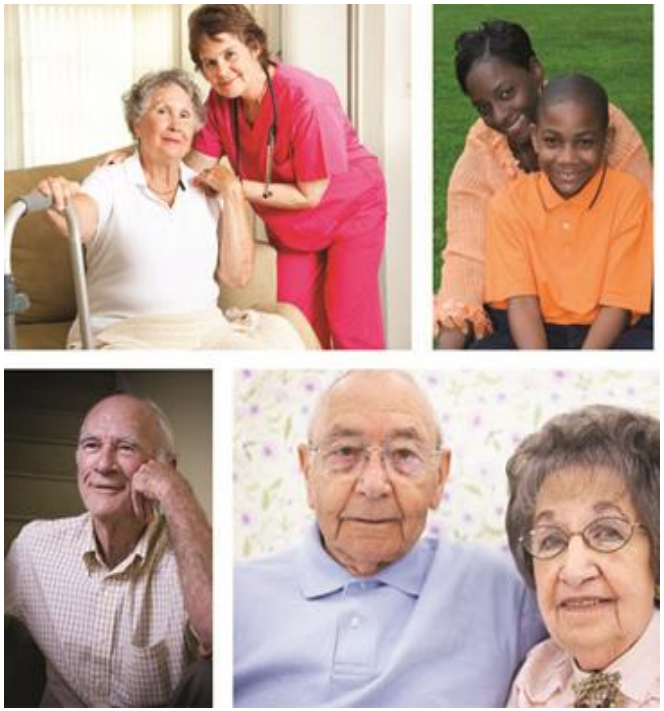


Plus
Commonwealth
Coordinated Care Plus
Your Health. Your Care.

COMMONWEALTH COORDINATED CARE PLUS

VACBP SPRING CONFERENCE

APRIL 26, 2018

Department of Medical Assistance Services

VIRGINIA'S MEDICAID PROGRAM
DMAS
INNOVATION • QUALITY • VALUE

Agenda Slide

- CCC Plus Program Update
- Community Mental Health and Rehabilitation Services & ARTS
- Care Coordination Efforts
- Next Steps

CCC Plus Implementation Recap

CCC Plus phased in regionally August 2017 – January 2018

Tidewater	Central	Charlottesville	Roanoke Alleghany & Southwest	Northern & Winchester	CCC & Remaining ABD
✓	✓	✓	✓	✓	✓
August	September	October	November	December	January

CCC Plus Implementation Highlights:

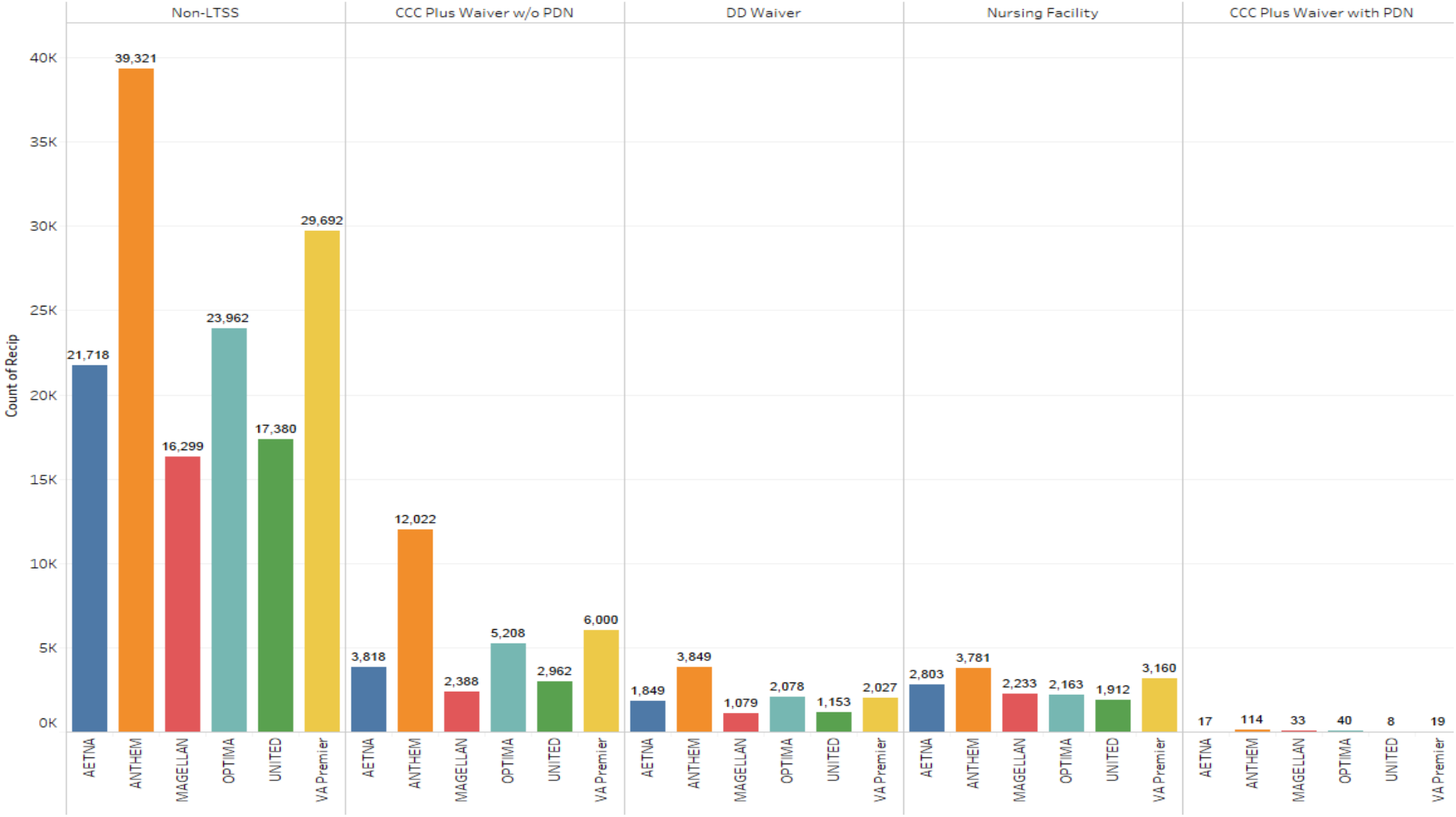
- Planning and design phase included Stakeholder input – Began March 2015
- Plans were selected via competitive procurement (April 2016 – December 2016)
- CMS waiver authority 1915(b) and 1915 (c) – Approved April 2017
- MCO readiness activities - December 2016 – July 2017
- Regional member and provider town halls – June 2017 – November 2017
- Regional implementation - Aug 2017 – Jan 2018
- August 2017 Contracts and Rates - approved by CMS December 2017
- January 2018 Contracts and Rates – submitted to CMS for approval December 2017

DMAS has worked with stakeholders on every phase of the project including to resolve implementation concerns such as provider payments, coordination with Medicare, and continuity of care

CCC Plus Enrollment by Plan by Region

As of 3/5/2018							
MCO	Tidewater	Central	Charlottes-ville	Roanoke Alleghany	Southwest	Northern VA/ Winchester	Total
Aetna	5,379	8,862	3,908	3,578	3,931	4,695	30,353
Anthem	13,329	16,057	5,446	4,887	3,532	16,105	59,356
Magellan	6,486	4,783	2,872	2,432	2,157	3,398	22,128
Optima	10,531	7,383	7,544	2,447	2,612	3,088	33,605
United	4,289	4,619	2,201	3,143	2,262	6,995	23,509
VA Premier	5,106	9,588	7,126	8,787	6,613	3,870	41,090
Total	45,120	51,292	29,097	25,274	21,107	38,151	210,041

CCC Plus Enrollment by LTSS Benefit



Source: VAMMIS. March 5, 2018

Continuity of Care Period

After April 1, 2018

- Maintain the Member's current providers for up to **30 days**, and
- The health plan will honor the service authorizations issued by DMAS or the DMAS Contractor for the length of the existing service authorization or 30 days (whichever is sooner).
- The health plan will extend this time frame as necessary to ensure continuity of care pending the provider's contracting with the health plan or the Member's safe and effective transition to a contracted provider.

Implementation Monitoring

Two Pronged Approach

Standard Monitoring Activities

- Host weekly Implementation Monitoring Calls with each Health Plan
- Review and discuss weekly dashboards
- Track and discuss progress of items on Issues log
- Review and discuss weekly missed trip log

Dynamic Monitoring Activities

- Respond to concerns from members, advocates and providers
  - Resolution of specific concern
  - Research root cause of the concern and take necessary action
- Examples:
  - Chart reviews to address quality of care concerns

Implementation Monitoring: Weekly Dashboards

- Health Risk Assessment completion rates by effective date by subpopulation
- Care Coordinator staffing and ratios
- Claims Processing by service category
- Continuity of Care Authorizations
- Complaints, Grievances and Appeals
- Call Center Activity

Compliance Plan

Compliance Plan Development

- Identify all deliverables in contract, by section
- Determine data needs and availability required to monitor each deliverable
- Prioritize deliverables
- Determine method of monitoring
- Determine frequency of monitoring activities-consider “natural” set points, e.g. data availability (quarterly reports, etc)
- Review internal resources and expertise-tap into other DMAS subject matter expert as indicated
- Finalize compliance plan for management approval

Ongoing monitoring includes follow-up on information received through complaints, grievances and appeals, calls with plans, etc.

- Develop tracking mechanism for points assessment
- Assess points based on Contract specifications and non-compliance
- Process for recommending corrective action plans and financial penalties – discussion with management

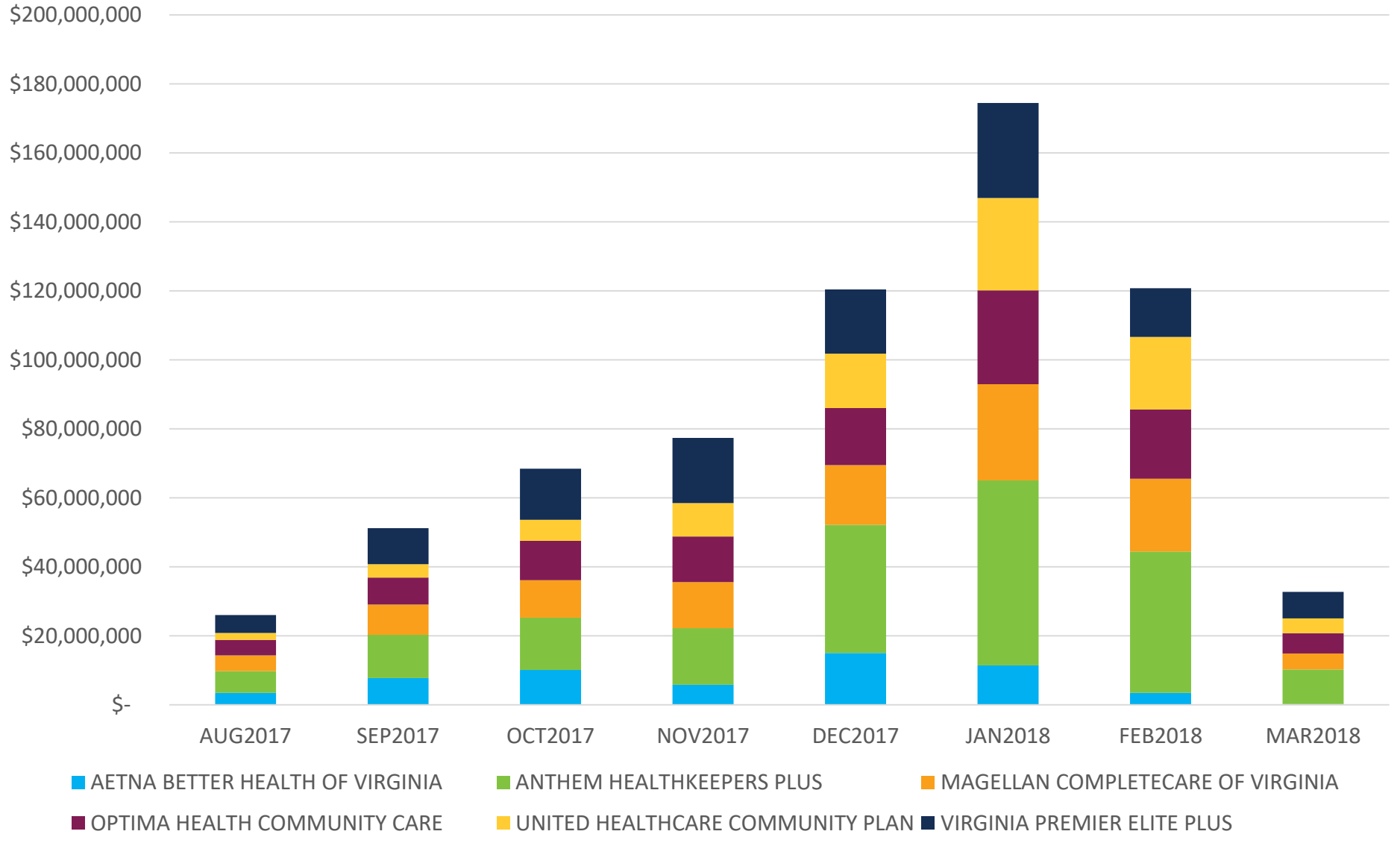
CCC Plus Encounters

CCC Plus uses the new Encounter Processing System (EPS) for encounters. Along with transportation, CCC Plus was in the first group to use the new EPS system. MCOs started submitting encounters in Fall 2017.

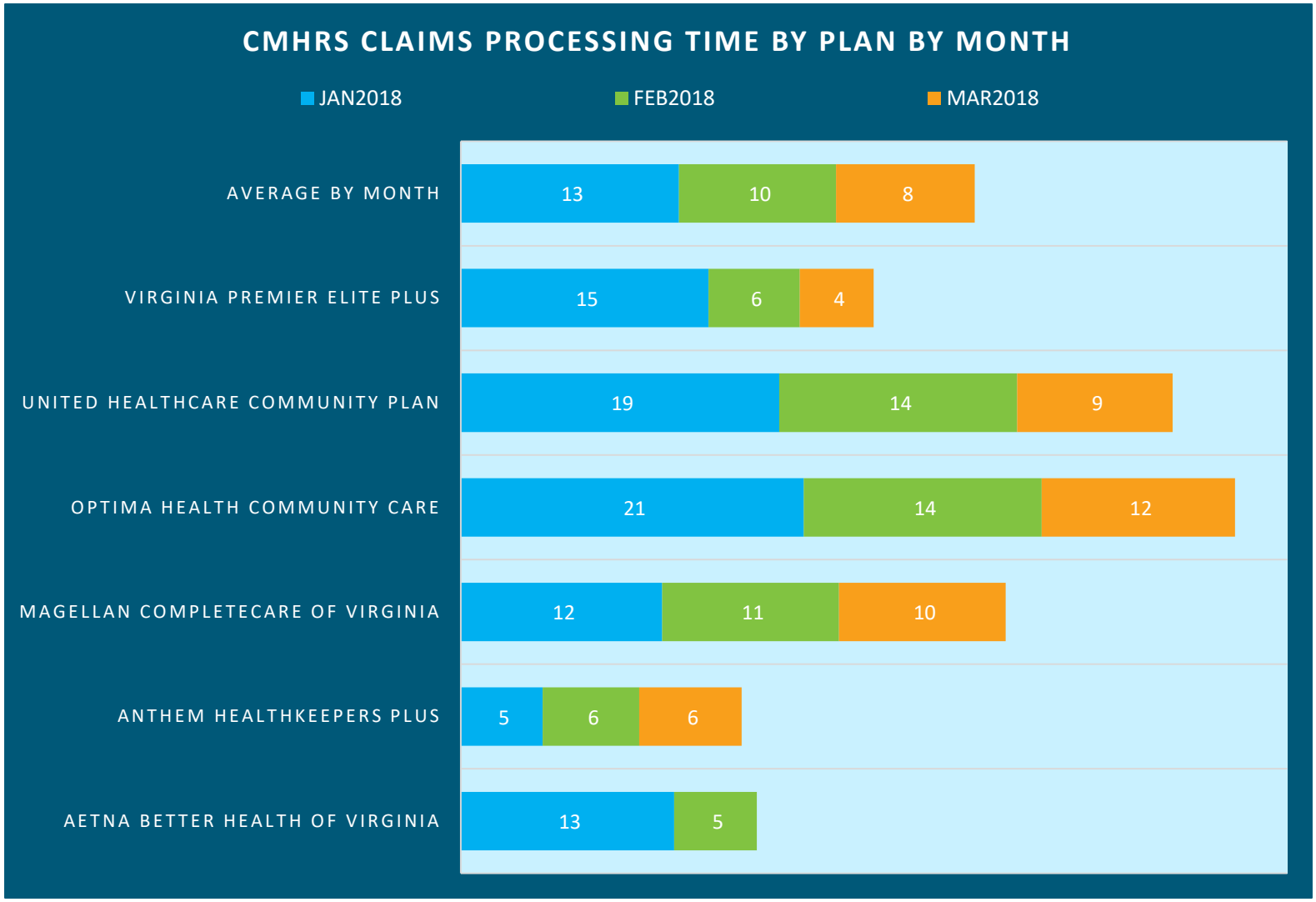
- Encounters include medical, practitioner, facility and pharmacy claims.
- Meets CMS requirements and DMAS business requirements via a series of data validation edits.
- Validated data is reliable and used to analyze service utilization, quality and cost trends
- Interfaces with other data systems that track such data as, but not limited to:
  - Member demographics, eligibility, and enrollment
  - Provider demographics, taxonomy, and enrollment
  - Medicaid Pharmacy Benefit Manager (PBM) Contractor for collection of pharmacy rebates
- CCC Plus uses data quality monitoring tools to ensure that valid and reliable data enters the EPS.
- This data will be transferred downstream to the data warehouse where quality data reports and other feedback loops can be developed and distributed to end users.

MCO Payments Submitted in Encounters

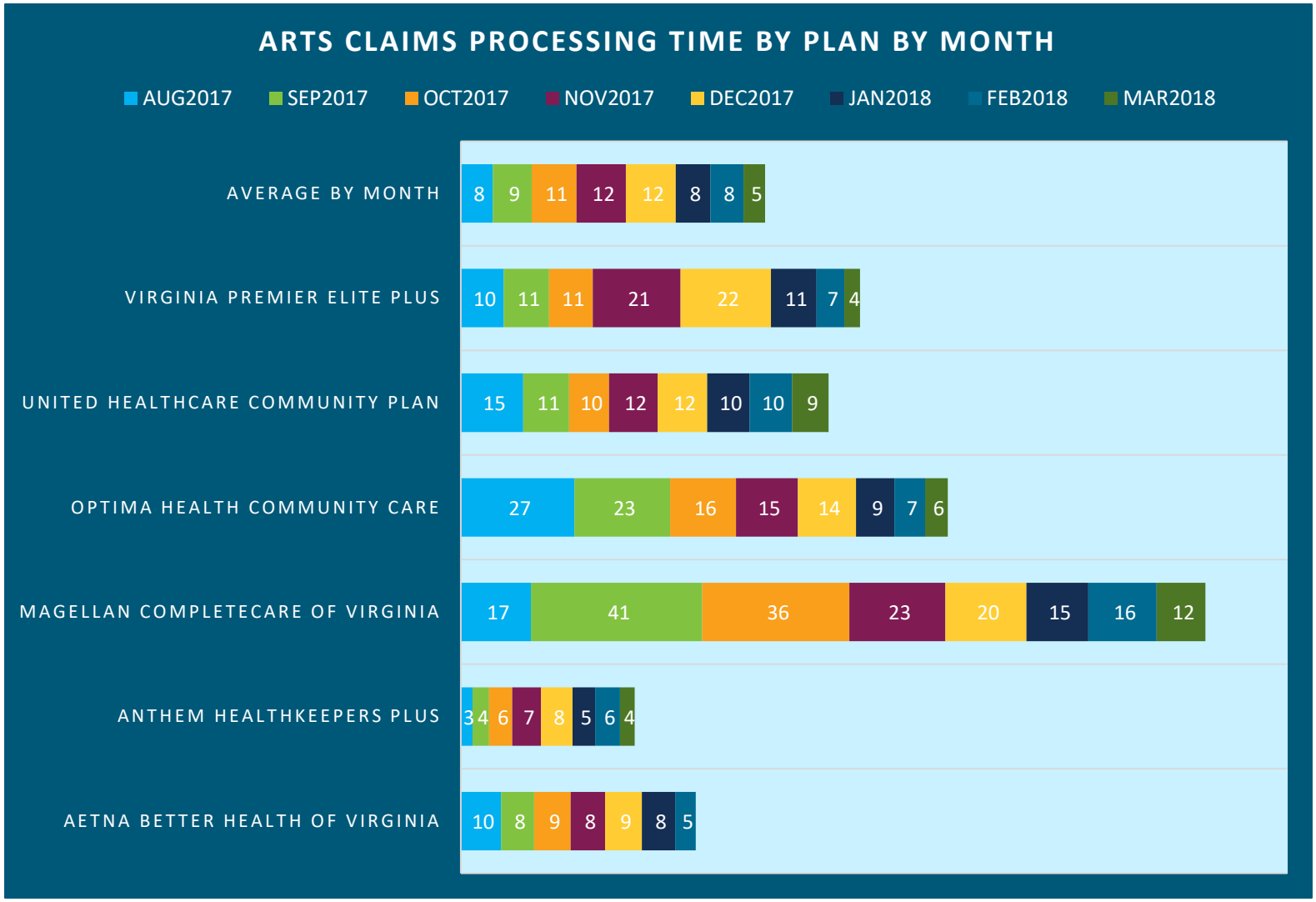
based on service date



CMHRS Claims - Average Processing Time



ARTS Claims - Average Processing Time



Encounter Status

As of March 9, 2018				
MCO	Passed	Failed	Total	% Passed
Aetna	180,185	61,627	241,812	74.5%
Anthem	897,569	135,329	1,032,898	86.9%
Magellan	387,943	54,852	442,795	87.6%
Optima	569,343	12,278	581,621	97.9%
United	324,352	702	325,054	99.8%
VA Premier	465,030	35,920	500,950	92.8%
Total	2,824,422	300,708	3,125,130	90.4%

Recent Outreach Activities

Dates	Type
10/2017 - present	Provider Conference Calls
1/2018-present	CMHRS Provider Calls
7/2017- 1/2018	Member Calls

Community Mental Health Rehabilitation Services

CCC Plus Health Plans began managing the following services on January 1, 2018:

- Mental Health Case Management
- Therapeutic Day Treatment (TDT) for Children
- Day Treatment/ Partial Hospitalization for Adults
- Crisis Intervention and Stabilization
- Intensive Community Treatment
- Mental Health Skill-building Services (MHSS)
- Intensive In-Home
- Psychosocial Rehab
- Behavioral Therapy
- Mental Health Peer Supports

The **90 day continuity of care period** for these services ended 3/31/2018. Please visit the CMHRS website for more information.

MCO Readiness and DMAS/Provider Engagement on CMHRS Transition

October-November 2017

--Weekly CCC Plus CMHRS MCO Implementation Workgroups

--Medicaid Memo to Providers

--Dedicated CCC Plus CMHRS Inbox for Provider Questions

--Weekly Provider Calls with MCOs

--CCC Plus State Steering Committee Meetings and Standardization Sub-Committee

--VACSB Fall Conference

--Virginia Psychosocial Rehabilitation Association Conference

--Virginia Coalition of Private Provider Association

December 2017

--CMHRS Provider Webinars

--DMAS Website Updated with CMHRS FAQ and Multiple Operational Resources for Providers

--Onsite Readiness Visits at the MCOs

--Dedicated CCC Plus CMHRS Inbox for Provider Questions

--CCC Plus State Steering Committee Meetings and Standardization Sub-Committee

January 2018 to Present

--Weekly CCC Plus CMHRS Provider Calls

--DMAS Website Updated with Post-Implementation Resources Based on Provider Input

--VACSB MH/SUD Council

--Virginia Association of Community Based Providers

--Dedicated CCC Plus CMHRS Inbox for Provider Questions

--CMHRS Training for MCO Care Coordinators

--CCC Plus State Steering Committee Meetings and Standardization Sub-Committee

Community Mental Health Rehabilitation CMHRS Service Standardization

- Maintain current DMAS program rules
- Compliance with Mental Health Parity
- Enhanced individualized clinical management with focus on member progress
- Standardization Sub-committee streamlined authorization processes and registration forms
- DMAS rates are the minimum
- Continuity of care period through March 31, 2018
  - Some plans extended the COC Period to ensure credentialing is complete.

Common Operational Issues Since CMHRS January 1, 2018 Implementation

Provider Complaints
Plan unresponsive during credentialing/complicated process
Provider complaints of unpaid claims*
MCO system not showing claims submitted
Complaints of not having questions answered timely and correctly
Excessive time spent on phone calls trying to resolve issues and/or staff unknowledgeable
Not issuing Continuity of Care Authorizations*

**DMAS is monitoring and working closely with the MCOs as they resolve and correct issues associated with claims processing and Continuity of Care Authorizations.*

Transportation

CCC Plus Reservations	Phone Number	Type of Transportation
Aetna Better Health of Virginia	(800) 734-0430 Option 1	All ages and all levels of service
Anthem HealthKeepers Plus	(855) 325-7581	All ages and all levels of service
Magellan Complete Care of Virginia	(877)790-9472	All ages and all levels of service
Optima Health Community Care	(855) 325-7558	All ages and all levels of service
United Healthcare Community Plan Regions 2,4,5 (Central, Roanoke/Alleghany/Southwest)	(844) 604-2078	All ages and all levels of service
United Healthcare Community Plan Regions 1,3,6 (Tidewater, Charlottesville/Western Northern/Winchester)	(888) 258-0521	All ages and all levels of service
Virginia Premier Elite Plus	(877) 719-7358	All ages and all levels of service

CARE COORDINATION FEATURES AND BENEFITS

Virginia's Care Coordination Model

Meaningful patient-level engagement and coordination through MCO partnership

Designed the Care Management Unit and Care Coordinator Role

Established Clear MCO Expectations

Care Coordinator Role

Every member is assigned an MCO Care Coordinator who performs the following functions

Assess

- Conduct/ coordinate Health Risk Assessment
- Identify barriers to optimal health

Plan

- Drive the development of person-centered, individualized care plan
- Include plan to support social determinants of health

Communicate

- Establish collaborative relationships that connect the enrollee, MCO, and providers

Coordinate

- Help navigate the health care system
- Coordinate team of health care professionals
- Support care transitions

Monitor

- Track progress towards goals
- Monitor status to avoid disruption in care
- Update plan of care

Care Coordinator Expectations

Virginia took a collaborative, hands-on approach with MCOs to establish clear expectations for care coordinators

Direct Issue Resolution Process with Care Coordinator Management and Clinical Leads

Timely Information Sharing, Communication, & Training (multiple channels)

Questions Answered Directly from Care Coordinators

Customized Training On-Site

Active engagement and support improved the performance of care coordinators

Value of Care Coordination

Care Coordinators work with providers to ensure seamless care delivery

- Develop relationships with providers across the care continuum and ensure continuity
- Help providers improve enrollee health outcomes by coordinating care not in their health care setting
- Clarify goals for care

Care Coordinators work with enrollees to ensure goals and needs are communicated and met

- Assess/understand enrollee goals and needs and recognize barriers to meeting them
- Assist enrollees to develop and carry out plan
- Support enrollees through transitions
- Educate enrollees so they can make informed decisions

Health Risk Assessment-HRA

- Shortly after becoming enrolled in CCC Plus, the member's Care Coordinator will complete a comprehensive Health Risk Assessment (HRA).
- During this assessment, the Care Coordinator works closely with the Member to identify the medical and behavioral health needs of the individual, and the member's strengths and supports.
- The Care Coordinator also works with the member to develop an understanding of the services that the individual is already receiving and through which providers.

Individualized Care Plan (ICP)

- The Care Coordinator will work with the member and the providers (as identified by the member) to develop a comprehensive, person-centered, individualized care plan (ICP).
- This is accomplished by working with an engaged interdisciplinary care team (ICT), which includes medical, behavioral, and long term services and supports providers, as well as other formal and informal supports identified by the member and documented in the ICP.
- If the Member is receiving targeted case management (TCM) services, the Care Coordinator will work collaboratively with, and not duplicate the services provided by, the TCM.
- ICP's must be developed by the end of the members service authorization.
  - Services cannot be ended or adjusted by the MCO until the HRA and ICP is completed.

Care Coordinator Contact Information

- CCC Plus Members are assigned a Care Coordinator to personally assist members and their treating providers
- For assistance identifying a member's Care Coordinator, please contact the assigned health plan directly at:

Aetna	Anthem	Magellan	Optima	UnitedHealthCare	VA Premier
1-855-652-8249 press #1 and ask for CC.	1-855-323-4687 Press #4	1-800-424-4524	757-552-8398 OR Toll Free:1-866-546-7924	Members: 1-866-622-7982 Providers: 1-877-843-4366	1-877-719-7358; Prompt: 3-3-4-1

Care Coordinators Can Help

- Serves as point of contact to ensure members get services and care they need
- Available to answer questions about programs for enhanced care planning options and risk management
- Helps to resolve barriers to care such as possible network and transportation issues
- Ensures appropriate authorizations are in place and that changes occur promptly
- Leads the Interdisciplinary Care Team for individualized care planning and transition of care needs
- Advocates for members and providers helping members

Care Coordination in Action: Building a Support System

Member's Situation:

- Blind, chronically ill and suffering from mental health issues
- Isolated from family and friends
- Personal care discontinued
- Living in deteriorating conditions and facing eviction

Partnership between the Member and the Care Coordinator

- The Care Coordinator built trust with the member and the member agreed to assistance.
- The Member contacted siblings and friends for help.
- The Member stayed with a friend while the siblings cleaned her apartment.
- The apartment complex fumigated and replace needed appliances.
- The Care Coordinator arranged for the member's personal care services to resume. The attendant will assist with maintaining living conditions and meal preparation.

Making a Difference in People's Lives

Virginia used creative, targeted strategies to ensure seamless transition to managed care for those with complex care needs

DMAS recognized that Paul's transition to managed care needed **extra attention**.

DMAS's Care Coordinator **worked proactively** with Paul, his family and the MCO Care Coordinator to ensure a seamless transition.

During a **face-to-face visit**, both Care Coordinators, Paul, and his family discussed Paul's current status, care needs and developed a **comprehensive service plan**.

This **warm handoff** ensured a successful transition to managed care. We are excited to see Paul doing so well and fulfilling his personal mission to help others!

Inspired by son, family creates Virginia travel guide for people with disabilities

By Bill Lohmann
Jul 22, 2017

WOODFORD If he'd had the chance, Paul Duke knows he would have served in the Army.

"Tank commander," he said, his voice soft and almost inaudible compared with the ventilator that keeps air pumping through his lungs.

He is surrounded, in his room, by military paraphernalia: models of tanks, posters of war planes, videos of military documentaries and dramas, an autographed photo of Gen. Calvin Waller, second in command during Operation Desert Storm to Gen. Norman Schwarzkopf. He

Click here to learn more about how Paul is making a difference

OPPORTUNITIES

Care Coordination

Specialized Services

Integrated Care

Quality

Health Outcomes

Next Steps

- CMHRS Resources on DMAS Website:

  http://www.dmas.virginia.gov/Content_pgs/mltss-trn.aspx
- Friday CMHRS Provider Call Continues
- Partnering with VCU to evaluate initial Care Coordination efforts
- Carving in Residential Services

Questions? CCCPlusCMHRS@dmas.Virginia.gov

DMAS Website Resources

http://www.dmas.virginia.gov/Content_pgs/mltss-trn.aspx

CMHRS TRANSITION

- Provider Training Information and Registration
- CMHRS Transition One Pager
- Updated MCO Contracting/Credentialing Contacts
- Provider Reference Guide

CCC PLUS ELIGIBILITY TRACKING, AUTHORIZATION AND CLAIMS PROCESSES FOR CMHRS

- CMHRS Provider Reference-Doing Business with CCC Plus MCO's

PROVIDER WEBINAR TRAINING SLIDE DECKS

- AM Session - CCC Plus CMHRS Transition Overview
- PM Session - CCC Plus CMHRS Service Authorization Form Overview

FREQUENTLY ASKED QUESTIONS

- AM Session
- PM Session

PROVIDER WEBINAR RECORDED SESSIONS

- CMHRS Transition to CCC Plus – Morning Session
- CMHRS Transition to CCC Plus – Afternoon Session

CCC PLUS STANDARDIZED FORMS FOR CMHRS

- Important Tip for Opening Forms
- CCC Plus Registration Form
- CMHRS & Beh Therapy Continued Stay SRA
- Day Tx PHP Rehab Services Inital SRA
- EPSDT Beh Therapy Initial SRA
- ICT Rehab Services Initial SRA
- IIH Rehab Services Initial SRA
- MHSS Rehab Services Initial SRA
- PSR Services Initial SRA
- TDT Rehab Services Initial SRA
- CIR Revised Final.11-02-2017.FormFill

Thank You!