CMHRS Provider Webinars- FAQ

December 5-7, 2017- Morning Sessions:

CMHRS Transition Overview

Additional resources and recorded training sessions can be found on the DMAS website at the following links:

CMHRS Transition

CCC PLUS ELIGIBILITY TRACKING, AUTHORIZATION AND CLAIMS PROCESSES FOR CMHRS

- CMHRS Provider Reference-Doing Business with CCC Plus MCO's

PROVIDER WEBINAR TRAINING SLIDE DECKS

- AM Session - CCC Plus CMHRS Transition Overview
- PM Session - CCC Plus CMHRS Service Authorization Form Overview

PROVIDER WEBINAR RECORDED SESSIONS

- CMHRS Transition to CCC Plus – Morning Session
- CMHRS Transition to CCC Plus – Afternoon Session

Q1: What is the Ratio of Care Coordinators to Members in the CCC Plus program?

Ratios (Effective in 1/1/18) are based on assessed need and categories of care (see below)

CCC Plus Care Coordination Staffing Ratios by Population			
High-Risk Populations			Moderate to Low Risk Populations
CCC Plus Waiver Populations	Nursing Facility Populations	Other High-Risk Populations	Emerging High-Risk
1:70	1:175	1:100	1:400

CCC Plus Waiver including Technology Assisted and Standard levels of care; Section 5.1.1(a).	Nursing Facility including Specialized Care and Long-Stay Hospital Section 5.1.1(b).	Individuals with Serious Mental Illness (SMI) Individuals (duals and non-duals) with complex or multiple conditions who are identified by the plan or self-identified as having conditions that are not well managed, e.g. multiple ED visits, multiple inpatient admits, or have a lack of medication adherence, etc. Section 5.1.1 (c – n) if they meet high-risk criteria per 2 above.	All other individuals (duals and non-duals) not already identified in the high-risk population groups; includes populations (duals and non-duals) with complex or multiple conditions who are well managed. Populations listed in 5.1.1, (d-o), including DD Waiver individuals are included unless they meet high-risk criteria.
See Section 5.1.1			

Q2: How will providers be notified of members' interdisciplinary care plan?

- A: 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.
- ICP's must be developed by the end of the member's service authorization.
    - Services cannot be ended or adjusted by the MCO until the HRA and ICP is completed.

The MCO Care Coordinator will be in contact with the member's provider to communicate and potential changes, all adverse actions including reductions and denials of services will be communicated by the MCO in writing with member or provider appeal rights being given at that time.

Q3: How does CCC Plus affect ABA Services. FAMIS is not included.

If the member remains in FAMIS Behavioral Therapy services will continue to be administered by Magellan. If the member remains in FAMIS Plus/Medallion or FFS Behavioral Therapy will continue to be administered by Magellan

For all members who are enrolled into CCC Plus Behavioral Therapy will be administered by the CCC Plus MCO.

Q4: Do all IIH services need to move to CCC Plus?

No. Only the CCC Plus members preassigned. Check eligibility for all members served by your agency.

Q5: When will we receive notification of authorizations?

Shortly after the "Go Live" date of January 1 the MCO's will begin mailing notices on behalf of their enrolled members to all providers of their authorized services. At that time members and providers will receive written notification. Contact the members MCO to ensure your payment processing information is on record.

Q6: UHC said they weren't accepting new providers.

MCOs can manage their network. If their network is sufficient, they don't have to accept all willing providers. Network management is a dynamic process that involves assessing membership and member service history to ensure that an adequate highly qualified network is maintained by the MCO's in accord with the DMAS CCC Plus MCO contract which can be found online in the DMAS Website.

Q7: Still waiting to hear back from MCOs on credentialing. When can expect to hear from the MCOs?

Continuity of Care ends 90 days after 1/1/2018, during the continuity of care period the MCO does not need to transition services to an in network provider. Work with the MCO to get in network by contacting the members MCO at:

Continuity of Care Provisions Until April 1, 2018

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 .

Q8: Any plans use Availity?

Providers should contact the MCO network contacts to learn how to do business with each of the MCO's.

http://www.dmas.virginia.gov/Content_atchs/mltss/Updated%2011.14.2017.CCC%20Plus%20Health%20Plan%20Credentialing%20Contact%20Information.pdf

Q9: Is there a reason why, during COC, the authorization cannot be honored throughout the entire authorization?

Providers are encouraged to communicate with the member's health plan for detailed responses. In general, the continuity of care period is used to assess service delivery and to identify all of the member's services and providers to promote continuity of care. Once the MCO is able to complete the assessment process the MCO will be able to adjust services based on the member's goals and service needs and identify providers in their network or out of their network to pursue to meet the members service needs.

Q10: Clarify if ABA is a part of the CMHRS transition along with peer services. And still use the same procedure code.

CMHRS, Behavioral therapy and MH Peer Support Services 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.

- Provider types remain the same.
- No changes to program requirements.
- No changes to billing codes

Q11: If client's authorization runs out can we extend as a non-participating provider?

Yes, for all dates after 1/1/2018 the provider will have to extend authorizations using the members CCC Plus MCO.

Q12: Are the rates negotiable?

DMAS assigned rates are the minimum required payment for CMHRS but providers may enter into unique reimbursement or other arrangements with the MCO over time based on demonstrated results.

Q13: If our clients have not yet selected a health care plan, will one be automatically selected for them and if so how will the identified agency know this?

Please refer all member MCO selection questions to Maximus where more information can be found at: https://www.cccplusva.com/member-materials

Providers will need to verify eligibility changes using provider portals (for those in the MCO's network) and by using the Magellan of Virginia (BHSA) Provider Portal. January 1, 2018 assignments are available in the portal after December 21st and on the 21st of each subsequent month.

Q14: Is the CCC Plus care manager a Magellan (BHSA) care manager?

No, Magellan of Virginia, or the BHSA is not the same as Magellan Complete Care, the CCC Plus MCO.

Q15: Will Magellan continue to administer services for adults or just children and adolescents?

Yes, the Magellan BHSA will continue to administer behavioral health services for the GAP, Medallion 3 and Fee for Service enrolled members.

Q16: When a child is discharged from an RTC will they be placed back in Medicaid FFS before being re-enrolled in CCC Plus?

Yes, Magellan BHSA Residential Care Managers will help the facility to coordinate aftercare services available upon discharge.

Q17: Do all IIH and TDT clients need to be moved to CCC Plus?

No, the CCC Plus enrolled members will be impacted but members enrolled in the Medallion 3 and Fee for Service programs will remain administered by Magellan BHSA.

Q18: Is Sponsored Residential carved out?

Yes. Sponsored Residential is not a CMHRS benefit, all DD Waiver services remain carved out from CCC Plus.

Q19: If a provider has requested to be in an insurance network, when can they expect to have a response? We have contacted each insurance under CCC+ back in September and are still waiting a response, even after multiple attempts to contact them.

Please contact the MCO's using the assigned behavioral health contacts as shown in the material located in this link: Updated MCO Contracting/Credentialing Contacts

Q20: Is there a form for all CCC plus members such as a sra form for IIH, MHSS or do we have to contact each ins company?

Standardized CMHRS authorization forms have been posted to the DMAS Website:

CCC PLUS STANDARDIZED FORMS FOR CMHRS

- Important Tip for Opening Forms
- CCC Plus Registration Form
- CMHRS & Beh Therapy Continued Stay SRA
- Day Tx PHP Rehab Services Inital SRA
- EPSDT Beh Therapy Initial SRA

- ICT Rehab Services Initial SRA
- IIH Rehab Services Initial SRA
- MHSS Rehab Services Initial SRA
- PSR Services Initial SRA
- TDT Rehab Services Initial SRA
- CIR Revised Final.11-02-2017.FormFill

For more information on the submission process please refer to the "afternoon" Service Authorization training at: CMHRS Transition

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Q21: How soon will we be able to submit auths online vs faxing

After the Continuity of Care period, when more providers are in the MCO's network, the MCO's will be able to adjust how providers are able to do business with each MCO.

Q22: For outpatient services-will the provider have to be licensed or can we use licensed eligible staff?

Contact the members MCO to learn their network credentialing rules.

Q23: A CCC Plus MCO advised us that they will not be accepting new providers. Will they be accepting new providers for Behavioral Therapy in the future?

Refer to question #6 for a related response.

Q24: If we have authorizations expiring within the first week of the New Year, and need to be submitting re-authorization requests now, we assume that those will still go to Magellan up to December 31, 2017 in order to avoid gaps in coverage. Is this correct?

Yes.

Please note that Magellan of Virginia will continue to cover CMHRS services for Medallion 3.0 MCO enrolled members as well as fee-for-service members.

- In an effort to provide continuity of care for our CCC Plus members and promoting easier transition of CMHRS services for providers, **any member who has a current authorization for a CMHRS service with an end date of 12/16/17 through 1/10/18 will have the authorization automatically extended until 1/31/18** to allow providers sufficient time to submit any continued stay authorizations to the correct CCC Plus MCO. Providers are responsible for ensuring that members with extended authorizations meet medical necessity at time of service and the appropriate supporting documentation is in the medical record.

- **For All Members - Initial CMHRS Service Authorization Requests for Dates of Service Beginning Prior to 1/1/18:**

- Any initial authorization request submitted to Magellan prior to 1/1/18 will be reviewed and authorized based on medical necessity for the time period appropriate based on the specific needs of the member.

- **For All Members - Continued Stay CMHRS Service Authorization Requests for Dates of Services Prior to 12/31/17:**

- Any continued stay authorization request submitted to Magellan prior to 1/1/18 will be reviewed and authorized based on medical necessity for the time period appropriate based on the specific needs of the member.

- If providers submit continued stay service authorization requests for dates of services ending 12/16/17 through 1/10/18, Magellan will process those requests and use dates specified based on the specific needs of the member versus the automatic extension through 1/31/18.

Q25: Will there be consistency in claims requirements with all plans?

Yes, refer to Question #10 for more information.

Q26: Does the auth number have to be on the claim?

Yes

Q27: When should we expect updated contracts from the plans to include CMHRS?

Please contact the MCO's using the assigned behavioral health contacts as shown in the material located in this link: Updated MCO Contracting/Credentialing Contacts

Q28: The slide said that authorizations given from Magellan will be honored for the duration or 90 days. Is the same true for authorizations from CCC plans?

Please refer to the memo for clarification:

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

Q29: How do we receive compensation for claims if we have a client with a current authorization with Magellan and the clients new MCO is United Healthcare (if we aren't credentialed with United Healthcare)

Continuity of Care Period:

- Additional time for providers to finalize credentialing and contracting with the MCOs.
- Participating providers should contact the MCO to exchange information necessary for claims and payment processing.
- 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

Q30: Can you clarify again when the continuity of care period ends for ABD members who move into the CCC Plus plans eff. 1/1/18? 90 days from 12/1/17 or 90 days from 1/1/18? What happens to those clients that we currently see that may be receiving services through our agency and we aren't in network? Would they need to transition to a new provider?

Refer to Question 28 for more detail from the provider memo dated October 23, 2017

For all CCC Plus Members the CCC Plus MCOs will:

- Maintain the Member's current CMHRS providers for up to 90 days;
- *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
- 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.

Q31: Do authorization forms have to look exactly like the approved forms, or can we create a form in an EHR that looks different but contains all the same information?

- The CCC Plus CMHRS Service Authorization Review Form for initial requests as well as the CCC Plus CMHRS Service Authorization Extension Review Form for requests for each service are located online at http://www.dmas.virginia.gov/Content_pgs/mltss-trn.aspx
- CCC Plus CMHRS Service Authorization Review Forms are standard and used by all CCC Plus MCO's to administer the CMHRS benefits.
- Providers should submit to the health plans via the fax number listed for the appropriate health plan on the service authorization form.
- CCC Plus forms have the CCC Plus logo and contact information for all 6 MCO's
- ***Providers will continue to upload the Magellan BHSA SRA service authorization form to Magellan of Virginia to obtain authorization for FFS, FAMIS and Medallion 3 enrolled members not enrolled in CCC Plus.***

- *That is a grand total of 7 payers including the Magellan BHSA for 2018.*

Q32: Can you clarify regarding the 12/16/17 through 1/10/18 process. Are providers still required to submit a continuing stay authorization to Magellan, or are you saying that they will automatically be extended even if we do not submit a written request?

Yes, refer to the Magellan BHSA website for more information:

http://www.magellanofvirginia.com/media/1654473/12-06-17_ccc_plus_transition.pdf

Q33: If a member has a CMHRS authorization that is up after the 1/10/18 date. Will the provider need to wait until after 1/1/18 and submit a continued stay request to the new CCC Plus MCO or can they submit it prior to that to the current plan?

Providers will need to wait until after 1/1/2018 to submit CMHRS authorization requests to the CCC Plus MCO's.

Q34: What will be a realistic turnaround rate following our submission of claims?

Clean claims will be processed within 14 days of submission by the CCC Plus MCO's.

Q35: Currently when clients are being closed from services, we have to provide them with a DMAS right to appeal letter. Will we need to create a letter for each of the MCOs as they are now the Medicaid/MCO authority or will the single DMAS right to appeal letter be sufficient?

Please coordinate any service transitions with the members MCO Care Coordinator, they will assist with transition planning and hopefully avoid any appeal situations. Also, they will help facilitate the appeal process within the MCO. You can use the same letter with appeal rights.

Q36: Opt out letters-are they required? we are currently sending the letter but claims are denying-letter is not being used for claim processing-we still have to call on each claim-this is delaying revenue-will this be corrected soon?

Please send non CMHRS claims processing questions to CCCPlus@dmas.virginia.gov

Q37: Will there be any consideration for Magellan BHSA to use the newly approved standard form for Authorizations that will be used for the CCC+ program so that providers are not having to create/use multiple forms based on an individual's insurance coverage?

Magellan BHSA will continue to use the current SRA forms and will not change forms or their procedures at this time.

Q38: We are currently having difficulty with secondary claims for outpatient services for dual eligibles specifically for Va Premier-when will this be resolved to prevent further revenue delays?

Please send non CMHRS claims processing questions Virginia Premier or ask them during the weekly provider calls, refer to the schedule at: ◆CCC Plus Provider Q and A Conference Call Schedule – NEW

Q39: Hello we are credentialed with Aetna for private insurance, do we need to go through the entire re-credentialing process to provide services for Medicaid ABA Clients?

Please contact Aetna's network team directly, the network teams can be contacted using the information here ◆Updated MCO Contracting/Credentialing Contacts

Q40: Will it be possible to extend the continuity of care period for a provider who is close to completing the credentialing process and has a client under said MCO?

The continuity of care period will not be extended, however the authorization can be extended to out of network providers by the MCO at their discretion and based on provider specialties, network capacity for the service and ultimately based on the goals and service needs identified by the member.

Q41: How is the Care Coordinator different from a Case Manager? How is the Peer Specialist different from an agency Peer Specialist? If none, why the duplication of services and what is the value of duplication and the expenses of the duplication?

Please refer to the CMHRS Program Manual and the Peer Services Supplement for further clarification, also contact your members care coordinators to determine how to best align and integrate service delivery on behalf of the member and within the interdisciplinary team structure.

Q42: Is there a reason the continuity of care phase could not honor authorizations for the duration of the authorization? Many CMHRS service authorizations are for 6 months at a time; authorizations secured with Magellan after 10/02/2017 will then only last for 4 months ending on 03/31/2018, requiring authorization for services that were already authorized and prior to the date of a new authorization.

The CCC Plus health risk assessment and interdisciplinary plan will align service delivery with individual member goals and clinical needs. Services should be designed to ensure the correct duration, intensity and frequency of services match the member's individualized clinical needs and service goals within the context of their integrated care plan.

Q43: Are there any plans from the MCOs to utilize Availity for member eligibility and/or auth request submissions?

Each MCO is able to use defined systems, please contact the MCO network teams to determine which resources are available for use by their network providers.

Q44: We have built the auth forms in our EHR and need to know if the auth/registration forms are finalized before we start building the forms into templates with the CCC Plus logo. It's a lot of work to make changes to templates if there are any additional changes made to the forms.

Q45: Hello we are credentialed with Aetna, Anthem and United for private insurance, do we need to go through the entire re-credentialing process to provide services for Medicaid ABA Clients?

Please contact MCO network teams directly, the network teams can be contacted using the information here ◆Updated MCO Contracting/Credentialing Contacts

Q46: The contact from United Healthcare advised me that these questions; Some of our outstanding questions to the state: 1. Please clarify if Applied Behavior Analysis (ABA) interventions are part of the CMHRS services? 2. If yes, what codes should be utilized for ABA? a. What provider types should be utilized for ABA? b. Any restrictions on place of service for ABA? c. Prior authorizations required for ABA? Regards, need to be answered from the state prior to starting the credentialing process with any ABA providers in VA:

Please refer to the CCC Plus Transition memo dated 10/23/2017 and this presentation for more detail.

Please contact MCO network teams directly, the network teams can be contacted using the information here ◆Updated MCO Contracting/Credentialing Contacts

Q47: What about therapeutic consultation services under Medicaid Waiver services? Is it the same as the ABA services for authorization and billing?

ABA and Therapeutic Consultation for DD Waiver enrolled members are not the same service. DD Waiver services are carved out of the CCC Plus contract and are administered by DBHDS as they are currently. DD Waiver members are enrolled in CCC Plus unless they are in an exclusion category and their medical/clinical services are coordinated by the CC Plus health plan. Please contact the members care coordinator to find out how to participate in the member's interdisciplinary care team.

Q48: We are having trouble verifying our CCC Plus client's on the new website. We are only able to look into the past and not into the future.

The Magellan BHSA provider portal has been reviewed and is now fully accurate to use for identifying member MCO assignments in CCC Plus. As of December 21, 2017 providers are able to see all pending CCC Plus assignments beginning on January 1, 2018 as well as all current CCC Plus assignments.

Q49: If a consumer has CCC+, will the Magellan BHSA portal be updated to show that coverage/eligibility ends 12/31/17?

No, providers will be able to use the Magellan of Virginia Provider web portal to verify eligibility for all members. In early 2018 the DMAS provider web portal will be reactivated to allow formerly enrolled providers access to eligibility verification, stay tuned!

Q50: Is there a way to identify the Care Coordinator and their contact information assigned to each case without relying on the family to provide that information?

Providers would contact the member's care coordinator for assistance and instruction and also to facilitate transfer or discharge from services.

Magellan	UHC	Anthem	Aetna	VaPremier	Optima
800-424-4524	877-843-4366	1-855-323-4687 Press #4	1-855-652-8249 press #1 and ask for CC.	1-877-719-7358 select option for Care Management	757-552-8398 OR Toll Free 866-546-7924

Q51: Will the CCC MMP payers be passing authorization information to the CCC+ plans, much like Magellan will be?

Yes, new continuity of care authorizations will be generated by the CCC Plus plans for all members as they begin enrollment into CCC Plus.

Q52: can current providers assist with brining their members to the Care coordinator to make sure that their assessments are completed in a timely manner so that when continued stays are due they are in the system so providers can submit their continued stays on members or new registrations on members.

Yes, see above for care coordination contact information with all CCC Plus MCO's.

Q53: If the care coordinator does not complete the HRA and ICP timely, will providers be at risk for not getting paid for their services?

No

Q54: Will Care Coordinator ever ask for records to be sent to them and do we require a release in order to send records?

Both service authorization or UM staff may request records and Care coordinators may also request records from providers for specific situations. Providers would not be required to submit a consent form for exchange of information to render services.

Q55: Can you review the process for communication between the care coordinator and CSB case managers when a client has a guardian? For example, do you require guardianship papers first?

MCO Care Coordinators have an established process to identify guardian status but if that information is not available to them from DMAS systems, then they may request information through the CSB Case

Manager or DSS to identify guardians. You may contact the care coordinator to facilitate exchange of the guardian's contact information by calling one of the numbers listed above

Q56: For service authorizations that end after 1/10 (the date for automatic extension of the service authorizations through 1/31), but before 4/1, do the MCOs have the option to refuse to grant continuing service authorizations to out-of-network providers for reasons solely related to the provider being out-of-network?

Yes, this decision is based on the member needs and clinical progress demonstrated by the current provider as well as network capacity for the targeted services in that locality.