KEPRO
INTELLIGENT VALUE

VA Insider

Virginia Medicaid Service Authorization

Spring 2018

COMMONWEALTH COORDINATED CARE (CCC) AND MEDALLION

CCC and Medallion 3.0 Aged, Blind and Disabled (ABD) populations transition to Commonwealth Coordinated Care Plus (CCC Plus) January 1, 2018.

CCC Plus began August 1, 2017. The final region, Northern/ Winchester, enrollment date was December 1, 2017.

Providers serving CCC Plus members must submit service authorization requests to the member's managed care organization (MCO).

Primary Goals

- New statewide Medicaid managed care program began August 2017 for over 216,000 individuals.
- Participation is required for qualifying populations.
- The integrated delivery model includes medical services, behavioral health services and long-term services and supports (LTSS).
- Care coordination and person-centered care is included with an interdisciplinary team approach.

CCC Plus Advantages

- Improves **quality of care** for the individual.
- Offers a network of **high quality providers.**
- More **flexible** – includes added benefits.
- Care coordinators help individuals **navigate** the health care system and conduct health risk assessments.
- Health Plans provide **comprehensive** health coverage.
- Local providers, health plans and health care agencies **collaborate.**

Enrolle Protections

- During the **continuity of care** period of up to 90 days, MCOs have to pay existing providers fee for service-60 days.
- MCO must go **out of network** to provide a service that they don't have in network.
- Individuals in a Nursing Facility (NF) at the time of enrollment **will not be moved** even if the NF does not choose to participate. The NF will be paid as an out of network provider.

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Changing Health Plans

- Members have 90 days to change their Health Plans from the effective date of their enrollment in CCC Plus.
- The open enrollment period in 2018 will be held in the following months October/November/ December.
- "Good Cause" at any time (e.g. for continuity of care or due to poor quality care).
- Exemptions:
    - PACE Program of All-Inclusive Care for the Elderly

Q & A Commonwealth Coordinated Care

Q: What happens once someone has full Medicaid eligibility?

A: They will be picked up by a CCC Plus health plan. This takes 45-60 days. How often can a member change plans? Members can change plans prior to the effective date, or within 90 days of their enrollment date. For Tidewater, members would have until the middle of December to change health plans. Members can change health plans up to six times. Once they get back to their original health plan, they cannot change again.

Q: What happens if a member transitions from CCC Plus back to FFS?

A: KEPRO will honor the CCC Plus approval up to the last approved date, but no more than 60 calendar days from the date of the CCC Plus disenrollment under the continuity of care provision. For continuation of services beyond the 60 days, KEPRO will apply medical necessity/service criteria. Requests submitted after the continuity of care period will be reviewed as a retrospective review for the dates of service outside of the dates honored for the continuity of care period and timeliness will be waived.

Q: What happens when requests are submitted after the continuity of care?

A: The dates of service within the continuity of care period will be honored for the 60-day timeframe. The dates of service beyond the continuity of care period, timeliness will be waived and reviewed for medical necessity. All applicable criteria will be applied on the first day after the end of the continuity of care period. The best way to obtain the most current and accurate eligibility information is for providers to do their monthly eligibility checks at the beginning of the month. This will provide information for members who may be in transition to CCC Plus at the very end of the previous month.

Q: What are some CCC Plus exceptions?

A: If the service is not a Medicaid covered service, the request will be rejected. If the provider is not an enrolled Medicaid provider for the service, the request will be rejected. (In this situation, a Medicaid enrolled provider may submit a request to have the service authorized (Srv Auth); the Srv Auth Contractor will honor the CCC Plus approved days/units under the continuity of care period for up to 60 calendar days. The remaining dates of services will be reviewed and must meet service criteria, but timeliness will be waived as outlined above). If the service has been authorized under CCC Plus for an amount above the maximum allowed by Medicaid, the maximum allowable units will be authorized. Once member is FFS, only Medicaid approved services will be honored for the continuity of care. If a member transitions from CCC Plus to FFS, and the provider requests an authorization for a service not previously authorized under CCC Plus, this will be considered as a new request. The continuity of care will not be applied and timeliness will not be waived.

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When a decision has been rendered for the continuity of care/transition period and continued services are needed, providers must submit a request to the Srv Auth Contractor according to the specific service type standards to meet the timeliness requirements. The new request will be subject to a full clinical review (as applicable).

DMAS has published multiple Medicaid memos that can be referred to for detailed CCC Plus information. For additional information regarding CCC Plus, visit: http://www.dmas.virginia.gov/Content_pgs/mltss-home.aspx.

Early Periodic Screening and Diagnostic Treatment (EPSDT) Services and DD Waiver Reminder:

Effective **August 1, 2017**, service authorization requests for the following services provided to individuals enrolled in one of the DD waivers are to be submitted to the Virginia Department of Behavioral Health and Developmental Services (DBHDS). DBHDS will utilize EPSDT rules and necessary documentation in authorizing these services for individuals under the age of 21.

Effective July 31, 2017, Providers should no longer send EPSDT service authorization requests for these DD Waiver services to KEPRO.

Personal Care:

T1019 (agency directed)
S5126 (consumer directed)

Private Duty Nursing (PDN):

T1002 (RN)
T1003 (LPN)
G0493 (Congregate RN)
G0494 (Congregate LPN)

Assistive Technology (AT):

T5999

Inpatient Substance Abuse Requests

- Members that have been admitted to the ER with substance abuse disorder should be Service Authorized by the Magellan Health Plan.
- Providers requesting an Inpatient stay with a primary ICD-10 diagnosis code ranging from F1- F19 will need to submit the request to Magellan.
- If a member is authorized by KEPRO for a medical inpatient stay, but then requires a psychiatric hospital stay including substance abuse disorder, during the admission the provider will need to discharge the member from the medical stay and request an authorization from Magellan.

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2810 North Parham Road, Suite 305
Henrico, VA 23294
Toll-free: 888.827.2884
Tel: 804.622.8900
Fax: 877.652.9329
http://dmas.kepro.com

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