Overview of CCC Plus for CSB/BHA **MH/ID/DD** Case Managers

Plus
Commonwealth Coordinated Care Plus
Your Health. Your Care.

Virginia Association Of Community Services Boards, Inc.
Making a Difference Together

What is the Commonwealth Coordinated Care (CCC) Plus Program?

- The CCC Plus Program is a new DMAS initiative that will involve moving specific groups of Medicaid recipients from their current health insurance plan to a specially designed managed care program.
- The CCC Plus Program will begin on 8/1/17 in Tidewater and will be implemented across the state.
- The majority of CSB consumers (adult & children) with MH, SUD, ID/DD disorders/disabilities, and those infants/children receiving Early Intervention services who also receive EDCD waiver services will be moved into this new program.

Why did VA decide to develop CCC Plus?

- **TWO COMPELLING REASONS:**

  * to contain costs, and

  * to improve health outcomes in the target populations.

- **Why do we need to help the state contain costs?**
  The individuals in the CCC Plus target populations (which includes CSB consumers) represent only 7% of the total Medicaid population in VA, but account for over 21% of the total Medicaid expenditures. This percentage has continued to increase significantly every year.

- **What is causing this disproportionate escalation in costs and concern about health outcomes?**

  * Individuals in the CCC Plus target populations (including CSB consumers consumers) are often unable or unwilling to receive ongoing medical care.

Why did VA decide to develop CCC Plus?, cont.

- When they do seek medical care, they often go to a hospital emergency room for treatment of non-urgent conditions rather than to their PCPs or local medical care centers. In essence, they use the most intensive and expensive level of care for something that could be appropriately treated at a doctor's office.

- Consequently, when these individuals do receive care it is often very fragmented, with little/no coordination between providers.

- As a result of this substandard health care, these individuals (our consumers) are very likely to develop serious medical conditions that ultimately require very intensive and expensive courses of treatment,

  and

  they are likely to die at least 25 yrs. before the general population.

- It's 2017……our consumers deserve better.

What will be different with CCC Plus?

- CCC Plus was designed in a way that will ensure that all medical, behavioral, SUD, and long term services and supports (LTSS) are provided in an integrated fashion, and that the Program will be based on a value based payment system.

- What does that mean?

  * The state selected 6 Managed Care Organizations to administer the CCC Plus Program in VA.

  * Providers (including CSBs) will no longer interface with DMAS; instead they will work directly with the 6 MCOs.

  * All providers (including CSBs) will be required to collaborate with each other and with the MCO Care Coordinator to ensure that the individual receives effective and integrated services.

What will be different with CCC Plus? (cont.)

* The state will hold the MCOs accountable for containing costs and improving health outcomes, and in turn the MCOs will hold providers (including CSBs) to these same standards.

* CSBs will be responsible for helping our consumers access & utilize ongoing needed medical care and reduce the use of hospital emergency rooms for treatment of non-urgent conditions.

* CSBs will also be responsible for routinely collaborating with the MCO Care Manager, and all other providers as needed to ensure that services are integrated and coordinated.

Which MCOs will be administering the CCC Plus Program?

- The 6 MCOS listed below were selected to administer the CCC Plus Program in Virginia:
  - * Aetna
  - * Anthem
  - * Magellan
  - * Optima
  - * United Healthcare
  - * Virginia Premier

Who are the CSB consumers who will be moved into CCC Plus?

- First, individuals must have full Medicaid coverage to be included in the CCC Plus target population. (Limited coverage groups like GAP, QMB, etc., are excluded).

- Adults/children in low income families, FAMIS, FAMIS Moms & those individuals who qualify for Medicaid because they are pregnant women are also excluded.

- In addition to full Medicaid coverage, the CSB consumers who will be moved into CCC Plus will be those who receive Medicaid benefits because they are:

  * children who have been found to be intellectually, emotionally, or psychiatrically "disabled" based on a SSI disability determination (these children qualify under the Federal Medicaid definition for "Aged, Blind, or Disabled " (ABD), which may include children placed in foster care,

  * adults who have found to be psychiatrically disabled based on a SSI disability determination (part of ABD population),

  * individuals who receive the ID, DD, Tech, EDCD, and/or Day Support Waivers, or

  * individuals who reside in nursing facilities.

When will CSB consumers be moved into CCC Plus?

- CSB consumers who are Dual Eligible (full Medicaid/Medicare) and not enrolled in the current CCC Program & those consumers on the ID/DD, Tech Support, EDCD, and Day Support Waivers will be moved into CCC Plus according to the following timeframes:
  - * Tidewater region 8/1/17
  - * Central Va. region 9/1/17
  - * Charlottesville/Western Va. region 10/1/17
  - * Roanoke/Alleghany region 11/1/17
  - * Southwest region 11/1/17
  - * Northern Va./Winchester region 12/1/17

  Please note: 10 CSBs are represented in more than 1 region.

- The majority of CSB consumers across the state will transition into CCC Plus on 1/1/18. At that time, CSB consumers who are currently enrolled in the CCC Program & those adults and children who are considered to be ABD as determined via a SSI Disability Determination will move into CCC Plus (on 1/1/18).

When will CSB consumers be moved into CCC Plus? (cont.)

- CSBs need to delineate by individual consumers which ones will transition into CCC Plus on the regional "start date" and which ones will move into CCC Plus on 1/1/18, as outreach strategies and timeframes vary accordingly.

- Please start now…..you will need to know:

  * when to start preparing targeted consumers for the upcoming change in their insurance coverage,

  * when they will receive their initial MCO assignment letter,

  * the deadline that they will have for changing their MCO assignment, if needed,

  * the date they will receive their final MCO assignment letter, and

  * the date that their current insurance coverage ends and their new CCC Plus insurance plan begins.

When will the consumers be assigned to an MCO, and how will they be notified about the change in their Medicaid plan?

- The consumers who will be transitioned into CCC Plus will be "intelligently" assigned to one of the 6 participating MCOs. In essence, this means that Medicaid will try to keep a consumer with the same MCO that they currently have, if that MCO is one of the 6 participating CCC Plus organizations.

  (For example, if your consumer is currently enrolled in an Anthem Medicaid program, then the state will try to assign that consumer to the Anthem CCC Plus plan. However, those consumers who are currently enrolled with Humana/Beacon MCO will be assigned to a new CCC Plus MCO.)

- Consumers will begin to receive information in the mail from the various CCC Plus MCOs several months prior to their scheduled transition dates. (The dates will vary according to the respective regional start dates and/or the consumer's eligibility category; see Slide 9.)

- The consumers will receive an initial letter from Medicaid *approximately 30-45 days before their "go live" date* that states their initial MCO assignment.

Will the consumers be able to change MCOs?

- After receiving the initial notification letter and prior to their respective transition date, consumers will be able to call Maximus and change their assigned MCO. They may wish to do so based on the providers and additional services, supports, & resources included in each of the individual MCO plans.

- During the first year of implementation, the consumers will also be able to request a change in their MCO assignment during the first 90 days.

- After that time, enrollees will be allowed to change their MCO assignment only during the annual open enrollment period (which will occur on an annual basis between October-December).

- The consumers will receive a second letter from Medicaid right before their respective "go live" date that will confirm their final MCO assignment. The letter will also contain their new insurance card.

Please note: ***The consumers will be assigned to a new and different Medicaid insurance plan; they will no longer be able to use the old insurance card even if the MCO remains the same.***

How can I help my consumers through this transition?

- Please ask your Finance & MIS Departments to forward to you a list of your consumers that includes their CCC Plus start dates (varies by eligibility category).

- We are recommending that you:

  * work with your supervisor to determine when to start preparing your consumers/families for the change in their health insurance plan,

  * identify those consumers who may need to change MCOs because of differences in needed covered services/supports, or because their current PCP is not included in the provider panel of their newly assigned MCO (refer to initial assignment letter from DMAS), and help them select the MCO that best meets their needs, and

  * assist the consumers to notify all providers, especially their PCP and pharmacy about their new insurance plan/coverage.

How can I help my consumers through this transition?, cont.

- We strongly recommend that CSBs schedule meetings with the Care Managers from each of the MCOs assigned to their CSB prior to the "go live" date in their respective regions to begin to work together to form viable care coordination teams.
- The CSB and the MCO Care Managers will also need to decide the processes/formats that they will use to collaborate with each other regarding routine and urgent matters.
- CSBs are required to share consumer specific ID/DD/BH information with the MCOs. SUD related information is protected by specific federal restrictions. In those cases, we are recommending that the CSBs routinely ask the consumers to sign ROI forms to allow the CSBs to share this information with the MCOs.
- Remember….the purpose of sharing information is to work together with the MCOs to coordinate care on behalf of the consumers so we can help them improve their physical health and quality of life.

Final Thoughts

- We can make a difference…….
- We can help improve the health of our consumers….so they will not continue to die 25 years before the general population.
- We can also help contain escalating health care costs so that more funding can be redirected to essential services/supports.