Commonwealth Coordinated Care

Medicare & Medicaid working together for you

Quick Provider Reference Guide
August 2014

For more details about this program, visit the website at:
http://www.dmas.virginia.gov/Content_pgs/altc-enrl.aspx

Or contact the Office of Coordinated Care at the Department of Medical Assistance Services by email at:
CCC@dmas.virginia.gov

Important: Information contained in this guide is subject to change without notice

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

COMMONWEALTH COORDINATED CARE QUICK REFERENCE GUIDE

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1. Commonwealth Coordinated Care Program Overview

The Commonwealth Coordinated Care (CCC) program is a collaborative initiative between the Center for Medicare Services (CMS) and the Department of Medical Assistance Services to integrate Medicare and Medicaid services rules and payments into one delivery system for individuals who are eligible for both full Medicare and full Medicaid (dual eligible individuals). A high portion of dual eligible individuals have chronic health conditions and functional impairments and receive services through two separate but overlapping programs that are uncoordinated and result in fragmented, sub-optimal care and outcomes.

Under this initiative, CMS, DMAS and three Medicare Medicaid Plans (MMPs), including ***Anthem HealthKeepers***, ***Humana*** and ***Virginia Premier***, have contracted to provide Medicare Part A, B, and D benefits and Medicaid benefits to CCC enrollees (see details in Section 10 of this guide). The MMPs are encouraged to implement unique and innovative care practices and enhanced benefits, such as behavioral health homes, partnerships with Area Agencies on Aging (AAAs), extended dental care, etc, in order to improve health outcomes for the enrollees.

Goals of CCC

The goals of CCC include: reducing fragmentation; providing high-quality and coordinated care; improving the health and lives of enrolled individuals; reducing the need for avoidable services, such as hospitalization and emergency room use; encouraging individual participation in treatment decisions; and supporting the goal of providing treatment in the least restrictive, most integrated setting.

Quality

To ensure these goals are being met, CMS and DMAS have established over 100 separate quality measures that the contracted MMPs are responsible for reporting. Furthermore, a comprehensive evaluation is being conducted by DMAS and George Mason University staff in order to gauge stakeholder satisfaction and the overall success of the program.

Transition of Care

Under the three-way contract with DMAS and CMS, to ensure continuity of care, the Medicare Medicaid Plans (MMPs) honor all existing plans of care, with current treatment providers, including honoring service authorizations for up to 180 days after the member's CCC enrollment begin date.

Person Centered, Coordinated Care

CCC includes a strong, person-centered service coordination/care management component, integration with an array of providers for continuity of care, ongoing stakeholder participation, outreach and education and the ability for innovation to meet the needs of the dual population.

This person-centered approach is facilitated through a Health Risk Assessment (HRA) and Care Coordination services, both of which are provided by the beneficiary selected MMP. The HRA is provided to every enrollee and incorporates medical, behavioral health, long term supports, and social needs. Enrollees will be active participants in the HRA process. Results of the HRA will be used to confirm the appropriate level of care for the enrollee and as the Plan of Care.

Care coordination, the hallmark of CCC, is a person-centered process where every enrollee will work with a care coordinator through the MMP's who assist the enrollee in gaining access to needed services. The care coordinator will work with the beneficiary, their family members, if appropriate, their providers and anyone else involved in their care to help them get the services and supports that they need.

2. CCC Eligibility and Enrollment

Eligibility for the CCC Program

Individuals that qualify for CCC include:

- ✓ Individuals who are *full benefit duals*; or individuals who are dually eligible for Medicare and Medicaid. Full benefit duals are entitled to benefits under Medicare Part A (hospital) and enrolled under Medicare Parts B (medical and behavioral health) and D (pharmacy), and receive full Medicaid benefits. CCC includes individuals enrolled in the Elderly or Disabled with Consumer Direction (EDCD) Waiver and qualifying individuals residing in nursing facilities (NF);
- ✓ Individuals who are age 21 and older at the time of enrollment; and
- ✓ Individuals that reside in a CCC participation region (described in Section 5 of this guide);
- ✓ Additional information about the CCC and related program materials are available at: http://www.dmas.virginia.gov/Content_pgs/mmfa-imme.aspx.

Exclusion from CCC Participation

Some dually eligible individuals are excluded (not able to participate) in CCC. Excluded populations include the following individuals: children (under age 21), those with other insurance coverage, hospice participants, residents of intermediate care facilities serving individuals with Mental Health or Intellectual Disabilities, individuals admitted to State institutions for mental disease, participants in federal home and community-based waiver programs other than the EDCD Waiver, Money Follows the Person (MFP) Program participants, Program of All-Inclusive Care for the Elderly (PACE) participants; however, PACE participants may enroll in CCC if they choose to disenroll from PACE, and CMS Independence at Home (IAH) demonstration participants; however, IAH participants may enroll in the CCC if they choose to disenroll from IAH.

How to Enroll into CCC

All eligible beneficiaries receive letters from DMAS notifying them of their eligibility to participate in the CCC program. Beneficiaries also have access to the services of an enrollment broker, MAXIMUS. MAXIMUS provides education about the CCC program to eligible beneficiaries and processes enrollment and disenrollment requests received by telephone and mail. Individuals interested in the CCC program may call MAXIMUS via the CCC Help line at 1-855-889-5243 or visit the website at www.virginiaccc.com.

A trained MAXIMUS representative can look up the caller's doctors or other healthcare providers to ensure they are in the MMPs network. They are also able to review each plan available in the caller's area. The MAXIMUS representative can sign up beneficiaries over the phone and eliminate the need for paperwork. If, at any time, an enrollee decides to change plans or opt-out of CCC, they can call MAXIMUS to complete those actions.

Eligible members can enroll in CCC or obtain additional information by calling:
1-855-889-5243
(TTY/TDD 1-800-817-6608)

How to Verify CCC Enrollment

It is important for providers to verify an enrollee's eligibility at each point of service. Verification of a client's participation in CCC can be done through the DMAS MediCall audio response system (1-800-884-9730 or 1-800-772-9996) or the DMAS web-based internet option, available on the Virginia Medicaid Web Portal, at: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal. Both options are available at no cost to the provider. The web-based, automated response system (ARS) limits the provider's verification submission to 10 members at a time. Enrollment can also be verified through the enrollee's health plan.

Providers may also utilize the 270/271 HIPAA compliant electronic eligibility benefit inquiry and response transaction. This option gives providers a method for checking the eligibility/enrollment for up to 999 members at a time. This transaction includes eligibility and managed care enrollment data (including CCC enrollment information). The DMAS 271 response gives back information for up to a year back and one month forward. (Enrollment information for one month forward is available when sent after the monthly managed care assignment cycle that runs on the 18th of each month). For DMAS, the 270/271 is handled through Xerox, DMAS' Fiscal Agent. Detailed information on the 270/271 transaction and submission requirements is available on the Virginia Medicaid Web Portal in the 270/271 EDI Companion Guide, under the EDI Support tab (EDI Companion Guides).

Medicaid Eligibility and CCC enrollment verification

MediCall1-800-884-9730 or 1-800-772-9996

Virginia Medicaid Web Portal – www.virginiamedicaid.dmas.virginia.gov

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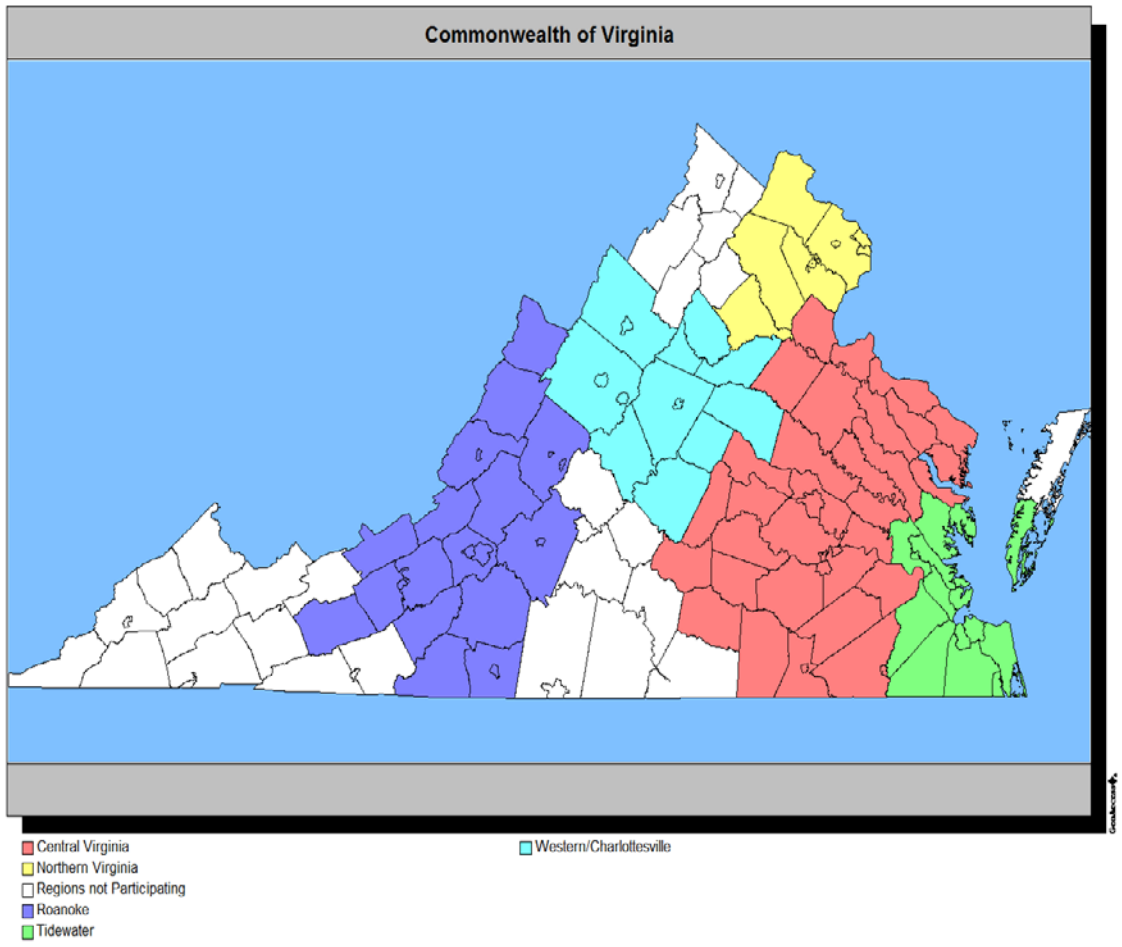
3. CCC COSTS

There are very few member co-pay responsibilities in the CCC program:

- NO premiums
- NO co-pays for doctor or specialist visits
- SOME co-pays for prescriptions
- NO co-pays or premiums for extra benefits
- CONTINUE to pay long-term care patient pays

4. CCC Participation Regions

The CCC program operates in five regions including Tidewater, Central, Roanoke, Charlottesville, and Northern Virginia. This includes over 100 counties and cities throughout the Commonwealth. A listing of participating counties and cities by region is on the next page. Health plan participation by city/county is available in the CCC comparison charts, available on-line at: http://www.dmas.virginia.gov/Content_pgs/mmfa-imme.aspx.



5. CCC Enrollment Timeline by CCC Participation Region

Enrollees can switch from one MMP to another or opt-in or opt-out of CCC at anytime.

Tidewater Region		
Voluntary enrollment begins: March 2014 (Coverage effective April 2014) Automatic enrollment begins: May 2014 (Coverage effective July 2014)		
Chesapeake	Mathews	Portsmouth
Gloucester	Newport News	Suffolk
Hampton	Norfolk	Virginia Beach
Isle of Wight	Northampton	Williamsburg
James City	Poquoson	York
Central Virginia/Richmond Region		
Voluntary enrollment begins: March 2014 (Coverage effective April 2014) Automatic enrollment begins: June 2014 (Coverage effective September 2014)		
Amelia	Greensville	Nottoway
Brunswick	Hanover	Petersburg
Caroline	Henrico	Powhatan
Charles City	Hopewell	Prince Edward
Chesterfield	King and Queen	Prince George
Colonial Heights	King George	Richmond City
Cumberland	King William	Richmond County
Dinwiddie	Lancaster	Southampton
Emporia	Lunenburg	Spotsylvania
Essex	Mecklenburg	Stafford
Franklin City	Middlesex	Surry
Fredericksburg	New Kent	Sussex
Goochland	Northumberland	Westmoreland
Roanoke and Charlottesville Regions		
Voluntary enrollment begins: May 2014 (Coverage effective June 2014) Automatic enrollment begins: August 2014 (Coverage effective October 2014)		
Roanoke		Charlottesville
Alleghany	Highland	Albemarle
Bath	Lexington	Augusta
Bedford	Martinsville	Buckingham
Bedford City	Montgomery	Charlottesville
Botetourt	Patrick	Fluvanna
Buena Vista	Pulaski	Greene
Covington	Roanoke City	Harrisonburg
Craig	Roanoke County	Louisa
Floyd	Radford	Madison
Franklin County	Rockbridge	Nelson
Giles	Salem	Orange
Henry	Wythe	Rockingham
		Staunton
		Waynesboro
Northern Region		
Voluntary enrollment begins: June 2014 (Coverage effective July 2014) Automatic enrollment begins: September 2014 (Coverage effective November 2014)		
Alexandria	Fairfax County	Manassas City
Arlington	Falls Church	Manassas Park City
Culpeper	Fauquier	Prince William
Fairfax City	Loudoun	

6. CCC Outreach and Education

Since the CCC implementation in March, DMAS has offered a variety of outreach and educational opportunities to interested stakeholders, including Town Hall meetings in each of the five regions. Fact sheets and educational materials as well as scheduled Town Hall meetings are posted on the DMAS website at: http://www.dmas.virginia.gov/Content_pgs/altc-enrl.aspx.

DMAS also hosts weekly Stakeholder Conference Calls. These calls are separated into provider calls (by type) and beneficiary calls. Conference calls feature CCC updates and opportunities for stakeholders to ask questions of DMAS and MMP staff. The schedule for these calls is available on the DMAS website at: http://www.dmas.virginia.gov/Content_pgs/mmfa-imme.aspx.

DMAS and the three MMP's host a Quarterly Advisory Committee. At these meetings DMAS along the MMPs present the progress of the program, including successes and difficulties realized, and any upcoming CCC events and projects to the Advisory Committee. The members of the Advisory Committee are made up from a number of consumer advocacy groups, provider associations as well as consumers. Minutes from CCC advisory committee meetings is available on the DMAS website at: http://www.dmas.virginia.gov/Content_pgs/mmfa.aspx.

MMP Specific Education and Outreach Efforts

Each of the MMPs host web based training modules for providers (par and non-par). These trainings cover a variety of topics including service authorizations, claims, and care coordination. Links to the CCC specific web pages for each of the MMP's is available below.

ANTHEM HEALTHKEEPERS:
https://mediproviders.anthem.com/va/pages/providereducation.aspx

HUMANA:
https://www.humana.com/provider/medical-providers/network/learn-more/

VIRGINIA PREMIER:
https://www.vapremier.com/providers/completecare-overview/virginia-health-care-provider-resources/

7. MMP CONTACT INFORMATION

Anthem HealthKeepers	
Member Services and Nurse Line	Member Services 1-855-817-5787 Nurse Hot Line 1-866-864-2544
Provider Services and Credentialing	Provider Services 1-855-817-5788 http://www.anthem.com/wps/portal/ahpprovider?content_path=provider/co/f5/s2/t0/pw_000621.htm&state=co&label=Become+an+Anthem+Blue+Cross+and+Blue+Shield+Network+Provider
Behavioral Health	1-855-817-5787
Medical Management	1-855-817-5787
Pharmacy	1-855-817-5787
Transportation	1-855-817-5787
Vision	1-855-817-5787
Service Authorization	1-855-817-5788 Behavioral Health Inpatient: 1-877-434-7578; Outpatient: 1-800-505-1193
Claims	HealthKeepers, Inc. P.O. Box 27401 Richmond, VA 23279 https://mediproviders.anthem.com/va/pages/claims.aspx
Outreach	1-855-817-5787

MMP CONTACT INFORMATION

Humana	
Member Services and Nurse Line	Member Services 1-855-280-4002 / Nurse Line 1-855-235-8579
Provider Services and Credentialing	Medical / Provider / Non- LTSS Line 1-855-280-4002 Independent Living Systems (ILS) – Long-term Support Services Provider Line- 1-866-224-6947
Behavioral Health	Beacon - 1-855-765-9704
Medical Management	1-800-523-0023
Pharmacy	1-800-865-8715
Transportation	1-855-253-6869
Vision	1-855-280-4002
Service Authorization	Medical 1-800-523-0023 LTSS 1-800-559-3581 opt. 5 Behavioral Health 1-855-765-9704
Claims	Medical Claims For electronic claim submission, the claims payer ID is 61101. Our central gateway for EDI transactions is Availity, but claims can be submitted via these clearinghouses: ZirMed, Gateway, EDI, McKesson, Capario and SSI Group. ILS- Claims payer ID is 45048 Beacon Health Strategies – Claims payer ID is43324

	Paper Claims P.O. Box 14601 Lexington, KY 40512-4601 Long-term Support Services Independent Living Systems (ILS) SMS/VA c/o Independent Living Systems P.O. Box 21596 Eagan, MN 55121 Behavioral Health 10200 Sunset Dr. Miami, FL 33173
Outreach	Paige Wickstrom- Community Outreach Manager – 1- 804-683-8307 or email awickstrom@humana.com Sabrina Carr- Community Outreach Representative – Tidewater-1-757-589-6300 or scarr11@humana.com Dana Murdock- Community Outreach Representative – Roanoke, Charlottesville, and NOVA- 1-540-287-2900 or dturtonmurdock@humana.com James Smith- Community Engagement Consultant- 804-205-5698 office/1-804-687-2052 or email jsmith136@humana.com Lynne Vest- Community Engagement Consultant- 804-205-5696 office/1-804-647-7006 or email lvest@humana.com

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MMP CONTACT INFORMATION

Virginia Premier	
Member Services and Nurse Line	Member Services- 1-855-338-6467 Nurse Line- 1-800-256-1982
Provider Services and Credentialing	1-800-727-7536
Behavioral Health	1-855-338-6467
Medical Management	1-855-338-6467
Pharmacy	1-855-338-6467
Transportation	1-855-338-6467
Vision	1-855-338-6467
Service Authorization	1-855-338-6467
Claims	1-855-338-6467
Outreach	1-855-338-6467

8. MMP's Credentialing Process and Contact Information

CCC MMPs are required to provide access to care through high-quality, credentialed providers. The respective credentialing process /criteria may vary by plan. The table below highlights each MMP's process and provides contacts and web links for where to locate more detailed information.

Anthem Healthkeepers

Credentialing

Credentialing is an industry-standard, systemic approach to collecting and verifying an applicant's professional qualifications. This approach includes a review of relevant training, licensure, certification and/or registration to practice in a health care field, and academic background. Our credentialing process evaluates the information gathered and verified and determines whether the applicant meets certain criteria related to professional competence and conduct as well as licensure and certification. We use current National Committee for Quality Assurance (NCQA) and Accreditation Association for Ambulatory Health Care standards and guidelines for the accreditation of managed care organizations, as well as state-specific requirements, to credential and recredential licensed independent providers and organizational providers with whom we contract. This process is completed before a provider is accepted for participation in our network.

Long-Term Support and Services Providers

The following are some of the steps included in our organizational provider credentialing process:
Verification of a current copy of your state license.
Investigation of any restrictions to a license, the results of which could impact your participation in our network.
Evidence of professional and general liability coverage.
Disclosure of ownership statement: CMS requires us to obtain certain information regarding the ownership and control of entities with which we contract for services for federal employees or federal health plans. This form is required for participation in the network.

Provider Type	For More Information:
Medical Professional Providers (licensed)	http://www.anthem.com/wps/portal/ahpprovider?content_path=provider/co/f5/s2/t0/pw_000621.htm&state=co&label=Become+an+Anthem+Blue+Cross+and+Blue+Shield+Network+Provider
Ancillary Providers (licensed)	http://www.anthem.com/wps/portal/ahpprovider?content_path=provider/co/f5/s2/t0/pw_000621.htm&state=co&label=Become+an+Anthem+Blue+Cross+and+Blue+Shield+Network+Provider
Behavioral Health Providers (licensed)	http://www.anthem.com/wps/portal/ahpprovider?content_path=provider/co/f5/s2/t0/pw_000621.htm&state=co&label=Become+an+Anthem+Blue+Cross+and+Blue+Shield+Network+Provider
LTSS Providers	Interested LTSS providers may contact Mari Dean to request a credentialing application and participation agreement. Mari.dean@amerigroup.com; office: 757-473-2737 x34639; fax: 757-473-2737

Humana

Credentialing of physicians and other health care providers

Humana participates with the Council for Affordable Quality Healthcare (CAQH) Universal Provider Datasource®, an online service to help physicians and other health care providers more easily and cost effectively provide required credentialing information to health care organizations and health plans.

Humana and ChoiceCare® network physicians and certain other health care providers can utilize CAQH's Universal Provider Datasource for recredentialing, instead of completing a Humana-specific credentialing application. New physicians and other health care providers joining the network may also use CAQH for the initial credentialing process.

Universal Provider Datasource provides a fast and easy way to securely submit credentialing information to multiple health plans and networks by entering information just one time. Application data can be submitted anytime through the convenience of the Internet or by fax. This simplified credentialing process reduces paperwork and saves time for health care providers and their staff. Best of all, this service is provided at no cost to participating providers.

Provider Type	For More Information:
Medical Providers - Contracted	For additional information or clarification on Humana's credentialing process, visit https://www.humana.com/provider/medical-providers/network/learn-more/credentialing
Medical Providers- Join Our Network	Providers interested in joining the Humana network and our credentialing process should reference the following link for more information: https://www.humana.com/provider/medical-providers/network/learn-more/
For Behavioral Health	Providers interested in joining our behavioral health network should reference the following link for more information: http://www.beaconhealthstrategies.com/becoming_a_provider.aspx
For Long Term Services and Supports (LTSS)	Providers interested in joining our LTSS network should reference the following link for more information: 866-224-6947 or email virginiaproviders@ilshealth.com
For Pharmacies	Providers interested in joining our pharmacy network should reference the following link for more information: https://www.humana.com/provider/pharmacists/support/join-our-network

Virginia Premier

All practitioners must meet initial credentialing standards and criteria to be eligible for providing services to VPCC's members. The credentialing policies and procedures specify the types of practitioners to credential and recredentialed, the verification sources used, the criteria for credentialing and recredentialing and the process for making credentialing and recredentialing decisions. The Credentialing Department shall validate and/or confirm information related to the credentialing and/or recredentialing of a prospective or participating practitioner by utilizing the primary source or its designee(s) pursuant to requirements of VPCC, the Department of Medical Assistant Services (DMAS), the National Committee for Quality Assurance (NCQA), CMS (Center for Medicaid and Medicare Services) and/or any other applicable regulatory body More information can be found on the website : https://www.vapremier.com/providers/completecare-overview/medical-management/quality-initiatives/

Provider Type	For More Information
All	For more information on Virginia Premier's credentialing process, please visit the Credentialing tab here: https://www.vapremier.com/providers/completecare-overview/medical-management/quality-initiatives/ Or contact your Provider Service Representative at 1-855-338-6467
All	Providers interested in joining the Virginia Premier network should contact us at: https://www.vapremier.com/providers/join-our-network/

9. MMP Referral and Service Authorization Requirements

MMP	PCP REFERRAL	SERVICE AUTHORIZATION REQUIREMENTS
Anthem HealthKeepers	No referral is needed to see an in-network PCP	**Anthem HealthKeepers MMP** Members do not need any referral for the following services: • Screening mammograms • Outpatient behavioral health services • Influenza and pneumococcal vaccinations • Routine physical examinations, prostate screening and preventive women's health services (e.g., Pap smears) Except for emergency or out-of-area urgent care and dialysis services, in general, Members must obtain services within the **Anthem HealthKeepers Medicare-Medicaid Plan (MMP)** network or obtain a precertification for covered services outside the network. PCPs may only refer Members to **Anthem HealthKeepers MMP** contracted network specialists to ensure the specialist receives appropriate clinical background data and is aware of the Member's ongoing primary care relationship. If a Member wants to receive care from a different specialist or the required specialty is not available within the contracted network, the PCP should contact Provider Services at MMP Customer Care at 1-855-817-5788. PCPs must obtain precertification from **HealthKeepers, Inc.** before referring Members to non-plan Providers. Certain services/procedures require precertification from **HealthKeepers, Inc.** for participating and nonparticipating PCPs and specialists and other providers. Please refer to the list below or the Precertification Lookup tool online, or call Provider Services at MMP Customer Care at **1-855-817-5788** for more information. You can also access information concerning precertification requirements on our website at www.mediproviders.anthem.com/va The following are examples of services requiring precertification before providing the following non-emergent or urgent care services: • Inpatient mental health services • Behavioral health partial hospitalization

		• Skilled Nursing Facility (SNF) • Home health care • Diagnostic tests, including but not limited to MRI, MRA, PET scans, etc. • Hospital or ambulatory care center-based outpatient surgeries for certain procedures • Elective inpatient admissions • Transplant evaluation and services • Any non-emergency service from or referral to a non-contracted Provider • Durable Medical Equipment (DME) • Outpatient IV infusion or injectable medications • Prosthetics • Certain reconstructive procedures • Occupational, speech and physical therapy services • Long Term Services and Supports (including EDCD waiver Providers)
Humana	No referral is needed to see an in-network PCP	**Services listed on Humana's prior authorization list must be authorized before services are eligible for payment consideration. The prior authorization list may be accessed at:** **https://www.humana.com/provider/medical-providers/education/referral/** **Long Term Services and Supports (LTSS):** **Members Who Have Services in Place at the Time of Enrollment** 1. Members who have already been enrolled in a Long Term Care Program and have a history of authorizations are sent to the authorization unit in aggregate. The authorization team outreaches to the service provider and confirms the following: i. Member is actively getting services with the provider ii. Type of services provided iii. Units of services provided iv. Provider's accurate billing information 2. The authorizations are generated for the selected providers and faxed to the provider 3. Confirmation calls are made to the provider of assuring receipt of authorizations 4. Notes are updated on the member's care plan to indicate receipt of authorizations 5. Follow up calls are made by the case manager and case manager assistants ensures

		services are in place **New Service Request:** 1. Member is contacted by the Case Manager to perform a face-to face visit 2. Case Manger looks for an existing care plan at time of visit and review with member while on-site 3. The Case Manager uploads a completed care plan and all associated authorization requests 4. The authorizations are generated for the selected providers and faxed to the provider 5. Confirmation calls are made to the provider of receipt of authorizations 6. Notes are updated on the member's care plan to indicate receipt of authorizations 7. Follow up calls are made by the case manager and case manager assistants ensures services are in place **Behavioral Health:** Providers may submit preauthorization requests for behavioral health services via facsimile, to Beacon at 1-855-765-9705 using the request forms posted on our BH website https://provider.beaconhs.com . Please note that these request forms are the same for all MCO's. Requests may also be submitted by calling 1-855-765-9704. Non-par providers should call in their initial requests for behavioral health. Authorization is not required for traditional outpatient counseling and medication management services delivered by participating providers
Virginia Premier	No referral is needed to see an in-network PCP	If the inpatient stay is not medically necessary, the plan will not pay for it. In some cases the plan will pay for services received while the member is in the hospital or a nursing facility. https://www.vapremier.com/members/completecare/member-resources/plan-costs/ Outpatient Medical Services- The plan pays for medically needed services received in the outpatient department of a hospital for diagnosis or treatment of an illness or injury as well as outpatient diagnostic tests and therapeutic services and supplies. More information can be found in Chapter 4 of the Member Handbook. https://www.vapremier.com/members/completecare/member-resources/plan-costs/

		Outpatient Behavioral Health- The plan will pay for mental health services provided by mental health professionals as well as other medically necessary mental health services. More detailed information is provided in Chapter 4 of the Member Handbook. https://www.vapremier.com/members/completecare/member-resources/plan-costs/ Home Health- The plan covers services from a licensed nurse or a home health aide for members who qualify. Services may include the following: Rehabilitation therapies, including physical therapy, occupational therapy, and speech-language therapy. More detailed coverage information can be found in Chapter 4 of the Member Handbook. https://www.vapremier.com/members/completecare/member-resources/plan-costs/ Outpatient Rehabilitation Therapies (PT, OT, and SLP)- The plan will pay for physical therapy, occupational therapy, and speech therapy. More detailed coverage information can be found in Chapter 4 of the Member Handbook. https://www.vapremier.com/members/completecare/member-resources/plan-costs/ Long term Support Services- The plan will cover long-term services and supports (LTSS). Before receiving LTSS, Virginia Premier CompleteCare will make sure that the member qualifies for the services. https://www.vapremier.com/members/completecare/member-resources/plan-costs/ Durable Medical Equipment and Supplies-VA Premier will pay for all medically necessary durable medical equipment that Medicare and Medicaid usually pay for. If the supplier in the member's area does not carry a particular brand or maker, the member may ask them if they can special-order it. https://www.vapremier.com/members/completecare/member-resources/plan-costs/ Pharmacy- The plan covers drugs covered by Medicare Part A and Part B. A comprehensive formulary can be found on the website. https://www.vapremier.com/members/completecare/plan-documents/

10. Appeals

Provider Appeals

The provider appeals process for CCC functions differently than other Medicare or Medicaid programs. Instead of submitting one appeal to CMS for denied Medicare authorizations or payment and one to DMAS for Medicaid authorizations or payment, the provider submits their appeal request to the responsible MMP. The MMP is obligated to provide an appeal process that complies with all federal and state regulations. Additionally, the MMP is required to provide CMS and DMAS notice of when an appeal is filed, detailed information on the appeal and status updates as the appeal is adjudicated. For denied Medicare appeals the MMP automatically forwards the appeal to the Independent Review Entity for review and reconsideration. For denied Medicaid claims, if the filing provider is not satisfied with the outcome of the appeal to the MMP the provider can appeal to DMAS. Those appeals will be adjudicated through the DMAS Provider Appeal Process in accordance with 12VAC30-20-500 et. seq. More information is available in section 2.15 of the CCC executed contract with the MMP, CMS, and DMAS, available on the DMAS website at http://www.dmas.virginia.gov/Content_pgs/valtc.aspx. Additionally, more detailed information on each of the MMPs' provider appeal processes is available on the MMPs' website at the links is below. Contact information has also been provided for your reference.

Beneficiary Appeals

The beneficiary appeals process is a Medicare-Medicaid streamlined process where the beneficiary, or the representative filing an appeal on the beneficiary's behalf, submits their appeal request to the responsible MMP. The MMP is obligated to provide an appeal process that complies with all federal and state regulations. Additionally, the MMP is required to provide CMS and DMAS notice of when an appeal is filed, detailed information on the appeal and status updates as the appeal is adjudicated. For denied Medicare appeals the MMP automatically forwards the appeal to the Independent Review Entity for review and reconsideration. If a Medicaid appeal is denied by the MMP, the beneficiary can challenge the denial through the State Fair Hearing Process, in accordance with 12VAC30-110-10 through 12VAC30-110-380. More information is available in section 2.14 of the CCC executed contract with the MMP, CMS, and DMAS, available on the DMAS website at http://www.dmas.virginia.gov/Content_pgs/valtc.aspx. Additionally, more detailed information on each of the MMPs' provider appeal processes is available on the MMPs' website at the links is below. Contact information has also been provided for your reference. Contact information has also been provided for your reference.

Anthem HealthKeepers

Provider Appeals	Beneficiary Appeals
Must be received within 120 calendar days of initial decision	Must be received within 60 calendar day of initial decision
By Mail: Payment Disputes HealthKeepers, Inc. P.O. Box 61599 Virginia Beach, VA 23466-1599	**By Mail:** Complaints, Appeals and Grievances HealthKeepers, Inc. P.O. Box 61116 Virginia Beach, VA 23466-1599
By Phone: 1-855-817-5788 Monday through Friday 8:00am to 10:00pm	**By Phone:** 1-855-817-5787 Monday through Friday 8:00am through 8:00pm **By Fax:** 1-855-856-1724
	For more information: https://mss.anthem.com/CCC/Pages/grievances-appeals.aspx

Humana

Provider Appeals	Beneficiary Appeals
Provider requests for Claims Reconsiderations must be received by Humana within 18 months of the date the claim was paid unless state or federal law or the Agreement require another time period or the claim will not be reopened or reconsidered.	Appeals must be submitted within 60 calendar days from the date of the adverse determination notice, unless the Member can demonstrate good cause.
By Mail: Humana Correspondence PO Box 14601 Lexington, KY 40512	**By Mail:** Humana Inc. Attn: Grievances and Appeals PO Box 14546 Lexington, KY 40512-4546
By Phone: 1-855-817-5788 Monday through Friday 8:00am to 8:00pm	**By Phone:** 1-855-280-4002 Monday through Friday 8:00am to 8:00pm
For more information: http://apps.humana.com/marketing/documents.asp?file=2091427	**For more information:** https://www.humana.com/individual-and-family/

Virginia Premier

Provider Appeals	Beneficiary Appeals
Must be received within 60 calendar days of initial decision	Must be received within 60 calendar days of initial decision
By Mail: Claims Appeals CCC by Virginia Premier PO Box 4468 Richmond VA 23220-0307	**By Mail:** VPCC Grievances and Appeals Provider and Member Appeals P.O.Box 5244 Richmond, VA 23220
By Phone: 1-855-338-6467 **By Fax:** 1-877-739-1362 or 804-343-0300	**By Phone:** 1-855-338-6467 **By Fax:** 804-649-9647
For more information: https://www.vapremier.com/assets/ProviderManual-APIUpdate.pdf	**For more information:** https://www.vapremier.com/members/completecare/contact-us/complaints-appeals-grievances/

11. Accessing CCC Covered Services

The MMP provides Medicare and Medicaid covered benefits as described below. Federal Mental Health Parity rules apply to inpatient and outpatient (traditional and non-traditional) behavioral health services. The MMP provides Medicare and Medicaid benefits as defined by CMS and DMAS, and as described in the CCC three-way contract, available on the DMAS website at: http://www.dmas.virginia.gov/Content_pgs/valtc.aspx . All covered service benefit limits should be verified through the beneficiaries' MMP.

Medicare Part A	Medicare Part B	Medicare Part D
Inpatient care in hospitals, skilled nursing facility care (excluding custodial, long-term care), TDO, state IMD*, and home health services.	Doctor and other health care provider services, outpatient treatment, ambulatory surgery center services, outpatient hospital services (including medical and surgical services and supplies, X-rays, MRIs, CT scans, EKGs), kidney dialysis services and supplies, clinical research studies, ambulance services, durable medical equipment (DME) and supplies, outpatient mental health services, preventive services and screenings, second opinion services, chemotherapy, chiropractic services, lab services, medical nutrition therapy, PT, OT, and speech therapies, prosthetic and orthotic items, telehealth, transplant services, emergency room services, etc.	Prescription drug coverage

Medicaid – Medical	Medicaid Behavioral Health	Medicaid Long-Term Care and Long Term Care Support Services (LTSS)
Medicaid covered services that are not covered by Medicare, including but not limited to: some high-risk prenatal services, some DME and supply items, non-emergency transportation, certain drugs covered by Medicaid but not otherwise covered under Medicare, including but not limited to certain OTCs, barbiturates, prescription vitamins and minerals, etc.	Non-traditional behavioral health services, including: Mental health treatment - crisis intervention, crisis stabilization, day treatment/partial hospitalization, intensive community treatment, mental health skill building services, and psychosocial rehab (e.g., clubhouse model). *(Mental health case management is carved-out of the CCC Contract.)* Substance abuse treatment – case management, crisis intervention, day treatment, intensive outpatient treatment, residential treatment for pregnant and post-partum women, day treatment for pregnant and post-partum women, opioid treatment,	Nursing facility care, and long-term care support services (LTSS) through the Elderly or Disabled with Consumer Direction (EDCD) Waiver Services, including: Adult day health care, personal care (agency and consumer directed), personal emergency response system (PERS), respite care (agency and consumer directed), and transition services.

* The MMP covers State IMD services until the end of the month when the member is disenrolled from the CCC program.

MMPs may cover additional services not covered by traditional Medicare and Medicaid, for a list of these services see the MMP comparison charts, available on the DMAS website at: http://www.dmas.virginia.gov/Content_pgs/mmfa-imme.aspx.

12. Accessing Services Not Covered Under the CCC Contract

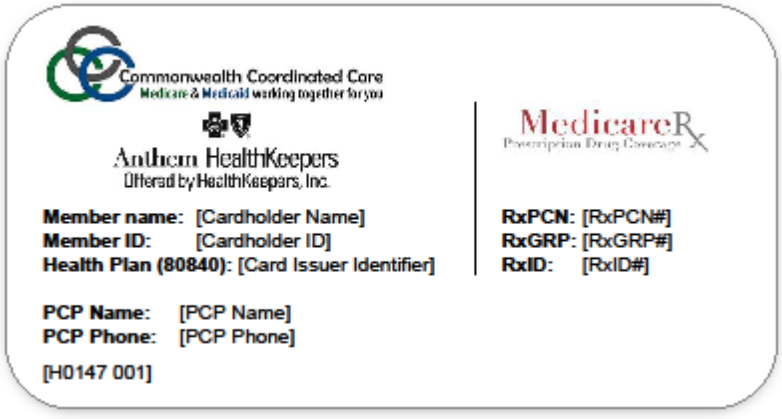
Carved Out Services	
Case Management Services for Participants of Auxiliary Grants	This is not a widely used program and is included as part of the annual reassessment screening process for assisted living recipients. This service will continue to be managed through the DMAS fee-for-service program.
Mental Health or Intellectual Disability Targeted Case Management Services.	These services are provided by local Community Services Boards, and will continue to be paid through Magellan, the DMAS contracted behavioral health services administrator (BHSA). CCC enrollees are still eligible to receive targeted case management services.

For Members Who Enroll in or Receive a Service that Requires Exclusion From CCC Participation	
• Enroll in a home and community based care waiver other than EDCD, or • Are admitted to an intermediate care facility for individuals with intellectual disabilities or admitted to a State IMD.	The member would follow the existing process for admission to the facility or for waiver enrollment and service authorization. The beneficiary will remain in the CCC program through the end of the month, and then will transition to fee-for-service Medicaid and Medicare. Services covered under the CCC contract will be covered through the member's CCC MMP until the person is disenrolled from the CCC program.
CCC members admitted into Hospice.	Upon admission to Hospice Care the service provider is required to complete and submit form 421A to DMAS. This form will dis-enroll the beneficiary from CCC at the end of the month*. During the transition period, for non-hospice related services: • All Medicare part A and B services are covered through Medicare Fee For Service, • All Medicaid–only, demonstration-only, supplemental and Part D services are covered by the assigned MMP.

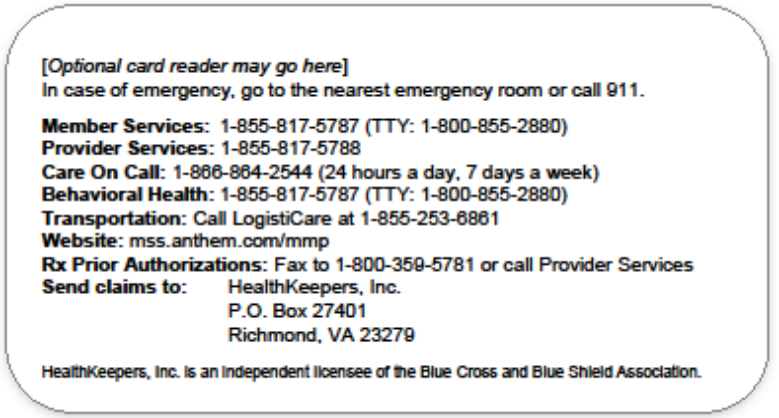
13. Sample CCC ID Cards

Anthem HealthKeepers *CCC* ID Card

FRONT



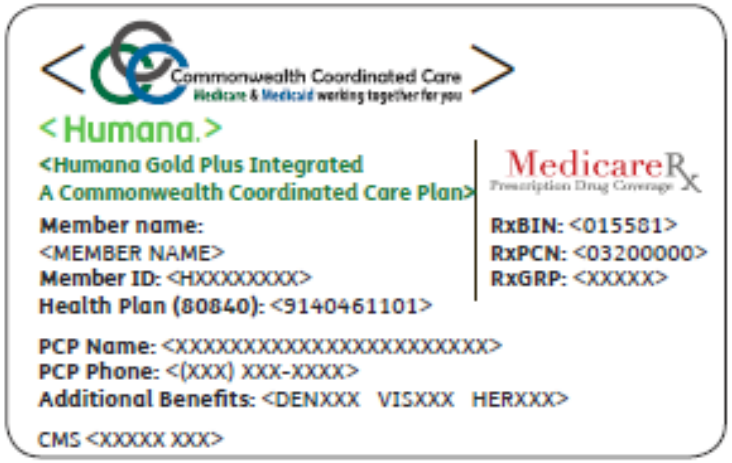
BACK



Humana *CCC* ID Card

FRONT **BACK**

Individual MAPD VA MMP HMO



Virginia Premier *CCC* ID Card

FRONT

Member name: <Cardholder Name>
Member ID: <Cardholder ID#>
Health Plan (80840): <Card Issuer Identifier>

PCP Name: <PCP Name>
PCP Phone: <PCP Phone>

BACK

For urgent or emergency care, dial 911 or go to the nearest urgent/emergency facility.

If you need medical assistance after hours or on the weekend, call our NurseLine at 1-800-256-1982.

Member Service: 1-855-338-6467
Website: www.vapremier.com/completecare

Send claims to: CompleteCare Claims
PO Box 4468
Richmond, VA 23220