

BROADCAST DMAS-27

DATE: May 11, 2018

TO: Local Directors and medical assistance staff

FROM: Patti Davidson, Program Analyst, Integrated Care Division, Department of Medical Assistance Services

SUBJECT: Interim patient pay adjustment process for individuals enrolled in the CCC Plus program

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The purpose of this broadcast is to clarify for local Departments of Social Service (DSS) the **interim procedures** for processing patient pay adjustment requests from nursing facility and Medicaid Community-based Care (CBC) patients who are enrolled in one of the Commonwealth Coordinated Care (CCC) Plus managed care organizations (MCOs).

Background

Per policy in M1470.230 and M1470.430 of the Medical Assistance Eligibility Manual, patient pay adjustment requests are submitted by the patient, authorized representative, or provider to the LDSS. For nursing facility patients, most adjustment requests for non-covered services under \$500.00 may be approved directly by the LDSS; if the amount exceeds \$500.00, the request must be approved by the Department of Medical Assistance Services (DMAS). When the individual receives CBC services, DMAS approval for deductions of non-covered services from patient pay is not required, regardless of the amount of the deduction.

As of January 1, 2018, the majority of Medicaid-eligible individuals who receive long-term care (LTC) services are covered under the CCC Plus program through one of six (6) MCOs: Anthem HealthKeepers, Inc., Aetna Better Health of Virginia, Magellan Complete Care of Virginia, Optima Health Community Care, United Healthcare Community Plan, and Virginia Premier Elite Plus.

As part of the CCC Plus program, each health plan offers enhanced benefits, such as adult dental services or hearing aids, outside of the required contracted Medicaid services. Some of these enhanced benefits happen to be services that are frequently submitted to the LDSS as patient pay adjustments. If there are other coverage sources available for these services or items, Medicaid policy requires that the request for coverage first be submitted to those sources and exhausted there, before the LDSS/DMAS may consider or approve a patient pay adjustment. Consequently, many of the requests received by LDSS since January 1, 2018, have been denied with the requirement to seek coverage (or a letter of denial) from the individual's CCC Plus health plan.

LDSS Action

DMAS is currently working with the CCC Plus MCOs to develop the process for distinguishing enhanced benefit services from allowable patient pay deductions and has not yet issued updated directives to nursing facilities, other providers, and VDSS/LDSS. Therefore, until further notice, we are instructing providers and nursing facilities in particular, to continue sending all patient pay adjustment requests to the patient's LDSS eligibility worker. **Eligibility workers, please review and process patient pay adjustment requests without requiring submission of the request to the individual's CCC Plus plan.**

An updated broadcast will be posted when this process is finalized and changed. You are welcome to share this broadcast message with other LDSS and nursing facility staff.

Should you have questions regarding this broadcast, please send an email to the CCC Plus inbox at cccplus@dmas.virginia.gov. Do not include protected health information (PHI) in emails sent to this address.