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MEDICAID MEMO

TO: All Community Mental Health and Rehabilitation Service Providers, Behavioral Therapy Providers, Residential Treatment Services Providers, Magellan Healthcare of Virginia, and Managed Care Organizations

FROM: Cynthia B. Jones, Director
Department of Medical Assistance Services (DMAS)

MEMO: Special

DATE: 10/23/17

SUBJECT: Transitioning Community Mental Health Rehabilitation Services (CMHRS) into the CCC Plus Program

For Medicaid individuals who are enrolled in the Commonwealth Coordinated Care Plus (CCC Plus) Program, DMAS is preparing to transition the Community Mental Health Rehabilitation Services (CMHRS) into the CCC Plus managed care organization (MCO) contract. A separate transition is planned for individuals who are enrolled in the Medallion 3.0 and FAMIS programs.

The purpose of this memo is to provide information about this transition and other updates associated with mental health services and CCC Plus. The CCC Plus program began its regional roll out on August 1, 2017. This regional roll out will continue until December 1, 2017. Additionally, all current CCC (dual demonstration) members and all Aged, Blind and Disabled individuals currently in the Medallion 3.0 program will move to CCC Plus on January 1, 2018. For more details about the CCC Plus Program, please visit the DMAS website at http://www.dmas.virginia.gov/Content_pgs/mltss-home.aspx. Questions regarding CCC Plus can be emailed to CCCPlus@dmas.virginia.gov. Questions regarding the CMHRS transition into CCC Plus can be emailed to CCCPlusCMHRS@dmas.virginia.gov.

The CMHRS transition to CCC Plus will occur January 1, 2018. On this date, Magellan of Virginia, DMAS's Behavioral Health Services Administrator (BHSA), will no longer administer CMHRS for CCC Plus-enrolled members. Instead, CMHRS will transition into the CCC Plus MCO contract, utilizing DMAS' current CMHRS coverage criteria and program requirements. CMHRS coverage for Medallion 3.0 members will continue to be administered through Magellan of Virginia until the implementation of Medallion 4.0 at the end of 2018. Magellan of Virginia will continue to manage the CMHRS services for individuals who are enrolled in the DMAS fee-for-service program (including, but not limited to, the Governor's Access Plan, individuals who are excluded from managed care, and individuals who are awaiting managed care enrollment).

The list of services that will transition into CCC Plus on January 1, 2018 includes:

Community Mental Health Rehabilitation Services	Procedure Code
Mental Health Case Management	H0023
Therapeutic Day Treatment (TDT) for Children / Assessment	H0035 HA / H0032 U7
Day Treatment/ Partial Hospitalization for Adults / Assessment	H0035 HB / H0032 U7
Crisis Intervention	H0036
Intensive Community Treatment / Assessment	H0039 / H0032 U9
Mental Health Skill-building Services (MHSS) / Assessment	H0046 / H0032 U8
Intensive In-Home / Assessment	H2012 / H0031
Psychosocial Rehab / Assessment	H2017 / H0032 U6
Crisis Stabilization	H2019
Behavioral Therapy / Assessment	H2033 / H0032 UA
Mental Health Peer Support Services or Family Support Partners – Individual	H0025
Mental Health Peer Support Services or Family Support Partners – Group	H0024

Please note that Treatment Foster Care Case Management and Therapeutic Group Home services (formerly known as Level A and Level B) will remain carved-out of CCC Plus at this time. Additional details are provided later in this Memo.

Additionally, all CCC Plus MCOs are required to pay the CMHRS providers using established DMAS reimbursement rates as the minimum payment level. There will be no changes made to current program regulations, medical necessity criteria, procedure codes, and unit values for these services at this time. Some Service Authorization processes will be standardized across the CCC Plus MCOs; DMAS, the Virginia Association of Community Services Boards (VACSB) and the Behavioral Health Associations have been working with the CCC Plus MCOs to reach a consensus on what can be standardized. In addition, DMAS is hosting workgroup meetings with the CCC Plus MCOs and Behavioral Health provider association representatives. Workgroup discussions are covering topics such as credentialing requirements, CMHRS program requirements, claims processing, and care coordination.

Care Coordination and Continuity of Care

The CCC Plus program has a variety of processes in place to ensure continuity of care. For example, all CCC Plus-enrolled members have an assigned Care Coordinator through their MCO. 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 medical and behavioral health needs, 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. 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. TCM includes case management for addiction and recovery treatment services (ARTS), mental health, developmental disabilities, treatment foster care, early intervention, and high risk prenatal and infant services.

For these reasons, unless the member is newly enrolled in CCC Plus, the CMHRS services received (and the CMHRS providers) should be already be known to the member's Care Coordinator, and these services should be identified in the member's ICP, prior to January 1, 2018 when the CMHRS services transition to CCC Plus. There will also be a significant number of members who will transition from the Medallion and CCC programs to CCC Plus on January 1, 2018. For individuals who are newly enrolled in CCC Plus on January 1, 2018, the MCO will be working with the member and the member's service providers to complete a HRA and to develop a comprehensive ICP.

Continuity of Care Provisions Until April 1, 2018

Regardless of whether the member is new to CCC Plus on January 1, 2018, or has been enrolled in CCC Plus prior to the CMHRS transition on January 1, 2018, to ensure continuity of care and a smooth transition for all CCC Plus Members the CCC Plus MCOs will:

1) Maintain the Member's current CMHRS providers for up to 90 days;
2) Honor service authorizations (SAs) issued prior to enrollment, including those with out of network providers, for up to 90 days or until the authorization expires, whichever comes first; and
3) 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 qualified provider within the MCO's provider network or as authorized by the MCO out-of-network.

Exceptions to these continuity of care provisions include the following circumstances:

1) The Member requests a change;
2) The provider chooses to discontinue providing services to a Member as currently allowed by Medicaid;
3) The MCO or DMAS identify provider performance issues that affect a Member's health or welfare; or
4) The provider is excluded under State or Federal exclusion requirements.

This 90-day continuity of care period also serves to provide additional time for providers to finalize credentialing and contracting with the MCOs. To facilitate timely claims payment, non-contracted providers should contact the MCO to ensure that the MCO has all of the necessary information in place for claim payment purposes. Additional information for what is needed by each MCO to pay out of network providers is available at: http://www.dmas.virginia.gov/Content_atchs/mltss/Medical%20Provider%20CCC%20Plus%20Update%209.19.17.docx.

Continuity of Care Provisions After April 1, 2018

After April 1, 2018, continuity of care provisions will continue to apply for members who transition to CCC Plus from fee-for-service or for members who transition between MCOs. To ensure continuity of care and a smooth transition for all CCC Plus Members at all times, the CCC Plus MCOs will:

1) Maintain the Member's current CMHRS providers for up to 30 days,
2) Honor SAs issued prior to enrollment, including out of network providers, for up to 30 days or until the authorization expires, whichever comes first; and,
3) 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 qualified provider within the MCO's provider network or as authorized by the MCO out-of-network.

Exceptions to these continuity of care provisions include the following circumstances:

1) The Member requests a change;
2) The provider chooses to discontinue providing services to a Member as currently allowed by Medicaid;
3) The MCO or DMAS identify provider performance issues that affect a Member's health or welfare; or,
4) The provider is excluded under State or Federal exclusion requirements.

Credentialing Process for CMHRS Providers and Behavioral Therapy Providers:

Providers must be credentialed with the member's MCO in order to bill for Community Mental Health Services rendered to the CCC Plus member beyond the continuity of care period. The CCC Plus MCOs have started developing their networks of behavioral health providers in preparation of the January 1, 2018 effective date to cover the full scope of the Medicaid CMHRS. CMHRS and Behavioral Therapy providers who have not already been in contact with the CCC Plus MCOs should contact them now to begin the credentialing and contracting process. The credentialing process includes an application review period to ensure all required information is included. Providers must submit all required information as requested by the MCO. The CCC Plus MCOs are not under contract to accept any willing provider but are required to ensure member access to timely care through a sufficient network of high quality, credentialed, and knowledgeable providers in each level of care. Credentialing and contact information for each of the CCC Plus MCOs is available on the DMAS website, select the CCC Plus/MLTSS tab and look for *Information for Interested Stakeholders and Providers*. The credentialing contact information for the CCC Plus MCOs can be found at the end of this memo (Appendix A).

Psychiatric Residential Treatment and Therapeutic Group Home Services:

At this time, Psychiatric Residential Treatment Services are excluded from CCC Plus as well as Medallion 3.0. Members who are admitted to a Psychiatric Residential Treatment Facility are removed from CCC Plus or Medallion 3.0 managed care enrollment and covered by fee-for-service Medicaid for their admission, which is administered by Magellan of Virginia. There is no change to this process for January 1, 2018.

Previously, the former Group Homes Level A and B were considered to be part of the Medicaid CMHR services. As of July 1, 2017, these group homes are now one level called Therapeutic Group Homes and are now associated with Residential Treatment Services. Refer to the Medicaid Memo Dated 6/1/2017 and also the new Residential Treatment Services Manual found on the DMAS Web Portal. Therapeutic Group Home Services are **carved out** of CCC Plus and Medallion 3.0. Members admitted to a Therapeutic Group Home will remain in CCC Plus or Medallion 3.0 and their providers should submit claims for services, other than the Therapeutic Group Home per diem, through the respective managed care program. The status of these services will stay the same for CCC Plus and Medallion 3.0.

Both of these services will continue to be administered through Magellan of Virginia until they are carved into CCC Plus and Medallion 4.0.

Treatment Foster Care- Case Management:

Treatment Foster Care- Case Management Services (TFC-CM) are also carved out of CCC Plus and Medallion 3.0. Members admitted to TFC-CM currently remain in CCC Plus or Medallion 3.0 and their providers should submit claims for services, other than TFC-CM, through the respective managed care program.

TFC-CM services will continue to be administered through Magellan of Virginia until it is carved into CCC Plus and Medallion 4.0.

Appendix A: CCC Plus Health Plans Credentialing Contact Information

MAGELLAN BEHAVIORAL HEALTH OF VIRGINIA (Behavioral Health Services Administrator)

Providers of behavioral health services may check member eligibility, claims status, check status, service limits, and service authorizations by visiting www.MagellanHealth.com/Provider. If you have any questions regarding behavioral health services, service authorization, or enrollment and credentialing as a Medicaid behavioral health service provider please contact Magellan Behavioral Health of Virginia toll free at 1-800-424-4046 or by visiting www.magellanofvirginia.com or submitting questions to VAProviderQuestions@MagellanHealth.com.

MANAGED CARE PROGRAMS

Most Medicaid individuals are enrolled in one of the Department's managed care programs (Medallion 3.0, CCC, CCC Plus, and PACE). In order to be reimbursed for services provided to a managed care enrolled individual, providers must follow their respective contract with the managed care plan/PACE provider. The managed care plan/PACE provider may utilize different prior authorization, billing, and reimbursement guidelines than those described for Medicaid fee-for-service individuals. For more information, please contact the individual's managed care plan/PACE provider directly.

Contact information for managed care plans/PACE providers can be found on the DMAS website for each program as follows:

- Medallion 3.0: http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx
- Commonwealth Coordinated Care (CCC): http://www.dmas.virginia.gov/Content_pgs/mmfa-isp.aspx
- Commonwealth Coordinated Care Plus (CCC Plus): http://www.dmas.virginia.gov/Content_pgs/mltss-proinfo.aspx
- Program of All-Inclusive Care for the Elderly (PACE): http://www.dmas.virginia.gov/Content_atchs/ltc/PACE%20Sites%20in%20VA.pdf

VIRGINIA MEDICAID WEB PORTAL

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, claims status, payment status, service limits, service authorizations, and electronic copies of remittance advices. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov. If you have any questions regarding the Virginia Medicaid Web Portal, please contact the Conduent Government Healthcare Solutions Support Help desk toll free, at 1-866-352-0496 from 8:00 a.m. to 5:00 p.m. Monday through Friday, except holidays. The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.

KEPRO PROVIDER PORTAL

Providers may access service authorization information including status via KEPRO's Provider Portal at http://dmas.kepro.com.

"HELPLINE"

The "HELPLINE" is available to answer questions Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays. The "HELPLINE" numbers are:

1-804-786-6273	Richmond area and out-of-state long distance
1-800-552-8627	All other areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid Provider Identification Number available when you call.

TO ALL MEDICAID PROVIDERS: PROVIDER APPEAL REQUEST FORM NOW AVAILABLE

There is now a form available on the DMAS website to assist providers in filing an appeal with the DMAS Appeals Division. The link to the page is http://www.dmas.virginia.gov/Content_pgs/appeal-home.aspx and the form can be accessed from there by clicking on, "Click here to download a Provider Appeal Request Form." The form is in PDF format and has fillable fields. It can either be filled out online and then printed or downloaded and saved to your business computer. It is designed to save you time and money by assisting you in supplying all of the necessary information to identify your area of concern and the basic facts associated with that concern. Once you complete the form, you can simply print it and attach any supporting documentation you wish, and send to the Appeals Division by means of the United States mail, courier or other hand delivery, facsimile, electronic mail, or electronic submission supported by the Agency.

PROVIDERS: NEW MEDICARE CARDS ARE COMING

CMS is removing Social Security Numbers from Medicare cards to help fight identity theft and safeguard taxpayer dollars. In previous messages, CMS has stated that you must be ready by April 2018 for the change from the Social Security Number based Health Insurance Claim Number to the randomly generated Medicare Beneficiary Identifier (the new Medicare number). Up to now, CMS has referred to this work as the Social Security Number Removal Initiative (SSNRI). Moving forward, CMS will refer to this project as the New Medicare Card.

To help you find information quickly, CMS designed a new homepage linking you to the latest details, including how to talk to your Medicare patients about the new Medicare Card. Bookmark the New Medicare Card homepage and Provider webpage, and visit often, so you have the information you need to be ready by April 1st.

Providers (which includes fee for service, Medicaid Managed Care Organizations, and Commonwealth Coordinated Care Plus) may share the following information with members:

MEMBERS: NEW MEDICARE CARDS ARE COMING

Medicare will mail new Medicare cards between April 2018 and April 2019. Your new card will have a new Medicare Number that's unique to you, instead of your Social Security Number. This will help to protect your identity.

Additional information is available at the following link:
https://www.medicare.gov/forms-help-and-resources/your-medicare-card.html

Appendix A

CCC Plus Health Plan Credentialing Contact Information		
Plan		**Credentialing Contact**
aetna AETNA BETTER HEALTH® OF VIRGINIA	Aetna Better Health of Virginia	Contacts: Leslie Weatherless-Kerr & Donnesha Lewis Patricia Thomas, Provider Relations Manager Phone: 1-855-652-8249 Email: VAcredentialing-aetna@aetna.com (credential status) & Aetnabetterhealth-VAProviderRelations@aetna.com (applications submissions)
Anthem HealthKeepers Plus Offered by HealthKeepers, Inc.	Anthem HealthKeepers Plus	Contacts: Annette Powell, Tidewater _ Phone: 804-393-6763 John Bachand, Central/Western _ Phone: 804-354-4063 Beth Condyles, Northern _ Phone: 804-516-2499 Deborah Tankersly, Southwest _ Phone: TBA
Magellan COMPLETE CARE	Magellan Complete Care of Virginia	Contact: Kenya Onley Email: VAMLTSSProvider@MagellanHealth.com Phone:1-800-424-4524
OptimaHealth	Optima Health Community Care	Contracting Contacts: Kresha Garland, Tidewater Phone (757)252-3141 Email: KRGARLAN@sentara.com Deborah Abbey-Bada, Central, Northern & Winchester Phone: (757) 983-9671 Email: MDABBEYB@sentara.com Didi France, Charlottesville, Western, Roanoke, Alleghany & Southwest Phone: (540) 562-8236 Email: DAFRANC1@sentara.com Credentialing Contact: Contact: Linda Winebrenner Phone: 757-687-6333 Email: OrgProviderApp@sentara.com
UnitedHealthcare Community Plan	United Healthcare	Contact: Taylor Fink Phone: 763-361-6233 Email: vacccbh@optum.com
VA Premier Virginia Premier Health Plan, Inc.	Virginia Premier Elite Plus	Contracting Contact: John Strube Phone: 804-819-5151, ext.56051 Email: John.Strube@VaPremier.com Credentialing Contact: Kim Paige Phone: 804-819-5151, ext. 55352 Fax: 804-819-5171 Email: kimberly.paige@vapremier.com