge to leave their environment.

Safety, however, isn’t the only role occupational and physical therapists play in the lives of patients and caregivers.



The methods they use and regimens they prescribe are also aimed at helping patients maintain a sense of independence and enjoyment out of life. For example, a caregiver may report that their family member can no longer feed himself, when, in reality, an adjustment to a mealtime routine like placing the spoon in the person’s hand may trigger him to begin eating on his own.

Allied health professionals help people with dementia and their caregivers manage unique challenges that go above and beyond the typical aging process.



Maintaining a sense of independence can keep individuals with dementia engaged in activities that give their life meaning.

“Everyone’s looking at how we can better coordinate the care of this population of patients. Historically, these have all operated as very independent, fragmented systems, and that just can’t continue.”

— MIKE ROWE (M.H.A. ’91/HA), LONG-TERM CARE ADMINISTRATOR

Or, say a person has always loved playing cards, but can’t always remember the rules to a certain game; the caregiver can provide other ways to interact with a deck of cards, like sorting by color or suit.

“We don’t just look at the spaces they occupy,” Teitelman says, “we look at how they occupy that space and what they do to occupy their time. But whether it’s occupational therapy or physical therapy or any other discipline, I think we all tend to gravitate toward finding ways to help people continue to engage in the things that give their life meaning.”

For many people with dementia, that meaning can be derived from their spirituality, and for Berry, of Westminster Canterbury, spirituality doesn’t necessarily have to mean organized religion (though, of course it can mean exactly that). It can be finding joy in music or being out in nature — anything that gives a person

hope, inspiration or solace. Just as a family counselor or a physical or occupational therapist might perform an assessment of a person’s environment and abilities, the patient counselor, chaplain or faith leader must similarly assess what makes a person light up and gives them peace.

“The main thing I do is listen and be present with them in whatever moment they’re experiencing, to help them find a spiritual center in any way that I can,” Berry says. “I try to be a safe, nonjudgmental presence for them and to let them know they’re never alone.”

Caring for the caregiver

In an ideal world, a physical therapist could come into the home of every person with dementia and work with them on strength-building exercises, an occupational therapist could periodically come and observe a person in a series of particular activities and measure functional capacity, a counselor could come and talk about particular anxieties a person may be feeling. Unfortunately, however, the bulk of that care most often falls on a person’s loved ones.

According to the Alzheimer’s Association, 80 percent of care provided to those with Alzheimer’s and related conditions is provided by unpaid caregivers, and in 2012, those caregivers provided 17.5 billion hours of unpaid care valued at \$216.4 billion. The challenges caregivers face, though, revolve as much around the stress and emotional toll of caregiving as it does providing daily assistance.

“We have to understand that families are sometimes involved in a grief process, as the individual with the disease may not be ‘the someone’ they know and trust,” says Caren Phipps (M.S. ’81/RC), a licensed professional counselor and a licensed marriage and family therapist. “They have to be able to accept permanent change, which is very difficult and disruptive, and they’ll need assistance in developing skills to cope with that.”

Helping caregivers requires building stronger support networks and simply

getting information out there, which is something Ed Ansello, Ph.D., executive director of the Virginia Center on Aging, says continues to be a prime focus. Concordant to that, Ansello says, is the added challenge brought by the fact that more people with developmental disabilities are living long enough to develop these conditions as well, causing extra burden on even experienced caregivers who may be unused to dealing with dementia.

“Regardless of the specific condition or circumstances, you never want to lose family caregivers in the equation,” Ansello says. “You want to find ways to build resources and conduct training to reinforce a caregiver’s ability to continue what they’re doing, because it’s so extremely valuable. But you also have to help them think of themselves, too — how to care for their own health and find respite for themselves — because that’s just as vital as the care they provide.”

What the future holds

The easiest explanation for the projected increase in dementia diagnoses referenced at the outset is that more people, in general, are living longer, and because people are living longer, hospitals are also seeing an increase in elderly patients presenting for surgery — particularly in the field of orthopedics and cardiac surgery.

“One of the things we’re interested in, then,” says Chuck Biddle, Ph.D., CRNA, professor and director of research in the VCU Department of Nurse Anesthesia, “is finding whether there are things we’re doing in the OR that might accelerate or even precipitate cognitive decline. There are so many factors patients experience during surgical care, so we’re looking at the different drugs used in anesthesia, the amount of blood loss, how long they’re under anesthesia, what kind of operation they’re having, what a patient’s temperature is before, during and after operation, what time of day the surgery is performed. ...

[H]ow do factors like these influence their postoperative cognition, both long term and short term? And are there things we can change to improve that cognitive performance after surgery?”

Biddle and his team have made some inroads into answering those questions through an observational study, which can lay the groundwork for more pinpointed and intensive investigations into those areas, Biddle says, particularly concerning drug types and drug dosages. However, research into what roles surgery and anesthesia may play in the onset of dementia is still very new, and Biddle is quick to point out that people shouldn’t avoid seeking the care they need for fear that a surgery might cause the onset of dementia or cognitive decline.

When it comes to dementia, however, fear is often a prevailing emotion — fear of becoming dependent on others, fear of not being able to remember various things, fear of needing assisted living services. With the projected increase in diagnoses, though, a higher demand for more and better integrated assisted living services seems unavoidable.

For Mike Rowe (M.H.A. ’91/HA), a long-term care administrator in training at Westminster Canterbury, this demand is going to expand not only the role of health care administrators, but also the approach of health administration education programs to include more long-term care emphasis.

“Everyone’s looking at how we can better coordinate the care of this population of patients — from hospital care, to nursing home care, to home health care, to respite care, to assisted living, to hospice,” Rowe says. “Historically, these have all operated as very independent, fragmented systems, and that just can’t continue. Administrators in long-term care have to know what’s going on in all

In 2012, 15.4 million family and friends provided 17.5 billion hours of unpaid care to those with Alzheimer’s and other dementias — care valued at \$216.4 billion — and due to the physical and emotional toll of caregiving, these caregivers accrued \$9.1 billion in additional health care costs of their own.

— ALZHEIMER’S ASSOCIATION



Even as allied health professionals and researchers work to find better ways to treat dementia, the benefits of simply sitting with a person and providing a nonjudgmental presence in their lives will never change.

One in every three seniors dies with Alzheimer's disease or another dementia, making it the second-largest contributor to death among older Americans.

— ALZHEIMER'S ASSOCIATION

of these sectors, and vice versa. It's no longer enough to be intimately involved with patients when they're in your building. You have to know how all of the other players are affecting your patients when they're not with you."

Rowe cautions that it isn't just health care providers and administrators who will have a hand in meeting that demand for care. The Alzheimer's Association estimated that the direct costs of caring

for those with Alzheimer's disease in the U.S. in 2013 would reach \$203 billion, with \$142 billion of that total being costs of Medicare and Medicaid, which pushes the discussion into the sociopolitical spectrum as well, and by 2050, the association estimates that those costs of care will have increased by more than 500 percent.

It's more than just the economics of the health care system that dementia figures to impact, however. As James Rothrock (M.S. '78/RC), commissioner of the Virginia Department for Aging and Rehabilitative Services, suggests, the population of those over

the age of 65 in the commonwealth alone will reach just under 2 million by 2030, and many of those people will still be in the workforce, as people are continuing to work later in life due to economic concerns.

People trained in vocational rehabilitation counseling, then, are going to be further tasked with determining whether individuals presenting symptoms of dementia are capable of performing substantial gainful activity, if they're not of retirement age.

"Although few, if any, individualized plans for employment will be written for clients presenting dementia as a disabling condition for vocational rehabilitation services," Rothrock says, "the vocational rehabilitation counselor must be aware of this disease, as it will impact families, businesses and caregivers."

In many ways, though, while quantifiable, it's nearly impossible to qualify those impacts. Again, numbers can only tell part of a story. They can't show the pain of not being recognized by a loved one during a visit, or the toll that near-constant worry and attention can take on a caregiver. Numbers can't describe the fear of becoming a burden to loved ones, or the compassion in just sitting and listening to a patient or family member.

The stories of how we care for those with dementia are heard one at a time. They're told through chaplains dedicated to counseling those with memory loss, and through scientists working to better detect and prevent these conditions. They're told through therapists who work to build the physical, occupational and emotional strength needed to face a diagnosis and all of the days that follow. They're told through gerontologists educating providers, families and communities, through administrators coordinating better care systems and through a school which supports that care at every turn. ☺

Andy Bates is a contributing writer for VCU Allied Health.

Funding Alzheimer's research

Two funds managed out of the School of Allied Health Professions provide support for research aimed at advancing our understanding of Alzheimer's disease.

Alzheimer's and Related Diseases Research Award Fund: As an organization with its finger on the pulse of Virginia's aging population and the people who serve that population, who better than the Virginia Center on Aging at VCU to recognize the need for research, no matter how seemingly small, into conditions that currently affect more than 5 million Americans.

Since 1982, the VCoA has administered grants from the Alzheimer's and Related Diseases Research Award Fund, which is appropriated annually by the state General Assembly and remains one of the most effective state-supported seed grant programs in the country.

While these grants typically weigh in at less than \$40,000 individually, from the \$3 million in grants awarded since 1982, awardees have gone on to obtain an additional \$32 million in funding thanks in part to findings secured through their ARDRAF projects.

Since 1982, the VCoA has awarded 145 grants in total, with VCU researchers obtaining 43, or nearly 30 percent, of those awards.

Alzheimer's Disease Fund: The Alzheimer's Disease Fund, administered by the Department of Gerontology, was created in 1983 as a way to support graduate student education and research in the field of dementia, Alzheimer's disease and related conditions. Sparked by the efforts of the late Stephen W. Harkins, Ph.D. (M.P.H. '09), who was instrumental in establishing the first support group for Alzheimer's disease in Virginia,

and his wife, Janice N. Harkins (M.S. '84/PT), the fund has continued to grow and impact our understanding of these conditions, as well as establish best practices moving forward.

To contribute to the Alzheimer's Disease Fund, visit support.vcu.edu/give/gerontology, or contact Jessica F. Gurganus, assistant dean for development and external relations, at (804) 828-3269 or jfgurganus@vcu.edu.



10 Key Points about Commonwealth Coordinated Care

1

Commonwealth Coordinated Care (CCC) is an enhancement: Medicare & Medicaid were never built to work together, creating gaps and overlaps in your care; therefore, Virginia is offering CCC to blend Medicare and Medicaid. With CCC **you keep your Medicare & Medicaid** benefits with the added benefit of **Care Coordination**.



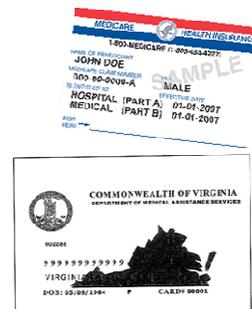
2

When it comes to your healthcare, **choice** is important. That is why with CCC you are not locked in when you choose a CCC health plan. You can even choose to “opt-out” of CCC completely. There is no “open enrollment.” You can opt-in or change your CCC plan at any time.



3

To qualify for CCC you must be 21 & older and receiving Medicare Parts A, B, & D and receiving FULL Medicaid benefits. In addition to individuals living in the community, CCC is also available to individuals receiving the Elderly & Disabled with Consumer Direction (EDCD) Waiver and those living in nursing facilities. You must live in a CCC region to participate. For a list of CCC localities visit the DMAS website at http://www.dmas.virginia.gov/Content_atchs/altc/altc-anst6.pdf



4

Some individuals are exempt from CCC, including: Individuals receiving any other Home and Community Based Waiver, those receiving hospice, or those with other comprehensive insurance.



5

Care Coordination is the primary benefit of CCC. If you enroll in CCC, a care manager from your plan will get to know you and work with you to achieve your health goals. The Care Manager will coordinate your appointments and services. There is no cost for this benefit and Care Coordination is currently not available under traditional Medicare and Medicaid benefits.



6

What about your doctors? When choosing a CCC health plan, check to see which plan has your doctor and other healthcare providers in their network. If your doctor or other healthcare providers do not participate with your plan, **you may continue receiving care from your providers for up to 6 months to allow you to transition to in-network providers.** Your providers will also have the opportunity to join the health plan's network.



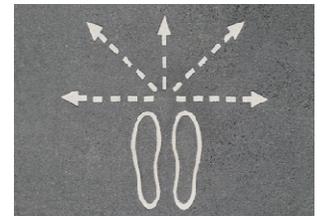
7

Cost: There are **no premiums or co-pays for doctor or specialist visits.** You may have **some co-pays for prescription drugs.** If your plan offers extra benefits, like foot care or dental care, you do not pay premiums or co-pays for extra benefits.



8

To **choose a plan**, look to see which plans are offered in your area, which plans have your doctors and hospital and other healthcare providers in their network, and review the extra or supplemental benefits offered (such as foot care, dental care, hearing care-extra benefits vary by plan).



9

To **enroll in CCC**, call MAXIMUS (the enrollment broker) at **1-855-889-5243**. Trained MAXIMUS representatives can look up your doctors or other healthcare providers and review each plan available in your area. The MAXIMUS representative can sign you up over the phone-so **there is no paperwork to fill out!** If you decide to change plans or decide CCC is not for you, call MAXIMUS to change plans or leave the CCC program (called opting out) at any time.



10

You can voluntarily choose your health plan and your coverage will typically begin the 1st of the following month (example: enroll March 20 & your coverage starts April 1). **If you do not proactively choose a plan or opt out of CCC (by calling MAXIMUS), a plan will be chosen for you and you will be notified by a letter.**



Remember **# 2!** You have the opportunity to change plans or opt-out of CCC at any time.

For more information, visit the CCC website at http://www.dmas.virginia.gov/Content_pgs/altc-enrl.aspx



Frequently Asked Questions for Individuals and their Families

<p>What is Commonwealth Coordinated Care (CCC)?</p>	<p>CCC is a program that combines your Medicare and Medicaid benefits into one health plan (referred to as a Medicare-Medicaid Plan) of your choice.</p>
<p>What is a Medicare-Medicaid Plan (MMP)?</p>	<p>Within the CCC are a variety of MMP health plans. A MMP manages a group of health care providers that work together to give you care. This group may include doctors, hospitals, specialists, pharmacies, and long term services and supports providers. Sometimes a MMP is called a “health plan”.</p> <p>Each MMP has its own group of providers. This group is the health plan’s “network of providers.” After you join a MMP, you will get your services from the plan’s network of providers. Your health plan works with all of these providers so that you get the care you need.</p>
<p>Is the CCC program voluntary?</p>	<p>Yes, the CCC program is voluntary. You can decide not to join (opt out) or withdraw from the program at any time and return to your original Medicare and Medicaid coverage.</p>
<p>Am I eligible for CCC?</p>	<p>Individuals may qualify for CCC if they are at least 21 years old, receive full Medicare and full Medicaid benefits (including those in the Elderly or Disabled with Consumer Direction (EDCD Waiver) and those residing in nursing facilities), and live in participating areas within the Commonwealth of Virginia. “Full benefits” means your Medicare card says “Entitled to Hospital (Part A) and Medical (Part B)” Medicare Part D (pharmacy benefit) and you have a Medicaid card with full Medicaid benefits.</p>
<p>Which areas of the Commonwealth participate in CCC?</p>	<p>The CCC will operate in 5 regions across the Commonwealth (Central Virginia, Northern Virginia, Roanoke, Tidewater and Western/Charlottesville regions). This includes over 100 counties and cities in Virginia.</p>
<p>How do I join CCC?</p>	<p>You will receive a letter in 2014 which will provide a phone number to call to sign up. This number will connect you with a trained person who will help you and discuss the different health plan options available to you.</p>



<p>When do I enroll in CCC?</p>	<p>Enrollment in the Central Virginia and Tidewater regions will begin in early 2014, with services starting in March 2014. Enrollment in the Roanoke, Charlottesville and Northern Virginia regions will begin in May 2014, with services effective June 2014.</p>
<p>Can I still see my regular provider(s) if I join CCC?</p>	<p>If your provider is part of your new health plan's network, you may continue to see him/her. Health plans will allow you to continue seeing your current doctors and other providers for 180 days from the time you enroll in the plan. After that, you will have to see providers that are part of your health plan's network. If your provider is interested in participating in the CCC network, he/she may contact DMAS at CCC@dmas.virginia.gov for further information.</p>
<p>Will I have coverage for my prescription drugs under the CCC program?</p>	<p>Yes, your health plan will cover your prescription drugs as prescribed by your doctor. When signing up with your health plan, see the plan's handbook for specific limitations or exclusions.</p>
<p>What services does CCC cover?</p>	<p>Your health plan will include all Medicare and Medicaid services, Medicaid EDCD Waiver services, and nursing facility services. Your health plan also will offer additional benefits that are only available to individuals enrolled in CCC, such as person-centered care coordination.</p>
<p>What does care coordination mean and what will a care coordinator do for me?</p>	<p>Care coordination is a person-centered process that assists you in gaining access to needed services. The care coordinator will work with you, your family members, if appropriate, your providers and anyone else involved in your care to help you get the services and supports that you need.</p>
<p>Will information be available in alternate formats or languages other than English?</p>	<p>Yes. For example, you may request information in Spanish, Braille or large print. A TTY line will be available for individuals who are deaf or hard of hearing.</p>
<p>What if I travel out of state and require medical care? Does CCC cover me in another state?</p>	<p>Urgent or emergency care is covered under CCC. When signing up with your CCC health plan, see the plan's handbook for specific information on out-of-network and out-of state coverage.</p>



<p>What are the benefits of the CCC and why should I sign up for the program?</p>	<ul style="list-style-type: none"> • You receive better coordination of care through one health plan. • You don't pay extra to join. • You have one health plan card and one number to call for answers to questions about all your benefits. • You work with a care coordinator. This person will work with you, the health plan, and your providers to make sure you get the care you need. • You will be able to help direct your own care with help from your care team and care coordinator.
<p>What if I join a health plan and then don't like it?</p>	<p>You can withdraw from the CCC program at any time and go back to your original Medicare and Medicaid. Or, you can choose another health plan available under CCC.</p>
<p>Can I switch to another health plan within CCC?</p>	<p>Yes, you can switch to another health plan that is available in your region at any time.</p>
<p>I am on the EDCD waiver. Will I continue to have the option to direct my own home-based long term services and supports?</p>	<p>Yes, you will continue to have this option under the CCC program.</p>
<p>Can I enroll in CCC if I am a recipient of the Auxiliary Grant?</p>	<p>Yes, recipients of the Auxiliary Grant are also eligible to enroll in CCC.</p>
<p>I am in a nursing facility. Will I have to change nursing facilities if I join CCC?</p>	<p>No, individuals residing in a nursing facility may remain in their facility as long as they continue to meet DMAS' criteria for nursing home care, unless they or their families prefer to move to a different nursing facility or return to the community.</p>
<p>Where can I get more information?</p>	<p>More information may be found at http://www.dmas.virginia.gov/Content_pgs/altc-home.aspx.</p>