2017: THE TRANSITION TO CCC PLUS
The Commonwealth Coordinated Care (CCC) dual demonstration program will continue to operate through December 2017.

DMAS has provided some detail on the phase out.

THE END OF CCC
CCC Plus is the next iteration of managed Medicaid LTC and will be a mandatory Medicaid-only managed care product for the entire State (including the CCC regions)

- Program is Medicaid-only, but participating plans must also offer (or be working toward) a Dual-Special Needs Plan (D-SNP) on the Medicare side

- DMAS released the Request for Proposals (RFP) 4/29/16
  - 21 managed care organizations (MCOs) formally indicated interest
  - DMAS narrowed the field to seven MCOs (next slide)
  - Six of the seven MCOs decided to sign a contract with DMAS (next slide)
And Then There Were Seven Six:

- Aetna*
- AmeriHealth Caritas*
- Anthem
- Arlington Healthcare Group
- CareFirst
- CareSource*
- Gateway

* Met with VHCA staff
Current regional rollout schedule of CCC Plus

- **Tidewater:** August 2017
- **Central:** September 2017
- **Charlottesville/Western:** October 2017
- **Roanoke/Alleghany:** November 2017
- **Southwest:** November 2017
- **Northern/Winchester:** December 2017

For the CCC participants, coverage will begin January 2018.
Regional Launch Detail (from DMAS)

CCC Plus Program Regional Launch

- Tidewater Assign 6/18
- Central Assign 7/18
- Charlottesville Assign 8/18
- Roanoke, Alleghany & Southwest Assignment 9/18
- Northern & Winchester Assignment 10/18

Assignment happens on the 18th of each month beginning in June.

- June: Tidewater Effective 8/1
- July: Central Effective 9/1
- August: Charlottesville Effective 10/1
- September: Roanoke Alleghany & Southwest Effective 11/1
- October: Northern & Winchester Effective 12/1

CCC Plus enrollment is effective on the 1st of the next month following assignment, approximately 45 days after initial assignment.
DMAS Outreach Plan
(See: http://www.dmas.virginia.gov/Content_pgs/mltss-meetings.aspx)

<table>
<thead>
<tr>
<th>Launch Date</th>
<th>Regions</th>
<th>Town Hall Meetings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aug 1, 2017</td>
<td>Tidewater</td>
<td>July</td>
</tr>
<tr>
<td>September 1, 2017</td>
<td>Central</td>
<td>August</td>
</tr>
<tr>
<td>October 1, 2017</td>
<td>Charlottesville/Western</td>
<td>September</td>
</tr>
<tr>
<td>November 1, 2017</td>
<td>Roanoke/Alleghany</td>
<td>October</td>
</tr>
<tr>
<td>November 1, 2017</td>
<td>Southwest</td>
<td>October</td>
</tr>
<tr>
<td>December 1, 2017</td>
<td>Northern/Winchester</td>
<td>November</td>
</tr>
</tbody>
</table>
Who is included:

- Duals who were not included in the CCC demonstration (those under 21; those in regions not under CCC; those with other comprehensive coverage, etc.):
  DMAS estimates \( \approx 45,000 \) not eligible for CCC

- Non-Dual Medicaid recipients:
  DMAS estimates \( \approx 19,000 \) in LTC (NF & HCBS) / 79,000 not in LTC

- CCC Population:
  DMAS estimates \( \approx 28,634 \) enrolled / 40,678 not enrolled

NOTE: The CCC participating population will not transition to CCC Plus until January 2018, BUT CCC non-enrolled (40,678) will be part of the initial roll-out
### Nursing Center Population Drill-Down

<table>
<thead>
<tr>
<th>Category</th>
<th>Tidewater 8/1/2017</th>
<th>Central 9/1/2017</th>
<th>Charlottesville / Western 10/1/2017</th>
<th>Roanoke / Alleghany 11/1/2017</th>
<th>Southwest 11/1/2017</th>
<th>Northern / Winchester 12/1/2017</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFS DUAL NF Residents</td>
<td>2,205</td>
<td>2,689</td>
<td>2,513</td>
<td>1,889</td>
<td>1,505</td>
<td>2,194</td>
<td>12,995</td>
</tr>
<tr>
<td>FFS Non-DUAL NF Residents</td>
<td>483</td>
<td>462</td>
<td>226</td>
<td>209</td>
<td>147</td>
<td>354</td>
<td>1,881</td>
</tr>
<tr>
<td>TOTAL NON CCC NF Residents</td>
<td>2,688</td>
<td>3,151</td>
<td>2,739</td>
<td>2,098</td>
<td>1,652</td>
<td>2,548</td>
<td>14,876</td>
</tr>
<tr>
<td>CCC NF Residents (all 1/1/18)</td>
<td>828</td>
<td>1,049</td>
<td>335</td>
<td>697</td>
<td>0</td>
<td>371</td>
<td>3,280</td>
</tr>
<tr>
<td>TOAL MLTSS NF Prospective Population</td>
<td>3,516</td>
<td>4,200</td>
<td>3,074</td>
<td>2,795</td>
<td>1,652</td>
<td>2,919</td>
<td>18,156</td>
</tr>
<tr>
<td>TOTAL MLTSS Prospective Population</td>
<td>46,185</td>
<td>52,751</td>
<td>29,958</td>
<td>25,681</td>
<td>21,723</td>
<td>39,057</td>
<td>215,355</td>
</tr>
<tr>
<td>% NF</td>
<td>7.6%</td>
<td>8.0%</td>
<td>10.3%</td>
<td>10.9%</td>
<td>7.6%</td>
<td>7.5%</td>
<td>8.4%</td>
</tr>
</tbody>
</table>
Who is not included (relevant to nursing centers):

- QMBs
- Veterans Nursing Facilities
- PACE recipients
- Hospice and ESRD recipients (unless they are in MLTSS prior to needing these services)

What is not included (relevant to nursing centers):

- Dental
- Preadmission Screening
Prompt payment
- “The contractor [MCO] shall ensure clean claims for NFs...are processed within fourteen (14) days of receipt of the clean claim”

Medicaid Rate Floor
- “The Contractor [MCO] shall pay NFs no less than the Medicaid rate for Medicaid covered days, using DMAS’ methodology, or a different negotiated rate as mutually agreed upon by the provider and the Contractor.”
  - VHCA was successful in the 2017 General Assembly Session to get budget language adding protection to the Medicaid rate floor provision so that instead of a simple administrative contract change, there will be a requirement to modify regulations
  - By requiring the rate floor in Medicaid managed care regulations, DMAS will have to go through a formal process if in the future the decision is made to drop the rate floor
Any Willing Provider

- “The Offeror [MCO] is **not required** to contract with all willing providers, however its network must meet network adequacy requirements.” (emphasis added)

- Regardless of network status, individuals in NFs at the time of CCC Plus enrollment may remain in that NF as long as they continue to meet DMAS criteria for nursing facility care
  - VHCA continues to work with DMAS to modify language around the circumstances where a resident can be moved to reference the existing OLC / APS processes around the enrollee “health and welfare” provision
Uniform Billing for NFs

- RFP and Draft contract stated: “DMAS reserves the right to require uniform billing practices and claims submissions processes for NFs”
- VHCA pressed DMAS to invoke this option based on the multiple claims processing issues experienced under CCC
- Final contract states: “DMAS requires the Contractor [MCO] to implement uniform billing practices and claims submissions processes for NFs…”
- We have offered to work with DMAS and the MCOs on this requirement

Sanctions for Non-Compliance with Payment Requirements

- Draft contract did not include claims issues for sanctions – VHCA pointed this out
- The final contract includes “Noncompliance with Claims Adjudication Requirements” as a sanction-able issue
Pre-Admission Screening (PAS) / Uniform Assessment Instrument (UAI)

- The CCC Plus contract requires certification by the NF that the UAI is on file.
- To the extent there is not a UAI, the MCO is essentially instructed to deny payment for long-term care services (including NF).
  - DMAS has agreed that NF residents will be exempted from the UAI requirement as it pertains to non-payment by the MCOs. Specifically, they have said:
    “DMAS is making the change in the contract to indicate that the MCOs will not require the NF Providers to have a UAI but will require the MDS in situations where the UAI is not available. The contract language also reflects that DMAS will work with stakeholders on a process to make it easier to obtain a UAI.”
  - VHCA is still working with DMAS and the MCOs on the details of this approach. NOTE: we do not believe this approach will be permanent, particularly if the work group modifies/streamlines the UAI.
Financial incentive to MCOs to keep/move participants to community-based services:

- DMAS will blend the nursing center population with the waiver population in terms of their payment to the MCOs
  - This means MCOs will be reimbursed below cost for our residents and will be reimbursed above cost for the waiver recipients, on average
  - VHCA opposed this approach in comments to DMAS, due to the enormous financial pressure this would place on the MCOs to limit or deny coverage to the extent transitioning to the community was not attainable
  - Irrespective of the blended rate paid to the MCOs, nursing centers will be paid at least at the Medicaid rate
- DMAS/General Assembly would not yield on this
Recognition of the NF as a Care Coordinating Entity

- RFP requires Plans to describe:
  - how the Plan “will coordinate with other existing ICT meetings, including but not limited to, those held in NFs…”
  - “how the ICT process will interface with the development of a comprehensive ICP”
  - “how the Offeror [Plan] will incorporate and leverage external existing plans of care”
  - “how the initial ICP and any care plan revisions are communicated among the member, ICT, and other pertinent providers”
  - how the Plan “will … empower and support the care team in proactively recognizing signs of emerging issues (e.g., depression, fall risk, etc.) and mechanism for follow-up on identified risks” [emphasis added throughout]
Health Risk Assessments (HRAs) by the plans

- The MCOs are required to conduct initial and on-going HRAs for NF residents
- VHCA had commented that there was no direction to the plans to utilize the MDS assessment process that NFs must utilize, which also drives the RUGs assignment
  - DMAS Response: “During initial discussions, the MCOs have agreed to utilize the NF’s care team process whenever possible.”
  - There seems to be some recognition of the need for consistency in the face-to-face meetings, but we are not yet satisfied with a formal answer
  - VHCA was successful in the 2017 General Assembly Session in getting legislation introduced on a wide-array of Medicaid managed care issues to explicitly require that:

For recipients of long-term care, the managed care organization shall participate in and collaborate with the existing interdisciplinary care team planning process already established pursuant to federal law and regulations in the development of the care plan
Role and Requirements for Care Coordinators

- (At a minimum) Plans must provide a single, 24/7 toll free number for member care coordination support
- Plan must describe how they will notify providers of:
  - The name of assigned care coordinator
  - How to contact the care coordinator
  - When the care coordinator is available
  - Alternative resources if the assigned care coordinator is unavailable
  - When there is a change to the member’s assigned care coordinator
Role and Requirements for Care Coordinators (continued)

- Care Coordinators must:
  - Be locally/regionally based
  - Be available to meet with members face-to-face as needed
  - Act as the primary point of contact for members and the ICT
Role and Requirements for Care Coordinators (continued)

Must execute the following responsibilities:

1. participate in the HRA process
2. lead ICT meetings and facilitate communications among relevant parties
3. monitor the provision of services as outlined in the ICP and achievement of desired outcomes
4. assess for appropriate changes or additions to services, facilitate referrals for the members, and ensure the ICP is updated as necessary
5. ensure that appropriate mechanisms are in place to receive enrollee input
6. ensure member complaints and grievances are submitted according to the policies and procedures
7. actively participate during care transitions
Model of Care Improvements:

- “The Contractor [Plan] shall have at least one full-time dedicated staff person without a caseload in each region in which the Contractor serves MLTSS [CCC Plus] members to assist individuals with transitions where the goal is to serve individuals in the community versus relying on institutional care”

- “shall be responsible for proactively identifying MLTSS [CCC Plus] members in NFs or other institutions who are candidates for transitioning to the community and for assisting with the completion of the transition process”

Contract modified the ratio of patients per care coordinator from 1:140 to 1:175 for NFs
Administrative Simplification

- Plans are required to show how they plan to identify and contract with physicians and ancillary providers who already contract with NFs.

- Readiness review includes system capacity for claims processing/payment and care coordination capabilities (so did CCC).
  - Sub-contractors are allowed (but subject to readiness review).
  - Plans required to “maintain a dedicated queue to assist long-term services and support providers with enrollment, service authorization, or reimbursement questions or issues” for at least 12 months from regional implementation.
Other Issues of Interest:

- 5 year contract with up to 5 annual renewals = 10 years
- 2 or more Plans per region – currently, all six plans in all six regions
- 90 day continuity of care provision (not for NF, but would affect ancillary services)
- DMAS/Plan to align, whenever possible, enrollment in MLTSS and D-SNP
- Plans must cover telemedicine
- Common Core Formulary (>=Medicaid FFS Preferred Drug List)
DMAS is seeking permission from CMS to passively enroll participants in Anthem CCC and VA Premier CCC to the respective D-SNPs when they transition to Anthem CCC Plus and VA Premier CCC Plus on January 1, 2018 – not yet clear if CMS will allow this.

We believe Humana CCC will be distributed among all six plans as Humana is not participating in CCC Plus.
CCC PLUS GAME PLAN

- VHCA staff are working with DMAS through various stakeholder groups through implementation issues.
  - Members from our Ad Hoc Committee on Managed Care and our Payment for Services Committee are both involved, directly and indirectly, in MLTSS pre-implementation meetings/conversations.
  - It is envisioned that these meetings will continue post implementation as necessary, likely with direct participation of the Ad Hoc Committee on Managed Care and the selected health plans (like under CCC).
- We will be updating the general membership as MLTSS develops through electronic means and through face-to-face opportunities (like VHCA District meetings) as necessary.
- Also, see DMAS’ website (http://www.dmas.virginia.gov/Content_pgs/mltss-home.aspx) for program updates and information.