PROVIDER MANUAL

Molina Complete Care

Commonwealth Coordinated Care Plus and Medallion 4.0

2022

MOLINA HEALTHCARE | Molina Complete Care

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Section 1: Introduction

About Molina Complete Care

Molina Complete Care (MCC) is an integrated health plan combining physical and behavioral health care and community and social supports. Our clinical and operational model of care offers our members access to high-quality, clinically appropriate, affordable health care that is tailored to each individual's needs. Our goal is to improve health care outcomes and the overall quality of life for our members and their families.

MCC is a division of Molina Healthcare, Inc., a health care management company that focuses on fast-growing, complex and high-cost areas of health care, with an emphasis on managing the care and benefits for specialty populations.

About our Commonwealth of Virginia program participation

MCC entered into a contract with the Department of Medical Assistance Services (hereinafter referred to as "DMAS") for the provision of services to Virginia Medicaid beneficiaries. This includes the Commonwealth Coordinated Care Plus (CCC Plus) and Medallion 4.0 programs.

CCC Plus focuses on high-quality and integrated care for individuals requiring complex care, serving populations with long-term service and supports needs, such as those on community-based or disabilities waivers, or aged, blind, or disabled individuals. Medallion 4.0 provides high-quality care for Virginia's pregnant moms, children and adults. This includes coverage for the Family Access to Medical Insurance Security (FAMIS) population and other expanded populations that may be deemed eligible by DMAS.

MCC provides the full scope of services and deliverables through an integrated and coordinated system of care as required, described and detailed herein, consistent with all applicable laws and regulations, and in compliance with service and delivery timelines as specified by the contract with DMAS.

MCC complies with DMAS and applicable federal Managed Long-Term Services and Supports (MLTSS) requirements, in addition to applicable accreditation standards.

About this handbook

This provider handbook is a companion to your Participating Agreement with MCC. The policies and procedures outlined in this handbook are specific to participating providers in compliance with our CCC Plus and Medallion 4.0 contracts with DMAS. Any change to the policy and procedures included in this handbook will have an effective date at least 60 days after the distribution of the written notice of such changes to all MCC participating providers.

Model of care

MCC delivers a fully integrated model of care specifically designed for members of DMAS's CCC Plus and Medallion 4.0 programs.

Our model works to improve the health status of Virginians by developing person-centered care coordination delivered through Integrated Health Neighborhood (IHN) teams that combine community resources and non-traditional services within local health systems. We ensure that members have access to natural and peer supports, housing, and employment in addition to traditional behavioral and medical treatment.

Our providers are the key to our success in delivering person-centered care. Together we can leverage our strength, experience and expertise to improve outcomes for individuals in need of comprehensive care.

Integrated Health Neighborhood℠ teams

MCC's goal to improve our members' care and health outcomes can only be achieved within the context of where our members live—within their communities. Our model builds an infrastructure with the health and social services system called the Integrated Health Neighborhood (IHN), which customizes the delivery of care by region and supports and enhances the relationship between members and their providers.

Because our team members live and work within the communities where our members reside, they have firsthand knowledge of community strengths, resources, services and service gaps. IHN team members include care coordinators, health guides, peer specialists and navigators, and community outreach specialists supported by housing specialists, employment specialists, clinical pharmacists, medical directors, and others.

The IHN is MCC's mechanism to drive close collaboration with community partners, enhancing our ability to provide person-centered care to our members. It naturally bridges language and cultural barriers, and more effectively and efficiently facilitates access to services to support our members and their families where they live, work and play.

Continuity of Care and Transition of Care requirements

MCC understands the importance of offering members a choice of providers and caregivers. Accordingly, we make every effort to establish contractual relationships with providers that have established histories with our members to become part of our participating provider network.

We support a seamless member transition to our CCC Plus and Medallion 4.0 programs that prevents disruption or duplication of care while ensuring member safety. We work with DMAS to help ensure that services delivered during periods of transition are not reduced, modified or terminated in the absence of an updated assessment or Individualized Care Plan (ICP). During the transition and/or initial enrollment with MCC, members may continue receiving services established/authorized prior to

enrollment for a period of up to 30 days. This includes established/authorized care with a non-participating provider.

During transitions of care, we focus on:

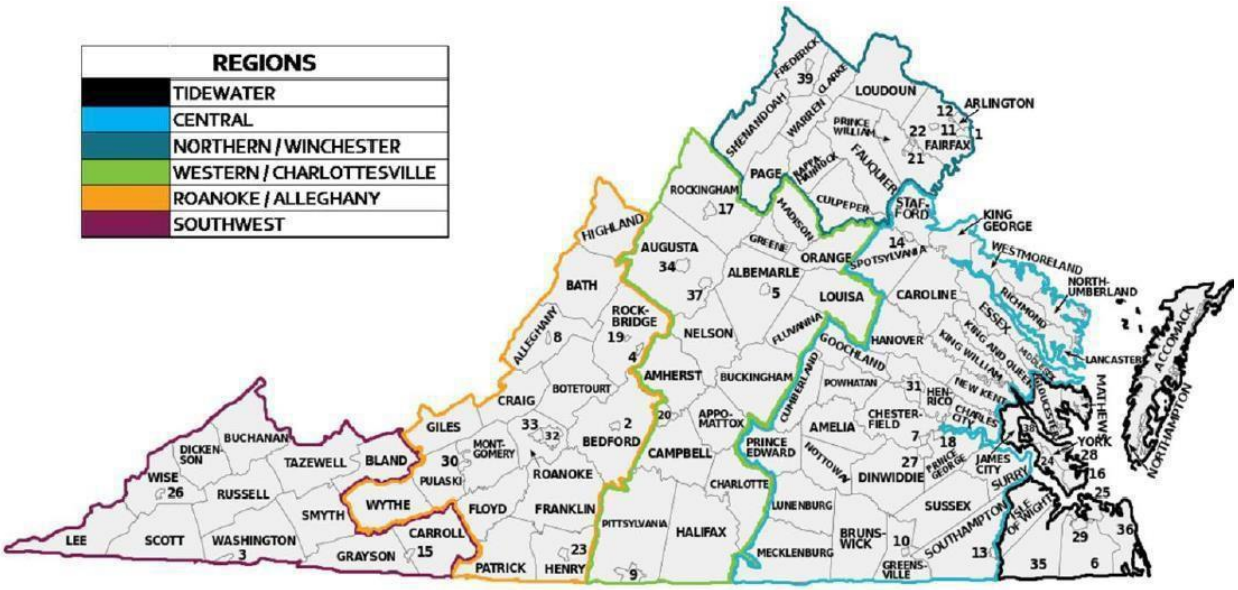
- Ensuring that members have no disruption, duplication or interruption of service
- Ensuring that providers are paid in a timely and accurate manner
- Implementing health care delivery and service enhancements to improve clinical and quality outcomes and deliver cost savings for the state of Virginia

All aspects of our care coordination program and other MCC services (such as pharmacy services) are available and accessible to members based on need. We collaborate with members, providers, community partners, state agencies and other key stakeholders to fully integrate the delivery and provision of all covered services to members. We actively participate in community reinvestment by offering care and service programs to assist in promoting safe, high-quality and cost-effective care.

Section 2: Quick reference information

Service Areas

MCC offers enrollment into its CCC Plus and Medallion 4.0 programs statewide in all six DMAS regions.



A list of CCC Plus and Medallion 4.0 regions by locality is available on the DMAS website: https://www.dmas.virginia.gov/#/index

Contact telephone numbers and websites

We encourage you to visit our provider website at www.MCCofVA.com. You can look up authorizations and verify the status of a claim using our provider portal, in addition to completing other key provider transactions. We've designed our website to provide easy access to information and answers to questions you may have about MCC.

Our Customer Care Representatives are available from 8 a.m. – 6 p.m. local time, Monday through Friday. You may contact us via any of the methods below:

- Phone:
  - CCC Plus: 1-800-424-4524
  - Medallion 4.0: 1-800-424-4518
- Fax: 1-855-472-8574
- Email: MCCVA-BHUM@molinahealthcare.com

Subcontractors and intercompany partners with MCC

MCC works with a number of partners and subcontractors to coordinate and manage covered services in several specialty areas.

Service	Vendor	Contact
Vision	VSP—routine vision care services	1-800-877-7195
Lab services	LabCorp	1-888-522-2677
Transportation	Veyo (non-emergency)	1-877-790-9472
Dialysis	Fresenius/DaVita	CCC Plus: 1-800-424-4524 Medallion 4.0: 1-800-424-4518
Orthotics/Prosthetics	Hangar Orthotics and Prosthetics	CCC Plus: 1-800-424-4524 Medallion 4.0: 1-800-424-4518
Pharmacy	CVS Caremark	CCC Plus: Phone: 1-800-424-4524 PA Fax: 1-844-278-5731 Medallion 4.0: Phone: 1-800-424-4518 PA Fax: 1-844-278-5731

Dental benefits are now handled by the DMAS Dental Benefits Administrator, who can be reached at 1-888-912-3456.

Member eligibility and sample ID cards

MCC requires our members to keep their ID cards with them at all times. If a member loses their ID card, please have them contact MCC Member Services at the number below to obtain a new card:

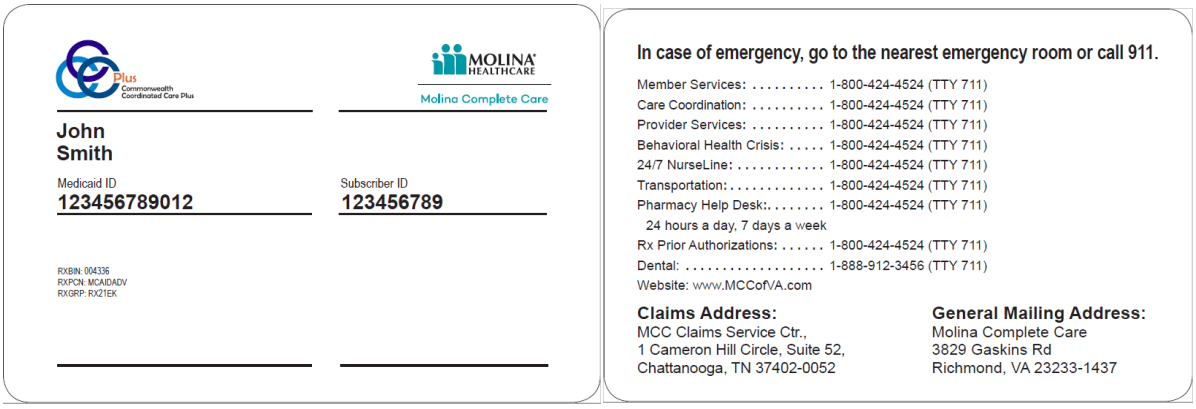
- CCC Plus: 1-800-424-4524 (TTY 711)
- Medallion 4.0: 1-800-424-4518 (TTY 711)

We will send them a new member ID card within five business days.

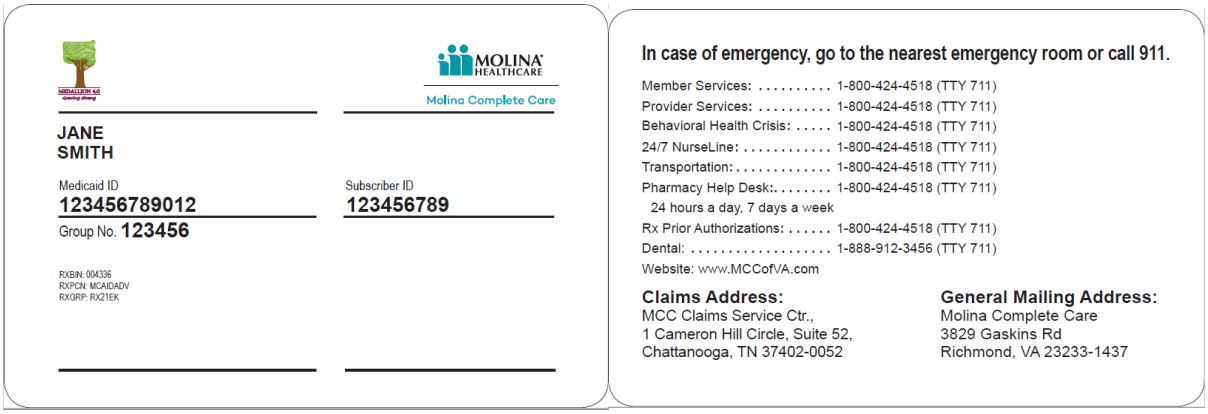
Please note that a member ID card is not a guarantee of payment for services rendered. The provider's office is responsible for verifying eligibility at the time of each office visit by:

- Phone
  - CCC Plus: 1-800-424-4524– Medallion 4.0: 1-800-424-4518
- Online at www.MCCofVA.com

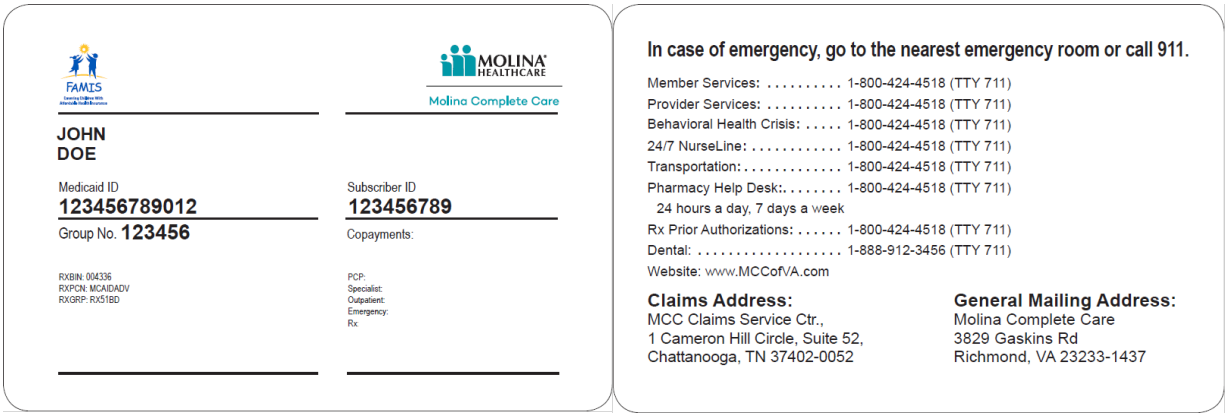
CCC Plus member ID card



Medallion 4.0 member ID card



Medallion 4.0 FAMIS member ID Card



Section 3: Provider Services, support and training

Provider Services

Our Provider Relations Representatives and Network Management teams are committed to our providers and work to establish a positive experience with MCC by:

- Providing MCC plan orientation
- Providing education and support to facilitate best practices and cultural competency
- Assisting with strategies related to the development and management of the MCC provider network
- Supporting the processes that lead to resolution of operational shortfalls (e.g. claims payment issues)
- Implementing provider practice-based quality initiatives (e.g. patient registries, P4Q programs, provider scorecards)
- Distributing and reviewing various MCC reports

Provider Relations

Our provider support approach delivers an integrated, highly involved provider relations team organized for each region. This model fosters health care integration at the systems and services level by ensuring superior collaboration and communication with all providers across the continuum of care.

Our Provider Relations Representatives and Network Management Specialists engage providers through direct outreach and support. Each DMAS region has a regionally based network provider relations manager, as well as a team of assigned provider network specialists and contract network coordinators responsible for all providers in their assigned area. The team facilitates contracting, provides technical assistance, conducts site visits and educates network providers. Our Provider Relations and Network Management teams provide ongoing technical support, engage and update providers whenever programmatic changes are made as well as ensure that providers understand the changes.

Our field-based Provider Relations Representatives are the core of our provider engagement strategy, working to ensure issues are quickly resolved. They also assist providers with the appeals process as needed.

Contact our Provider Relations and Network Management teams via:

- Phone:
  - CCC Plus: 1-800-424-4524
  - Medallion 4.0: 1-800-424-4518
- Email: MCCVA-Provider@molinahealthcare.com

Provider orientation and education

This section outlines training and education program requirements, documentation standards and available resources to ensure effective training and education of employees and providers who support MCC's CCC Plus and Medallion 4.0 programs. We conduct provider orientation and offer ongoing provider education and training activities regarding the CCC Plus and Medallion 4.0 programs and all applicable federal and state requirements as deemed necessary by MCC or DMAS.

We provide resources to support providers and offer technical assistance to meet their individual needs on an ongoing basis. Initial provider orientation and training can be accessed on our provider website at www.MCCofVA.com.

We encourage our providers to ensure their personnel are trained on the CCC Plus and Medallion 4.0 programs, the annual model of care training and compliance program training to meet requirements. Training is available to providers through instructor-led sessions, webinars and online resources.

Provider orientation

MCC offers a comprehensive provider orientation to introduce the CCC Plus and Medallion 4.0 programs and the special needs of our members. Orientation topics include but are not limited to:

- CCC Plus/Medallion 4.0 programs covered services, including enhanced and carved-out services
- Introduction to managed care
- MCC's model of care
- Policies and procedures (e.g., claims submission standards, process, payment, service authorizations)
- Eligibility criteria and eligibility verification
- The role of the enrollment broker as the beneficiary support system for enrollment and disenrollment
- Member rights and responsibilities
- Provider responsibilities and special needs of members that may affect access to and delivery of services (e.g., transportation needs, accommodations to members with special needs)
  - This includes ensuring provision of services in accordance with applicable State and Federal law and compliance with the electronic and information technology accessibility requirements under the federal civil rights laws, including Sections 504 and 508 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA)
- Appointment access and availability standards
- Recognizing and reporting signs of elder abuse/neglect and financial abuse
- Grievance and appeals procedures
- Procedures for reporting fraud, waste and abuse

- Medicaid manuals, memoranda, and other related CCC Plus program documents
- Billing instructions compliant with DMAS's encounter data submission requirements
- Marketing practice guidelines and provider responsibilities when representing MCC
- Person-centered supports and compliance with CMS Home- and Community-Based Waiver (HCBS) setting provisions
- Provider resources available on www.mccofva.com
- MCC provider handbook
- Provider self-audits
- Contacting network staff

To ensure staff and providers continue to expand their cultural competency, we require providers to complete annual cultural competency training. Providers may receive cultural competency training through MCC, or other sources such as the CMS Medicare Learning Network, conferences, materials developed by their agency, workshops, etc. Providers are required to retain copies of staff training records as evidence of completion of this training requirement.

Fraud, waste and abuse (FWA) training

MCC maintains FWA training programs as required by Centers for Medicare & Medicaid Services (CMS) and provides said educational and training information annually.

FWA training programs may include topics such as:

- Definition of fraud, waste and abuse
- How to identify fraud
- Upcoding
- Unbundling
- Member fraud
- Anonymous reporting
- No retribution rule
- False Claims Act
- Anti-Kickback
- HIPAA/HITECH
- How to report suspected fraud
- Consequences for noncompliance

General compliance program training and education

MCC providers must implement general compliance program training. Providers must ensure that their employees are knowledgeable about all applicable Medicaid requirements related to their job functions. We will conduct audits and other reviews to ensure providers meet compliance program and model of care training requirements. You may satisfy training requirements through online or classroom training. You must complete compliance program training within 90 days of initial contracting and annually thereafter.

You must retain and maintain proof of training and we may periodically request such proof from you. Examples of proof of training can include copies of sign-in sheets, employee attestations or electronic certifications for each employee. The attestation must verify that employees have read and received MCC standards of conduct and compliance program policies and procedures.

General compliance training may include topics such as:

- Description of the compliance program
- Compliance policy and procedures
- Standards of conduct
- Commitment to business ethics and Medicare/Medicaid program requirements
- How to report noncompliance
- Anonymous reporting with our 24-hour hotline: 1-866-606-3889
- Non-retaliation for reporting compliance issues
- Disciplinary actions
- Privacy and security
- Cultural competence
- Model of care

Trainings may occur in the following instances:

- Upon hire and/or appointment to a new job function
- When requirements change
- When employees are found to be noncompliant
- As a corrective action to address a noncompliance issue
- When an employee works in an area implicated in past fraud, waste or abuse

CMS has also developed a general compliance and FWA training. The module is available through the CMS Medicare Learning Network (MLN) at: http://www.cms.gov/MLNProducts.

Model of care training

Network providers are accountable for ensuring personnel are trained on the MCC model of care upon joining our network and annually thereafter to meet state and federal requirements. Model of care training covers participation in an interdisciplinary care team, care coordination for the vulnerable sub-populations including health risk screening, risk stratification, assessments, care plan, service arrangements, and follow-up and monitoring. Audits and credentialing procedures are used to ensure providers meet model of care training requirements.

Section 4: Provider roles and responsibilities

Primary care provider role

The primary care provider (PCP), with the support of the Interdisciplinary Care Team (ICT), is responsible for the overall care of our members. This responsibility includes providing direct care, referring members for behavioral health, specialty or ancillary care, and coordinating care with MCC and these providers for greater clinical outcomes.

A PCP must be:

- Currently licensed by the Commonwealth of Virginia;
- A family practice, internal medicine, general practice, OB/GYN, or geriatrics practitioner; or
- A specialist who performs primary care functions in locations that include, but are not limited to, Federally Qualified Health Centers, Rural Health Clinics, Health Departments and other similar community clinics; and
- In good standing with the federal and federal/state Medicaid (DMAS) program.

All PCPs have the following responsibilities to their assigned members regardless of reimbursement structured defined under the Participating Provider Agreement:

- Ensuring children with special health care needs, individuals in foster or adoption assistance, and members living with blindness or disabilities have a visit with their assigned PCP within 60 calendar days of enrollment with MCC and every year after
- Providing, evaluating, and triaging for their assigned member's care 24 hours a day/7 days per week including arranging/facilitating referrals for specialty care needs.
- Giving members access to office visits with their assigned or covering PCP for the evaluation and management of common or chronic conditions
- Administering preventive care services, including well-child, adolescent, and adult preventive medicine, nutrition, health counseling and immunizations. Immunizations must be provided in accordance with the VDH Virginia Vaccines for Children program requirements
- If you are assigned to provide care to children and adolescents, you agree to provide comprehensive, periodic health assessments or screenings which meet reasonable standards of practice as specified in the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) medical periodicity chart established by DMAS for Medicaid members.
- Providing the following services for MCC members:
  - Effective oversight/coordination/management of assigned member care while in the hospital, skilled nursing facility, custodial nursing facility, hospice, or acute rehabilitation unit
  - Well woman exams including breast exam and routine gynecological care
  - Therapeutic injections including cost of medication
  - Allergy injections (includes administration)
  - Standard testing and/or rhythm strips EKGs in adults, basic pulmonary functiontests
  - Minor surgical procedures (i.e., aspiration, incisions and drainage)

- Simple splinting and treatment for fractures, removal of foreign body or cerumen from external ear, rectal exams
- Standard screening vision and hearing exams
- PPD skins test
- Laboratory work performed in the PCP office that does not require Clinical Laboratory Improvement Amendments (CLIA) certification (i.e., urinalysis)
- Ensuring pregnant members are advised of the value in HIV testing and agree to request consent. If a member refuses testing or treatment, you agree to document refusal in the medical record
- Coordination with MCC Care Coordinators and/or Case Managers for members in high-risk pregnancies or any other high risk/ complex medical needs

PCP's who administer childhood immunizations are also strongly encouraged to enroll in the Virginia Vaccines for Children program (VVFC). Information about the program, including enrollment forms, is available at https://www.vdh.virginia.gov/immunization/vvfc/. This program allows qualifying providers to receive publicly funded vaccines at no cost. (Note: vaccines and/or immunizations provided to FAMIS members within the Medallion 4.0 program are excluded from the VVFC publicly funded program).

PCP assignment for non-dual eligible members

MCC assigns all non-dual members to a PCP at the date of enrollment. Members may select a different PCP at any time if they choose. When we call the member to schedule an initial assessment, we offer the member the opportunity to change their PCP assignment. We can assist members in finding new PCPs.

Our experience shows that members often require highly specialized primary care services to address their complex needs, along with MLTSS services and supports. Our approach to PCP assignment links members to the PCP best suited to meet their needs, including allowing a specialist to serve as PCP if necessary. We prioritize PCP assignment with Federally Qualified Health Centers and Community Service Boards as available and appropriate so members can receive primary care services at a location that best meets their needs.

PCP assignment for dual eligible members

For dual eligible members, we utilize all DMAS and Medicare information provided to identify the member's PCP and enhance our care coordination efforts. We assist the member in finding or changing a PCP, including contacting the individual's Medicare health plan case manager when necessary.

We work with PCPs to coordinate care and invite the individual to participate in ICTs. We inform dual eligible members about their right to access Medicare providers, regardless of whether the provider is in our network, and without having to obtain prior approval.

Primary behavioral health provider roles

PCPs may provide any clinically appropriate behavioral health services within the scope of their practice. Conversely, behavioral health providers may provide physical health care services if, and when, they are licensed to do so within the scope of their practice.

Behavioral providers are required to use Diagnostic and Statistical Manual of Mental Disorders (DSM-V) classification when assessing the member for behavioral health services and document the DSM-V diagnosis and assessment/outcome information in the member's medical record.

Behavioral health providers are encouraged to submit, with the member's or the member's legal guardian's consent, an initial and quarterly summary report of the member's behavioral health status to the PCP. The PCP Communication Form (DMAS-225) may be used for this purpose. Communication with the PCP should occur as clinically indicated.

We urge behavioral health providers to pay particular attention to communicating with the member's PCPs at the time of discharge from a behavioral health inpatient stay and throughout their relationship. We recommend faxing the discharge instruction sheet or a letter summarizing the hospital stay, including prescribed behavioral health medications, to the PCP. Any changes in the treatment plan should be noted. The PCP is also encouraged to share changes in the treatment plan and summary of hospitalization with the behavioral health providers.

Fostering a culture of collaboration and cooperation helps maintain a seamless, integrated continuum of care between medical and behavioral health, and positively impacts member outcomes. If a member's medical or behavioral health condition or medication regimen changes, we expect that both PCPs and behavioral health providers will communicate those changes to each other. The ICT and Care Coordinator are available to help maintain continuity of care and coordination of members with complex needs by supporting communication between behavioral health and medical providers.

The specialist role

A specialist is any licensed provider providing specialty medical services to members. A PCP may refer a member to a specialist when medically necessary. Specialists must obtain authorization from MCC before performing specific procedures or when referring members to non-contracted providers.

Please visit www.MCCofVA.com for a list of services that require prior authorization. You can review prior authorization requirements in the Summary of Benefits or the Evidence of Coverage, or call Customer Care:

- CCC Plus: 1-800-424-4524
- Medallion 4.0: 1-800-424-4518

The specialist should:

- Communicate the member's condition and recommendations for treatment or follow-up with the PCP
- Send the DMAS-225 PCP Communication Form (if applicable), including medical findings, test results

assessments, treatment plan and any other pertinent information

- Understand that, if a specialist needs to refer a member to another provider, the referral should be to another MCC participating provider
- Be aware that any referral to a non-participating provider will require prior authorization from us

Specialist as PCP

Female members may choose to have their participating OBGYN and/or GYN providers as their PCP. Members may select their option to have their OBGYN or GYN at any time by calling:

- CCC Plus: 1-800-424-4524 (TTY 711)
- Medallion 4.0: 1-800-424-4518 (TTY 711)

With approval, other specialists may also act as the PCP for a member. This is often beneficial for members who have a life-threatening, degenerative and/or disabling condition, or a disease requiring prolonged specialized medical care. The member's PCP is responsible for requesting that a specialist assume the PCP function. Such requests should be made to the utilization management or care coordination department and approved by the MCC medical director.

Provider responsibilities

Network provider participation

MCC is dedicated to selecting health care professionals, groups, agencies and facilities to provide member care and treatment across a range of covered services as defined by DMAS.

To be a network provider of health care services with MCC under the CCC Plus and/or Medallion 4.0 programs, you must be credentialed and contracted according to MCC and DMAS standards. Providers are subject to applicable licensing requirements.

Your responsibility, as an MCC network provider of health care services, is to:

- Provide medically necessary covered services to members whose care is managed by MCC and comply with all applicable non-discrimination requirements
- Maintain eligibility to participate in Medicare/Medicaid or other federal or state health programs. You may not be excluded from participation while under agreement with MCC
- Comply with all terms of your Participating Agreement. In the event there is a conflict between the terms of your Agreement and the terms of the CCC Plus or Medallion 4.0 contract, the DMAS contract will apply
- Follow the policies and procedures outlined in this handbook, any applicable supplements and your provider participation agreement(s) as well as DMAS policies and regulations

- Provide services in accordance with applicable Commonwealth of Virginia and federal laws and licensing and certification bodies. Contracted providers for the CCC Plus or Medallion 4.0 networks are required to abide by DMAS regulations and manuals, and maintain active licensure for their contracted provider type and specialty at each service location
- Provide covered services to MCC members as outlined in this handbook and applicable supplements and your provider agreement(s), as well as DMAS policies and regulations without exclusion or restriction on the basis of religious or moral objections
- Agree to cooperate and participate with all system of care coordination, quality improvement, outcomes measurement, peer review, and appeal and grievance procedures
- Make sure only providers currently credentialed with MCC render services to MCC members
- Follow MCC's credentialing and re-credentialing policies and procedures
- Participate and collaborate in value-based payment programs and strategies (as agreed upon in your Participating Provider Agreement) that contribute and align with MCC and DMAS care goals and outcomes for members

MCC's responsibilities are to:

- Assist with your administrative questions during normal business hours, Monday through Friday
- Not prohibit, or otherwise restrict health care providers acting within the lawful scope of practice, from advising or advocating on behalf of the member who is the provider's patient, for the member's health status, medical care, or treatment options, including any alternative treatments that may be self-administered, any information the member may need in order to decide among all relevant treatment options, the risks, benefits, and consequences of treatment or non-treatment. And not prohibit nor restrict the member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions
- Ensure health equity in the coverage and provision of services. This includes parity in process and coverage policy between covered medical and behavioral health service needs
- Ensure members' access to Native American and/or other Indian Health Services Providers (IHS) providers, where available
- Assist providers in understanding and adhering to our policies and procedures, the payer's applicable policies and procedures, and other requirements including but not limited to those of the National Committee for Quality Assurance (NCQA)
- Maintain a credentialing and recredentialing process to evaluate and select network providers that does not discriminate based on a member's benefit plan coverage, race, color, creed, religion, gender, sexual orientation, marital status, age, national origin, ancestry, citizenship, physical disability or other status protected by applicable law

Provider performance

As a function of provider oversight responsibilities, MCC observes the over- and under-utilization of health services. We may conduct provider review to measure utilization of common inpatient and outpatient services as preventive services, HEDIS clinical performance measures and pharmacy

utilization. Summary reports for these measures are available to individual providers upon request and routine reporting can be developed. If a provider is found to be performing below minimum care standards, this information is shared with the provider so that positive changes in practice patterns can be instituted. We can assist in developing a plan of action, as needed.

If any further action is needed, we may conduct an onsite assessment to meet with the provider. If the reporting insufficiencies continue, this can result in reporting to appropriate committees or possible termination of participation with MCC.

Cultural competency and health equity

MCC is dedicated to ensuring that all members, providers and staff are treated with dignity and respect concerning their values, race, color, age, gender, ethnicity, sexual orientation, gender identity, or expression of religion, creed, ancestry, national origin, disability, veteran's status or background culture.

We recognize and value the cultural diversity of our membership and support interventions that promote an effective health care encounter between a member and provider where language or cultural values regarding health and healing may vary. Our objective is to meet our members' cultural competency and health disparity needs by providing culturally appropriate linguistic services to members, hiring staff (including Clinical Coordinators and Member Services representatives) of similar cultural background and language preferences, and promoting cultural sensitivity training throughout our provider network. To meet this objective, we collect data on member language and race, produce periodic reports, and continuously monitor members' needs so that changes can be made internally and externally to meet those needs and to mitigate member barriers. MCC annually reports to DMAS to outline these efforts to address health disparities for the CCC Plus and Medallion 4.0 populations.

MCC participating providers must ensure that their services are provided in a culturally competent manner to our members. We expect our participating providers to provide health care that is sensitive to the needs and health status of different population groups. This includes members with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, and physical or mental disabilities. We offer our participating providers support and education resources on cultural care competence as part of our initial and ongoing provider orientation and training. Materials are also available on www.MCCofVA.com. Interpreter services and language line support are made available to participating providers by contacting MCC at:

- CCC Plus: 1-800-424-4524
- Medallion 4.0: 1-800-424-4518

Continuity and coordination of care

When MCC receives a newly enrolled member or when a member chooses a different health plan or payer, we make every effort to ensure that the member's care and services continue without disruption. We comply with the DMAS continuity of care requirements which allow members to continue receiving previously approved services for a period of up to 30 days following enrollment. We collaborate with the member's PCP and other providers to ensure a seamless continuity of care

experience for members who are transferring to or from a different health plan or payer. Providers who are not currently part of the MCC network but are serving a new MCC enrollee are invited to consider joining the network by calling:

- CCC Plus: 1-800-424-4524
- Medallion 4.0: 1-800-424-4518

Members have the right to continue receiving needed services, even if the member may no longer be able to receive them from the same provider. We strive to provide members with services that are rendered by in-network providers whenever possible; however, care and services will not be denied due to the member having a non-network provider. If a member is in a nursing facility, the member can maintain the current nursing facility provider.

Medical supply, equipment and medication providers will be reviewed to ensure continuity of provision, payment and quality.

As soon as MCC is notified of a newly enrolled member the MCC care coordination team will, at minimum, carry out the following:

- Collaborate with the member, the PCP, other providers, and the receiving or sending health plan to obtain/provide member information related to the respective program assessments and service plan/care plan information. Our care coordination team will complete the respective health risk assessment, which includes continuity of care questions once the member is enrolled, followed by the use of other branching assessments, ICT meetings, and Individualized Care Plan (ICP) creation based on member need. The most current assessment and ICP will be requested/shared with documentation of same
- Assist members in finding in-network providers whenever possible
- Assist nursing facility-confined members in exploring the possibility of returning to the community
- Conduct/enter clinical information, including assessments and ICP, and/or other information, will be into MCC's clinical documentation system

Access and availability standards

Hour coverage: All providers must provide coverage 24 hours a day/7 days a week. Regular hours of operation must be clearly defined and communicated to the members, including arranging for on-call and after-hours coverage. Such coverage must consist of an answering service, call forwarding, provider call coverage or other customary means approved by MCC. The after-hours coverage must be accessible using the medical office's daytime telephone number and the call must be returned within 30 minutes of the initial contact.

Hours of operation parity: MCC requires the hours of operation that practitioners offer to Medicaid members to be no less than those offered to Medicaid fee-for-service members.

Coverage during absence: The provider must arrange for coverage of services during absences due to

vacation, illness, or other situations where the provider is unable to provide services. An MCC participating provider must provide coverage.

Appointment wait time requirement: The provider must offer appointments to our members in accordance with DMAS standards to timely access to care and services taking into account the urgency of the need for services and within the timeframes outlined below.

Providers shall ensure that office staff is aware of and follows these standards as described in this provider handbook. We audit our providers on a routine basis to ensure that your offices are compliant with this policy.

For pregnant members, initial prenatal care appointments are as follows:

Service Type	Appointment standards *CCC Plus*	Appointment standards *Medallion 4.0*
Emergency services	Immediately upon member's request	Immediately upon member's request
Urgent medical services (symptomatic office visits)	Within 24 hours of member's request and/or as member's condition warrants	Within 24 hours of the member's request
Routine primary care services	Within 30 calendar days of the member's request	Within 30 calendar days of the member's request
Maternity care	First trimester - Within 14 calendar days of the member's request Second trimester - Within 7 calendar days of member's request Third trimester - Within 5 business days of member's request High risk pregnancy - Within 3 business days or immediately if an emergency exists	First trimester – Within 7 calendar days of member's request Second trimester - Within 7 calendar days of member's request Third trimester - Within 5 business days of member's request High risk pregnancy - Within 3 business days or immediately if an emergency exists

Timely medical evaluation: The provider will ensure that all patients have a professional evaluation within one hour of their scheduled appointment time. If a delay is unavoidable, the patient will be informed and provided an alternative.

Member panel: The PCP agrees to at least one full-time equivalent (FTE), regardless of specialty type, for every 1,500 members (excluding dual eligible), and there must be one FTE PCP with pediatric training and/or experience for every 1,500 members under the age of 18. No PCP may be assigned members in excess of these limits, except where mid-level practitioners are used to support the PCP's practice.

PCP and specialty care providers: The provider agrees to maintain open accessibility for MCC members to appropriate and covered health care services and agrees to notify the plan immediately in the event that a PCP or specialty care provider is no longer able to accept new Medicaid members in the practice.

CCC Plus member eligibility, enrollment and disenrollment

CCC Plus includes Medicaid members who:

- Receive Medicare benefits and full Medicaid benefits (dual eligible)
- Receive Medicaid long-term services and supports (LTSS) in a facility or through one of the home- and community-based (HCBS 1915(c)) waivers
- Are eligible in the Aged, Blind, and Disabled (ABD) Medicaid coverage groups, including ABD members previously enrolled in the Medallion 4.0 program
- Members enrolled in the Developmental Disabilities Support (DD) waiver will be enrolled in CCC Plus for their non-waiver services only, and their waiver services will continue to be covered through Medicaid fee-for-service.

DMAS reserves the right to transition additional populations and services into the CCC Plus program in the future. As additions are made, providers will be notified and our handbook will be updated.

CCC Plus Waiver enrollment process

Enrollment in CCC Plus waiver is mandatory for eligible members to receive waiver services. DMAS has sole authority and responsibility for enrollment into the MLTSS program.

Regardless of age, the request for enrollment in the CCC Plus waiver originates from four different possible sources: acute care hospitals, nursing facilities, the local department of social services (LDSS), or the local health department (LHD) in the locality where the member resides. All members must be Medicaid eligible and have a Virginia Universal Assessment Instrument (UAI) completed by their local preadmission screening team (which consists of a representative from the LDSS and the LHD) within their community, or by an acute care hospital discharge planner if the member is hospitalized. There is no cost to be screened to determine eligibility for the CCC Plus waiver. There may be a Patient Pay required for services based on the member's earned and unearned income. The LDSS eligibility worker will determine if a member has a Patient Pay responsibility.

Based on the results of the UAI and financial review, DMAS determines if the member meets eligibility criteria for the subpopulations mentioned above. DMAS notifies the Managed Care Organizations (MCOs) via a weekly eligibility file of enrollment into CCC Plus, and the subpopulation

for which the member is enrolled.

The member may request to change MCOs within 90 days after the initial enrollment effective date into CCC Plus. After the initial 90 days, the member may not disenroll without cause until the next open enrollment period.

Upon enrollment, MCC will conduct an initial Health Risk Assessment (HRA) to determine the member's needs and complete an Initial Individualized Care Plan (ICP) which includes, but is not limited to, the member's expressed goals, services the member needs and will receive (regardless of payer source), and the member's preferences for their care and provider selection.

Upon enrollment, each CCC Plus member receives a MCC member ID card reflecting his/her PCP name and effective date. The Member Services number for MCC is located on the back of the ID card.

Disenrollment from current MCO with cause

The member may request to change MCOs within 90 days after the initial enrollment effective date into the CCC Plus program, without cause. After the initial 90 days, the member may not disenroll without cause until the next open enrollment period.

Below are the reasons a member may request disenrollment from his/her current MCO at any time. A member may be disenrolled from their current MCO only when authorized by DMAS.

- The member moves out of the MCO's service area
- The member needs related services to be performed at the same time, not all related services are available within the MCO's network, and the member's PCP or other provider determines that receiving the services separately would cause unnecessary risk for the member
- The member who receives LTSS would have to change their residential, institutional, or employment supports based on that provider's change in status from an in-network to an out-of-network provider with the MCO and, as a result, would experience a disruption in their residence or employment
- Other reasons as determined by DMAS, including poor quality of care, lack of access to covered services, or lack of access to providers experienced in dealing with the member's care needs

CCC Plus Waiver disenrollment

Voluntary disenrollment from CCC Plus Waiver

A member may request to voluntarily disenroll from the LTSS waiver for any reason. The request must be made by the member directly to their assigned Care Coordinator. The Care Coordinator will educate the member the ramifications of losing the waiver and that if they should change their mind and desire to have waiver services reinstated, they would need to be rescreened and found eligible for the LTSS waiver again.

The Care Coordinator would then complete the required notification to DMAS noting the member's

choice to terminate waiver services. DMAS will be responsible for termination of waiver services and updating the member's eligibility (as appropriate) based on this decision and will then notify the MCO.

Involuntary disenrollment from CCC Plus

A member's enrollment in the CCC Plus program will end upon the occurrence of any of the following events:

- Death of the member
- Cessation of Medicaid eligibility
- The member meets at least one of the exclusion criteria as determined by DMAS
- Transfer to a Medicaid eligibility category not included in the CCC Plus program
- Certain changes made within the Medicaid Management Information System (MMIS) by eligibility case workers at the Department of Social Services

MCC notifies DMAS in the event it becomes aware of circumstances that might affect a member's eligibility or whether there has been a status change such that a member would be disenrolled from MCC.

In addition to the reasons above, there may be other appropriate reasons for involuntary disenrollment from LTSS. Those reasons may include, but are not limited to, the following related to program participation:

- MCC has determined (and DMAS has reviewed and concurs) that the member's needs can no longer be safely met in the community and the member has declined nursing facility placement
- MCC has determined (and DMAS has reviewed and concurs) that the member's needs can no longer be safely met in the community, and at a cost that does not exceed the cost of nursing facility care for which the member would qualify
- The person no longer meets the qualifications for LTSS services (and DMAS has reviewed and concurs) or the person is no longer receiving LTSS

LTSS may continue throughout the involuntary disenrollment and appeal process(es) until final determination by DMAS is received. In the event of an appeal, ongoing monitoring is conducted to evaluate for change in the circumstances contributing to the disenrollment.

Although MCC may not request disenrollment of a member, we will inform DMAS promptly when we have reason to believe that a member may satisfy any of the conditions for disenrollment from the CCC Plus program as described above.

MCC is responsible for the disenrolling member until the disenrollment is processed by DMAS and will provide medically necessary covered services through the member's disenrollment date.

MCC will be notified of the member's disenrollment via the 834 Enrollment File from DMAS.

Patient Pay for Long-Term Services and Supports

Patient Pay refers to an individual's obligation to pay towards the cost of LTSS if the member's income exceeds certain thresholds. Patient Pay is required to be calculated for every individual receiving LTSS and/or custodial care at a nursing facility or receiving waiver services, although not every eligible individual will end up having to pay each month. When a member's income exceeds an allowable amount, he or she must contribute toward the cost of his or her LTSS. This contribution is known as the Patient Pay amount.

DMAS will provide information to MCC identifying members who are required to pay a Patient Pay amount and the amount of the obligation as part of its monthly transition report. MCC will work with its providers to ensure understanding of its policies and procedures to ensure exchange of information including collection of the Patient Pay amounts.

MCC is required to establish a process to ensure collection of the Patient Pay amounts by the appropriate providers. We shall reduce reimbursements to LTSS providers equal to the Patient Pay amounts each month. We use DMAS' method for assigning Patient Pay collection to LTSS providers unless an alternate methodology is approved by DMAS. Refer to DMAS manuals for DMAS's process on Patient Pay.

Medallion 4.0 member eligibility, enrollment and disenrollment

Medallion 4.0 membership includes the following:

- Low Income Families with Children (LIFC)
  - Adults—parents and other caretaker relatives of dependent children with household income at or below a standard established by the state
  - Children and infants—children and infants younger than 19 with household income at or below standards based on this age group
  - Pregnant women—women who are pregnant or postpartum with household income at or below a standard determined by the state
  - Note: children qualifying under this eligibility group meet the following criteria:
    - They are younger than age 19
    - They have a household income at or below the standard established by the state
- Children and Youth with Special Health Care Needs (CYSHCN)—children and youth with special health care needs that have or are at increased risk for a chronic physical, developmental, behavioral or emotional condition(s) and may need health and related services of a type or amount over and above those usually expected for the child's age
- Early intervention—services designed to meet the developmental needs of children and families and to enhance the development of children from birth to the day before the third birthday who have:
  - A 25% developmental delay in one or more areas of development,
  - Atypical development, or
  - A diagnosed physical or mental condition that has a high probability of resulting in a developmental delay
- Children in foster care—children who have been temporarily or permanently displaced from their

birth parents and are in the custody of the state
- Substance exposed infants, including infants with Neonatal Abstinence Syndrome
- Newborns
- Individuals covered under Medicaid Expansion
- Those eligible for Family Access to Medical Insurance Security (FAMIS)
  - FAMIS (Title XXI CHIP program)—CHIP provides low-cost health coverage to children in families that earn too much money to qualify for Medicaid. FAMIS members are assigned a copay level ($2/$5) based on the guidance provided by DMAS. Regularly validate the member's eligibility to ensure the accurate copayment amount is collected at the time services are rendered
  - FAMIS MOMS—uninsured pregnant females, noteligible for Medicaid with family income at or below 200% of the federal poverty level (plus a 5% disregard). Covered services for FAMIS MOMs are the same as the covered services for Medicaid Medallion 4.0 members.

Medallion 4.0 enrollment

DMAS retains sole responsibility for determining member eligibility for Medallion 4.0 programs and services. DMAS also retains sole responsibility for determining enrollment with MCC. MCC has agreed to enroll and provide coverage for members as determined by DMAS.

Upon DMAS transmittal of the 834 Enrollment File, MCC immediately loads the file into the eligibility source system and provides coverage immediately to members as indicated by the enrollment start date of coverage for the applicable members.

Medallion 4.0 disenrollment

A Medallion 4.0 member will lose program eligibility upon occurrence of any of the following events:
- Death of the member
- Cessation of Medicaid/FAMIS eligibility
- Transfer to the Commonwealth Coordinated Care Plus program
- Certain changes made within the Medicaid Management Information System by eligibility case workers at the Department of Social Services.
- Members that meet at least one of the following exclusion criteria listed below (DMAS determines if the member meets the criteria for exclusion):
  - Inpatient members in long-stay hospitals
  - Members placed on Spend Down by DSS
  - Home community-based waivers
  - CCC Plus program participation
  - Out of area residency
  - Receiving hospice services
  - Members with insurance purchased through the Health Insurance Premium Payment Program (HIPP)
  - Limited life expectancy
  - Members who are inpatients in hospitals at the scheduled time of enrollment
  - Members enrolled in the birth injury fund
  - Members who have an eligibility period that is less than three months

- Members who have an eligibility period that is only retroactive
- Members who are enrolled in the Program of All-Inclusive Care for the Elderly (PACE) benefit
- Members who are enrolled in Medicare and Medicaid
- Members in Plan First family planning
- Members enrolled in FAMIS Select
- Medically complex individuals included in the Medicaid Expansion population

Effective periods for Medallion 4.0 enrollment and disenrollment

- All enrollments are effective 12:00 a.m. on the first day of the first month in which they appear on the enrollment report, except for newborns, whose coverage begins at birth
- All disenrollments are effective 11:59 p.m. on the last day of enrollment. If the disenrollment is the result of a plan change, it is effective the last day of the month. If the disenrollment is the result of any exclusion, it may be effective any day during the month

Americans with Disabilities Act requirements

The provider must ensure that the programs and services are as accessible (including physical and geographic access) to individuals with disabilities as they are to individuals without disabilities. Specifically, providers shall comply with the ADA (28 CFR § 35.130) and Section 504 of the Rehabilitation Act of 1973 (29 USC § 794) and maintain capacity to deliver services in a manner that accommodates the needs of its members by:

- Providing flexibility in scheduling to accommodate the needs of members
- Providing interpreters or translators for members who are deaf and hard of hearing and those who do not speak English
- Ensuring that individuals with disabilities are provided with reasonable accommodations to ensure effective communication, including auxiliary aids and services; reasonable accommodations will depend on the particular needs of the individual
- Ensuring safe and appropriate physical access to buildings, services and equipment
- Ensuring providers allow extra time for members to dress and undress, transfer to examination tables, and extra time with the practitioner to ensure that the individual is fully participating and understands the information
- Demonstrating compliance with the ADA by conducting an independent survey or site review of facilities for both physical and programmatic accessibility, documenting any deficiencies in compliance and monitoring correction of deficiencies

Prohibition against discrimination

In accordance with your provider agreement, as a participating provider, you are prohibited from discriminating against a member based on color, race, creed, age, gender, sexual orientation, disability, place of origin, source of payment or type of illness or condition. You must provide services to members in the same manner as you provide those services to all non-Medicaid members. Additionally, in accordance with 42 CFR § 438.206, you must offer hours of operation that are no less than the hours of operation offered to commercial members or other Virginia Medicaid programs, if the provider serves only Medicaid members.

Second opinion

Members have the right to a second medical opinion. If a second opinion cannot be provided from an MCC participating provider, arrangements can be made for a second opinion outside the network. Please contact our Health Services department:

- CCC Plus: 1-800-424-4524
- Medallion 4.0: 1-800-424-4518

Referrals

Consistent with our model of care, MCC has established a referral policy which promotes care coordination, integration and access. We do not require in-network referrals to be approved by the health plan; however, the provider's records are expected to include evidence that care has been coordinated among the member's treating providers.

Specifically, a PCP should refer the member for specialty care and send their National Provider Identification (NPI) number, clinical records and other relevant information to the specialist at the time of the referral, in advance of the appointment. Specialists are expected to provide a written report to the primary care provider after seeing the member.

All providers are expected to maintain medical records that reflect this coordination. If coordination is oral, the providers' records should include documentation of the communication. We require specialists to include the primary care provider's NPI number in field 17b on claims for office-based services. Exceptions to this requirement include:

- Provider is in the same provider group, or has the same tax ID or type II NPI, as the referring physician
- Services were provided after hours (99050)
- Emergency services (services performed in place of service 23)
- Obstetrics/gynecology claims
- Billing or referring physician is from any of the following:
  - Federally qualified health center
  - Urgent care center
  - County health departments
- Self-referrals—members may self-refer for certain services, including:
  - Family planning services
  - Annual eye exams by optometrist
  - Some chiropractic, podiatric and dermatologic services
  - Well-woman examinations
  - Behavioral health services

For these excluded services, we request your assistance in communicating and coordinating the care of members. However, we pay for direct-access services without completion of field 17b.

If medically necessary care cannot be provided by in-network providers, care can be provided by an

out-of-network provider. In these exceptional cases, MCC require the provider to obtain prior authorization.

Provision of assessment and counseling services

Initial assessment: The PCP must conduct a health assessment of all new members within 90 days of the effective date of enrollment. The PCP is responsible for notifying MCC if unable to contact the member to arrange the initial assessment within 90 days.

Members entering protective custody: The PCP agrees to physically screen members taken into the protective custody, emergency shelter or foster care programs within 72 hours or immediately, if required.

Pregnancy

Due to the complexities of pregnancy, combined with some of the social determinants of health experiences including homelessness, substance abuse, food insecurity, teenage pregnancy, a diagnosis of serious mental illness/serious emotional disorder/substance use disorder (SMI/SED/SUD) and related treatments, we consider all pregnant members to be high risk.

We expect providers to do the following when caring for this vulnerable population.

1. **Pregnancy identification:** The provider is responsible for notifying MCC when they identify a pregnant member. If notification is faxed, it should include the member's name, ID number, and due date.
2. **Referrals to Healthy Start and WIC:** The provider agrees to refer pregnant women or infants to Healthy Start and WIC programs.
3. **HIV counseling for pregnant women:** The provider agrees to provide counseling and offer the recommended anti-retroviral regimen to all pregnant women who are HIV-positive and to refer them and their infants to Healthy Start programs, regardless of their screening scores.
4. **Hepatitis B screening for pregnant women:** The provider agrees to offer screening for Hepatitis B surface antigen to all women receiving prenatal care. If they test positive, the provider agrees to refer them to Healthy Start regardless of their screening score and to provide Hepatitis B Immune Globulin and the Hepatitis B vaccine series to children born to such mothers.

Network development

MCC is dedicated to recruiting and retaining individual practitioners, groups, agencies and facilities with the health care credentials to provide care and treatment across a range of products and services to members in Virginia.

Types of providers

MCC refers members to credentialed and contracted providers in private practice, practitioners in a group practice, and provider organizations including facilities and agencies.

MCC providers belong to one of these categories:

- **Individual practitioner:** a professional provider who is licensed by the Virginia Department of Health Professions and who provides health care services and bills under his or her own Taxpayer Identification Number. Individual practitioners must meet MCC credentialing criteria (see the next section on Credentialing and Recredentialing) and have a fully executed provider agreement with MCC. Examples of professional providers include, but are not limited to:
  - Doctor of Medicine
  - Doctor of Osteopathy
  - Doctor of Dental Surgery
  - Doctor of Podiatry
  - Doctor of Optometry
  - Doctor of Psychiatry
  - Nurse midwife
  - Licensed physical therapist
  - Licensed psychologist or other licensed behavioral health, specialty behavioral health or Addiction and Recovery Treatment Services (ARTS) provider
  - Certain certified registered nurse
  - Licensed audiologist
  - Licensed speech-language pathologist
  - Licensed clinical social worker
  - Licensed occupational therapist
  - Licensed marriage and family therapist
  - Licensed professional counselor
  - Licensed dietitian nutritionist
- **Group Practice:** a provider practice contracted with MCC as a group entity, and as such, bills as a group entity for the services performed by its MCC-credentialed practitioners. Practitioners affiliated with the group must complete the individual credentialing process, and the group must have at least one active/credentialed group member to be eligible to receive referrals from MCC.
- **Organization:** a facility or agency licensed and/or certified in Virginia to provide health care or ancillary services and have a fully executed provider agreement with MCC. Examples of facilities include, but are not limited to:
  - General acute care hospitals
  - Psychiatric facilities
  - Specialty behavioral health providers and counselors, including ARTS or Community Mental Health Rehabilitative Services (CMHRS) providers
  - Substance use disorder treatment centers
  - Skilled nursing facilities (SNFs)
  - State-owned psychiatric hospitals
  - Ambulatory surgical centers
  - Renal dialysis facilities
  - Hospice
  - Home health
  - Rehabilitation hospitals
  - Long-term acute care facilities
- **Ancillary provider:** a freestanding or facility-based provider with a specialty to supplement the

professional provider and facility network. Examples of ancillary providers include, but are not limited to:

  - Ambulance
  - Durable medical equipment
  - Early Intervention
  - Home infusion
  - Orthotics/prosthetics
  - Independent laboratories
  - Others including some CMHRS providers

- **Long-Term Services and Support (LTSS) provider:** a facility-based or home- and community-based services provider. Examples of LTSS provider services include, but are not limited to:
  - Adult day health care
  - Personal care
  - Respite care
  - Personal emergency response system
  - Services facilitation
  - Skilled private duty nursing
  - Assistive technology
  - Environmental modifications

Your responsibility as an MCC provider is to:

- Provide MCC with a complete Form W-9 for the contracting entity to facilitate referrals and claims processing
- Notify MCC and complete a new Form W-9 if your contracted entity changes
- Notify MCC of any changes to the list of practitioners in your group within 10 business days
- Notify MCC of changes in your service location, mailing and/or financial address information
- Adhere to credentialing policies outlined in this handbook

MCC's responsibility is to:

- Review providers and prospective providers for network participation without regard for race, color, creed, religion, gender, sexual orientation, marital status, age, ethnic/national identity, ancestry, citizenship, physical disability, disabled veteran, or veteran of the Vietnam Era status, or other status protected by applicable law
- Develop and implement recruitment activities to solicit quality health care providers to participate in the DMAS CCC Plus and Medallion 4.0 programs
- Not make credentialing or recredentialing decisions based solely on the type of procedure or patient type in which the practitioner specializes; selection and retention criteria do not discriminate against providers who serve high-risk populations or specialize in the treatment of costly conditions
- Make website-based tools available to providers so they can update their practice information in a convenient online fashion

Credentialing, recredentialing and organizational assessment

MCC is committed to promoting quality care for its members. In support of this commitment,

practitioners and organizational (facility or agency) providers must meet and maintain a minimum set of credentials to be able to provide services to members. MCC credentials practitioners and assesses organizational providers in accordance with criteria established by MCC and in compliance with applicable regulatory requirements and nationally recognized accreditation standards.

MCC credentials acute, primary, behavioral, ARTS and LTSS providers in compliance with federal standards at 42 CFR § 438.214, the most recent NCQA standards, and state standards described in 12 VAC 5-408-170.

We encourage practitioners to utilize the online universal credentialing process offered by the Council for Affordable Quality Healthcare (CAQH). Be sure to give MCC access to your application information, review and attest to its accuracy and completeness, and call the CAQH Help Desk at 1-888-599-1771 or email providerhelp@proview.caqh.org for answers to your questions related to the CAQH application or website.

Throughout the credentialing process, practitioners have the right to review information submitted to support their application for credentialing, and to correct erroneous information. Please note: MCC is not required to make certain information available including references, recommendations and peer review protected information. Corrections should be submitted within 30 days of notification to:

Molina Complete Care
Attn: Network Department
3829 Gaskins Road
Richmond, VA 23233

Upon request, practitioners have the right receive the status of their credentialing/recredentialing application. Requests for application status can be directed to MCC's Customer Care:

- CCC Plus: 1-800-424-4524
- Medallion 4.0: 1-800-424-4518

MCC's credentialing committee utilizes a peer review process to evaluate appropriateness for inclusion in the provider network. The credentialing committee reviews practitioner credentialing information, including, but not limited to:

- Licensure for independent practice that is unrestricted, unencumbered, and without other terms, conditions and/or limitations, including probationary status through an appropriate licensing agency
- Board certification, or residency training, or professional education, where applicable
- Hospital privileges in good standing or alternate admitting arrangements, where applicable
- Current valid federal Drug Enforcement Administration (DEA) certificate and state Controlled Dangerous Substance (CDS) registration (as applicable)
- State and federal exclusion/sanction activity including Medicare/Medicaid services (OIG-Office of

Inspector General) and applicable state Medicaid Exclusions List(s)
- Current liability insurance in compliance with minimum limits set by MCC's provider
- agreement
- Malpractice settlements made on behalf of the practitioner
- Member need and access, subject to applicable state laws

The credentialing committee reviews organizational provider assessment information, including, but not limited to:

- Confirmation of good standing with state and federal regulatory bodies, typically evidenced via licensure
- Appropriate current accreditation from an MCC-accepted accrediting body
- If not accredited, successfully complete an MCC-performed site visit upon request
- If MCC has approved the state licensure or CMS criteria as meeting standards, a CMS or state licensing/certification site review may be substituted in lieu of a site visit by MCC
- Compliance with MCC's minimum requirements for professional and general liability insurance coverage, as outlined in your Provider Participation Agreement
- State and federal exclusion/sanction activity including Medicare/Medicaid services (OIG-Office of Inspector General) and applicable state Medicaid Exclusions List(s)

Organizational providers must attest to their compliance with provider participation requirements as defined in applicable DMAS Provider Manual(s), found at https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual. In addition, network providers rendering services to CCC Plus Waiver members are required to comply with the following regulations: 12VAC30-120-900 through 12VAC30-120-995.

MCC will notify practitioners of the outcome of the initial credentialing process. MCC also may notify practitioners of successful recredentialing; however, if no notification is received, successful recredentialing can be assumed.

MCC network providers are required to undergo recredentialing/reassessment at least every 36 months. Recredentialing review includes evaluation of practitioner performance in the MCC network including, but not limited to clinical care, service and outcomes, member service and adherence to MCC policies and procedures.

More information on MCC's credentialing criteria can be found at www.MCCofVA.com.

Appealing decisions that affect network participation status

Participating providers have a right to appeal MCC quality review actions that are based on issues of quality of care or service that affect the conditions of the provider's participation in the network. Customer requirements and applicable federal and state laws may impact the appeals process; therefore, MCC outlines the process for appeal in the written notification that details the changes in the conditions of the provider's participation.

MCC offers participating providers an opportunity for a formal appeal hearing when we take action to terminate network participation due to quality concerns. Providers receive notice in writing of the action. Specifics of the appeal and notification processes are subject to customer, state or federal requirements. Notification includes: the reason(s) for the action, the right to request an appeal, the process to initiate a request for appeal, summary of the appeal process, and that such request must be made within 33 calendar days from the date of MCC's written notification.

Providers must follow the instructions outlined in the notification letter if requesting an appeal. Providers may participate in the appeal hearing either telephonically or in-person and may be represented by an attorney or another person of the provider's choice. Providers are notified in writing of the appeal decision within 30 calendar days of completion of the formal appeal hearing.

Providers whose network participation is terminated due to license sanctions or disciplinary action, or exclusion from participation in Medicare, Medicaid or other federal health care programs, no longer meet MCC's network participation criteria and are offered an internal administrative review unless otherwise required by customer, state or federal requirements. Providers are notified in writing of their network participation status, reason for denial of ongoing participation, and informed of their right to an internal administrative review. Providers are permitted no more than 33 calendar days from the date of MCC's written notification to request an administrative review if they disagree with the reasons for the termination. The provider is notified in writing of the outcome within 30 calendar days of the administrative review.

Termination from the MCC network

MCC's philosophy is to maintain a diverse, quality network of providers to meet the needs of our members. In addition, we believe providers should advocate on behalf of members in obtaining care.

Network providers will not be terminated from the network for any of the following reasons:

- Advocating on behalf of a member
- Filing a complaint against MCC
- Appealing a decision of MCC
- Requesting a review of or challenging a termination decision of MCC
- Having a practice that includes a substantial number of patients with expensive medical conditions
- Objection to the provision of or refusal to provide a health care service on moral or religious grounds
- Any refusal to refer a patient for health care services when the refusal of the practitioner is based on moral or religious grounds and the practitioner has made adequate information available to the members in the practitioner's practice

Network providers may be terminated from the network for the following reasons, including, but not limited to:

- Failure to submit materials for recredentialing within required timeframes
- Any restriction, probation, suspension, revocation or surrender, or condition, limitation or qualification of the provider's license or accreditation

- The provider is convicted of a criminal offense, including any offense related to involvement in any Medicare or Medicaid program or has been terminated, suspended, barred, voluntarily withdrawn as part of a settlement agreement, or otherwise excluded from any federally or state-funded health care programs
- Quality of care or quality of service concerns as determined by MCC
- Failure to meet or maintain MCC's credentialing criteria, including any insurance requirements
- Failure to comply with any other obligations outlined in your MCC Provider Participation Agreement, including those within this provider handbook
- Provider ceases to be in compliance with applicable laws, a violation of which would materially impact the ability of the provider to conduct business and meet obligations
- Provider-initiated termination
- There is no current business need within the provider's geographic area, subject to applicable state and federal law

MCC will make a good faith effort to provide members written notice of termination of a contracted provider within at least 15 calendar days of the termination effective date to all members who regularly use the provider's services. This will include all members who are in a course of active treatment with the provider, assigned to the provider as a PCP, or have prior authorized care with the provider. We will allow the members in active treatment to continue to receive care from the provider until the course of treatment is completed, another provider is selected, or during the next open enrollment period—not to exceed six months after the termination date. Pregnant members are permitted to continue the course of treatment until completion of postpartum care. The only exception to the above would be if the treating provider has been excluded/barred from providing services to Medicaid or Medicare recipients.

If a provider is terminated for cause, notification will occur as soon as practicable (not to exceed five business days, but immediately if the member is in imminent danger) and the following continuity of care provisions do not apply.

In the event of a contract termination by either party, the provider will continue to render necessary care to MCC member(s) consistent with contractual or legal obligations. A terminated provider can refuse to provide care to a member who is abusive or noncompliant. All services provided under the continuity of care provisions will be reimbursed at the rates included in the last active contract.

If you choose to terminate your contract with MCC, you should:

- Check the terms of your Provider Agreement
- Submit your notice of termination in writing, in accordance with the terms of your provider agreement, to:

  Molina Complete Care
  Attn: Network Department
  3829 Gaskins Rd.
  Richmond, VA 23233
- Group provider practices shall immediately notify MCC, in writing, in the event that a health care professional ceases to be affiliated with the provider group for any reason. The group practice

must ensure that members under the care of the terminating practitioner are transferred to another group practitioner who is credentialed with MCC

- If you are a group provider practicing under a group agreement and you terminate your affiliation with the group, MCC expects you to facilitate transition of members in your care to another group provider who is credentialed with MCC.

Section 5: Risk management and critical incident reporting

Critical incident reporting

Critical incidents shall include but not be limited to the following incidents during the provision of care by MCC staff and contracted providers:

- Unexpected death of an MCC member
- Suspected physical or mental abuse of an MCC member
- Theft against an MCC member
- Financial exploitation of an MCC member
- Severe injury sustained by an MCC member
- Fall of an MCC member
- Medication error involving an MCC member
- Sexual abuse and/or suspected sexual abuse of an MCC member
- Abuse and neglect and/or suspected abuse and neglect of an MCC member

Providers must report Critical Incidents and actions to MCC:

- Within 24 hours* of the provider's discovery/awareness of the critical incident
- If the initial report is submitted verbally, a written MCC Critical Incident Report form must be submitted to MCC within 48 hours*
- Reports may be submitted verbally by calling:
  - CCC Plus: 1-800-424-4524
  - Medallion 4.0: 1-800-424-4518
- Reports may be submitted electronically by secure e-mail to MCCVA-CI@molinahealthcare.com, or by fax at 1-866-325-9157, 24 hours/day, 365 days/year

Additional requirements:

- Immediately, and not to exceed **24 hours*** from the incident, the provider must take steps to prevent further harm to any and all members and respond to any emergency needs of members
- Providers must conduct an internal critical incident investigation and submit a report on the investigation as soon as possible, and no later than 30 days after the date of the incident. MCC will review the provider's report and follow up with the provider as necessary to ensure that an appropriate investigation was conducted, and corrective actions were implemented within applicable timeframes
- Providers are required to cooperate with any investigation conducted by MCC or outside agencies (e.g., DMAS, Adult Protective Services, and law enforcement).

Note:* *24- and 48-hour timeframes refer to actual clock hours,* ***NOT* *business days.*

Issues related to non-compliance may be escalated to the MCC Provider Credentialing Committee for evaluation of the provider's continued credentialing eligibility.

Providers may access the current version of the MCC Critical Incident Report form at www.MCCofVA.com. Providers may also request a copy of the form by calling Customer Care:

- CCC Plus: 1-800-424-4524
- Medallion 4.0: 1-800-424-4518

Identifying and reporting abuse, neglect and exploitation

The Virginia Abuse Hotline serves as the central reporting center for allegations of abuse, neglect, and/or exploitation for all children and vulnerable adults in Virginia. As a contracted provider, you are required to report suspected or known abuse, neglect, or exploitation immediately by calling one of the following hotline numbers:

Child Protective Services:

- In Virginia: 1-800-552-7096
- Outside Virginia: 1-804-786-8536
- Adult Protective Services: 1-888-832-3858
- Hearing-impaired: 1-800-828-1120

The hotlines will accept a report when there is reasonable cause to suspect that:

- A child who can be located in Virginia, or is temporarily out of the state but expected to return in the immediate future, has been harmed or is believed to be threatened with harm from a person responsible for the care of the child
- Any vulnerable adult who is a resident of Virginia or currently located in Virginia is:
  - Believed to have been abused or neglected by a caregiver in Virginia
  - Suffering from the ill effects of neglect by self and is in need of service
  - Being exploited by any person who stands in a position of trust or confidence, or any person who knows or should know that a vulnerable adult lacks capacity to consent, and contains or uses, or endeavors to obtain or use, their funds, assets or property

Section 6: Compliance/program integrity

Fraud, waste and abuse responsibilities

MCC does not tolerate fraud, waste or abuse, by providers, members or staff.

Accordingly, we have instituted extensive fraud, waste and abuse programs to combat these problems. MCC's programs are wide-ranging and multi-faceted, focusing on prevention, detection and investigation of all types of fraud, waste and abuse in government programs and private insurance.

MCC's expectation is that the provider will fully cooperate and participate with its fraud, waste and abuse programs. This includes, but is not limited to, permitting MCC access to member treatment records and allowing MCC to conduct on-site audits or reviews. MCC also may interview members as part of an investigation, without notifying the provider.

Our policies in this area reflect that both MCC and providers are subject to federal and state laws designed to prevent fraud and abuse in government programs (e.g., Medicare and Medicaid), federally funded contracts and private insurance. MCC complies with all applicable laws, including the Federal False Claims Act, state false claims laws (see state-specific information on our provider website), applicable whistleblower protection laws, the Deficit Reduction Act of 2005, the American Recovery and Reinvestment Act of 2009, the Patient Protection and Affordable Care Act of 2010 and applicable state and federal billing requirements for state-funded programs, federally funded programs (e.g., Medicare Advantage, SCHIP and Medicaid) and other payers.

The provider's responsibility is to:

- Comply with all laws and MCC requirements
- Comply with all federal and state laws regarding fraud, waste and abuse
- Provide and bill only for medically necessary services that are delivered to members in accordance with MCC's policies and procedures and applicable regulations
- Ensure that all claims submissions are accurate
- Notify MCC immediately of any suspension, revocation, condition, limitation, qualification or other restriction on the provider's license, or upon initiation of any investigation or action that could reasonably lead to a restriction on the provider's license, or the loss of any certification or permit by any federal authority, or by any state in which you are authorized to provide health care services
- Cooperate with MCC's investigations. MCC's expectation is that you will fully cooperate and participate with its fraud, waste and abuse programs. This includes, but is not limited to, permitting MCC access to member treatment records and allowing us to conduct on-site audits or reviews. MCC also may interview members as part of an investigation, without notifying providers.

Definitions—fraud, waste and abuse

- **Fraud:** an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/her or some other person. It includes any act that constitutes fraud under applicable federal or state law
- **Abuse:** provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to government-sponsored programs, and other health care programs/plans, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary costs to federally and/ or state-funded health care programs, and other payers
- **Waste:** over-utilization of services or other practices that result in unnecessary costs.

Some examples of potential fraud, waste and abuse include:

- Billing for services or procedures that have not been performed or have been performed by others
- Submitting false or misleading information about services performed
- Misrepresenting the services performed (e.g., up-coding to increase reimbursement)
- Retaining and failing to refund and report overpayments (e.g., if your claim was overpaid, you are required to report and refund the overpayment, and unpaid overpayments also are grounds for program exclusion)
- A claim that includes items or services resulting from a violation of the Anti-Kickback Statute now constitutes a false or fraudulent claim under the False Claims Act
- Providing or ordering medically unnecessary services and tests based on financial gain
- An individual provider billing multiple codes on the same day where the procedure being billed is a component of another code billed on the same day (e.g., a psychiatrist billing individual therapy and pharmacological management on the same day for the same patient)
- An individual provider billing multiple codes on the same day where the procedure is mutually exclusive of another code billed on the same day (e.g., a social worker billing two individual psychotherapy sessions on the same day for the same patient)
- Providing services over the telephone or internet and billing using face-to-face codes
- Providing services in a method that conflicts with regulatory requirements (e.g., exceeding the maximum number of patients allowed per group session)
- Treating all patients weekly regardless of medical necessity
- Routinely maxing out of members' benefits or authorizations regardless of whether or not the services are medically necessary
- Inserting a diagnosis code not obtained from a physician or other authorized individual
- Violating another law (e.g., a claim is submitted appropriately but the service was the result of an illegal relationship between a physician and the hospital such as a physician receiving kickbacks for referrals)
- Submitting claims for services ordered by a provider that has been excluded from participating in federally and/or state-funded health care programs
- Lying about credentials, such as degree and licensure information

Provider payment suspension

Pursuant to 42 C.F.R. §§455.23 and 438.608(a)(8), MCC may suspend payments to both participating or non-participating providers upon notification or direction from DMAS. In the event MCC receives a notification to suspend due to a credible allegation of fraud and/or other sanction, payment for otherwise covered services may be withheld until it is determined by DMAS to release suspension of payment and/or a final decision has been made with respect to the providers continuous eligibility to provide covered services to CCC Plus or Medallion 4.0 members. If the suspension reason and/or finding from DMAS results in a material breach to the Participating Provider Agreement, MCC may take additional actions such as transition of member care, panel assignment suspension, suspension/denial of credentialing status or provider/contract termination.

Reporting suspected fraud, waste or abuse

MCC expects providers and their staff and agents to report any suspected cases of fraud, waste or abuse. We will not retaliate against the provider if they inform MCC, the federal government, state government or any other regulatory agency with oversight authority of any suspected cases of fraud, waste or abuse.

MCC has the responsibility to assess the merits any allegation of fraud, waste, or abuse. We will coordinate and fully cooperate and assist DMAS and any state or federal agency in identifying, investigating, sanctioning or prosecuting suspected fraud, abuse or waste. MCC will provide records and information, as requested.

Reporting to MCC

Reports of provider fraud, abuse or waste should be made to MCC via one of the following methods:

- Molina AlertLine: 1-866-606-3889
- Website: https://molinahealthcare.alertline.com

Reports to the Corporate Compliance Hotline may be made 24 hours a day/7 days a week. The hotline is maintained by an outside vendor. Callers may choose to remain anonymous. All calls will be investigated and remain confidential.

To report suspected recipient fraud to DMAS, contact:

Department of Medical Assistance Services Recipient Audit Unit
600 East Broad Street, Suite 1300
Richmond, VA 23219
Phone: 1-800-371-0824
Email: Recipientfraud@DMAS.virginia.gov
Website: https://www.dmas.virginia.gov/

Confidentiality and HIPAA

Confidentiality is a key consideration of MCC's operations and processes. MCC has developed policies and procedures that describe how we protect the privacy of confidential health information that is

used or disclosed by our company, consistent with provisions of the Health Insurance Portability and Accountability Act (HIPAA).

Some of the ways that MCC protects access to protected health information (PHI) include:

- Utilizing strict guidelines for how member information may be used and disclosed
- Requiring all employees to understand and adhere to the processes for responding to any unauthorized uses or disclosures of confidential member information
- Requiring employees and visitors to sign statements concerning confidentiality of information, release of information, and communication requirements
- Making sure that the Authorization to Use or Disclose Protected Health Information form we use complies with applicable state and federal laws
- Monitoring provider adherence to privacy policies and procedures through site visits, quality reviews and routine contact
- Monitoring member feedback through the complaint process, member satisfaction survey results, and internal quality audits
- Complying with applicable state and federal laws and accrediting organization standards
- Establishing and maintaining procedures for timely and appropriate responses to member rights issues, including but not limited to requests for confidential communications, access to protected health information, amendments to protected health information and accounting of disclosures
- Implementing technical barriers and protections to systems by requiring authorizations and passwords to access systems containing confidential information
- Requiring employees to use the minimum necessary information for routine uses and disclosures of health information.

As an MCC provider, your responsibility is to:

- Comply with applicable state and federal laws and regulations that pertain to member privacy and confidentiality of PHI
- Use only HIPAA-compliant authorization forms and consent for treatment forms that comply with applicable state and federal laws*
- Use only secure email and secure messaging when requesting member PHI
- Establish office procedures regarding communication with members (e.g., telephone and cellphone use, and written, fax and internet communication)
- Establish a process that allows members to access their records in a confidential manner
- Establish systems that safeguard member PHI at the provider location and anywhere PHI may be stored
- Maintain the confidentiality of a minor's consultation, examination, and treatment for a sexually transmissible disease, in accordance with Virginia laws and regulations
- Participate in and comply with MCC's quality review, site visit process and contract obligations

**When the HIPAA Privacy Rule is applicable, it allows MCC and our providers to use and disclose PHI for treatment, payment and health care operations activities.*

MCC's responsibility is to:

- Collaborate with providers to protect member privacy and confidentiality
- Request the minimum necessary PHI to perform needed health care operations and payment activities
- Only respond to electronic (internet) requests for PHI through secure email channels
- Only provide PHI upon receipt of a valid authorization of use and disclosure form

HIPAA transaction standards

To address HIPAA and its regulations regarding standard interface between health care organizations and providers, we send and receive HIPAA standard transactions. HIPAA standard transactions define the required formats for encounter data, referrals, authorizations, enrollment and claims data between members, providers, health care organizations and others that require this information.

As an MCC provider, your responsibility is to:

- Comply with HIPAA standard transactions requirements for all covered transactions submitted to MCC
- Use your National Provider Identifier (NPI) on all electronic transactions submitted to MCC
- Use current standard procedure, diagnostic, and revenue codes on all claims transactions submitted to MCC

MCC's responsibility is to:

- Be able to receive and send the HIPAA standard transactions
- Use clearinghouses or online services to provide the administrative functions required to establish HIPAA-compliant electronic communications
- Inform you about how to contact us to initiate electronic communications

HIPAA standard code sets

HIPAA specifically identifies the following procedure and diagnostic code sets as standard:

- ICD-10-CM
- CPT®-4 and modifiers
- HCPCS Level II and modifiers
- Revenue codes
- Place of Service codes
- Type of Bill codes

MCC requires the use of these standard code sets (and successor code sets when published, upon their effective dates) on both paper and electronic claim transactions.

As an MCC provider, your responsibility is to:

- Make sure all electronic information submitted to MCC contains current standard codes in accordance with HIPAA requirements
- Apply for and use a National Provider Identifier (NPI) on all claims submitted to MCC
- Obtain a current copy of MCC's Universal Services List (USL) for standard codes for most facility

and program services
- Use current standard codes, and successor code sets on their effective date, on electronic and paper claims submitted to MCC

To comply with HIPAA, MCC will:

- Recognize standard procedure and diagnostic codes and communicate those standards to providers
- Be compliant with HIPAA's standard coding requirements
- Accept only compliant codes in covered electronic transactions
- Accept only covered electronic transactions that include an NPI
- Share your NPI with health plans with which we coordinate your HIPAA-standard transactions
- Advise you on how to contact us to initiate electronic communications
- Provide notice on remittance vouchers for services submitted with invalid codes
- Maintain information about HIPAA code sets on our website

Provider promotional, marketing and outreach activities

All promotional, marketing and outreach activities must be conducted in a responsible manner so that potential members receive the most accurate and complete information possible to allow the member to make an informed decision.

Provider promotional, marketing and outreach activities must comply with all relevant federal and state laws, and provisions in the MCC contract related to marketing requirements. This includes, when applicable, the anti-kickback statute, and civil monetary penalty prohibiting inducements to members (42 CFR § 438.104).

Provider promotional, marketing and outreach activities targeting prospective members may not:

- Engage in any informational or marketing activities which could mislead, confuse, or defraud prospective members or misrepresent DMAS (42 CFR § 438.104)
- Directly or indirectly, conducting door-to-door, telephonic, or other "cold call" marketing of enrollment at residences and provider sites (42 CFR § 438.104)
- Participate in any mailings on behalf of a health plan without being processed through DMAS
- Conduct unsolicited personal/individual appointments to influence enrollment in a health plan
- Offer financial incentive, reward, gift, or opportunity to prospective members as an inducement to enroll in a health plan
- Conduct continuous, periodic activities to the same prospective member (e.g., monthly or quarterly giveaways) as an inducement to enroll in a health plan
- Assert that prospective members must enroll with a health plan to keep from losing benefits

Presence on federal and state exclusion list

MCC is required to review the sanctions and exclusions prior to entering into a contract with a provider and on a monthly basis thereafter. As a contracted provider, you are also required to perform monthly checks of state and federal exclusion and sanction lists to ensure you do not employ

staff, or utilize contractors or individuals with ownership interest, as per your contract with MCC. MCC and its contracted providers are prohibited from employing or contracting with any individual who is excluded from participation in any federal or state health care or contracting programs.

Providers identified as being excluded will be denied participation or terminated from participation in the MCC network and will not be considered for participation or reinstatement until the exclusion is lifted and reinstatement is verified. Reinstatement is not automatic. A new application must be submitted, and the credentialing process begun again.

Excluded providers may not receive any payments from federal or state health care programs. MCC will immediately stop all payments to providers upon confirmation of provider's sanction or exclusion and will withhold payment until such time that an investigation is complete and MCC is allowed by state and federal regulators to release payment.

Providers must ensure that no management staff, individuals with ownership interest in the provider's practice or other persons who have been excluded by Medicaid, Medicare or other federal or state health care programs are employed or subcontracted by the provider. Providers must immediately notify MCC of any imposed sanction or adverse action taken against the provider, any individual with ownership interest in the practice, any member of their staff or subcontractor.

Providers must disclose to MCC whether they, a staff practitioner or subcontractor have any prior violation, fine, suspension, termination or other administrative action as a result of violation of any of the following:

- Medicare or Medicaid laws
- The rules or regulations of any state where the provider practices
- The federal government
- Any public insurer

Section 7: Member rights and responsibilities

Member rights

Key provider responsibilities related to member rights and responsibilities are:

- **Treatment of members:** The provider agrees to treat all members with respect and dignity, to provide them with appropriate privacy and to treat member disclosures and records confidentially, giving the members the opportunity to approve or refuse their release in accordance with HIPAA and applicable state laws
- **Disclosure of information to member:** The provider agrees to provide to members complete information concerning their diagnosis, evaluation, treatment and prognosis, and to give members the opportunity to participate in decisions involving their health care, regardless of whether the member has completed an advance directive, except when contraindicated for medical reasons

Members have the right to:

- Receive timely access to care and services in accordance with MCC contracts and federal and state regulations
- Receive a prompt response to questions and requests
- Know who is providing their medical services and care
- Know what services are available. This includes if the member needs an interpreter because they do not speak English
- Choose to receive long-term services and supports in their home or community or in a nursing facility
- Have confidentiality and privacy about their medical records and when they get treatment
- Receive information on available treatment options and alternatives presented in a manner appropriate to the member's condition and ability to understand
- Have a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit
- Receive treatment for any emergency medical condition that will deteriorate from failure to provide treatment
- Know if medical treatment is for purpose of experimental research. If it is, the member can refuse or accept the services
- Get information in a language they understand—they can get oral translation services free of charge
- Receive reasonable accommodations to ensure they can effectively access and communicate with providers, including auxiliary aids, interpreters, flexible scheduling, and physically accessible buildings and services
- Receive information necessary for them to give informed consent before the start of treatment
- Be treated with respect and recognition for his or her dignity and right to privacy

- Request and receive a copy of their medical records and request that they be amended or corrected, as specified in 45 CFR §§ 164.524 and 164.526
- Participate with practitioners in making decisions regarding his or her health care, including the right to refuse treatment
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other federal regulations on the use of restraints and seclusion
- Get care in a culturally competent manner without regard to disability, gender, race, health status, color, age, national origin, sexual orientation, marital status, religion, handicap or source of payment
- Be informed of where, when and how to obtain the services they need from MCC, including how they can receive benefits from out-of-network providers if the services are not available the MCC network
- Receive full information and counseling on the availability of known financial resources for their care
- Know whether the health care provider or facility accepts the MCC contract rates
- Receive in writing from the provider, before receiving any non-covered services, notice:
  - Of the non-covered service(s) to be rendered
  - That said services are not covered under the member benefits
  - That the member will be liable for the cost of the service(s)
  - The cost of the service(s)

  Upon request, provide a copy of such writing to MCC. If the member does not agree to pay for such non-covered services in writing, neither the member nor MCC is liable for the cost
- Freely exercise their rights in a way that does not adversely affect the way the provider treats them
- Voice complaints or file appeals to the state about MCC or the care it provides
- Appoint someone to speak for them about their care and treatment and to represent them in an Appeal
- Make advance directives and plans about their care in the instance that they are not able to make their own health care decisions
- Change their health plan once a year for any reason during open enrollment or change their MCO after open enrollment for an approved reason
- Appeal any adverse benefit determination (decision) by MCC that they disagree with that relates to coverage or payment of services
- File a grievance about any concerns they have with our customer service, the services they have received, or the care and treatment they have received from one of our network providers
- Receive information about MCC, its services, its practitioners and providers and member rights and responsibilities
- Make recommendations regarding MCC's member rights and responsibilities policy, for example by joining our Member Advisory Committee

Members also have certain responsibilities, which include:

- Presenting their MCC membership card whenever they seek medical care

- Providing complete and accurate information to the best of their ability on their health and medical history to MCC
- Reporting unexpected changes in their health status
- Participating in their care team meetings, developing an understanding of their health problems, and providing input in developing mutually agreed upon treatment goals to the degree possible
- Following plans and instructions for care that they have agreed to with their practitioners and keep their doctor appointments. If they must cancel, call as soon as they can
- Following the provider's conduct rules and regulations
- Receiving all their covered services from MCC's network
- Obtaining authorization from MCC prior to receiving services that require a service authorization review
- Calling MCC whenever they have a question regarding their membership or if they need assistance
- Telling MCC when they plan to be out of town so we can help them arrange their services
- Using the emergency room only for real emergencies
- Calling their PCP when they need medical care, even if it is after hours
- Telling MCC when they believe there is a need to change their plan of care
- Telling MCC if they have problems with any health care staff
- Calling MCC Member Services about any of the following:
  - If they have any changes to their name, address, or phone number. They must also report these to their case worker at their local Department of Social Services
  - If they have any changes in any other health insurance coverage, such as from their employer, their spouse's employer, or workers' compensation
  - If they have any liability claims, such as claims from an automobile accident
  - If they are admitted to a nursing facility or hospital
  - If they get care in an out-of-area or out-of-network hospital or emergency room
  - If their caregiver or anyone responsible for them changes
  - If they are part of a clinical research study

The Commonwealth of Virginia must ensure that each member is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the health plan and its providers or DMAS treat the member. As a participating provider, you are expected to not only respect these rights, but assist members in leveraging these rights.

Health care advance directives

The patient's right to decide

Every competent adult has the right to make decisions concerning his or her own health, including the right to choose or refuse medical treatment. When a person becomes unable to make decisions due to a physical or mental change, such as being in a coma or developing dementia (like Alzheimer's disease), they are considered incapacitated.

To make sure that an incapacitated person's decisions about health care will still be respected, the legislature of the Commonwealth of Virginia enacted legislation pertaining to health care advance

directives. The law recognizes the right of a competent adult to make an advance directive instructing his or her physician to:

- Provide, withhold, or withdraw life-prolonging procedures
- Designate another individual to make treatment decisions if the person becomes unable to make his or her own decisions
- Indicate the desire to make an anatomical donation after death

Questions about health care advance directives

What is an advance directive?

It is a written or oral statement about how an individual wants medical decisions made should he or she not be able to make them. It can express an individual's wish to make an anatomical donation after death. Some people make advance directives when they are diagnosed with a life-threatening illness. Others put their wishes into writing while they are healthy, often as part of their estate planning. Three types of advance directives are:

- A living will
- A health care surrogate designation
- An anatomical donation

An individual may wish to complete any one or a combination of the three types of advance directives, depending on his or her needs.

What is a living will?

It is a written or oral statement of the kind of medical care an individual wants or does not want if her or she becomes unable to make their own decisions. It is called a living will because it takes effect while he or she is still living. Many individuals discuss this with their health care providers or attorneys to be certain they have completed the living will in a way that their wishes will be understood.

What is a health care surrogate designation?

It is a document in which a person names someone else to make medical decisions for him or her if he or she is unable to do so. It can include instructions about any treatment an individual does or does not want, similar to a living will. It may also designate an alternate surrogate.

What is an anatomical donation?

It is a document that indicates a person's wish to donate, at death, all or part of his or her body. This can be an organ and tissue donation to persons in need, or the donation of a body for training of health care workers. An individual can indicate his or her choice to be an organ donor by designating it on his or her driver's license or state identification card, signing a uniform donor form, or expressing the wish in a living will.

Are individuals required to have an advance directive under state law?

No, there is no legal requirement to complete an advance directive. However, without one, decisions about an individual's health care or an anatomical donation may be made by a court-appointed

guardian, a spouse, an adult child, a parent, an adult sibling, an adult relative, or a close friend. The person making decisions may or may not be aware of an individual's wishes. An advance directive better assures that an individual's wishes will be carried out.

Must an attorney prepare the advance directive?
No, the procedures are simple and do not require an attorney, although some individuals choose to consult one. However, an advance directive, whether it is a written document or an oral statement, needs to be witnessed by two individuals. At least one of the witnesses cannot be a spouse or a blood relative.

Can a person change their mind after completing an advance directive?
Yes, an advance directive can be changed at any time. Any changes should be written, signed and dated. However, it can also be changed by oral statement, physical destruction of the advance directive, or by writing a new advance directive. If a person's driver's license or state identification card indicates he or she is an organ donor, but he or she no longer wants this designation, he or she can contact the nearest driver's license office to cancel the donor designation, and a new license or card will be issued.

What if an individual filled out an advance directive in another state and needs treatment in Virginia?
An advance directive completed in another state, as described in that state's law, can be honored in Virginia.

What should a person do with their advance directive if he or she chooses to have one?

- If a person wants to designate a health care surrogate and an alternate surrogate, he or she should be sure to ask the person to agree to take on this responsibility, discuss with him or her how matters should be handled, and provide the surrogate with a copy of the document
- Make sure that his or her health care provider, attorney, and the significant persons in his or her life know that about the advance directive and tell the surrogate where it is located or provide him or her with a copy
- Set up a file where a copy of the advance directive (and other important paperwork) can be kept. Some people keep original papers in a bank safety deposit box
- Keep a card or note in his or her purse or wallet that states he or she has an advance directive and where it is located
- If an individual changes his or her advance directive, he or she should be sure that their health care provider, attorney and other significant persons have the latest copy

More information on health care advance directives

Before making a decision about advance directives, an individual might want to consider additional options and other sources of information, including designating a durable power of attorney, through a written document, naming another person to act on his or her behalf. It is similar to a health care surrogate, but the person can be designated to perform a variety of activities (e.g., financial, legal, medical, etc.). An attorney can provide further information.

You can get the Virginia Advance Directives form at: http://www.virginiaadvancedirectives.org/the-virginia-hospital—healthcares-association–vhha–form.html

The form is also available from a doctor, a lawyer, a legal services agency, or a social worker. You can also contact MCC Member Services to ask for the form.

Nothing in this handbook shall be interpreted as requiring a member to execute an advance directive or agree to orders regarding the provision of life-sustaining treatment as a condition of receipt of services under the Medicaid program. Complaints concerning noncompliance with the advance directive requirements may be filed with DMAS.

Changing primary care provider or primary behavioral health provider

The PCP relationship is critical to our members, and MCC will assign a PCP to most members upon enrollment. Members are free to see any PCP within our network. Providers should encourage their members to contact MCC customer service to update their PCP by:

- Calling Member Services:
  - CCC Plus: 1-800-424-4524 (TTY 711)
  - Medallion 4.0: 1-800-424-4518 (TTY 711)

PCP changes are effective on the date of request.

Section 8: Member grievances and appeals

MCC is required to have a system in place to respond to grievances, appeals and complaints received from members, and we are required to provide to all network providers and subcontractors information about the grievance and appeals processes. MCC ensures that individuals making decisions regarding grievances or appeals:

- Are not involved in any previous level of review or decision making or a subordinate of the decision maker
- Have the appropriate clinical expertise to make the decision

MCC is not responsible for handling appeals related to carved-out or excluded services.

Grievances

In accordance with 42 CFR § 438.400, a grievance is an expression of dissatisfaction about any matter other than an "adverse benefit determination." A grievance is any complaint or dispute expressing dissatisfaction with any aspect of MCC or a provider's operations, activities, or behavior. A grievance may be filed at any time. With the member's written consent, a provider or authorized representative may file a grievance on behalf of a member. Possible subjects for grievances include, but are not limited to, quality of care or services provided, aspects of interpersonal relationships such as rudeness of a PCP or employee of MCC, or failure to respect the member's rights, as provided for in 42 CFR § 438.400 et seq. MCC will maintain a system that meets, at a minimum, the following standards:

- Timely acknowledgement of receipt of each member grievance
- Timely review of each member grievance
- Standard response, electronically, or in writing, to each member grievance within a reasonable time, but no later than 30 days after MCC receives the grievance
- Expedited response, orally or in writing, within 24 hours of when MCC receives the grievance, to each member whenever MCC extends the appeal timeframe or refuses to grant a request for an expedited appeal

In some cases, MCC will submit a request to DMAS to extend the time frames for resolution of grievances by up to 14 calendar days. The request for extension can be requested by a member, if MCC provides evidence of the need for additional information and proof that the delay would be in the member's best interest. The member will receive a written response from MCC.

Grievance forms are available in this handbook or online at www.MCCofVA.com. If the member or their authorized designee (provider, family member, etc.) needs help with filing a grievance, please call the Grievance and Appeals department toll-free at:

- CCC Plus: 1-800-424-4524 (TTY 711)
- Medallion 4.0: 1-800-424-4518 (TTY 711)

Interpreter services are available. Our Grievance and Appeals department is available from 8 a.m. to 8 local time, Monday through Friday.

Please send the member's grievance or appeal to MCC by:

- Email: MCCVA-Appeals@molinahealthcare.com
- Mail:

  Molina Complete Care Attn:
  Complaint Coordinator
  3829 Gaskins Rd.
  Richmond, VA 23233

Appeals process

MCC supports the right of our members to request a review of adverse actions or benefit determinations ("adverse determination"). We accept appeal requests from our members, their authorized representatives, and their providers for any covered service that has been denied, reduced, suspended or terminated. A member's authorized representative may be anyone who is authorized to file the appeal request on behalf of the member, so long as the member has provided written permission. Examples of designees include a family member, legal guardian, or attorney.

Standard appeal

Members may file an appeal with MCC within 60 calendar days from the date on the adverse benefit determination notice. Appeals may be filed verbally, in writing, via fax or email.

To file an appeal, members can call us toll free at:

- CCC Plus: 1-800-424-4524 (TTY 711)
- Medallion 4.0: 1-800-424-4518 (TTY 711)

Interpreter services are available. Our Grievance and Appeals department is available from 8 a.m. to 8 local time, Monday through Friday.

If needed, our agents will help complete the appeal request. Members can send their written appeal to MCC by:

- Email: MCCVA-Appeals@molinahealthcare.com
- Mail:

  Molina Complete Care Attn:
  Complaint Coordinator
  3829 Gaskins Rd.
  Richmond, VA 23233
- Fax: 1-866-325-9157

MCC will make a decision on an appeal within 30 calendar days from the initial date of receipt of the appeal. The written notification will include the decision, and in the case of a denial or partial denial,

the reason for denial, including information on their second level appeal rights through the State Fair Hearing process with DMAS.

Expedited appeal

MCC has an expedited review process for appeals if we or the member's provider determines that the time expended in a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. If you are filing an expedited appeal on behalf of an MCC member, we will make a decision within 72 hours from the initial receipt of the expedited appeal.

Continuation of benefits

While the appeal decision is being made, the member can continue to receive care for previously authorized services if the member requests continuation of benefits either within 10 days of the date on the notice of adverse benefit determination, or by the date the change in services is scheduled to occur. If the final decision is not in the member's favor, the member may be charged. If the final decision is in the member's favor, services will be reinstated within 72 hours for expedited and standard appeals.

State Fair Hearing process

State Fair Hearing

Members, their authorized representatives, or their provider have a right to appeal MCC's adverse determination on their appeal request through the State Fair Hearing process. Completion of MCC's appeal process is a prerequisite to filing for a State Fair Hearing. A member is also able to file for a State Fair Hearing if MCC fails to adhere to the required timeframes for processing the member's appeal. DMAS conducts evidentiary hearings in accordance with regulations at 42 CFR § 431(E) and 12 VAC 30-110-10 through 12 VAC 30-110-370.

The appeal for a State Fair Hearing must be filed within 120 days after receipt of MCC's appeal decision. Standard appeals must be requested in writing to DMAS by the member or their authorized representative. DMAS will resolve these within 90 days of the date of filing the appeal. Expedited appeals may be filed by telephone or in writing. DMAS will resolve these within 72 hours. Members needing assistance filing a State Fair Hearing appeal can call MCC at:

- CCC Plus: 1-800-424-4524 (TTY 711)
- Medallion: 1-800-424-4518 (TTY 711)

Interpreter services are available. Our Grievance and Appeals department is available from 8 a.m. to 8 p.m. local time, Monday through Friday.

MCC will attend and defend our appeals decisions at all hearings or conferences in person or on the phone, as deemed necessary by DMAS.

If DMAS reverses a decision to deny, limit, or delay services, where such services were not furnished while the appeal was pending, MCC must authorize the disputed services no later than 72 hours from the date MCC receives the notice reversing the decision. MCC does not have the right to appeal DMAS' appeal decisions.

FAMIS members do not receive State Fair Hearings. After exhausting MCC appeal rights, FAMIS members must submit any further appeal to KEPRO, DMAS's external review organization, at:

KEPRO External Review
2810 N. Parham Road Suite #305
Henrico, Virginia 23294

A FAMIS member may also submit a written request via secure link on the KEPRO website at https://dmas.kepro.com/ by clicking on the external appeal link. The member must submit a request for external review within 30 days of the MCO's appeal decision.

Continuation of benefits

While the State Fair Hearing decision is being made, the member can continue to receive care for previously authorized services if the member requests continuation of benefits either within 10 days of the date on the notice of adverse benefit determination, or by the date the change in services is scheduled to occur. If the final decision is not in the member's favor, the member may be charged. If the final decision is in the member's favor, services will be reinstated within 72 hours.

Section 9: Provider reconsiderations and appeals

Provider reconsiderations

Provider appeals are requests made by MCC providers (in-network and out-of- network) to review MCC's adverse benefit determination in accordance with the statutes and regulations governing the Virginia Medicaid appeal process. After a provider exhausts MCC's internal appeal process, Virginia Medicaid affords the provider the right to two administrative levels of appeal (informal appeal and formal appeal) in accordance with the Virginia Administrative Process Act (Code of Virginia Section 2.2-4000 et seq.) and Virginia Medicaid's provider appeal regulations (12 VAC 30-20-500 et seq.).

Providers may submit reconsiderations to MCC if a provider has rendered services to a member and has been denied authorization/reimbursement for services or has received reduced authorization/reimbursement.

A provider may file an appeal with MCC within 60 calendar days from the date of the adverse benefit determination notice/remittance advice. Failure to file an appeal with MCC within this timeliness standard shall result in an administrative dismissal.

We will not conduct medical necessity retro authorization review through the provider claims appeal process, except in the following circumstances:

- Emergency Medical Treatment and Labor Act (EMTALA)—Provider must indicate this on appeal
- Claim was legitimately submitted to the incorrect Managed Care Organization (MCO)—Provider must include a copy of the Admit Form documenting the name of the MCO the member was enrolled in, and a copy of the Remittance Advice documenting the denial of the claim as not being enrolled in the MCO within 30 calendar days of the date of the Explanation of Payment
- "John" or "Jane" Doe Admission—Provider must submit a copy of the admission sheet or other supporting records documenting that the coverage was not known
- The service is directly related to another service for which prior approval has already been obtained and that has already been performed
- The new service was not a known need at the time the original authorization was obtained
- MCO denied the service due to the member having primary insurance at the time authorization was submitted

A provider must file the appeal with MCC in writing, although the appeal may be started verbally. The appeal must identify the issues, adjustments or items the provider is appealing and include any supporting documentation, which explains or satisfies the reason for the original denial and why it

should be paid accordingly.

To file an appeal:

- Call:
  - CCC Plus: 1-800-424-4524
  - Medallion 4.0: 1-800-424-4518
- We're available from 8:00 a.m. to 6:00 p.m. local time, Monday through Friday. Providers can leave a message after hours that will be returned on the next business day.
- Mail:

  Molina Complete Care Attn: Appeals Specialist
  3829 Gaskins Rd.
  Richmond, VA 23233
- Secure e-mail: MCCVA-Appeals@molinahealthcare.com
- Fax: 1-866-325-9157

Appeal resolution

All provider appeals will be thoroughly investigated using applicable statutory, regulatory and contractual provisions, collecting all pertinent facts from all parties and applying MCC written policies and procedures. At the conclusion of the review, which shall not exceed 30 days, the provider will receive a written decision with an explanation of the decision.

For appeals not resolved wholly in favor of the provider, MCC's written Notice of Internal Appeal Decision will include the description of appeal rights for a DMAS informal and formal appeal, including the address for filing the appeal, the timeframe, and the list of pertinent statutes/regulations governing the appeal process.

Informal and formal appeals rights

Medicaid providers have the right to appeal adverse decisions to DMAS. However, MCC's internal appeal process must be exhausted prior to a DMAS provider filing an appeal with the DMAS Appeals Division. All provider appeals to DMAS must be submitted in writing and within 30 calendar days of MCC's last date of denial to:

DMAS Appeals Division
600 East Broad Street
Richmond, VA 23219

Provider appeals to DMAS will be conducted in accordance with the requirements set forth in Virginia Code 2.2-4000 et seq. and 12 VAC 30-20-500 et seq. There are two levels of sequential administrative appeal: (i) the informal appeal and (ii) the formal appeal.

The informal appeals decision shall be issued within 180 calendar days of receipt of the notice of informal appeal. If the informal appeal decision is adverse to the provider, the provider has the right

to file a formal appeal with DMAS within 30 calendar days of the provider's receipt of the DMAS informal appeal decision.

The formal appeal shall identify each adjustment, patient, service date or other disputed matter that the provider is appealing. Failure to file the formal appeal within the timeliness standard will result in an administrative dismissal. The hearing officer for the formal appeal will submit a recommended decision to the DMAS director with a copy to the provider within 120 calendar days of the filing of the formal appeal notice. Further information on either the informal or formal appeals process can be obtained from DMAS.

Section 10: Medical management

Utilization management

Our Utilization Management (UM) program encourages optimal use of health care services and supports for the evaluation, treatment, and integration of medical and behavioral health conditions, in addition to long-term services and supports. MCC's UM and Care Coordination teams collaborate to ensure seamless, timely, and accurate care and service authorization processes. Our UM program supports continuity and coordination of care for physical, LTSS and behavioral health providers. The program develops, implements and continuously monitors the Health Services, Care Coordination, and UM work plans, generating policy and procedures and providing general direction and guidance toward policy execution.

The UM and Care Coordination programs work with the Quality Improvement Committee (QIC) to ensure the health and well-being of MCC members. We achieve this through the development and administration of health care benefits and health care coordination processes that facilitate the availability and accessibility of services in accordance with corporate policies, federal, state, and local regulations and accreditation standards.

The program meets its objectives in part by conducting prospective, concurrent and discharge planning review of services rendered to its members. Our UM department monitors quality, continuity and coordination of care as well as overutilization and underutilization of services. High-risk/high-utilizing cases are followed closely by UM staff to ensure that the most cost-effective services are identified, coordinated, implemented and evaluated on a continual basis. Services provided are not less than the amount, duration and scope for the same services delivered to fee-for-service (FFS) Medicaid members. Medically necessary services are no more restrictive than those used in the DMAS defined program. Our UM criteria is available in writing, by mail or fax.

Call our toll-free number with any UM questions:

- CCC Plus: 1-800-424-4524 (TTY 711)
- Medallion: 1-800-424-4518 (TTY 711)

We're here from 8:00 a.m. to 6:00 p.m. local time, Monday through Friday. You can leave a voice mail messages after business hours, 24 hours a day and 7 days a week.

Our MCC team members:

- Can receive incoming calls regarding UM concerns after normal business hours
- Can accept collect calls
- Will identify themselves by name, title and our organization name of MCC when initiating or returning calls
- Offer TDD/TTY and language assistance services for members who need them

Providers can fax requests for medical necessity determinations 24 hours a day, 7 days a week. An on-call nurse is available after hours for emergent/urgent concerns.

Specific details can be found in the UM program description on www.MCCofVA.com.

Medical necessity criteria

MCC utilizes nationally recognized criteria, MCG Guidelines, to determine medical necessity and appropriateness of care. These criteria are designed to assist clinicians and providers in recognizing the most effective current health care practices to ensure quality of care to our members. They are not intended to serve as a set of rules or as a replacement for a physician's medical judgment about their patient's health care needs. MCC defaults to all applicable state and federal guidelines regarding criteria for authorization of covered services. We've also developed policies to complement nationally recognized criteria. If a member's clinical documentation does not meet the criteria, the case is forwarded to MCC's Medical Director for further review and determination. MCC's Medical Director is available to discuss individual cases with attending physicians upon request.

Utilization review determinations are based only on appropriateness of care, age, co-morbidities, complications, service and benefit coverage. MCC does not reward providers or any staff members for adverse decisions for coverage or services. There are no financial incentives for our staff members that encourage them to make decisions that result in underutilization.

Upon request, MCC will provide the clinical rationale or criteria used in making medical necessity determinations. You may request the information by:

- Calling:
  - CCC Plus: 1-800-424-4524
  - Medallion 4.0: 1-800-424-4518

  We're available from 8:00 a.m. to 6:00 p.m. local time, Monday through Friday. Providers can leave a message after hours that will be returned on the next business day.
- Faxing:
  - CCC Plus: 1-866-210-1523
  - Medallion 4.0: 1-855-769-2116
  - Behavioral Health: 1-855-339-8179
  - Physician-administered medications (e.g., HCPCS, JCodes): 1-844-278-5731
  - Outpatient (e.g., retail, mail order, specialty) prescriptions: 1-844-278-5731

If the member's ordering physician would like to discuss an adverse decision with MCC's Medical Director, they may call the Utilization Management department within five business days of the determination.

As LTSS services are not physician driven, these requests are out-of-scope for Peer to Peer discussions.

Post-stabilization services

Prior authorization is not required for coverage of post-stabilization services when these services are provided in any emergency department or for services in an observation setting. To request authorization for an inpatient admission or if you have any questions related to post-stabilization services, please contact the Utilization Management Department at:

- CCC Plus: 1-800-424-4524 (TTY 711)
- Medallion: 1-800-424-4518 (TTY 711)

Visit the Provider Forms page of www.MCCofVA.com for the most up-to-date listing of services requiring prior authorization.

Clinical practice guidelines

MCC has posted evidence-based clinical practice guidelines or protocols on www.MCCofVA.com for a wide variety of medical conditions and services delivered in different medical and behavioral health settings. Specific services and levels of care are determined by DMAS. MCC has adopted MCG clinical practice guidelines for management of medical, behavioral, home health, and nursing facility services. We utilize DMAS-specific criteria for MHS services and have developed proprietary clinical criteria, if needed over and above the MCGs.

MCC follows the American Society for Addiction Medicine (ASAM) criteria as well as the Department's criteria for medical necessity determination for the ARTS benefit as defined in 12 VAC 30-130-5000 et al.

MCC utilizes UM clinical decision support tools, which include:

- MCG for medical and behavioral conditions in addition to full suite of MCG modules and tools
- Molina Medical Policy
- Molina Pharmacy Criteria
- DMAS coverage guidelines
- American Society of Addiction Medicine (ASAM) (Virginia modified version) criteria for substance abuse as well as well as the Department's criteria for medical necessity determination for the ARTS benefit as defined in 12 VAC 30-130-5000 et al.
- Other state and federal guidelines

MCC adopts practice guidelines that meet the following requirements:

- Are based on valid and reliable clinical evidence or a consensus of health care professionals and service providers in a particular field
- Consider the needs and preferences of the members
- Are adopted in consultation with providers
- Are reviewed and updated periodically, as appropriate

MCC disseminates any revised practice guidelines to all affected providers and, upon request, to members and potential members.

Treatment adherence

MCC has medication and treatment adherence programs available to help ensure that members continue in care and obtain maximum benefit from their care. Through interdisciplinary meetings and treatment planning, we work in collaboration and coordination with our providers to establish and monitor treatment plans that are targeted and tailored to each member.

Our health guides, certified peer support specialists, Care Coordinators and ARTS Care Coordinators conduct outreach to members, providing them with the support they need to address barriers influencing their ability to obtain care and aiding them in care transitions that may be difficult to navigate. At each step we rely on the collaboration with our network providers to develop treatment adherence strategies that work for our members.

Mental health and substance use assessments

MCC's prefers providers use the following assessments:

- CAGE-AID for substance abuse
- Clinical Opiate Withdrawal Scale (COWS)
- Clinical Institute Withdrawal Assessment for Alcohol Scale (CIWA-Ar)
- AUDIT (Alcohol Use Disorders Identification Test)
- DAST-10 (Drug Abuse Screen Test)
- PHQ-9 for depression
- Mental Health Screening Form III

We recognize that there are additional tools for the assessment of substance abuse and mental health and support the use of other peer-reviewed and validated instruments.

Continuity of care

MCC will allow members in active treatment to continue receiving care from their current provider up to the first 30 calendar days with our plan. After the 30 days, we will work closely with the member and the non-participating provider to determine continuation of care by the non- participating provider. We will only authorize treatment in special cases. Please find additional continuity of care information in Section 4 of this handbook.

Prior authorization

Prior authorization must be requested for some services through MCC's UM department, which is available 24 hours a day, 7 days a week. Providers are expected to submit a pre-service authorization request prior to providing the service or care. Payment will be denied for any services that require an authorization but were not prior authorized. For questions or submissions, please call:

- CCC Plus: 1-800-424-4524 (TTY 711)
- Medallion: 1-800-424-4518 (TTY 711)

Fax prior authorization forms (found on the Provider Forms page of www.MCCofVA.com) to:

- CCC Plus: 1-866-210-1523

- Medallion 4.0: 1-855-769-2116
- Behavioral Health: 1-855-339-8179
- Physician-administered medications (e.g., HCPCS, JCodes): 1-844-278-5731
- Outpatient (e.g., retail, mail order, specialty) prescriptions: 1-844-278-5731

Please be sure to include all required supporting documentation.

Our Care Coordinators and Community Connectors work collaboratively in coordinating care with members and their PCP to ensure that all care and services are integrated into the member's comprehensive treatment plan. We may allow a standing authorization to be approved for members with chronic or disabling conditions. Providers should specifically request these authorizations when working with MCC case and disease managers on care plans for their patients.

Decisions on routine prior authorizations will be rendered within fourteen calendar days from the date of receipt of the request. Decisions on expedited prior authorization requests will be rendered within 72 hours from the date we receive the request, if we determine that the request qualifies for expedited consideration. We will notify you if the request will not be considered as an expedited request. We may extend a turnaround time by up to fourteen calendar days if the member requests an extension, if we request to DMAS a need for additional information and if the extension is in the member's best interest. Decisions for approved services are based only on appropriateness of care and service and existence of coverage.

If members receive care from out-of-network providers without prior authorization, MCC will not pay for this care. PCPs should contact us if they wish to request an exception referral for the member to see an out-of-network provider. If an out-of-network provider provides emergency care, the service will be paid.

For the most up-to-date listing of services requiring prior authorization, visit the Provider Forms page on www.MCCofVA.com.

Retrospective review

A retrospective review is the process of reviewing and making a coverage decision for services that have already been received (e.g., post-service decision). The provider may have received a notice via a claims explanation of payment that the claim will not be paid due to lack of prior authorization, or the provider may become aware prior to a claims submission that a service rendered required an authorization prior to payment. A retrospective review is afforded to inpatient facilities that did not obtain an authorization for an acute behavioral or medical stay and the notification of the admission is received after the member has been discharged from the facility. A retrospective review can be submitted up to 5 calendar days from the date of the discharge. For any requests after the 5 calendar days from discharge, the facility must submit a claim, and once the claim has been denied for no authorization, the review of the stay with supporting medical records can be submitted for an appeal to conduct a medical necessity review. To expedite this appeal process, the provider must submit a copy of the claim EOP and the medical records within 60 calendar days of the denied claim stating no

authorization. Requests exceeding this timeframe will be denied as untimely. Members are held harmless and have no financial liability for services rendered.

Non-hospital providers are expected to submit a pre-service authorization request to MCC prior to providing the service or care. These cannot be accepted as retrospective reviews. A retrospective review is afforded to inpatient facilities that did not submit a timely notification for an acute behavioral or medical stay. A claim must be submitted and once the claim has been denied for no authorization, the review of the service or care with supporting medical records can be submitted for an appeal to conduct a medical necessity review within 60 calendar days and include the copy of the claim EOP and the medical records. Visit www.MCCofVA.com to download the appeal form. Requests exceeding this timeframe will be denied as untimely. Members are held harmless and have no financial liability for services rendered.

Care Coordination program

We believe care coordination and case management services are integral tools in providing support for members across the continuum of care and services. We offer care coordination services to facilitate member assessment, care planning and advocacy to improve health and wellness outcomes for members. We support the treatment plans developed by our providers and ICTs and rely on our providers to help coordinate the placement and cost-effective treatment of members who are eligible for our Care Coordination programs. These range from high-risk, complex case management to health, wellness and disease management programs.

Members may be identified for Care Coordination in various ways, including:

- DMAS program requirements
- Internal referrals from other departments
- A referral from a member's PCP
- Self-referral
- Referral from a family member
- After completing a Health Risk Assessment
- Data mining for members with high utilization, high-risk conditions and gaps in care

Key elements of the Care Coordination process include:

- Clinical assessment and evaluation—A comprehensive assessment of the member is completed to determine where they are in the health continuum. This assessment gauges the member's available and needed supports and resources and seeks to align them with appropriate clinical needs and member goals
- Care planning—Collaboration with the member and/or caregiver as well as the PCP and other providers to identify the best ways to fill any identified gaps or barriers to improve access and adherence to the provider's plan of care
- Service facilitation and coordination—Utilizing community resources to facilitate member adherence with the plan of care. Activities may be as simple as reviewing the plan with the member and/or caregiver or as complex as arranging services, transportation and follow-up
- Member advocacy—Members are key participants in the ICT; the Care Coordination process

advocates on behalf of the member within the health care system when appropriate

Care Coordinators engage members in their health management and treatment plan and work collaboratively with PCPs and specialists to expedite access to care and needed services. They also support the PCP and/or behavioral health provider in actively linking the member to other providers, medical services, residential, social and other support services, as needed. Providers may request Care Coordination for any member.

Individualized, person-centered plan

MCC's model of care is person-centered, culturally relevant, recovery-oriented, community-focused, and evidence-driven. We focus on activities designed to improve quality of life and health outcomes by targeting and influencing behavioral, social, economic and clinical determinants of those outcomes at both the individual and group level.

This individualized, person-centered approach engages individuals living with disabilities and chronic conditions to actively interact with the provider delivery system to ensure choice, control, and access to a full array of quality services. This approach ensures optimal outcomes such as independence, health and wellness, and optimal quality of life.

The critical components of our person-centered plan are:

- Active participation by the member (or designee) in the ICP development and planning process that starts with the member's goals and meaningful choices of service alternatives
- Holistic ICPs based on a comprehensive needs assessment
- Opportunities to self-direct community-based services

Our approach builds an infrastructure within the health and services system that supports and enhances the relationship between members and providers. Based on the member's goals, choice, and medical and psychosocial necessity criteria, we offer holistic support and demonstrated cost savings through the delivery of medical and pharmacy services at the most appropriate, least restrictive level of care.

Population Health Management program

MCC has programs to help improve the health and wellness of your patients. The Population Health Management (PHM) programs are designed to help keep them healthy, improve their safety and manage multiple chronic illnesses. These programs include:

- Diabetes self-management
- Appropriate emergency department usage
- Smoking cessation
- Wellness programs for adults, children, pregnant members and infants

To learn more about these educational and interactive programs, please have your patient speak with their assigned Care Coordinator or call Member Services:

- CCC Plus: 1-800-424-4524 (TTY 711)
- Medallion: 1-800-424-4518 (TTY 711)

Disease management program

We have several disease management programs to assist you in effectively helping members better self-manage their chronic disease. Our Care Coordinators fully integrate disease management approaches into their daily routine and engagement with members. A sample of these programs include:

- Asthma/COPD
- CAD/CHF
- Hypertension
- Diabetes
- Depression
- Oncology
- High-risk maternity

To enroll a member in a disease management program, please call Member Services:

- CCC Plus: 1-800-424-4524 (TTY 711)
- Medallion: 1-800-424-4518 (TTY 711)

Complex case management

We offer a complex case management program to members at no additional cost. The program helps our members navigate the health care system to facilitate appropriate delivery of needed medical care and services. It encourages appropriate use of health care services, improves quality of care and ensures access to care. You can refer your patients with multiple co-morbidities or those who may have recently experienced a critical event. If you treat a member who would benefit from this service, have them call Member Services and ask for a Care Coordinator in complex case management; or, you can refer them directly.

- CCC Plus: 1-800-424-4524 (TTY 711)
- Medallion: 1-800-424-4518 (TTY 711)

Long Term Services and Supports (LTSS) program

LTSS is a Medicaid program that helps CCC Plus members with their home and community-based needs. Each member has an assigned Care Coordinator who can help with ongoing needs or complete an assessment to identify if there are any additional health care resources for your patient. If you would like to refer one of your patients, please have them call 1-800-424-4524 (TTY 711) and ask to speak to a Care Coordinator.

24/7 NurseLine

MCC offers a 24/7 NurseLine to assist members with a wide variety of health care and service needs. The NurseLine staff, who are all registered nurses, help members choose appropriate psychosocial, medical and behavioral services, find a physician or hospital in their community, understand treatment and covered services options, achieve a healthy lifestyle, or answer medication questions. The NurseLine nurses reinforce health education about appropriate ER use and help members understand the resources and services available and how to access them. Members can reach the NurseLine at:

- CCC Plus: 1-800-424-4524 (TTY 711)
- Medallion: 1-800-424-4518 (TTY 711)

Preventive health and wellness

We've developed numerous education, promotion and outreach strategies, and continuously monitor the effectiveness of these strategies, to encourage healthy behaviors and ensure all members receive appropriate screenings and treatment, if needed. To promote self-care and personal responsibility, we offer member incentive programs that reward members for activities such as completing a preventive visit or health risk assessment. By participating in these healthy behaviors, members can earn rewards that are loaded onto a Complete Care Counts reloadable debit card that they can use to purchase health-related services and supplies. To learn more, visit www.MCCofVA.com.

Transitions of care

We support a comprehensive transition of care program which includes the member, the member's primary Care Coordinator, the MCC transitions coordinator, the member's PCP, other care providers, and the ICT members in all aspects of the member's care transitions. We apply this approach when a transition occurs, as members move from one care or residential setting to another due to a planned choice, change in health status, circle of support, living circumstance, or moving in and out of the justice system.

We employ transitions coordinators who are subject matter experts and are based within each region. The care transition coordinators offer expert assistance and support with any type of transition of care. This support is available to the primary Care Coordinator assigned to each member, the member, PCP, other providers and the ICT. We incorporate nationally recognized best-practice approaches and measures, in addition to application of DMAS requirements and recommendations. Collectively, these approaches are based on key components of DMAS expertise and recommendations, the National Transitions of Care Coalition and Eric Coleman's Care Transitions Program®, and the Camden Coalition's work with super-utilizers to reduce preventable hospital readmissions. We believe that both planned and unplanned transitions require diligent planning, communication, and follow-up to avoid readmissions to acute care settings, hasty placements in institutions or re-institutionalizations.

Biosimilar program

We support a biosimilar UM program that includes select HCPCS (e.g., JCodes) that have biosimilar products.

A biosimilar product is highly similar to, and has no clinically meaningful differences in safety, purity and potency (safety and effectiveness) from, an existing FDA-approved reference product. A manufacturer developing a proposed biosimilar demonstrates that its product is highly similar to the reference product by extensively analyzing (i.e., characterizing) the structure and function of both the reference product and the proposed biosimilar. A manufacturer must also demonstrate that its proposed biosimilar product has no clinically meaningful differences from the reference product in terms of safety, purity, and potency (safety and effectiveness).

JCode utilization management medical necessity requests for reference products that have a biosimilar product will require a trial/failure of the respective biosimilar product. Patients with an existing authorization or currently or already on a reference product will not be required to try/fail a biosimilar product. Please refer to the Section 10: Medical Management, Utilization Management for additional information on service authorization requests.

Additional information on biosimilars may be accessed at U.S. Food and Drug Administration Biosimilar website at https://www.fda.gov/drugs/therapeutic-biologics-applications-bla/biosimilars.

Section 11: Covered Services

MCC provides the covered services required in Virginia's Medicaid program as defined under the State Plan for Medical Assistance Services, and further defined in the Virginia Administrative Code, Title 12 VAC 30-50, and the appropriate DMAS Provider Program Manuals at https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual.

Services listed as non-covered by Medicaid are covered when medically necessary for children under age 21 in accordance with federal EPSDT requirements. No covered services are excluded on the basis of religious, moral or ethical objections. A list of covered services can be found on our website at www.MCCofVA.com.

Emergency services

MCC covers, and is financially responsible for, all health screenings, evaluations and examinations that are reasonably calculated to assist the provider in arriving at the determination as to whether the member's condition is an emergency medical condition. MCC does not deny payment for emergency services obtained under any of the following circumstances:

- A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possess an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily or mental functions, or serious dysfunction of any bodily organ or part
- A representative of MCC instructs the member to seek emergency services

Members are instructed by MCC staff and through the member handbook to contact their PCPs after receiving emergency care services. In addition, the Customer Care and Care Coordination teams will help the member schedule a PCP appointment, if needed. Emergency room utilization is monitored regularly, and members with a pattern of overuse are followed by the ED Care Coordination and Care Coordination teams.

Out of area emergency services

If the member is away from home and has an emergency, they are instructed to go to the nearest emergency room or any emergency setting of their choice. MCC covers any medically necessary duration of stay in a non-contracted facility, which results from a medical emergency, until such time as we can safely transport the member to a participating facility. In such situations, the member should call their PCP as soon as possible.

EPSDT and immunizations

MCC is committed to supporting DMAS in its obligation to assure the federal government that EPSDT services are being provided as required. We cover EPSDT screenings according to American Academy of Pediatrics guidelines. In partnership with our network providers, we also offer comprehensive health care services through primary prevention, early intervention, diagnosis, and medically necessary treatment to correct or improve defects and physical or mental illness discovered by the screening of members under age 21. MCC:

- Screens, assesses, and monitors all children
- Covers immunizations
- Educates providers and schools regarding reimbursement of immunizations
- Works with DMAS to meet goals related to increased immunization rates

We use various education, promotion, and outreach strategies, and continuously monitor the effectiveness of these strategies to ensure that all members eligible for EPSDT are receiving appropriate screenings, diagnosis, and most importantly, treatment. We use multiple modes of communication to proactively contact members regarding EPSDT screenings and services. Members needing these services are identified by MCC's analytics systems. MCC staff helps members with transportation or service needs. When specific members are known to lack needed services such as immunizations or dental services, we reach out to encourage participation among those members.

Newborn hearing screenings

MCC requires all newborns to receive a hearing screening from an audiologist per EPSDT Global Coverage Guidelines. All screenings must be completed prior to hospital discharge after birth, unless appropriate communication has been provided to us. Follow-up visits should be scheduled if necessary, based on the results of the screening.

The appropriate written documentation of service (or referral if necessary) must be placed in the recipient's medical record within 24 hours after the provider completes the screening procedure or within 24 hours of the parent's or guardian's signed refusal of screening. This information should be provided directly to the PCP as the coordinator of care. The documentation must include the following:

- Type of screening test administered, date of test, and tester's name
- Results
- Interpretation
- Recommendations
- Follow-up referrals for treatment, if applicable
- Parent's or guardian's refusal of screening, if applicable

Maternal health program

MCC's maternal health program offers comprehensive, ongoing education and support to all pregnant members from identification through the post-partum period.

This program is built to optimize care and outcomes for our pregnant members and their newborns by engaging members, partnering with providers, and integrating community resources and non-traditional services into local health systems. Our model of care builds an infrastructure within the health system which supports and enhances the relationship between members and their providers. We use every means available to identify, engage and support our pregnant members and connect them to care to achieve the best possible outcome for her and her newborn. Our program empowers members with actionable health information and tools that inform, enable, influence and incentivize member engagement in self-management. We offer culturally sensitive, individualized interventions designed to help the pregnant member and her baby remain healthy.

Our maternal health program is designed to:

- Optimize the health of our pregnant members
- Promote the delivery of a healthy, full-term infant
- Lower overall health care costs related to pregnancy and newborn care

Family planning services

MCC will cover all family planning services and supplies for members of child-bearing age which delay or prevent pregnancy, including drugs, supplies and devices provided under the supervision of a physician, as set forth in 12 VAC 30-50-130 and 42 C.F.R. § 441.20. Consistent with 42 CFR § 441.20, MCC will provide coverage for its enrolled members for all methods of family planning including but not limited to barrier methods, oral contraceptives, vaginal rings, contraceptive patches and long- acting reversible contraceptives (LARCs).

MCC will not restrict a member's choice of provider or method for family planning services or supplies and will cover all family planning services and supplies provided to its members by network and out-of-network providers. We also allow the member, free from coercion or mental pressure, the freedom to choose the method of family planning to be used. MCC also acknowledges the Code of Virginia § 54.1-2969 (D) and (E), as amended, which states that minors are deemed adults for the purpose of consenting to medical services required in case of birth control, pregnancy or family planning, except for purposes of sexual sterilization. MCC doesn't include services to treat infertility or to promote fertility. Individuals enrolled in FAMIS have access to covered services that include drugs and devices provided under the supervision of an in-network physician.

As required by section 1902(a)(23)(B) of the Act, MCC will not require the member to obtain a referral prior to choosing a provider for family planning services. The member will be allowed to select any qualified family planning provider from in-network or out-of-network without referral. In addition to having a choice of family planning provider, members will be free to choose the method of family planning as provided in 42 CFR § 441.20.

Early intervention

Early identification of infants and children with developmental delays is critical to the future health of the child and the well-being of the family. For eligible infants and toddlers, Early Intervention (EI) services provide critical supports to family members and caregivers to enhance their child's development. These services are incorporated into the ICP for members under age three. Infants and toddlers under age two are referred to EI when there are risk factors for developmental delay, premature birth or suspicion of developmental delays.

Referrals to early intervention can be completed by the parent, Care Coordinator, medical or services provider, and parents are consulted prior to referral. Our Care Coordinators encourage parents to fully participate in the referral, assessment, and service planning process to ensure the infant or toddler receives all needed services. When the infant or toddler is in foster care, the Care Coordinator may assist with the transfer of clinical information, including diagnoses, medications, provider names, and other clinical assessments and available medical records.

We cover EI services in accordance with EI coverage criteria and guidelines and the EI Program Manual.

Telemedicine

MCC supports the use of telemedicine. Providers interested in providing telemedicine services should contact their provider contracting representative to add the appropriate addenda to their contract. The contract documents will spell out requirements and rates for telehealth, and training will be scheduled.

At a minimum, the requirements for providers participating in MCC's telemedicine program include:

- Interactive and real-time synchronized multimedia (audio and video) transmission
- Remote camera control is preferred; the provider must have a dedicated secure line and utilize an acceptable method of encryption
- The originating site (location of the member) must have telehealth support staff able to assist the member with the technical equipment and connection
- A protocol must be in place to access emergent or urgent clinical care if the designated telehealth support staff are not clinicians
- The member site must be a room that provides privacy
- Providers must:
  - Have completed basic training on telehealth equipment
  - Provide the same rights to confidentiality and security of clinical information as provided in face- to-face services
  - Include in the member's clinical record that the service was provided via telehealth

Community referrals

MCC provides assistance when there is a need for a referral for services outside of the covered benefits. We have relationships and linkage agreements with community providers that offer services which complement the traditional benefits covered by our plan. These relationships allow us to collaborate with agencies that offer important ancillary services such as emergency shelter, housing, home-delivered meals and emergency childcare.

Providers are encouraged to call us if a member need referrals of any kind. We count on a large network of providers and community contacts to meet our members' needs. Additional information and referrals to services either covered through the plan or ancillary community services may be accessed by calling:

- CCC Plus: 1-800-424-4524
- Medallion 4.0: 1-800-424-4518

Private Duty Nursing (PDN)

While PDN services are normally only covered under the Technology Assisted Waiver for eligible CCC Plus waiver members, MCC also covers medically necessary PDN services for children under age 21, consistent with criteria in the DMAS Manual and in accordance with EPSDT regulations, and for FAMIS members under the age of 18 when medically necessary. We understand that individuals who require continuous nursing that cannot be met through home health may qualify for PDN services.

We realize that children present with different conditions, which may result in the authorization and provision of traditionally uncovered services to correct, maintain or ameliorate the child's condition. These services will require medical necessity review. Any services requested and not approved can only be denied by a medical director to ensure that safety and optimal health outcomes are achieved.

Foster care

MCC covers services for children in foster care and those that receive adoption assistance if they meet the eligibility criteria. We extend coverage to all medically necessary EPSDT or required evaluation and treatment services of the foster care program, including services accessed out of our service area.

In addition, we collaborate with DMAS and Departments of Social Services in meeting the federal requirements related to the Virginia Health Care Oversight and Coordination Plan for children in foster care.

Substance use disorder

The identification of individuals with substance use disorders (SUD) involves approaches specifically designed to follow the laws and regulations that protect member privacy. MCC uses a predictive model and claims analysis to look directly and indirectly for SUD's or risks by looking at diagnoses, patterns of behavior and utilization, and other clinical variables. We also look for potential signs of SUD, such as claims associated with frequent ED visits for pain management or opiate prescriptions, opiate prescriptions of prolonged duration, polypharmacy, and any history of medication-assistant treatment (MAT).

We identify members using our Health Risk Assessment, which includes a substance use screening tool. MCC staff obtains appropriate member consent to share member information related to SUD diagnoses with a member's providers or support persons.

DMAS approved ARTS Care Coordinators possess expertise in working with individuals with SUDs and are experts in Virginia's ARTS system of care, MAT, and other providers working with individuals with alcohol, opiate, and other SUDs. They work closely with members in need of ASAM level treatment programs and work coordinate care with other Care Coordinators and certified peer specialists assigned to members with SUD. ARTS and other Care Coordinators ensure access to peer support services, housing and employment staff, transportation, and others needed for successful recovery.

For substance use members under the age of 18, the ARTS Care Coordinator engages both the child and family as permitted, as well as appropriate community supports such as schools. Care Coordinators ensure that EPSDT screening is provided to children with SUD and coordinate with the BHSA to ensure the member receives substance use residential treatment services and behavioral therapy as needed. For children in acute or residential facilities, the Care Coordinator works with the facility staff and care transition planners. The Care Coordinator helps family members access community-based mental health or substance services and support groups.

Mental Health Services and Behavioral Health Enhancement (BHE) services

Mental Health Services are a system of community-based behavioral health programs intended to provide clinical treatment to those individuals with significant mental illness or youth with, or at risk of developing, serious emotional disturbances.

These benefits are available to individuals who meet the service specific medical necessity criteria based on diagnoses made by Licensed Mental Health Professionals practicing within the scope of their licenses.

Mental health services, including, outpatient psychotherapy services, community-based, crisis and inpatient services. Community and facility-based services include:

- Mental Health Case Management
- Therapeutic Day Treatment (TDT) for Children
- Mental Health Skill-building Services (MHSS)
- Intensive In-Home
- Psychosocial Rehabilitation
- Behavioral Therapy Program
- Mental Health Peer Recovery Supports Services
- Mental Health Partial Hospitalization Program
- Mental Health Intensive Outpatient
- Assertive Community Treatment
- Multisystemic Therapy (MST)
- Functional Family Therapy (FFT)
- Mobile Crisis

- Community Stabilization
- 23-Hour Observation
- Residential Crisis Stabilization

Member rewards program

We encourage our members to make healthy choices and participate in activities that will help them be healthy and keep them from getting sick. Our members are eligible for member rewards if they take part in specific activities. The goal is to reward their healthy behavior. Members receive information on how to earn member rewards from their Care Coordinators (where applicable) or Member Services. If they leave MCC, rewards cannot be transferred to another health plan. For more information call:

- CCC Plus: 1-800-424-4524
- Medallion 4.0: 1-800-424-4518

Excluded benefits and services for Medallion 4.0

The following benefits and services will not be covered for members in the Medallion 4.0 program:

- Services for members who are scheduled for an inpatient hospital stay or surgery within 30 calendar days of the enrollment effective date, until the first day of the month following discharge
  - This process does not pertain to newborns unless there is a break in coverage
  - Members who are discharged from one hospital and admitted to another hospital within 24 hours (facility to facility transfers) for continued treatment of the same diagnosis shall not be considered discharged
  - This is not applicable to FAMIS members
- Freestanding psychiatric facility services for members aged 21 through 64 for admissions not prior authorized by MCC
- Services for FAMIS members in free-standing psychiatric hospitals
- Psychiatric residential treatment (level C) for FAMIS members
- Inpatient psychiatric treatment as a result of a Temporary Detention Order (TDO) outside of the coverage guidelines for inpatient behavioral health services for FAMIS members
- The following list of carved-out services are covered under the Medicaid State Plan and handled by DMAS directly on a fee-for-service basis:
  - Assisted suicide
  - Chiropractic services
  - Christian Science nurses
  - Experimental and investigational procedures
  - School health services
  - Targeted case management services
  - Abortions
  - Dental services, for adults that do not fall into the adult enhanced benefits
  - Specialized infant formula
  - Private Duty Nursing (PDN) for adults (over 19 yrs. for FAMIS and 21 yrs. for Medicaid)
  - Skilled nursing facility care

  - Home and community-based Medicaid waiver services
  - Behavioral dietary counseling through the Medicaid Works program
- The following types of prescription drugs:
  - Drugs used for anorexia or weight gain
  - Drugs used to promote fertility
  - Agents used for cosmetic purposes or hair growth
  - Agents used for the treatment of sexual or erectile dysfunction, unless such agents are:
    - Used to treat a condition other than sexual or erectile dysfunction, for which the agents have been approved by the FDA
  - All DESI (Drug Efficacy Study Implementation) drugs as defined by the FDA to be less than effective; compound prescriptions, which include a DESI drug, are not covered
  - Drugs which have been recalled
  - Experimental drugs or non-FDA-approved drugs
  - Any legend drugs marketed by a manufacturer who does not participate in the Medicaid Drug Rebate program
- Items or services (other than an emergency item or service, not including items for services furnished in an emergency room of a hospital) that are:
  - Furnished during any period when the member or entity is excluded from participation
  - Furnished at the medical directions or on the prescription of a physician during the period when such physician is excluded under participation and when the person furnishing suchitem or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person)
  - Furnished by an individual or entity that MCC is investigating (or has been informed by DMAS is investigating) relating to DMAS's determination that a credible allegation of fraud exists, unless DMAS determines there is good cause, in accordance with federal law, not to suspend such payments
  - Amounts expended for roads, bridges, stadiums, or any other item or service not covered under the Medicaid State Plan (not applicable to FAMIS)

Section 12: Member management support

Welcome call

The relationship between MCC and our members is initiated through a welcome call, during which they are informed about services provided and engaged to ensure they understand how to access services.

CCC Plus Care Coordination

All CCC Plus members are assigned a primary Care Coordinator who is available to assist the member with their needs. The Care Coordinator encourages new members to include the people closest to them in the Health Risk Assessment (HRA) process and/or in the initial visit with their Care Coordinator. Those individuals who represent the member's circle of support are an important part of the planning process and can provide helpful insights to the HRA. We make their involvement easy and convenient and seek their input whenever a reassessment occurs.

To accommodate members with limited English proficiency, our Care Coordinators have access to real-time interpreter services. We hire Care Coordinators with a background in diverse cultures and populations. All staff that interface directly with members are trained to communicate in a culturally and developmentally appropriate manner.

Medallion 4.0 Care Coordination

As with our CCC Plus members, the welcome call for Medallion 4.0 members provides introduction to the person-centered mission and vision of the health plan, and initiates our primary objective to create a care plan that will foster positive health outcomes and identify supportive community resources. Succeeding at these objectives promotes the member's overall health and improves their socioeconomic independence.

Health Risk Assessments cover the members':

- Health care needs
- Mental health needs
- Interventions previously received
- Any additional services required

MCC takes all reasonable steps to assure that the following newly eligible/enrolled populations receive an assessment within 60 days of initial enrollment:

- Children and Youth with Special Health Care Needs (CYSHCN), including Early Intervention, and adoption assistance children, substance exposed infants
- Children in foster care
- High-risk pregnant women (appointments scheduled within 3 days of identification)
- Those who stratify into care coordination based on MCC's risk stratification model

Appointment scheduling

Our model of person-centered care requires us to provide services as expeditiously as the member's health condition requires. To achieve this, we expect the following appointment standards be closely adhered to when rendering care to Medicaid and FAMIS members:

- Emergency care—scheduled immediately
- Urgent care—scheduled within 24 hours of the member's request
- Routine primary care services—scheduled within 30 days of the member's request
- This standard does not apply to appointments for routine physical examinations, for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every 30 days, or for routine specialty services like dermatology, allergy care, etc.
- Maternity care appointments
  - 1st trimester—scheduled within 7 days of member's request for M4 members, and 14 days for CCC Plus members
  - 2nd trimester—scheduled within 7 days of member's request
  - 3rd trimester—scheduled within 3 days of member's request for M4 members, and 5 days for CCC Plus members
  - High-risk pregnancy—scheduled within 3 days of identifying the status of the member's pregnancy

Member Services

Members can report inquiries and/or concerns to Member Services between the hours of 8 a.m. to 8 p.m. local time, Monday through Friday:

- CCC Plus: 1-800-424-4524 (TTY 711)
- Medallion 4.0: 1-800-424-4518 (TTY 711)

Member Services is responsible for making sure members can easily access information about the Care Coordination program, including contact details for all providers and members of their team. Member Services helps schedule appointments, arranges peer support and education, schedules needed translations services for appointments, help with PCP changes, answer benefit inquiries and helps replace lost member ID cards. They also help members with claims, authorizations, updating demographic information, providing marketing materials and resolving concerns.

Incoming calls are documented and routed to the appropriate departments in cases where additional follow-up or outreach is required. The resolution is documented in the Member Services resolution management system upon completion of the reported inquiry/concern.

Interpreter services

MCC provides interpreter access for members from culturally and linguistically diverse backgrounds and for people with hearing, speech and communication impairments. Members living with a hearing or speech impairment can access the TTY/TDD service line by calling TTY 711. Members who don't have TTY can communicate with a TTY user through Message Relay Center (MRC). MRC has

TTY operators available to send and interpret TTY messages.

Participants with a specific language requirement or request can contact Member Services at:

- CCC Plus: 1-800-424-4524 (TTY 711)
- Medallion: 1-800-424-4518 (TTY 711)

Section 13: Enhanced benefits

MCC offers a variety of enhanced benefits and services to further support the needs of our members. You can find a complete list of enhanced benefits in the table below. Members can initiate access to these services directly. However, as a participating provider, you may also refer members to those services.

Service	Limits	Eligibility
Adult physicals We will reimburse your PCP for routine physicals (one per year).	Covered – one per year	Available to members age 21 and older
Bicycle helmets We will provide one bicycle helmet per year for children under 18.	Covered – one per year	Available to children under 18
Community Connections We provide an online search tool to help you find important services in your area, like housing, food, job training and more.	Covered	Available to all members, family members, and caregivers
Complete Care Counts Get up to $50 in gift cards each year when you do things that help your health, like: • Complete your initial health risk assessment with your CareCoordinator (CCC Plus members only) • Quit smoking • Get your annual physical • Go to all your doctor visits when pregnant and visit your doctor for a postpartum visit • Seeing your doctor within a week after hospital discharge	Covered – up to $50 per year	Available to all members

Service	Limits	Eligibility
Environmental modifications We pay up to a $1,500 lifetime benefit for non-waiver members, including changes to your primary residence or vehicle that will help you be more independent. This also includes things like a handrail or grab bar, widening a doorway, installing a walk-in shower, or the maintenance of these items.	Covered – $1,500 lifetime benefit cap	Available to all CCC Plus members that are not currently receiving waiver services. Pre-authorization required.
Home delivered meals We provide meals for members leaving a nursing facility or hospital. Up to three meals per day, for up to five days for members and one additional family member. These meals are freshly made. They enable members to recover without worry about nutrition, food shopping, or preparing meals.	Covered – Up to 3 meals per day, for up to 5 days, and includes one additional family member.	Available to members leaving a nursing facility or hospital. This includes meals for one family member as well.
Mother-Baby Connections Text messages with important health information to help: • Understand what is happening with your body • Recognize warning signs • Know what to expect during your delivery Members also get: • Infant sleep sacks and diapers • An invitation to baby showers hosted by MCC (hosted quarterly per region) • "Baby Basics" book • Rides to WIC appointments, Lamaze and parenting classes.	Covered	Pregnant Medallion 4.0 members

Service	Limits	Eligibility
Personal care attendant support We pay for up to 20 hours per year for a personal care attendant for non-waiver members when medically necessary. This support includes services that members need to be able to stay at home. Personal care provides help with activities of daily living (ADLs). These include things like bathing, dressing, eating and preparing meals. It also helps with instrumental activities of daily living (iADLs) like running errands and light housework.	Covered – Up to 20 hours per year	Available to all CCC Plus non- waiver members. Requires pre-authorization.
SaveAround coupon book We offer a discount coupon book for various retailers.	Covered – one book per year	Members age 18 and older
Smart phone program We offer smartphones with 350 free minutes, 1 GB of data and unlimited texting each month. We also provide text messaging programs to remind members of appointments and more.	Covered	All members
Sports physicals for children We will cover annual sports physicals performed by PCP (one per year).	Covered – one per year	Medallion 4.0 members ages 10-18
Transitions of care for foster children Foster children leaving foster care will get a backpack to ease their transition, including: • Personal hygiene items • Community resource guides • Area maps Case managers check in to make sure things go smoothly when kids go to a new home.	Covered	Foster children entering a new home

Service	Limits	Eligibility
Transitions of care for adults Adults with frequent or avoidable emergency room visits will receive a backpack, including: • Personal hygiene items • Community resource guides • Area maps • Pill box	Covered	Adults with frequent or avoidable emergency room utilization
Vision services (for adults) We pay for vision services for adults age 21 and older that have an active prescription from a participating provider. This covers up to $100 for eyewear allowance every two years for eyeglasses, with a limit of one pair of eyeglasses every two years. Or it will cover contact lenses with a limit of one pair of contact lenses every two years.	Covered – Up to $100 for eyewear allowance every 2 years	Available to members age 21 and older

Section 14: Covered pharmacy services

Pharmacy policy

Prescription drug benefits are managed through MCC and are administered by our prescription benefit manager, CVS Caremark. We offer coverage for outpatient prescription drugs listed on their Preferred Drug List (PDL). Medications not listed on the PDL will require service authorization to be considered for approval.

MCC pharmacy claims are processed by CVS Caremark, our pharmacy benefit manager. MCC members should obtain covered drugs from a pharmacy within the CVS Caremark Advanced Choice pharmacy network unless there is an emergency situation. The CVS Caremark Advanced Choice pharmacy network includes retail chain pharmacies, several local independent pharmacies, home infusion, mail order and specialty pharmacies. Additional information about the pharmacy network can be obtained by contacting the MCC pharmacy department at 1-800-424-4524 for CCC Plus and 1-800-424-4518 for Medallion 4.0.

Preferred drugs

MCC uses a preferred drug list (PDL). This is a list of prescription drugs approved by MCC for our members and includes the approved DMAS PDL. Generic drugs, certain brand name drugs and certain specialty drugs listed in the PDL are covered. Some drugs, even though they are listed on the PDL, may have special limitations such as quantity limits and age restrictions. Others may require the member to try and fail other preferred medications first. Non-PDL drugs may be requested through the service authorization process (see below). Some drugs are excluded from the pharmacy benefits such as those used for weight loss, infertility and cosmetic purposes. The PDL is available at www.MCCofVA.com.

The PDL does not:

- Require or prohibit the prescribing or dispensing of any medication
- Substitute for the independent professional judgment of the physician or pharmacist
- Relieve the physician or pharmacist of any obligation to the patient or others

Medication additions or deletions to the PDL reflect the decisions made by the Molina Pharmacy Therapeutics (P&T) Committee, and those decisions are inclusive of the DMAS PDL. The composition of the committee includes licensed pharmacists and medical doctors.

Specialty pharmacy

MCC uses the CVS Caremark Specialty Pharmacy division to provide specialty pharmacy services to your patients. Prescription drug requests for specialty medications for MCC members should be submitted to CVS Caremark Specialty Pharmacy for fulfillment. MCC limits the days-supply on specialty prescriptions to 34 days. Your patient may call CVS Caremark Specialty Pharmacy at 1-800-237-2767 to discuss opting out of this program and have his or her current specialty pharmacy

continue to provide the medication. To submit a prescription, or if you have questions, please contact CVS Caremark Specialty Pharmacy at 1-800-237-2767.

CVS Caremark Specialty pharmacy makes it easy for members to get their specialty medicine with services including:

- Coaching programs to help manage their condition
- Free delivery to member's home or another address within two days of ordering
- Supplies at no cost, such as syringes and needles
- Highly trained pharmacists and nurses available to answer any questions
- Insurance specialists to help them get the most out of their benefits
- Online member portal where they can request refills and learn more

Mail Order pharmacy

MCC uses the CVS Caremark Mail Order Pharmacy division to provide mail order services to your patients. Prescription drug requests for medications included on the Virginia Medicaid 90-day drug list should be submitted to CVS Caremark Mail Order Pharmacy for fulfillment. Your patient may call CVS Caremark Mail Order Pharmacy at 1-844-285-8668 to discuss using this service.

Service authorizations

The PDL attempts to provide appropriate and cost-effective drug therapy to all members covered by the MCC pharmacy program. If a patient requires medication that is not listed on the PDL, the physician can make a request for a non-preferred medication. It is anticipated that such exceptions will be rare and that PDL medications will be appropriate to treat the vast majority of medical conditions. For a member to receive coverage for a medication requiring service authorization, the physician or pharmacist must submit a service authorization request form and indicate the reason for the exception. All relevant clinical information and previous drug history should be included.

Call or fax the request to:

Phone:

- CCC Plus: 1-800-424-4524 (TTY 711)
- Medallion 4.0: 1-800-424-4518 (TTY 711)

Fax:

- CCC Plus: 1-844-278-5731
- Medallion 4.0: 1-844-278-5731

You can find service authorization forms at

https://www.molinahealthcare.com/providers/va/medicaid/resources/forms.aspx

Denial of services

If MCC denies a request for service authorization, we will issue a Notice of Action within 24 hours of the denial to the prescriber and the member. The Notice of Action will include appeal rights and instructions for submitting an appeal.

Over-the-counter items

Certain over-the-counter (OTC) items are covered for our members. Our PDL covers several OTC medications that can be obtained at a pharmacy with a prescription from a provider.

72-hour emergency supply policy

All participating pharmacies are authorized to provide a 72-hour supply of medication and will be reimbursed for the ingredient cost and dispensing fee of the 72-hour supply of non-PDL drugs (nonpreferred drugs). The following drug categories are not part of the MCC PDL and are excluded by DMAS; therefore, they are not covered by the 72-hour emergency supply policy:

- Drugs used for anorexia or weight gain
- Drugs used to promote fertility
- Agents used for cosmetic purposes or hair growth
- Agents used for the treatment of sexual or erectile dysfunction, unless such agents are used to treat a condition other than sexual or erectile dysfunction, for which the agents have been approved by the FDA
- DESI (Drug Efficacy Study Implementation) drugs considered by the FDA to be less than effective. Compound prescriptions, which include a DESI drug, are not covered
- Drugs that have been recalled
- Experimental drugs or non-FDA-approved drugs
- Drugs marketed by a manufacturer who does not participate in the Medicaid Drug Rebate Program

Newly approved products

Newly approved drug products will not normally be placed on the preferred drug list during their first six months on the market. During this period, access to these medications will be considered through the service authorization review process.

Section 15: Quality

Our commitment to quality

MCC is committed to continuous quality improvement and outcomes management through its quality improvement program, which includes assessment, planning, measurement and re-assessment of key aspects of care and service. In support of our quality improvement program, providers must be familiar with our guidelines and standards and apply them with our members in order to provide safe, effective, patient-centered, timely, efficient and equitable care in a culturally sensitive manner.

We depend on our providers to:

- Follow the policies and procedures outlined in this handbook
- Use evidence-based practices, and adhere to principles of patient safety
- Attend provider training and orientation sessions, as needed and requested
- Participate in the completion of a remediation plan if quality of care concerns arise
- Complete and return provider satisfaction surveys
- Consider incorporating the use of secure technology into your practice to make accessing services more convenient for members (e.g., email communication, electronic appointment scheduling, appointment or prescription refill reminders and online access to personal health record information)
- Help with transition of care if a member's benefits have been exhausted, you leave the network, or you receive a referral for a member whose provider has left the network, a member wants to change providers or stop services prior to service authorization expiration
- Assist in the investigation of member complaints and critical incidents, as necessary
- Attend meetings of our quality committees and provider advisory groups, as requested
- Take action on member gap-in-care information as applicable
- Be knowledgeable in quality improvement methods and tools including NCQA's health plan accreditation standards, HEDIS® measures and allow the use of performance data for quality improvement activities (e.g., reporting to members on provider performance and quality improvement projects)

MCC's responsibility is to:

- Consider your feedback on clinical practice guidelines, medical necessity criteria, prevention programs, patient safety policies and new technology assessments
- Consider providing your feedback to our quality committees
- Develop methods to compare treatments, outcomes and costs across the provider network in an effort to diminish the need for case-by-case review of care
- Provide member-specific clinical and quality reports to help you support your patients
- Monitor provider satisfaction with our policies and procedures as they affect you and your

practice
- Pay claims within applicable timeframes
- Work with you to develop a clear remediation plan to improve quality of care when necessary
- Provide timely information and decisions on credentialing and recredentialing processes
- Resolve claims disputes and appeals within applicable timeframes

Cultural competency

MCC is committed to embracing the rich diversity of the people of Virginia. We believe in providing high-quality care to culturally, linguistically and ethnically diverse populations, as well as to those who are visually and hearing impaired. All people entering the health care system must receive equitable and effective treatment in a respectful manner, recognizing the role that individual spoken languages, gender and culture play in a person's health and well-being.

Our staff are trained in cultural diversity and sensitivity to support our interactions with members, in order to refer members to providers appropriate to their needs and preferences. We also provide cultural competency training, technical assistance and online resources to help providers enhance their provision of high-quality, culturally appropriate services. We continually assess network composition by actively recruiting, developing, retraining and monitoring a diverse provider network compatible with the member population.

We depend on our providers to:

- Provide MCC with information on languages you speak
- Provide MCC with any practice specialty information you hold on your credentialing application
- Provide oral and American Sign Language (ASL) interpretation services
  - In accordance with Title VI of the Civil Rights Act, Prohibition against National Origin Discrimination, providers must make oral interpretation services available to persons with limited English proficiency (LEP) at all points of contact
  - Oral interpretation services are provided at no charge to members
  - Members must be provided with information instructing them how to access these services
  - Interpretation services are the facilitation of oral or sign-language communication, either simultaneously or consecutively, between users of different languages
- Translate any document that requires the signature of the member, and that contains vital information regarding treatment, medications, or service plans, into their preferred/primary language if requested by the member or his/her guardian
- Inform us if you object to the provision of any counseling, treatments or referral services on religious grounds

MCC's responsibility is to:

- Provide ongoing education to help you deliver competent services to people of all cultures, races, ethnic backgrounds, religions, and those with disabilities
- Provide language assistance, including bilingual staff and interpreter services, to those with

limited English proficiency during all hours of operation at no cost to the member
- Assist providers in locating interpreters for our members when requested by the member or when requested by the provider
- Provide easily understood member materials, available in the languages of the commonly encountered groups and/or groups represented in the service area
- Monitor gaps in services and other culturally specific provider service needs; when gaps are identified, MCC will develop a provider recruitment plan and monitor its effectiveness

Accreditation

Excellence in clinical care and service can be affirmed through recognition by national accrediting bodies, such as the National Committee for Quality Assurance (NCQA). MCC policies, procedures and quality initiatives are guided by national accreditation standards, including, but not limited to:

- Provider accessibility standards
- Site visits and medical/treatment record reviews
- Credentialing and recredentialing requirements
- Clinical practice guidelines
- Collaboration and coordination of care
- Care coordination and case management review processes
- Prevention/screening programs
- Member experience (satisfaction) surveys
- Member safety policies and initiatives
- Complaint, appeal and grievance policies and procedures
- Confidentiality policies and procedures
- Medical integration and coordination policies and procedures
- Provider quality remediation and review
- Member communication, including distribution of the member's Rights and Responsibilities statement
- Provider participation on our quality improvement committees
- Quality improvement and care coordination program descriptions
- Member requests to change providers and transition of care tracking

HEDIS® and performance measurement

MCC supports and promotes the use of evidence-based performance measures that help drive the adoption of recommended care and improvements in population health. The Healthcare Effectiveness Data and Information Set (HEDIS), is owned by the National Committee for Quality Assurance (NCQA) and is the most widely used measure set for driving quality rating systems, as well as for its individual measures which are increasingly used by employers, health plans, and government agencies to drive pay-for-performance quality programs.

HEDIS measures cover a wide span of indicators related to the management of physical and behavioral health. Final performance is calculated over the first six months of every calendar year for the prior calendar year. Some measures allow medical record data, and some reviews occur across a

multi-year period.

We depend on our providers to:

- Submit accurate and complete claims and encounter data within a timely manner of the rendered service
- Ensure that you and your office staff comply with our requests for medical records in the timeframes requested
- Notify our staff or delegated vendor immediately if the patient listed on a request for medical records is not seen by your practice
- Provide medical records for a member who was seen by a physician who has retired, died or moved, as data collection can go back as far as 10 years
- Assist us with quality improvement activities that improve the health and wellness of our population

MCC's responsibility is to:

- Provide education and information as needed regarding HEDIS and other performance measures for which we request your cooperation and assistance
- Communicate with you by phone, fax, in writing, or through secure electronic communications to request medical record documentation to verify service delivery

Member experience of care and satisfaction surveys

Obtaining member input on their experience of care, and satisfaction with their providers and us, is an essential component of our quality program. In addition to the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, which is mailed on an annual basis, we may survey specific cohorts of members who have received medical services, behavioral health treatment, and home- and community-based services to determine their level of satisfaction with the care and support they are receiving from us, and from providers in our network.

Your responsibility is to:

- Implement actions identified from satisfaction survey results when informed by MCC
- Involve members in their care and treatment plan
- Encourage members to provide feedback on the care and services received
- Update your practice and provider profile information, which members see in online provider searches, and monitor your reviews submitted by members

Provider input

Obtaining provider input is an essential component of our quality program. We obtain provider input on our programs and services through provider satisfaction surveys, participation in MCC quality committees and our provider website as detailed below.

Provider satisfaction surveys: We conduct provider satisfaction surveys in specified cycles and

engage participating providers in our provider networks who have rendered services to members during the survey period. Our goal is to determine provider levels of satisfaction with MCC and key aspects of the services received from us while assisting our members. If selected, you are responsible for completing and returning the survey in the timeframe requested. We share aggregate results of our provider satisfaction surveys with our providers, accreditation entities and members. These survey findings identify opportunities for improvement for our policies, procedures and services.

Provider Advisory Committee (PAC): In accordance with NCQA requirements, we will establish and maintain a PAC, consisting of providers contracting with MCC, and who serve our members. We seek to recruit at least two providers on the committee whose practices predominantly serve Medicaid members and other indigent populations. In addition, we will recruit at least one other participating provider on the committee who has experience and expertise in serving members with special health care needs. The committee will meet at least quarterly, or as frequently as needed. The committee's input and recommendations will be employed to inform and direct MCC quality management activities, as well as policy and operational changes.

MCC drives leadership and oversight of all aspects of health plan quality through the quality committee structure. We may request your participation in our PACs to give input on various topics important to the member and provider community.

The PAC is a subcommittee of MCC's quality improvement committee. The PAC advises on clinical topics, including medical and utilization management (UM) policies, UM criteria, pharmacy policies and documents, clinical practice guidelines and clinical programs. The PAC also advises and informs MCC on clinical expertise issues and quality initiatives such as NCQA, HEDIS, and provider surveys. The PAC is also charged with being aware of and responding to medical ethical issues that arise during the course of business.

Provider website: You can submit feedback through www.MCCofVA.com using the "Contact Us" feature at the top of the page.

Medical record standards

In support of our commitment to quality care, we request that our providers maintain organized, well-documented member medical records that reflect continuity of care for members. We expect that all aspects of treatment will be documented in a timely manner, including face-to-face encounters, telephone contacts, clinical findings and interventions. The complete list of requirements is documented below.

- Member identifying information, including name, member identification number, date of birth, gender, and legal guardianship (if any) should be included
- Providers must ensure a method for obtaining complete and current patient clinical information and maintaining an updated summary. Examples include a physical form, summary sheet, or

checklist that captures significant surgical procedures, past and current diagnoses or problems, allergies, untoward reactions to drugs and current medications

- Treatment plans must reflect evidence-based standards of care and be consistent with the diagnosis for each visit
- Each record must be legible and maintained in detail
- All entries must include the name and credentials of the provider rendering services (e.g., MD, DO, OD), including the date and signature of the provider. All notes written by physician extenders (ARNPs or PAs) must be co-signed by the assigned PCP, indicating their review and approval of the care rendered. All entries must be dated and signed by the appropriate party
- All entries must indicate the chief complaint or purpose of the visit, the objective, diagnoses, medical findings or impression of the provider
- All entries must indicate studies ordered (e.g., laboratory, x-ray, EKG) and referral reports
- All entries must indicate therapies administered and prescribed
- All entries must include the disposition, recommendations, instructions to the member, evidence of whether there was follow-up and outcome of services
- All records must contain an immunization history

EPSDT services must also meet the following additional documentation requirements:

- The medical record shall indicate which age-appropriate screening was provided in accordance with the periodicity schedule and all EPSDT related services whether provided by the PCP or another provider
- Documentation of each comprehensive screening shall, be made part of the medical record
- All records must contain information relating to the member's use of tobacco products and alcohol/substance abuse
- All records must contain summaries of all emergency services and care and hospital discharges with appropriate medically indicated follow-up
- Documentation of referral services must be in members' medical records. This is to include, but not necessarily be limited to, family planning services, preventive services and services for the treatment of sexually transmitted diseases
- All records must reflect the primary language spoken by the member and any interpretive needs of the member
- Include copies of any consent or attestation form used or the court order for prescribed psychotherapeutic medication for a child under the age of 13
- All records must identify members needing communication assistance in the delivery of health care services
- All records must contain documentation that the member was provided with written information concerning the member's rights regarding Advance Directives (written instructions for living will or power of attorney) and whether or not the member has executed an Advance Directive. If the member indicates they have an Advance Directive, a copy should be included. Providers cannot, as a condition of treatment, require the member to execute or waive an Advance Directive

Patient request

Providers must provide a copy of the member's medical records to members and their authorized representatives as required by MCC and within no more than 10 business days of the member's request.

Health plan request

For quality review and improvement purposes, and to support accurate HEDIS reporting, MCC may request medical records from you at different times during the year. We will provide an explanation for the request of the records, and detailed instructions for submission. Your responsibility is to make the records available for our review in the timeline requested at no extra charge.

Additionally, when a member changes his or her PCP, we will request the member's medical records or copies thereof be available to the new PCP within 10 business days from receipt of request.

Medical record confidentiality

Providers will ensure the confidentiality of all medical records in accordance with 42 CFR, Part 431, Subpart F and relevant HIPAA requirements. The confidentiality of a minor's consultation, examination, and treatment for a sexually transmissible disease must be maintained in accordance with s. 384.30(2), F.S.

Medical record review

We will review medical records to determine adherence with MCC standards for documentation and DMAS regulations. Reviews will be based on a random sample of all providers who are treating our members. The plan will also supplement other data sources such as HEDIS results and claims data to ensure compliance with clinical practice guidelines.

Section 16: Claims submission

General

As Participating Provider with MCC, you have established a contractual agreement to provide physical, behavioral and/or other long-term support services to our members. The arrangement is fee- for-service for the provision of covered health care services unless otherwise specified under your Participating Agreement. The rates established in your Participating Agreement are considered full payment for covered services provided. Accordingly, MCC members may not be balanced billed for any remaining amounts and/or difference between what is billed, and the provider's negotiated reimbursement rates defined in the rate exhibit of your Participating Provider Agreement.

Procedure for reimbursement of covered services

As a Participating Provider, you agree to bill all covered services provided to MCC members on the required forms and/or electronic claim file format. All claims should be billed on a fully completed CMS 1500, UB04 and/or CMS 1450 to be considered for adjudication and/or payment. Visit the Centers for Medicare and Medicaid Services (CMS) website at www.cms.hhs.gov to find more information about these forms and/or for more instruction and/or information on the proper use of claims forms for services.

Any claims requiring authorization should include the authorization number in the appropriate field of the CMS 1500, UB04 or CMS 1450 to assist with appropriate claims processing and timely claims payment. For a list of services requiring prior authorization, please visit the "For Providers" section of www.MCCofVA.com. A reference to the listing is also located in Section 10: Medical Management of this Provider Handbook.

Paper claims

MCC participating providers are strongly encouraged to submit their claims electronically. Electronically transmitted claims result in faster claims payment turnaround times and higher claims acceptance rates. If you choose not to bill electronically, we will accept paper claims. When paper claims are submitted, they must be on properly completed original red UB04, CMS-1450 or CMS-1500 (02-12) claim forms and laser-printed or typed.

MCC uses Optical Character Recognition (OCR) technology to scan paper claims; therefore, handwritten, photocopied or claims submitted on black and white forms may result in rejected claims transmissions.

Mail paper claims to:

Molina Complete Care Claims Service Center
1 Cameron Hill Circle, Suite 52
Chattanooga, TN 37402

Electronic claims and Electronic Data Interchange (EDI)

MCC encourages you to submit your claims electronically to experience the cost-saving benefits, administrative simplification as well as ease in submission and claims payment. MCC works with several claims clearinghouses including:

- Availity
- Office Ally
- Trizetto Provider Solutions (aka Gateway)
- Allscripts (aka Relay Health)

To check if MCC has a relationship with your clearinghouse, please call Customer Care:

- CCC Plus: 1-800-424-4524
- Medallion 4.0: 1-800-424-4518

MCC's clearinghouse payer ID for both CCC Plus and Medallion 4.0 claims is MCCVA.

Web-based and direct claims submissions

MCC offers a direct submit/web-based claims option through Availity. This functionality is available via our provider portal at www.MCCofVA.com. There is no charge to participating providers for submitting claims through the Availity tools. Availity supports keyed entry of claims on the portal and supports secure transfer/upload of batch claim files from most practice management systems. You must register with Availity to use the service and add MCC as one of your payers. If you are not currently registered with Availity please visit www.availity.com to get connected.

Electronic remittances

MCC offers electronic payment of your claims remittance. In order to get your claims payment direct deposited into your bank account, visit the Provider Materials page of our website and search for "Provider EFT/ERA sign-up" to enroll at the CAQH website.

Timely filing of claims

Claims for services provided to MCC members should be submitted within six months (180 days) of the date of service unless otherwise agreed upon in the Participating Provider Agreement. If not

otherwise defined in the Participating Agreement, and/or in the case of a non-participating provider who provides a covered service to MCC members, claims must be received within twelve months (365 calendar days) to be considered for processing and payment.

There are three timely filing exceptions that MCC takes under consideration:

1. Coordination of benefits—When an MCC member has a primary insurance, the primary insurance Explanation of Payment (EOP) or Medicare Summary Notice (MSN) is used to determine the timely filing deadline. For these claims, the time frame begins with the printdate on the primary insurance EOP or MSN.
2. Member with retroactive eligibility—When a member becomes eligible for a DMAS Medicaid program after the date of service, but their coverage is backdated to include the date of service, the time frame for timely filing begins on the date MCC receives notification from the enrollment broker of the member's enrollment.
3. Other (good cause)—MCC will consider exceptions on a case by case basis for other causes of filing delays, such as incorrect information provided by official sources.

Corrected claims, adjustments, or reconsiderations should be submitted within 180 days of the original claim paid date to be considered for reprocessing.

Payment timeframes

Processing and payment of claims for covered services are generally made within 30 calendar days of receipt of a clean claim as defined in the Provider Handbook.

Exception payment timeframes

Processing and payment of clean claims for covered services provided by Nursing Facilities, LTSS providers, ARTS and Early Intervention Providers is made within 14 calendar days from the date of receipt. When the service is covered by Medicare, the 14 calendar day timeframe begins post receipt of the secondary claim for processing.

Clean claims

A claim is considered clean when the service is billed on the appropriate CMS form (CMS-1500, 1450, or UB04), with current coding standards in the required form field and any required attachment or supporting documentation necessary to properly process and adjudicate the claim(s).

By definition, a "clean" claim is a claim that will not require MCC to investigate or update any information to apply proper adjudication and payment. Clean claims must contain all this information:

- Current industry standard data coding
- Attachments appropriate for submission and procedural circumstance
- Completed data elements field required for the CMS-1500, CMS-1450, or UB04

A claim is considered "unclean" if one or more of the following conditions exist due to a good faith determination and/or dispute regarding:

- The standards or format used in the completion or submission of the form
- The eligibility of the person listed for coverage
- The responsibility of another payer for all or part of the claim
- The amount of the claim or the amount currently due under the claim
- The benefits covered
- The manner in which services were accessed or provided
- The claim was submitted fraudulently

Correct form

MCC requires claims for professional services to be submitted using the CMS-1500 form. Claims for hospital/facility services (or other ancillary services) should be submitted using the CMS-1450 or UB-04 form.

Paper claims must be submitted on original red and white forms. Photocopies, black and white forms, or forms that contain stamped or handwritten content cannot be properly read by our OCR equipment and therefore may not be considered clean claims.

Standard coding

All fields should be completed using industry standard coding as outlined below:

Code Set	**Standard**
CPT-4 (Current Procedure Terminology)	Maintained and distributed by the American Medical Association, including its codes and modifiers, and codes for anesthesia services
CDT-1 (The Code on Dental Procedures and Nomenclature)	Maintained and distributed by the American Dental Association
ICD-10 CM (International Classification of Diseases	Maintained and distributed by the National Center for Health Statistics – Centers Disease Control and Prevention
HCPCS and Modifiers (CMS Common Procedure Coding System)	Maintained and distributed by the US Department of Health and Human Services
NDC (National Drug Codes)	Prescribed drugs, maintained and distributed of the U.S Department of Health and Human Services
ASA (American Society of Anesthesiologists)	Anesthesia services, the codes maintained by the American Society of Anesthesiologists
DSM-IV (American Psychiatric Services)	For psychiatric services, codes distributed by the American Psychiatric Association
Revenue Codes	For facilities, use the national or state uniform billing data elements specifications

Provider-specific coding, billing instructions and manuals

MCC follows DMAS guidance regarding billing and reimbursement. DMAS specific Provider Billing Instructions and Manuals as well as other coding instruction resources are available at https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderResources. Additional training and provider specific resources may also be made available on the MCC provider portal at www.MCCofVA.com.

Adherence to provider and service specific billing instructions as defined ensures that the required MCC encounter data will be accepted by DMAS and/or the State's encounter data warehouse.

Code review and claims editing

MCC applies coding and clinical edits to evaluate claims for accuracy and adherence to national industry and state standards for correct coding methodologies. These edits increase consistency of payment for providers by ensuring correct coding and billing practices are followed.

Claims Edit System (CES) by Optum

MCC uses a software application, CES, to automatically review and edit claims submitted by physicians and facilities. The system includes Medicaid National Correct Coding Initiative (NCCI) program edits and automatically detects coding errors related to unbundling, modifier appropriateness, diagnoses, and duplicate claims. NCCI edits reduce improper coding and inappropriate payment of Medicaid claims.

The CES system improves the accuracy of claims payment for all provider types (i.e. physicians, facilities, and suppliers) in accordance with the required editing protocols and according to CMS and Virginia Medicaid guidelines.

Types of NCCI edits

The National Correct Coding Initiative (NCCI) contains two types of edits:

1. NCCI procedure-to-procedure (PTP) edits that define pairs of Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes that should not be reported together for a variety of reasons. The purpose of the PTP edits is to prevent improper payments when incorrect code combinations are reported.
2. Medically Unlikely Edits (MUEs) define for each HCPCS/CPT code the maximum units of service (UOS) that a provider would report under most circumstances for a single beneficiary on a single date of service.

The NCCI methodologies in Medicaid

The Medicaid NCCI program consists of six methodologies. These are:

1. A methodology with PTP edits for practitioner and ambulatory surgical center (ASC) services

2. A methodology with PTP edits for outpatient services in hospitals (including emergency department, observation, and hospital laboratory services)
3. A methodology with PTP edits for durable medical equipment
4. A methodology with MUEs for practitioner and ASC services
5. A methodology with MUEs for outpatient services in hospitals
6. A methodology with MUEs for durable medical equipment

The Medicaid NCCI methodologies apply only to Medicaid fee-for-service claims that are reimbursed on the basis of HCPCS/CPT codes.

Components of the NCCI methodologies in Medicaid

Each of the Medicaid NCCI methodologies has four components. These are:

1. A set of edits
2. Definitions of types of claims subject to the edits
3. A set of claim adjudication rules for applying the edits
4. A set of rules for addressing provider appeals of denied payments for services based on the edits

The presence of a HCPCS/CPT code in a PTP edit, or of a MUE value for a HCPCS/CPT code does not necessarily indicate that the code is covered by any state Medicaid program or by all state Medicaid programs. States cannot use the files here for processing and paying Medicaid claims. It is important to understand that providers are obligated to code correctly even if edits do not exist to prevent use of an inappropriate code combination. Additional information and important notices concerning the National Correct Coding Initiative can be found at https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html.

Editing will apply to Professional (1500) and Facility (UB04) claims. Updates to edits range from bi-monthly to quarterly, based on the edit source.

Multiple procedure reimbursement policy

MCC utilizes and closely follows payment guidance and policy employed by the Centers for Medicare and Medicaid Services (CMS). Multiple procedures performed in the same operative session will be reimbursed at 100% of the contracted and/or negotiated rate for the first procedures from the highest payment group. All other procedures will be paid at 50% of respective rates. This is a professional payment policy applied to covered professional services billed for MCC members.

Reimbursement policy for comprehensive and component codes

MCC models industry policies modeled after the Correct Coding Initiative (CCI) administered through CMS, AMA current procedural terminology (CPT) and other general industry–accepted guidelines.

When two or more related procedures are performed during a single patient visit, there are

instances when a claim is submitted with multiple codes instead of one comprehensive code that fully describes the entire services. MCC will reimburse for the comprehensive code.

Evaluation and management on same day as surgery

When an evaluation and management (E&M) or inpatient consult procedure is established on the same day a surgical procedure is performed, the E&M procedure is considered included in the fee for the surgical procedure. The fee for certain supplies associated with the procedures is also included in the reimbursement for the surgical procedure. In some cases, an appropriate modifier will override the adjustment.

Global surgical package

A global period for surgical procedures is an industry-standard accepted concept where a single fee is billed and paid for all covered services rendered by the surgeon before, during, and after the procedure. The global period range for procedure within 10-days to 90-days are considered subject to the global period and considered inclusive to the surgical reimbursement fee applied.

Durable medical equipment billing

MCC coordinates, arranges, and authorizes appropriate durable medical equipment to support the care needs of its members. DME equipment types and the duration of needs is determined on a case by case basis based on the member's specific need in the care coordination planning and ongoing treatment coordination. MCC will make determinations and authorizations related to payment for DME based on the member's short term and long-term needs.

Participating DME providers should review their MCC authorization which will indicate if the service is rental, purchase, and/or transition to purchase:

- Rental only items—a period when the reimbursement is based on a daily fee for a particular DME item. DME services that are identified as continuous rentals, will be reimbursed at the daily rental allowance.
- Rental items with a purchase—a period that allows a rental item to pay up to the maximum allowable. Once the allowable rental period is met and the item is going to be purchased, the purchase will be paid over a maximum period of up to 10 months. Example: if an item is rented for 3 months, the purchase price will be divided into 10 monthly payments. The 3-month rental period payments will be subtracted from the 10-month payment. The remaining 7 months will be paid as monthly payments until the purchase price has been paid. The DME payment will not exceed the allowance for the DME purchase price item.
- Capped rental—an amount reimbursed on a monthly rental basis, which will not exceed the applicable number of continuous months, if present.

Billing with the appropriate rental or purchase modifier along will be key in ensuring the appropriate payment. Participating DME or other approved DME providers should consult the DMAS guidelines for provider-specific billing instructions at https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderResources.

Additional training and provider specific resources may also be made available on the MCC provider portal at www.MCCofVA.com.

Members receiving incontinence products

If a member leaves our plan and is covered under the DMAS fee-for-service program, the member will need to access incontinence supplies through the DMAS sole source contractor for incontinence supplies (Home Care Delivered). A member's enrollment with our plan is subject to change each month. Providers must hold the member harmless from liability for the cost of any services provided incorrectly a result of the provider's failure to verify member eligibility and enrollment.

Obstetrical, maternity care service and delivery billing

Obstetrical billing guidelines	

Global billing for OB care: Prenatal care, delivery, and postpartum care should be billed as an all-inclusive, single unit ("global bill"), except the first prenatal visit	CPT® codes:
	59400 (Vaginal delivery) 59510 (Cesarean delivery)
	
	Services included in global OB care Antepartum Care:
	• Initial OB visit and subsequent visits
	• Monthly visits to 28 weeks gestation
	• Biweekly visits to 36 weeks gestation
	• Weekly visits until delivery:
	  ○ Admission to hospital
	  ○ Admission history and physical examination Management of uncomplicated labor
	  ○ Vaginal delivery (with or without episiotomy, with or without forceps), or Cesarean delivery
	Postpartum care:
	• Hospital visits
	• Office visits following Vaginal or Cesarean delivery Pregnancy test (CPT codes 81025, 84702, 84703)

Obstetrical billing guidelines	
	Other: • All prenatal visits, including initial history and physical examinations • Pregnancy test (CPT codes 81025, 84702, 84703) • Urinalysis, initial and subsequent (CPT codes 81000, 81001, 81002, 81003, 81005) • Glucose tolerance test (82947) • Specimen collection (CPT code 99000) • Venipuncture and handling charges (CPT codes 36415 and 36416) • Initial evaluation and resuscitation of the newborn by the obstetrician • Observation or inpatient hospital care (99217, 99218, 99219, 99220, 99234, 99235, 99236, G0378) not resulting in delivery • Physician standby service (CPT code 99360) • Episiotomy (CPT code 59300) • Labor and delivery (vaginal or cesarean section) services including, but not limited to induction and any internal or external fetal monitoring performed and any obstetrical administered anesthesia except those services otherwise listed (CPT codes 59400, 59510, 59610, 59618) All postpartum care through 6 weeks, including suture removal, pap smears, and discussions on birth control (CPT codes: Q0091 pap and 99401 birth control counseling). Multiple vaginal or multiple cesarean deliveries are all reimbursed under the single global payment. Supervision of labor Delivery of placenta (CPT 59414)

Obstetrical Billing Guidelines	
Initial prenatal visit	Providers will be reimbursed for the initial prenatal visit separately from the "global fee" if the claim is submitted within 30 days of the date of service. Claims should include: • CPT Category II code 0500F • EDC (expected delivery date)
Subsequent visits	Subsequent office visits for global OB care and delivery are considered as part of the "global OB care" reimbursement. In addition to the global billing code, each subsequent visit should be listed along with: • CPT Category II code 0500F for prenatal visits • CPT Category II code 0503F to indicate the postpartum care visit These codes may be filed when the services are rendered or included on the claim with the global OB charge.
Submission of claims	Except for the first prenatal visit, charges for global OB care are to be submitted only after the postpartum visit. When billing for global OB care, the date of delivery is to be used as the billing date.
Surgical complications	These services should be coded separately using the appropriate CPT codes. (Examples: appendectomy, hernia, ovarian cyst, Bartholin cyst)
Medical complications of pregnancy	These conditions should be coded separately using the appropriate evaluation and management services CPT codes. (Examples: cardiac problems, neurological problems, diabetes, hypertension, pre-eclampsia, hyperemesis, pre-term labor, premature rupture of membranes)
High-risk pregnancy care/complications of pregnancy	Additional visits: MCC will reimburse for additional visits if the member experiences complications during pregnancy and requires more than 13 visits. The provider should code the additional services with a code representing the appropriate level of evaluation and management service. The documentation must reflect the necessity of these visits as well as any additional laboratory or radiologic tests performed.
Obstetrical care provided by two different providers	If a practitioner provides all or part of the antepartum and/or postpartum patient care but does not perform delivery due to termination of pregnancy, referral to another provider for delivery, member no longer with MCC, the provider should use the appropriate CPT codes: • Antepartum care only—1 to 3 visits—use the appropriate evaluation and management (E/M) codes • Antepartum care only—4 to 6 visits—use CPT code 59425 & 1 unit • Antepartum care only—7 or more visits—use CPT code 59426 & 1 unit • Postpartum care only—use CPT code 59430 Note: For other scenarios, refer to the CPT manual for the correct coding.

Out of network provider	Except during the initial continuity of care period, all services provided by out of network providers require prior authorization. Requests by out of network providers are sometimes approved based on ongoing continuity of care for the member.
Assistant at Cesarean delivery	Assistant at a Cesarean delivery should be coded using CPT code 59514 (Cesarean delivery only). Do not use CPT code 59510. 59510 is a global code that includes antepartum and postpartum care. Only use code 59510 if you were the physician who provided the antepartum and postpartum care.
Amniocentesis	Code amniocentesis separately from the global delivery code. Amniocentesis is not included in the Global CPT codes of 59400 (Vaginal delivery) or 59510 (Cesarean delivery).
Ultrasounds	Code ultrasounds separately from the global delivery code. Ultrasounds are not included in the Global CPT codes of 59400 (Vaginal delivery) or 59510 (Cesarean delivery).
Newborns	Facilities should submit the DMAS-213 or electronically through the DMAS Provider Web Portal under the Newborn E213 option at https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/Home/ Once a Medicaid/FAMIS identification number has been created for the Newborn, DMAS will send out a notice to the facility with the baby's Medicaid ID and assigned MCO so that claims for newborn services can be billed. Claims for newborns *must* be submitted under the newborn's Medicaid ID number. **Any claims received with the mother's Medicaid ID will be rejected by the claims system as an invalid member**. CCC Plus program: Newborns are not eligible for CCC Plus, so no newborns will be assigned to MCC under this program Medallion Medicaid, & FAMIS: Babies born to eligible MCC Medallion Medicaid, FAMIS, or FAMIS MOMs members will be automatically covered from date of birth until the last day of the third calendar month including the month of birth unless MCC is otherwise notified by DMAS of a termination of eligibility.

MCC participating providers should adhere to specific billing and coding guidelines to ensure proper claims processing and reimbursement for global care and delivery.

Nursing facility billing

Claims should be billed on the UB-04 claim form or the 837-I electronic format by the provider as currently billed. The RUG code should be submitted on the claim with the 0022 revenue code for room and board. The total charges for revenue code 022 should be zero and revenue code 0120 should continue to be reported.

Example of values to be reported:

Revenue code	HIPPS rate code	Units	Billed charges	Non-covered amount
0022	BB201	30	0.00	0.00
0120		30	6000.00	0.00

The RUG code determined by the RUG-IV 48 grouper must be reported in the first three digits of the Health Insurance Prospective Payment System (HIPPS) rate code locator on the UB-04 form. The type of assessment or modifier should be reported in the last two digits of the HIPPS rate code. Under the price-based reimbursement methodology, in addition to billing the revenue codes for room and board and ancillary services each nursing facility claim must contain one revenue code "0022" for each distinct billing period of the nursing facility stay.

MCC requires nursing facilities to report the assessment reference date with the occurrence code 50 for each RUG code reported in the HIPPS Rate Code field on the UB-04. The date of service reported with occurrence code 50 must contain the ARD associated with the applicable OBRA assessment. An occurrence code 50 is not required with the HIPPS code reported for default RUG AAA.

Please refer to DMAS billing guidelines and SFY 2018 Price-Based Rates on the DMAS website at https://www.dmas.virginia.gov/for-providers/general-information/rate-setting/nursing-facilities/.

Hospice billing

Hospice is a covered benefit for both CCC Plus members and FAMIS members. Medallion 4.0 members on hospice are considered an excluded population and are not eligible for hospice benefits.

Hospice Services are billed on a CMS-1450 (UB-04) form or 837-I electronic format and are comprised of five levels of daily care:

Revenue code	Service description	Unit type
0651	Routine Home Care	Per day
0652	Continuous Home Care	Hourly (Min. 8 hours)
0655	Inpatient Respite Care	Per day
0656	General Inpatient Care	Per day
0658	Hospice Room & Board-Nursing Facility Resident	Per day

Claims for members on hospice residing in a nursing facility should be billed on the CMS-1450 (UB-04) claim form or the 837-I electronic format. The RUG code should be submitted on the claim with the 0022 revenue code for room and board. The total charges for revenue code 022 should be zero and Revenue code 0658 should be reported.

Example of values to be reported:

Revenue code	HIPPS rate code	Units	Billed charges	Non-covered amount
0022	BB201	30	0.00	0.00
0658		30	6000.00	0.00

The occurrence code and assessment reference date should be reported in the occurrence code and occurrence span date form locators. Hospice room & board for members in a nursing facility will be paid at 100% of the nursing facility's rate.

To ensure proper claims payment, it is critical that providers bill the nursing facility information appropriately on the claim. The resident's nursing facility NPI should be billed in **Form Locator 78-79 Other Provider Name and Identifiers**.

Services provided during the last seven (7) days of life by a Registered Nurse (RN) or Social Worker are eligible for an additional "Service Intensity Add-on" payment equal to the continuous home care hourly rate.

Service Intensity Add on codes should be billed as follows:

Revenue code	Procedure code	Description	Unit type
0551	G0299	Skilled Nursing RN-Home Health or Hospice Setting	Per 15 minutes
0561	G0155	Services of Clinical Social Worker in Home Health or Hospice Setting	Per 15 minutes

Visits made after the member's death must be billed with a PM modifier (Post Mortem), and a discharge status of 20 (expired) or 40 (expired at home)

Coordination of benefits

MCC is the payer of last resort. When the member has commercial insurance coverage, providers must bill the commercial insurance first. This includes for children's early intervention services except for:

- Those services federally required to be provided at public expense as is the case for:
  - Assessment/Evaluation
  - Development or review of the Individual Family Service Plan (IFSP)
  - Targeted case management/service coordination
- Developmental services
- Any covered early intervention services where the family has declined access to their private health/medical insurance

Under these circumstances, and in following with federal regulations, the Early Intervention provider shall complete the Notification to DMAS: Family Declining to Bill Private Insurance form (available at https://infantva.org/Pr-PracticeManual-Forms.htm) and submit it with the bill.

Coordination of benefits is not applicable to Virginia Vaccines for Children (VVFC) claims submitted by VVFC providers. MCC will pay these claims.

Medicare

MCC participates in the automated claims crossover process for claims processing for our members who are dually eligible for Medicaid and Medicare.

Balance billing

Members must be held harmless for any charges for Medicaid covered services. This includes those circumstances where the provider fails to obtain necessary referrals, preauthorization, or fails to perform other required administrative functions. Providers may not balance bill MCC members for coinsurance, copayments, deductibles, financial penalties, or any other amount other than any Patient Pay for LTSS services. For information about Patient Pay for LTSS, refer to Section 4: Provider Roles and Responsibilities in this Provider Handbook.

Members will not be held liable for payments for covered services furnished by us or our vendors under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the enrollee would owe if the services had been provided directly to the member.

For non-covered services, Participating Providers must inform an MCC member that a service is not covered by MCC and obtain written consent prior to rendering the service.

Note: FAMIS co-payments are not considered billing a member for services.

Cost share and claims processing

Patient pay

MCC utilizes the methodologies defined by DMAS for processing claims. We assign patient pay collection to our participating LTSS providers. We will automatically reduce the patient pay amount from the final claims payment for LTSS providers such as: nursing facilities, hospice services, providers of private duty nursing in the Technology Assisted Waiver, Adult Day Care for members in the Elderly or Disabled with Consumer Direction (EDCD) waiver and agency-directed personal or respite care for members in the EDCD waiver.

Patient pay will be tracked monthly as claims are processed and will be deducted from each claim for LTSS included in the new patient pay processing on a first in (date of adjudication) first out basis until fully deducted. Providers must submit claims for all services, even if providers don't expect reimbursement for a claim due to patient pay. If patient pay is updated after claims are processed,

we will adjust impacted claims after receipt of the discrepancy report from DMAS.

Copayment

FAMIS members are responsible for payment of nominal copayments for some services. The copayment amounts are determined based on the member's household income, and we assign collection of these copayments to the providers.

MCC will automatically reduce the final claims payment by the amount of the copayment for the service.

FAMIS members have an annual maximum family copayment amount based on household income. Should FAMIS members reach their maximum family copayment amount after claims are processed, claims may require retroactive adjustment to reflect the accurate copayment amounts (DMAS-225 Form).

The Medicaid LTC Communication Form (DMAS-225) is used by the local Department of Social Services to inform LTSS providers of Medicaid eligibility and to exchange information. We will coordinate with the provider and office staff to ensure that a completed DMAS-225 is in the record of each member receiving nursing facility or waiver services.

Please refer to the September 2015 DMAS Medicaid Memo for additional information regarding DMAS's process on Patient Pay.

Provider overpayment refunds

If a provider identifies that a payment by MCC results in an overpayment, it is the provider's responsibility to reimburse MCC for the overpaid amount within 60 days of identification of the overpayment or the designated timeframe dictated in the Participating Provider Agreement. If the provider receives a notification of overpayment from MCC, the provider must either refund or dispute the overpayment by the date indicated on the notification. When refunding overpayments, the provider should return the overpayment with a copy of the Remittance Advice (RA) and a cover letter explaining why the payment is being refunded, or a copy of the MCC overpayment notification letter. Overpayments should be mailed to:

Molina Complete Care Medicaid
Attn: Recoveries Lockbox
401 Market Street Box 780192
Philadelphia, PA 19178-0192

If MCC determines that an overpayment has occurred, we will send a notification letter to the provider with an opportunity to either dispute or repay the amount of the overpayment. The recovery letter will have a resolution or "drag date" on it. If no payment or dispute has been received by the date indicated on the letter, the overpayment will be automatically offset against the next claims payment cycle.

Reimbursement under the Vaccines For Children (VFC) program

The national Vaccines for Children (VFC) program was established to help raise childhood immunization rates in the United States and to keep children up to age 19 in their medical home. The entitlement program is associated with each state's Medicaid plan. Children who are eligible for VFC vaccines are entitled to receive pediatric vaccines that are recommended by the Advisory Committee on Immunization Practices.

PCPs who administer childhood immunizations should be enrolled in the Virginia Vaccines for Children program (VVFC), administered by the Virginia Department of Health, and participate in the statewide immunization registry database. For more information, and to register, visit the VVFC Web site at http://www.vdh.virginia.gov/immunization/vvfc/, or call 1-800-568-1929 or 1-804-864-8055.

The Virginia Department of Health, Division of Immunization (DOI), supplies federally and state purchased vaccine at no cost to public and private health care providers. The VVFC program handles distribution of all vaccines provided by DOI.

MCC will reimburse $11 for administration fees for covered immunizations for VFC eligible children. The appropriate code for the vaccine must be billed along with the administration code CPT 90460—90461. These encounters must be submitted on a CMS 1500 claim form. MCC will also reimburse for the appropriate office visit fee on the same date as the immunization.

MCC will reimburse for the cost of privately purchased vaccines for adult, non-VFC eligible members.

NOTE: FAMIS eligible members are not covered under the VVFC program; however, MCC providers are still required to provide immunizations for FAMIS members in accordance with the most current Advisory Committee on Immunization Practices.

EPSDT dental services—fluoride varnish

Per the Medallion 4.0 EPSDT contract guidelines, non-dental medical providers may be reimbursed for application of dental fluoride varnish (99188) in accordance with the American Academy of Pediatrics guidelines. Fluoride varnish application should be billed to MCC on a CMS 1500 form, and providers are required to report utilization to DMAS on an annual basis.

Long Acting Reversible Contraception (LARC) utilization and reimbursement

MCC supports and covers family planning services and supplies for members of childbearing age that are intended to delay or prevent pregnancy for both participating and non-participating providers, and do not require authorization. Non-participating providers shall be paid no less than 100% of the applicable state Medicaid Fee Schedule. Covered family planning services include drugs, supplies and devices provided under the supervision of a physician. Family planning services do not include services to treat infertility or to promote fertility.

MCC and its providers should allow the member's freedom to choose their method of family

planning free from coercion or mental pressure. Accordingly, MCC covers the member choice to use long acting contraception as a part of their personal decisions with family planning and health optimization. LARC services are covered and reimbursed to both MCC participating and non-participating providers.

MCC will reimburse for all LARC devices provided in a hospital setting at rates no less than the Medicaid Fee Schedule in place at the time of service. The coverage of this service will be considered an add-on benefit and will not be included in the Diagnostic Related Group (DRG) reimbursement system for the inpatient hospital stay for the delivery.

We will reimburse participating or non-participating providers for the insertion of a LARC device immediately after delivery at a rate no less than the Medicaid fee schedule.

Prior authorization is not required for covered LARC J codes:

IUD

- J7297—Liletta
- J7298—Mirena
- J7301—Skyla
- J7300—Paragard

Implant

- J7307—Implanon/Nexplanon

Physician billing instructions

- Providers billing for the insertion of the device must bill on the CMS 1500 claim form using either 11981 (implant insertion) or 58300 (IUD insertion) depending on the device used and must use place of service Inpatient Hospital (21)
- Providers will also be allowed to bill for and receive separate reimbursement for the applicable CPT code for the delivery
- Providers can bill the following ICD-10 diagnosis codes:
    - Z30.430—Encounter for insertion of intrauterine contraceptive device
    - Z30.433—Encounter for removal and insertion of intrauterine contraceptive device
    - Z30.49—Encounter for surveillance of other contraceptives

Facility billing instructions

- Facilities bill all charges including those for the LARC on one inpatient UB-04 claim form
- The bill must contain the revenue code 0250, LARC device J code and NDC
- The LARC payment is paid on the inpatient claim in addition to the APR-DRG payment

Transition of coverage

MCC assumes responsibility for all managed care contract covered services authorized by DMAS or a prior MCO, rendered after the enrollment effective date, in the absence of a written agreement.

MCC will reimburse all participating and non-participating providers at no less than 100% of the published Medicaid Fee Schedule rates for services rendered during the applicable continuity of care period, and for authorized services after the expiration of the initial continuity of care period.

If the authorized service is an inpatient stay, payment of the claim will be allocated as follows:

1. Facilities contracted with MCC to reimburse the facility for services rendered to its members, at time of admission, based on a Diagnosis Related Grouping (DRG) payment methodology, MCC is responsible for the full inpatient medical hospitalization from the time of admission to discharge. This will be effective for any member who is actively enrolled in MCC on the date of admission, regardless if the member is disenrolled from MCC during the course of the inpatient hospitalization
2. Similarly, for FAMIS members who are hospitalized under fee-for-service at the time of admission, DMAS is responsible for the full DRG, admission to discharge, in accordance with DMAS established coverage criteria and payment rules
3. For facilities contracted with MCC to reimburse the facility for services rendered to its members based on per diem payment methodology, reimbursement responsibility will be shared between the former MCO and either DMAS or MCC. In the absence of a written agreement otherwise, the previous MCO, DMAS, or MCC shall each pay for the period during which the member was enrolled with the corresponding entity. This also applies to newborns hospitalized at the time of enrollment.
4. Under both DRG and per diem payment arrangements, MCC will be responsible for payment of practitioner services rendered during the hospitalization for any dates in which the member is actively enrolled with MCC on the date of service.

Retroactive additions & terminations

MCC will pay for covered services for members eligible per the 834 file received from DMAS. MCC is not be liable for the payment of any services covered under the contract rendered to a member after the effective date of the member's exclusion or loss of eligibility.

Exceptions to this policy exist related to specifically manufactured DME that was prior-authorized by MCC.

In cases where member disenrollment is anticipated, MCC is responsible for authorizing and providing all services covered under the Virginia Medicaid contract until officially notified of the termination from DMAS or its designated agent.

If a member is retroactively disenrolled or excluded from participation, MCC is not liable for payment of services rendered outside of the dates the member was enrolled with MCC.
Claims for the services rendered during the retroactive period should be submitted directly to DMAS, and that reimbursement of those claims by DMAS is contingent on the member meeting eligibility and coverage criteria requirements.

"Never Events" and Hospital Acquired Conditions

MCC will comply with 42 CFR 438 (g) requirements mandating provider identification of provider-preventable conditions (PPC) as a condition of payment, as well as the prohibition against payment for PPC as set forth in 42 CFR 434.6(a)(12) and 447.26. MCC's reimbursement for inpatient hospital services is based on the Provider Preventable Conditions (PPC) policy defined in 42 CFR 447.26.

Payments for Hospital Acquired Conditions (HACs) will be adjusted in the following manner. For DRG cases, the DRG payable will exclude the diagnoses not present on admission for any HAC. For per diem payments or cost-based reimbursement, the number of covered days will be reduced by the number of days associated with the diagnoses not present on admission for any HAC. The number of reduced days will be based on the average length of stay on the diagnosis tables published by the ICD vendor used by DMAS (Thomas Reuters).

No payment will be made for services for inpatients for the following Never Events:

- Wrong surgical or other invasive procedure performed on a patient
- Surgical or other invasive procedure performed on the wrong body part
- Surgical or otherwise invasive procedure performed on the wrong patient

No reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

Under 42 CFR 438.3(g), 434.6(a)12(i), and 447.26(b), MCC is prohibited from making a payment to a provider for PPCs that meet the following criteria:

- Is identified in the State Plan
- Has been found by DMAS, based upon review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines
- Has a negative consequence for the beneficiary
- Is auditable
- Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

Emergency services

MCC covers, and is financially responsible for, all health screenings, evaluations and examinations that are reasonably necessary to determine whether the member's condition is an emergency medical condition. MCC will not deny payment for emergency services obtained under any of the following circumstances:

- A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the

woman or her unborn child) in serious jeopardy, serious impairment to bodily or mental functions, or serious dysfunction of any bodily organ or part;
- A representative of MCC instructs the member to seek emergency services; or
- Emergency services and care is provided at a hospital without parental consent.

In accordance with 42 C.F.R. § 438.114, MCC does not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. Nor will MCC refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's PCP or MCC of the member's screening and treatment within ten calendar days of presentation for emergency services.

Members who have an emergency medical condition will not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. Post-stabilization care services will be covered in order to maintain, improve, or resolve the member's condition without preauthorization, when the MCC representative and the treating physician could not reach agreement and the physician was not available for consultation.

MCC will not retroactively deny a claim for an emergency screening examination because the condition, which appeared to be an emergency medical condition under the "prudent layperson" standard, as defined herein, was in fact non-emergency in nature.

Out-of-area emergency services

If the member is away from home and has an emergency, they are instructed to go to the nearest emergency room or any emergency setting of their choice. MCC covers any medically necessary duration of stay in a non-contracted facility, which results from a medical emergency, until such time as we can safely transport the member to a participating facility. In such situations, the member should call their PCP as soon as possible.

If an out-of-network provider provides emergency care, the service will be paid. Payments to non-contracted providers for emergency services may, at MCC's option, be limited to the treatment of emergency medical conditions, including post-stabilization care services and family planning services. Payment amounts shall be consistent with the pricing policies developed by MCC and in accordance with DMAS requirements, including DMAS rules and regulations for emergency or family planning services provided by non-contract providers.

Post-stabilization services

Prior authorization is not required for coverage of post-stabilization services when these services are provided in any emergency department or for services in an observation setting. To request authorization for an inpatient admission or have any questions related to post-stabilization services, please contact MCC's Utilization Management department at:

- CCC Plus: 1-800-424-4524
- Medallion 4.0: 1-800-424-4518

Abortions, Sterilizations & Hysterectomy (ASH) procedures

To ensure compliance with all state and federal regulations, MCC follows strict guidelines for payment of claims for ASH procedures.

All claims billed with procedure or diagnosis codes indicative of ASH procedures will pend for review **prior** to payment processing. Failure to submit any required documentation, submitting incomplete documentation, or failure to follow any stated guidelines will result in claims payment denial.

Abortion services

Induced (elective) abortions will only be paid for upon physician certification that in his or her professional medical judgment, the life of the mother would be substantially endangered if the fetus were carried to term.

As such, the attending physician must complete the abortion certification form MAP-3006 (found in Appendix A). The originating physician is required to supply a copy of the certification form to each of the other billing providers.

The MAP-3006 form must be completed appropriately and attached to each claim submitted related to the abortion procedure. Failure to submit or accurately complete the form will result in a claim denial.

Hysterectomy services

According to federal regulations, hysterectomy is not a sterilization procedure. MCC does not cover hysterectomies performed solely for the purpose of rendering an individual incapable of reproducing. Payment will be made for hysterectomies in the following situations:

1. Medically necessary—in order for MCC to cover a hysterectomy for medical necessity, the following must occur:
    a) The physician securing the authorization to perform the hysterectomymust inform the individual or her representative, if applicable, orally, and in writing before the surgery is performed that the procedure will render her permanently incapable of reproducing.
    b) The member or her representative must have signed a written Acknowledgement of Receipt of Hysterectomy Information form DMAS-3005 (found in Appendix B).
    c) The physician statement must be completed and signed by the physician, and in this situation, Block A must be marked. When a hysterectomy is performed as a consequence of abdominal exploratory surgery or biopsy, the Acknowledgement of Receipt of Hysterectomy Information Form (DMAS-3005) is also required. Therefore, it is advisable to inform the patient or her representative prior to exploratory surgery or biopsy. Again, Block A of the Physician Statement must be completed.
2. Emergency—when a hysterectomy is performed on an emergency basis because of life threatening circumstances, the following must occur:
    a) Block B of the Physician Statement must be marked and a description of the nature of the emergency must be included.

b) The completed Physician Statement must be attached to each claim form related to the hysterectomy (e.g., surgeon, hospital, anesthesiologist). The patient does not have to sign this form.

3. Sterility—if the patient is sterile prior to the hysterectomy, for the claim to be paid:
   a) Block C of the Physician Statement must be marked and a statement regarding the cause of the sterility must be included.
   b) The completed Physician Statement must be attached to each invoice related to the hysterectomy (e.g., surgeon, hospital, anesthesiologist). The patient does not have to sign the form.

A copy of the form DMAS-3005 **must** be appropriately completed and attached to each provider's invoice for a hysterectomy procedure for MCC to consider the claim for payment. Failure to provide the appropriate acknowledgement or certification will result in a claim denial.

Sterilization services

MCC does not cover any sterilization services for mentally incompetent, institutionalized individuals, or individuals under age 21.

Sterilization services are defined as any medical treatment, procedure, or operation for the purpose of rendering an individual permanently incapable of reproducing. This include "therapeutic" sterilizations—those sterilizations that are performed because pregnancy would be life-threatening to the mother.

To comply with federal regulations, MCC follows several strict guidelines with regard to claims payment:

1. The member is 21 years of age or older, without exception
2. The member is mentally competent or has been declared competent for purposes that include the ability to consent to sterilization
3. The member is able to understand the content and nature of the informed consent process
4. The member is not institutionalized
5. The member has voluntarily given informed consent in accordance with all the requirements below:

a) At least 30 days, but no more than 180 days have passed between the date of informed consent and the date of sterilization, except in the following instances:
   i. Sterilization may be performed at the time of emergency abdominal surgery if the patient consented to the sterilization at least 30 days before the intended date of sterilization and at least 72 hours have passed after written informed consent was given and the performance of the emergency surgery
   ii. Sterilization may be performed at the time of premature delivery if the following requirements are met: the written informed consent was given at least 30 days before the expected date of the delivery, and at least 72 hours have passed after written informed consent to be sterilized was given

A completed DMAS-3004 (Sterilization Consent Form) **must** accompany all claims for sterilization services. This requirement extends to **all** providers: attending physicians or surgeons, assistant surgeons, anesthesiologists, and facilities. Only claims directly related to the sterilization surgery, however, require consent documentation. Claims for pre-surgical visits and tests or services related to postsurgical complications do not require consent documentation.

Instructions for completing the form can be found in the Virginia Medicaid Physician/Practitioner Manual Covered Services and Limitations Section on page 53 (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual).

Billing for drug codes on medical claims

ALL CMS-1500, CMS-1450 (UB-04), electronic 837I and 837P transactions billed that contain drug codes (typically J or Q codes) **must** be billed with the appropriate NDC information.

Billing drug codes without an NDC, or without all required data elements, will cause claim rejections. Billing drug codes with an incorrect NDC (e.g., NDC does not match J code) will cause claim denials.

NDC Information should be billed as follows (CMS-1500 form, shaded fields 24A-24G):

The following qualifiers should be used when billing NDC information:

F2	International Unit
GR	Gram
ML	Milliliter
UN	Unit

To enter supplemental information, begin at 24A by entering the qualifier and then the information. Do not enter a space between the qualifier and the supplemental information. Do not enter hyphens or spaces within the NDC number.

CMS requires the 11-digit National Drug Code (NDC), therefore, providers are required to submit claims with the exact NDC that appears on the actual product administered, which can be found on the vial of medication.

The NDC must include the NDC Unit of Measure and NDC quantity/units. **When reporting a drug, enter identifier N4, the eleven-digit NDC code, Unit Qualifier, and number of units from the package of the dispensed drug.**

837I/837P		
Data Element	Loop	Segment/Element
NDC	2410	LIN03
Unit of Measure	2410	CTP05-01
Unit Price	2410	CTP03

Quantity	2410	CTP04

For electronic submissions, report in the LIN segment of Loop ID-2410.

Paper Claim Type	Field
CMS 1500 (08/05)	24 A (shaded claim line)
UB 04	43

Facility

Use Form Locator 43 of the CMS1450 and UB04 (with the corresponding HCPCS code in Locator for Outpatient and Facility Dialysis Revenue Codes 250 – 259 and 634 -636).

Physician

Use the red shaded detail of 24A on the CMS1500 line detail. Do not enter a space, hyphen or other separator between N4, the NDC code, Unit Qualifier and number of units.

The NDC must be entered with 11 digits in a 5-4-2 digit format. The first five digits of the NDC are the manufacturer's labeler code, the middle four digits are the product code, and the last two digits are the package size. If you are given an NDC that is less than 11 digits, add the missing digits as follows:

- For a 4-4-2 digit number, add a 0 to the beginning
- For a 5-3-2 digit number, add a 0 as the sixth digit
- For a 5-4-1 digit number, add a 0 as the tenth digit
- Enter the Unit Qualifier and the actual metric decimal quantity (units) administered to the patient. If reporting a fraction of a unit, use the decimal point. The Unit Qualifiers are:
    - F2—International Unit
    - GR—Gram
    - ML—Milliliter
    - UN—Unit

Billing multiple dates of service

When billing MCC for multiple dates of service on the same claim, to avoid hitting coding edits for MUE and other potential edits, please remember the following guidelines:

- Claims should not be billed for more than one calendar month, or cross months of service (e.g., 01/01/2018 - 02/28/18 or 01/25/18 - 2/3/18)
- Multiple visits or like services provided on the same date of service should be combined on one line to avoid system duplicate flags.

08/01/2018	T1019	50.00	1
08/01/2018	T1019	50.00	1

08/01/2018	T1019	100.00	2

- Each date of service should be billed on a separate service line so that the number of units per

day is clearly delineated and coding edits do not deny the claim.

Section 17: Behavioral health

Philosophy

MCC believes the most effective and appropriate behavioral health services are best delivered as part of a fully integrated recovery-oriented system that welcomes and engages members and participants at all points in their personal recovery journey—one that recognizes and builds upon individual strengths, needs and preferences of the member. Helping people reach their goals for a better life is our primary focus. We believe all people can recover from trauma, tragedy, or other stresses. We help people manage their long-term behavioral and chronic conditions and believe that people can and do get better and are able to build a life filled with meaning and purpose.

Approach

Our approach to delivering behavioral health services is structured to assure that improved behavioral health is achieved by making an impact, one member at a time, through highly individualized, community-based approaches to health care delivery, care coordination, and self-direction. Our model of care improves the behavioral health status of Virginians by engaging and empowering members, partnering with providers, and integrating community resources and non-traditional services into local health systems.

Early identification of high-risk members through mental health and substance use screening tools is critical to get members the care they need at the right time, in the right place and in the right amount. This leads to prevention and/or early intervention and promotes community tenure, which results in improved quality of life, satisfaction for our members and cost effectiveness.

We use a person-centered treatment planning approach that places the member and family in the center of the planning process and involves all stakeholders in the member's care. This approach promotes communication, integration, and coordination of care and services, reducing inefficiency and duplication of services. We deliver behavioral health services through a large established credentialed and contracted network that has the capability to provide services across the Commonwealth and across the continuum of care.

Behavioral health services

MCC is responsible for the management of the following types of medically necessary behavioral health services within the amount, duration, and scope described in DMAS's coverage chart. This includes the Mental Health Services (MHS) formerly known as Community Mental Health Rehabilitation Services (CMHRS)benefit, which is part of the CCC Plus program.

MHS are behavioral health interventions intended to provide clinical treatment to those individuals with significant mental illness or children with, or at risk of developing, serious emotional

disturbances. These benefits are available to individuals who meet the service specific medical necessity criteria based on diagnoses made by Licensed Mental Health Professionals practicing within the scope of their licenses.

Coverage for FAMIS MCO enrolled members includes only a subset of MHS. MHS covered for FAMIS MCO members is limited to the following services: Peer Recovery Support, Behavioral Therapy Services, Intensive In-Home, Therapeutic Day Treatment, Crisis Intervention, and Mental Health Case Management services. For purposes of ensuring parity under financial requirements (FR) provisions in the federal Mental Health Parity and Addiction Equity Act, there will be no copay for outpatient behavioral health services, including MHS services, provided to FAMIS members.
MCC uses a combination of Milliman Care Guidelines (MCG), proprietary Molina Healthcare guidelines and ASAM criteria in conjunction with DMAS's policies to make medical necessity determinations. MCC's guidelines are consistent with Federal and State requirements.

MCC's medical necessity criteria are not more restrictive than DMAS's criteria and its coverage rules and authorization practices comply with the Mental Health Parity and Addiction Equity Act (MHPAEA). MCC coverage rules for behavioral health treatment services are also compliant with Federal EPSDT coverage requirements for members under the age of 21.

Following approval by its QIC, MCC submits its medical necessity guidelines, program specifications and service components for behavioral health services to DMAS annually for approval no later than 30 days prior to the start of a new contract year, and no later than 30 days prior to any changes.

Facility-based solutions

Behavioral inpatient confinement as well as treatment at other higher levels of care is reserved for individuals who cannot be managed in a lower level of care due to severe behavioral and emotional issues; therefore, they are at great risk of a cycle of recidivism at these higher levels of care. There are multiple and complex issues that can impact the return to health for these individuals (e.g., medical co-morbidities, poor social support systems, etc.); accordingly, MCC has transitioned behavioral health services away from the traditional philosophy of utilization management and instead applies intensive personal care management to every case at the higher levels of care (e.g., inpatient, partial hospitalization, residential, and intensive outpatient solutions). MCC Care Coordinators assess members to understand their unique situation including their treatment providers and social support systems. Care Coordinators assist members through the following:

Education

- Teaching the nature of the disease(s)
- Explaining the importance of returning to whole health and promotion of wellness
- Planning an appropriate course of treatment
- Understanding the importance of coordination of care

Coordination of care

- Navigating through the health care system

- Connecting all treatment providers
- Building a community of support
- Identifying and removing barriers to care

Treatment shaping

- Reviewing and reconciling medication regimens, especially at care transitions
- Planning treatment
- Identifying available resources
- Enhancing strength-based interventions
- Incorporating relapse prevention strategies

Coordination of BH services with primary care

MCC recognizes the importance of integrating clinical behavioral health and SUD recovery with primary medical care. Staff members at all levels recognize the important role in assisting customer organizations in their efforts to monitor and improve the quality of behavioral health care delivered in the primary care setting. To achieve these goals, MCC's Medical Directors work with the Behavioral Health Director and others in the development and implementation of initiatives to improve care coordination, care transition, and outcomes. We collaborate with DMAS throughout this process, from development and implementation through assessment of impact. We emphasize data collection in multiple topic areas and collaborative data analysis to identify opportunities for improvement when possible.

Core components of MCC's integrated coordination strategy

- Exchange information with the behavioral health and recovery/resiliency treatment continuum and with PCPs by providers and Care Managers
- Provide information/education to PCPs to promote appropriate screening and assessments of BH diagnoses, treatment and referral of BH disorders commonly seen in primary care
- Review usage of psychotropic medications and provide guidance and education to PCPs and psychiatrists on best prescribing practices including implementing the recommendations of the Children's Learning Collaborative and the Integrated Health Collaborative
- Develop additional Integrated Care Learning Collaborative(s) associated with high risk and/or underserved populations
- Continue collaborative activities to improve integration of physical and traditional BH services within the delivery system for members who are considered high risk

Addiction and Recovery Treatment Services (ARTS)

MCC is committed to working with DMAS to improve the ARTS benefit and delivery systems for individuals with a substance use disorder (SUD) and to further the Commonwealth's goal that a sufficient continuum of care is available to effectively treat individuals with an SUD.

MCC's comprehensive evidence-based benefit design for the ARTS program includes recognized best practices in the Addiction Disease Management field, including a robust array of services and

treatment methods to address the immediate and long-term physical, mental and SUD care needs of the individual. Our system of care includes recognized best practices in the Addiction Disease Management field such as the American Society of Addiction Medicine (ASAM) criteria, the Centers for Disease Control Opioid Prescribing Guidelines, Office Based Opioid Treatment providers (OBOT)/Opioid Treatment Program (OTP), Medication Assisted Treatment (MAT), and SUD case management.

MCC employs ARTS Care Coordinators to manage SUD benefit requests and to coordinate ARTS services, transitions, and support members in recovery. Our ARTS Care Coordinators have all DMAS- required qualifications and experience including being licensed practitioners of the healing arts (including physicians or medical directors), licensed clinical psychologists, licensed clinical social workers, licensed professional counselors, nurse practitioners or registered nurses with clinical experience in treatment of SUD. The ARTS Care Coordinator performs an independent assessment of requests for all ARTS service levels (ASAM Levels 2.1, 2.5, 3.1, 3.3, 3.5, 3.7 and 4.0) using member information submitted by providers via the ARTS Service Authorization review forms.

MCC's ARTS Care Coordinators are knowledgeable about and may refer members to telehealth services for ARTS assessments to improve accessibility of services and member engagement. ARTS Care Coordinators also arrange for in-home evaluations when telehealth or other services are not viable due to transportation, psychosocial and/or health issues. ARTS Care Coordinators also provide ongoing support to providers with effective discharge and transition planning, care coordination, and opportunities to improve the quality of care.

ARTS eligibility

To receive ARTS services, members must meet the following medical necessity criteria:

1. Must have one diagnosis from the most recent Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders; or be assessed to be at risk for developing substance use disorder (for youth under 21);
2. Must meet the severity and intensity of treatment requirements for each service level defined by the most recent edition of the ASAM Criteria: Treatment Criteria for Addictive, Substance-Related and Co-Occurring Conditions. Medical necessity for all ASAM levels of care is based on the individual's assessed biopsychosocial severity and is defined by the extent and severity of the individual's problems as defined by a licensed clinician based on the individuals documented severity of need in all six (6) ASAM multidimensional assessment areas; and,
3. If applicable, must meet the ASAM adolescent treatment criteria. For individuals (other than those enrolled under the FAMIS program) under the age of twenty-one (21) who do not meet the ASAM medical necessity criteria upon initial review, a second individualized review will be administered to ensure the individual's treatment needs are assessed and medically necessary services will be coordinated to correct and ameliorate health conditions that are coverable under section 1905(a) Medicaid authority (EPSDT benefit).

ASAM criteria and provider qualifications

MCC uses ASAM criteria to guide the identification of medically necessary SUD services for

members. The following grid lays out each ASAM level of care and the corresponding agency license (if needed).

ASAM LOC placement	VDH/DBHDS/DHP license
4 Medically Managed Intensive Inpatient	Acute Care General Hospital (12VAC5-410)
3.7 Medically Monitored Intensive Inpatient Services (Adult) Medically Monitored High-Intensity Inpatient Services (Adolescent)	Inpatient Psychiatric Unit Acute Freestanding Psychiatric Hospital Substance Abuse (SA) Residential Treatment Service (RTS) for Adults/Children Residential Crisis Stabilization Unit Medical Detox License required for all
3.5 Clinically Managed High-Intensity Residential Services (Adults) / Medium Intensity (Adolescent) 3.3 Clinically Managed Population-Specific High-Intensity Residential Services (Adults)	Inpatient Psychiatric Unit (3.5)/Required for co-occurring enhanced programs SA RTS for Adults (3.3 or 3.5) and Children (3.5) SA and MH RTS for Adults and Children (3.3 or 3.5)/Required for co-occurring enhanced programs Supervised RTS for Adults (3.3) Medical Detox License required for 3.2 WM
3.1 Clinically Managed Low-Intensity Residential Services	MH & SA Group Home Service for Adults and Children (Required for co-occurring enhanced programs) SA Halfway House for Adults
2.5 Partial Hospitalization Services 2.1 Intensive Outpatient Services	SA or SA/Mental Health Partial Hospitalization (2.5) SA Intensive Outpatient for Adults, Children and Adolescents (2.1) Outpatient Managed Withdrawal Service Licensed required for 2WM
1 Outpatient Services	Outpatient Services
0.5 Early Intervention	N/A; All Licensed Providers
Opioid Treatment Program (OTP)	Opioid Treatment Program
Office-Based Opioid Treatment (OBOT)	N/A; Physician Offices

MCC contracts with a wide array of ARTS service providers to ensure there are sufficient ARTS services available to our members. Service providers include Acute Care General Hospitals, Acute

freestanding Psychiatric Hospitals, Substance Abuse Residential Treatment Centers, Residential Crisis Stabilization units, Mental Health Group Homes, Substance Abuse Halfway Homes, Substance Abuse Partial Hospital programs, Intensive Outpatient Services, traditional outpatient providers and peer support specialists. Outpatient providers meet DMAS's provider qualification requirements for ARTS covered services. MCC also contracts and credentials the Office Based Opioid Treatment (OBOT) providers approved by DMAS and the CMO and Pharmacy Director Workgroup using DMAS criteria and federal requirements. We provide DMAS a monthly report of the OBOT credentialed organizations in our network as defined in the Medallion 4.0 and CCC Plus contracts.

MCC's ARTS Care Coordinators, licensed physician advisors, or Medical Directors perform all independent assessment of requests for all ARTS intensive outpatient (ASAM Level 2.1), partial hospitalization (ASAM Level 2.5), residential treatment services and inpatient services (ASAM Levels 3.1, 3.3, 3.5, 3.7 and 4.0) using member information transmitted by providers via the ARTS Uniform Service Review Request Form with attached clinical documentation available. MCC reviews requests on an individual basis and determines the length of treatment and service limits based on the individual's most current multidimensional risk profile and applies the ASAM Treatment Criteria.

Service authorizations

MCC does not require service authorizations for Screening, Brief Intervention and Referral to Treatment (ASAM Level 0.5), Outpatient Services (ASAM Level 1.0), or services provided by a contractor credentialed OTP or OBOT organization. MCC requires a registration for ARTS Case Management and ARTS Peer Support Services.

To the greatest extent possible, MCC aims to maintain compliance with length of stay limits, (e.g., 30-day average length of stay for residential services). We recognize there will be situations where members require extended stays due to clinical and/or network reasons. Should length of stay limits be exceeded in such instances, MCC provides evidence to DMAS that such limits were exceeded due to the lack of provider availability (e.g., provider shortage area) in a lower ASAM level.

MCC may retroactively approve authorizations based on established provider enrollment contractual requirements after a provider has engaged a member in treatment to promote immediate entry into withdrawal management processes and addiction treatment.

Authorization timeframes

MCC responds to service authorization requests from providers using the ARTS Uniform Service Authorization Request Form within 72 hours for requests for placement at Intensive Outpatient and Partial Hospitalization (ASAM Levels 2.1 and 2.5). MCC responds to service authorization requests from providers using the ARTS Uniform Service Authorization Request Form within 72 hours for requests for placement in Residential Treatment (ASAM Levels 3.1, 3.3, 3.5, and 3.7) and Inpatient Hospitals at ASAM Level 4.0.

Medication Assisted Treatment (MAT) and Office-Based Opioid Treatment (OBOT)

MCC's MAT initiative seeks to increase the use of acamprosate, naltrexone (both in oral and injectable form), buprenorphine and other medications as approved by the State—in combination with proven psychosocial interventions—in the treatment of substance use disorders where clinically appropriate.

We are committed to ensuring all members with SUDs and providers of SUD treatment have education and access to MAT at all ASAM levels of care. The program not only focuses on patients who have been discharged from inpatient substance use treatment programs, but also targets individuals receiving outpatient case or disease management services. Through MAT measures, MCC monitors the number of cases in which physicians are prescribing medications and follows member readmission rates.

MCC focuses on provider education efforts to illustrate the importance of using appropriate medications when developing members' SUD treatment plans. The length of treatment is based on patient's changing multidimensional risk profile. Limits are individualized.

Per DMAS guidelines, MAT can be provided by:

- Opioid Treatment Providers (OTPs)—CSBs and private providers licensed by DBHDS
- Preferred OBOT providers—primary care clinics, FQHCs, outpatient psychiatry clinics, other physician offices, etc.
- Buprenorphine Waivered Practitioners are independent providers delivering MAT outside of an OTP, Preferred OBOT, or PMAT setting

OBOT resources

Medication	Prior Authorization Required
Buprenorphine/Naloxone products	-No for preferred products -Yes for non-preferred products
Buprenorphine monotherapy products	-No for preferred OBOTs (regardless of member gender or pregnancy status for females) -No for INN and OON non-OBOT providers for female members current pregnant -Yes for INN and OON non-OBOT providers for nonpregnant female members or male members.
Sublocade	Prior to 7/1/2021 – No for INN providers Post 7/1/2021 – PA is not required for all providers
Methadone	No (for opioid use disorder)
Naltrexone Long-Acting Injection	No for preferred products
Naltrexone (oral)	No for preferred products
Naloxone	No for preferred products

With an emphasis on medication assistance and coordinating integrated outpatient care services in treatment of patients with opioid dependence, office-based opioid treatment (OBOT) programs have proven to be effective, confidential, accessible and safe. They have resulted in overall reduced substance use in patients as well as in overall retention in treatment, recovery, and integration in the mainstream. The use of buprenorphine in treating opioid dependence (especially with a medication assisted model) is supported by medical literature, such as the evidenced-based retention percentages documented by the 2003 Kakko study as well as others at Yale University, Johns Hopkins, and the National Institute on Drug Abuse (NIDA).

MCC ensures all state requirements for OBOT services are followed through its UM, ARTS Care Coordinators, and network contracting activities.

Care Team requirements

- Buprenorphine-waivered physicians may practice in a variety of practice settings including primary care clinics, outpatient health system clinics, psychiatry clinics, FQHCs, CSBs, Local Health Departments, and physician's offices
- There must be on site a licensed behavioral health provider (licensed clinical psychologist, licensed clinical social worker, licensed professional counselor, licensed psychiatric clinical nurse specialist, licensed psychiatric nurse practitioner, licensed marriage and family therapist, licensed substance abuse treatment practitioner, or CSAC) providing counseling to patients

receiving buprenorphine

MAT requirements

- Buprenorphine monoproduct may be prescribed only to pregnant women. All other patients receive buprenorphine/naloxone or naltrexone products
- The maximum daily buprenorphine/naloxone dose 16 mg unless documentation of ongoing compelling clinical rationale for higher dose up to maximum of 24 mg
- The member must experience no tolerance to other opioids, soma, stimulants, or benzodiazepines except for patients already on benzodiazepines for 3 months during a relapse or tapering plan

Other Buprenorphine uniform requirements

- Diagnosis of Opioid Use Disorder
- At least 16 years of age
- Prescriber's personal DEA and XDEA numbers are required
- Individual is participating in psychosocial counseling
- Maximum of 16 mg per day
- Initial authorization for 3 months; subsequent authorizations for 6 months
- No set time limit or duration of treatment
- Buprenorphine only products for pregnant women
- Patient is locked-in to prescribing physician and dispensing pharmacy
- No concurrent use with benzodiazepines, tramadol, carisoprodol, other opiates or stimulants
- Urine drug testing at least 8 times per 12 months

Risk management and adherence monitoring requirements

MCC recognizes the importance of closely monitoring members who are receiving MAT to ensure adherence to prescribing protocols. MCC educates its treating providers about DMAS monitoring requirements and oversees provider adherence through UM activities and claims analytics. Providers are required to adhere with the following State requirements:

- Administer random urine drug screens, a minimum of 8 times per year for all patients
- Check the Virginia Prescription Monitoring Program at least quarterly for all patients
- Participate in opioid overdose prevention education including the prescribing of naloxone
- Ensure that new patients are seen at least weekly when initiating treatment. Once patients are seen for at least 3 months of treatment and demonstrate clinical stability (documented by the physician), appointments may be spaced to a minimum of monthly visits with the physician or licensed BH provider
- Periodically check for use of unused medications including count of opened medication wrappers, when clinically indicated

Benefits and authorization requirements

- Prior Authorizations are not required for buprenorphine or buprenorphine/naloxone
- A buprenorphine-waivered physician in the OBOT can bill all Medicaid health plans for substance abuse care coordination code (monthly per member payment) for members with

moderate to severe opioid use disorder receiving MAT
- Certified Peer Recovery Support specialist services can be billed
- Buprenorphine waivered residents can complete structured moonlighting experiences under the supervision of a credentialed attending physician
- MCC can provide public recognition (if desired) as a "Gold-Card" OBOT clinic who is a "preferred provider"

Substance use care coordination requirements

Patients are most likely to be compliant with OBOT services when ARTS care coordination is also provided. MCC will oversee the care coordination services provided by primary care and specialty medical settings to support treatment coordination and treatment adherence.

ARTS Care Coordinators perform the following care coordination activities:

- Integrate behavioral health into primary care and specialty medical settings through interdisciplinary care planning and monitoring patient progress and tracking patient outcomes
- Support conversations between buprenorphine-waivered physicians and behavioral health professionals to develop and monitor individualized treatment plans
- Link patients and community resources (including NA, AA, peer recovery supports, etc.) to facilitate referrals and respond to social service needs
- Track and support patients when they obtain medical, behavioral health, or social services outside the practice
- Care coordination service code must be billed with moderate to severe Opioid Use Disorder as the primary diagnosis by a buprenorphine-waivered physician prescribing MAT to the patient

Service coordination provider requirements:

- At least a bachelor's degree in social work, psychology, psychiatric rehabilitation, sociology, counseling, vocational rehabilitation or human services counseling; and has at least one year of substance abuse related clinical experience providing direct services to persons with a diagnosis of mental illness or substance abuse; or
- Licensure by the Commonwealth as a registered nurse with at least one year of clinical experience; or
- An individual with certification as a substance abuse counselor (CSAC) or CSAC Assistant under supervision.

Co-Occurring Disorders (CODs)

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), up to 50 percent of individuals in mental health treatment have a co-occurring substance use disorder. Similarly, up to 70 percent in substance abuse treatment have a behavioral health condition.

MCC's COD initiative encourages the need to prioritize treatment integration to address both mental health and substance abuse conditions and consider both conditions as primary throughout treatment service planning. As part of this effort, we revised our clinical screening and assessment tools to identify and account for patients suffering from CODs and developed descriptive COD communications for providers. MCC also offers training to our provider network on screening for,

assessing, and treating existing co-occurring disorders. MCC's BH providers can receive CE credit for the coursework they complete, and the trainings are free of charge.

Section 18: Patient Utilization Management Safety (PUMS) program

MCC members with behavioral health and substance use disorder (SUD) service needs may also be eligible for the Patient Utilization Management Safety (PUMS) program. The PUMS program is a utilization control and case management program designed to promote proper medical management of essential health care. Upon the member's placement in the PUMS, MCC may refer members to appropriate services based upon the member's unique situation.

Members are selected for review based on their behavior patterns and utilization practices compared with other members of the same population. Once a member meets the placement requirements, we may limit a member for twelve months to a single pharmacy, PCP, controlled substances prescriber, hospital (for non-emergency hospital services only) and/or, on a case-by-case basis, other qualified provider types as determined by MCC and the circumstances of the member. MCC may limit a member to providers and pharmacies that are credentialed in its network.

Potential members for the program can be referred by MCC utilization management staff, Care Coordinators, providers, pharmacies, emergency rooms and other facilities, and social service agencies based on evidence of over-utilization of health care services and/or when there is suspicion of fraud. Typical behavioral health reasons for referral to the program are when members are suspected of activities such as drug abuse or dependence, prescription forgery and/or selling drugs.

At the end of the 12-month period, MCC re-evaluates members to determine whether they continue to display behavior or patterns that indicate they should remain in the PUMS program.

Section 19: Long-Term Services and Supports (LTSS)

Introduction

The Virginia Commonwealth Coordinated Care Plus (CCC Plus) program is a Medicaid program that includes long-term services and supports (LTSS). The LTSS program includes members who reside in a nursing facility or are receiving community-based services through the CCC plus Waiver. Each LTSS member has an assigned Care Coordinator who collaborates with and assists the member with their health care needs. The LTSS program provides an opportunity to create a seamless, integrated health services delivery program.

The primary goals of LTSS are to:

- Improve quality of life, satisfaction, and health outcomes for members who are enrolled
- Demonstrate a seamless, one-stop system of services and supports
- Provide assistance, via service coordination, in navigating the service environment, assuring timely and effective transfer of information, and tracking referrals and transitions to identify and overcome barriers
- Provide care coordination for members with complex needs that integrates the medical and social models of care, ensures member choice and rights, and includes members and family members in decision making using a person-centered model
- Support seamless transitions between service/treatment settings
- Facilitate communication between providers to improve the quality and cost-effectiveness of care
- Arrange services and supports to maximize opportunities for community living and prevent or delay the need for Nursing Facility placement
- Improve system-wide quality and monitoring
- Align with DMAS' Delivery System Reform Incentive Payment (DSRIP) initiatives

LTSS promotes quality and cost-effective coordination of care for eligible CCC Plus members with chronic, complex, and complicated health care, social service and custodial needs in a nursing facility or home- and community-based care setting. Care coordination involves the systemic process of assessment, planning, coordinating and implementing services and the evaluation of care received through a fully integrated physical health, behavioral health, and LTSS program to ensure the care needs of the member are met.

LTSS benefits

NOTE: For the purpose of the following sections, 'LTSS members' are defined as members who are waiver eligible and currently receiving Long-Term Services and Supports in either a Nursing Facility (NF), or are enrolled in the CCC Plus Waiver formally known as the Elderly or Disabled with

Consumer Direction (EDCD) Waiver, and the Technology Assisted (Tech) Waiver.

Covered services

LTSS members receive the same benefits as all other CCC Plus members (see Section 11). Additionally, the following benefits are available to LTSS members when the services have been identified as needed by the MCC Care Coordinator or LTSS provider.

Service	Benefit Limit	CCC Plus Waiver	Tech Waiver	Nursing Facility
Adult Day Health Care	1 Day = Min of 6 hours	X		
Assistive Technology	Max of $5,000 per member per state fiscal year (July 1 to June 30)	X	X	
Environmental Modification (EM)	Max of $5,000 per household per state fiscal year (July 1 to June 30)	X	X	
Hospice	N/A	X	X	
Long Stay Hospital	N/A	X	X	
Nursing Facility	N/A			X
Personal Care	CCC Plus Waiver Members: Can receive services through an agency and/or consumer directed; max of 56 hours per week for 52 weeks per year. For those requiring more than 56 hours per week, specific expectation criteria must be met; Max limit of 8 hours per day for supervision	X	X	
	Technology Dependent Waiver members: Max of 112 hours per week (combination of skilled Private Duty Nursing and Personal Care hours, but may not be performed at the same time or duplicate any other service received)		X	
Personal Emergency Response System (PERS) — (with or without Medication Monitoring)	Installation—1 per lifetime Monitoring—Monthly Medication Set-Up—Min of every 14 days	X		

Respite Care—Skilled (can be member or congregate)	Max of 480 hours per fiscal year (July 1 to June 30) Agency Directed Only		X	
Respite Care—Unskilled (can be agency and/or consumer directed)	Max of 480 hours per state fiscal year (July 1 to June 30) (combination of agency and consumer direction)	X		
Services Facilitation	N/A	X		
Skilled Private Duty Nursing (PDN) — (RN and LPN—can be member or congregate)	Max 16 hours per day and is reviewed based on medical necessity.		X	
Transition Coordination	N/A	X	X	X
Transition Services	Limited to 1-time cost of $5,000; available within first 30 days of transition to qualified residence.			X

Note: DMAS is solely responsible for the addition or deletion of any service or supply, with the exclusion of the Enhanced Benefits identified in Section 13.

Consumer-directed Model of Care and Agency-directed Model of Care

CCC Plus members who qualify for the CCC Plus Waiver can receive services such as personal care that assists the member with their activities of daily living (ADLs) like dressing, bathing, toileting, eating and assistance with self-administration of medication, and Instrumental Activities of Daily Living (IADL) like laundry, food preparation and housekeeping. Respite care services can be skilled or unskilled. Skilled respites services are performed by a nurse through agency directed (AD) care only. Unskilled respite services are performed by the member's aide and can be either consumer directed (CD) or AD.

Respite services are utilized for the relief of the unpaid primary caregiver to help ease the physical and emotional stress of providing support and care to the waivered individual. Personal care and respite care services are provided to the member through CD services, AD services, or, if appropriate, a combination of both. The Care Coordinator collaborates with the member to help ensure the delivery of care is appropriate for that members needs whether it is through CD or AD services.

AD Services are provided to members by an in-network agency of their choice. The agency is responsible for providing care and submitting the appropriate forms and documentation that support the need for the requested LTSS services. Once the forms and documentation are received, they will then proceed through the authorization review process. Once a determination has been made, notification is sent to the provider and member concerning the authorization request.

If members elect to receive LTSS services through the CD model of care, they may do so by choosing an in-network Services Facilitator (SF) to assess their needs, provide training and guidance needed for them or their designee to become an employer of record (EOR). As an EOR, the member or their identified representative is responsible for hiring, training, supervising and firing attendants. The EOR cannot be the paid attendant caregiver, attendant or SF. The SF is responsible for submitting the appropriate forms and documentation that support the need for LTSS services. Once the forms and documentation has been received, they will then proceed through the authorization review process. Once a determination has been made, notification is sent to the provider and member concerning the authorization request.

If the member has elected CD services, the Fiscal/Employer Agent (F/EA), ACES$, is responsible for establishing accounts for the EOR by securing a federal identification number and establishing the tax accounting process. ACES$ also processes requests for new workers and completes their enrollment, enabling them to be compensated for the CD services they provide. ACES$ processes timesheets and distributes paychecks for all enrolled workers while maintaining accountability for the hours each member has available for use.

LTSS authorizations

When MCC reviews authorization requests, we take a multifactorial approach and take into consideration each individual member's needs. We review and consider the provider documentation and justification, member assessments completed by the Care Coordinator and review of the CCC Plus provider manual. Once a determination has been made, a notification letter is sent to the provider. MCC does not require unskilled home- and community-based services to be ordered by a treating physician, but the Care Coordinator may consult with the treating physician as appropriate regarding the member's physical health, behavioral health, and LTSS needs and to facilitate communication and coordination. Skilled home- and community-based services require a physician's order.

For LTSS members receiving services at home or in the community, the Care Coordinator collaborates with the LTSS provider to ensure the appropriate services are in place.

Section 20: Helpful links and provider resources

Provider portal

MCC is committed to reducing administrative burdens on our providers by offering web-based tools for retrieving and exchanging information. We offer quick and easy resources online for providers. Our provider website, www.MCCofVA.com, is our primary portal for provider communication, information and business transactions. This website is continually updated to provide easy access to information and greater convenience and speed in exchanging information with MCC. We encourage you to use our website often as a self-service tool for supporting your practice or organization.

To realize the benefits of the MCC provider website, you should:

- Have access to a personal computer, internet service provider and currentweb browser software
- Visit our websites frequently to take advantage of new capabilities and access resources
- Provide us with feedback on any difficulties you may experience in using our online resources or on ideas you have for enhancements

MCC's responsibility is to:

- Maintain operation of online services 24 hours a day, seven days a week
- Inform users of service problems if they occur
- Use your feedback to continually improve our website capabilities
- Provide online access to the following applications:
    - Member eligibility inquiry
    - Request for initial and subsequent authorization
    - Authorization inquiry and report download
    - View authorization approval letters
    - Claims submission
    - Claims inquiry and online explanation of payments (EOPs)
    - Check credentialing and contract status for all providers
    - Display/edit practice data (to enable you to monitor and request changes to your practice information)
    - Electronic Funds Transfer (EFT) signup
    - Cultural competency tools
    - Online demos to help providers navigate website applications
    - Comprehensive library of clinical practice information
    - Other tools and information beneficial to providers serving MCC members

Connect with Availity

The Availity Health Information Network provides a single secure web portal connection to multiple payers including MCC. This web-based, full-service information exchange offers a claims clearinghouse and real-time transactions at no charge to our providers. Transactions include eligibility and benefits, claim status, claim submission, electronic remittance, and authorizations and referrals. The portal encompasses administrative, financial, and clinical services, supports both real- time and batch transactions and is HIPAA compliant. Please consult our provider website at www.MCCofVA.com for specific functionality and release schedule available for MCC through Availity.

To register, go to www.Availity.com. Click on the "register" option in the top right corner of the screen. Before you register you will need the following information:

1. Your organization's name, address and federal tax ID number
2. Primary Controlling Authority (PCA)—this person has legal authority to sign agreements for your organization and, typically, is an owner or senior partner. Availity will work with this person should any legal or policy questions arise
3. Primary Access Administrator (PAA)—this person is legally responsible for verifying staff identities and roles, assigning Availity access to staff as appropriate to role, and maintaining user access and information; this person is typically an office or department manager or administrator and is appointed by the PCA, although the PCA may take on this role if desired

Checking claims status online

Regardless of the method of claim submission, providers can check the status of claims online. You can verify claims have been received, pended or finalized using the Availity Claim Status Tool. This tool is a fast and easy online claim status tool that provides real- time claim status and payment information. You must be registered with Availity to use this free tool—see above for information about registering. Please consult our provider website regularly for release updates at www.MCCofVA.com.

To access the Claim Status Tool:

1. Go to www.Availity.com and log in
2. Select "Claims Status Tool" under "Claims Management" in the left-hand menu
3. Choose MCC in the payer field
4. Search for claims by the patient identification number or claim number
5. Information provided includes:
   a. Claim status
   b. Billed amount
   c. Ineligible amount(s)
   d. Paid amount

e. Check/EFT voucher
f. Check date
g. Payee name
h. Line item breakdowns

Additional tips for locating claims:

- When asked, “is the provider name the same as the organization name?” answer “No”
- The NPI is the billing NPI from the submitted claim
- The date of service can be the exact date of service or a date range (30 day maximum)
- Only complete the required fields that are marked with a red asterisk

Connect with Customer Care

You can reach MCC Customer Care from 8:00 a.m. to 6:00 p.m. local time, Monday through Friday, except for company holidays.

- CCC Plus: 1-800-424-4524
- Medallion 4.0: 1-800-424-4518
- Email: MCCVA-Provider@molinahealthcare.com

Our Customer Care associates can provide claim status information, answer reimbursement questions, and provide other assistance. We also have a dedicated queue to assist long-term care providers with enrollment, service authorizations, and reimbursement questions or issues. Outside of regular hours, providers receive a recorded message about accessing the online services, and an IVR selection menu with prompts for leaving a voicemail message, which is returned on the next business day; and/or to utilize our automated eligibility line. In addition, providers have direct access to our nurse advice line, twenty-four hours a day, seven days a week.

Department of Medical Assistance Services (DMAS) website references

- Behavioral Health Services: https://www.dmas.virginia.gov/#/behavioralhome
- Commonwealth Coordinated Care Plus program: https://www.dmas.virginia.gov/#/cccplus
- Dental services: https://www.dmas.virginia.gov/#/dentalservices
- DMAS website: http://www.dmas.virginia.gov/
- DMAS Provider Manuals: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual
- DMAS Provider Portal: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal
- Early Intervention (EI): https://www.dmas.virginia.gov/for-providers/maternal-and-child-health/early-intervention-services/
- Early Periodic Screening Diagnosis and Treatment (EPSDT): https://www.dmas.virginia.gov/for-providers/maternal-and-child- health/early-intervention-services/

Section 21: Glossary of terms

Abuse: Either: (1) Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes member practices that result in unnecessary cost to the Medicaid program; or, (2) the suspected or known physical or mental mistreatment of a member which must be reported immediately upon discovery.

Appeal (member): A member's request or a provider on behalf of a member's request for review of the MCC's coverage or payment determination, in accordance with 42 CFR § 438.400 et seq. In accordance with 12VAC30-110-100, appeals for denial determinations must initially be filed with MCC. The filing of an internal appeal and exhaustion of MCC's internal appeal process is a prerequisite to filing an external appeal to Medicaid.

Appeal (provider): Requests made by MLTSS providers (in-network and out-of-network) to review an adverse benefit determination in accordance with the 172 statutes and regulations governing the Virginia Medicaid appeal process. After a provider exhausts the appeal process, Virginia Medicaid affords the provider the right to two administrative levels of appeal (informal appeal and formal appeal) in accordance with the Virginia Administrative Process Act (Code of Virginia section 2.2-4000 et seq.) and Virginia Medicaid's provider appeal regulations (12 VAC 30-20-500 et seq.).

Authorized Representative: A person who is authorized to conduct the personal or financial affairs for an individual who is 18 years of age or older.

Concurrent Review: Utilization management reviews conducted during a member's continued hospital stay. Concurrent review determines medical necessity for treatment at the appropriate level of care. Concurrent reviews are also conducted for outpatient procedures and services to extend a current course of treatment

Covered Service: A medically necessary service or supply shown in the contract for which benefits may be available.

Department of Medical Assistance Services (DMAS): The single State Agency in the Commonwealth of Virginia that administers the Medicaid program under Title XIX of the Social Security Act and the Children's Health Insurance Program (known as FAMIS) under Title XXI of the Social Security Act.

Durable Medical Equipment (DME): Medical equipment, supplies, and appliances consistent with 42 CFR 440.70(b)(3).

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body functions, or serious dysfunction of any bodily organ or part; or with respect to a pregnant woman who is having contractions, (1) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (2) that transfer may pose a threat to the health or safety of the woman or the unborn child.

Emergency Medical Transportation: Urgent care transportation to and from your covered medical and dental appointments.

Emergency Services: Those health care services that are rendered by participating or non-participating providers, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the member's health or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy; (2) serious impairment to bodily or mental functions; or (3) serious dysfunction of any bodily organ or part or behavior.

Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT): Medicaid's comprehensive and preventive child health program benefit for individuals under the age of 21 (excluding members under the FAMIS benefit) that provides coverage for children with a comprehensive set of screenings, interventions, and other support services. EPSDT was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) legislation and includes periodic screening, vision, dental, and hearing services. In addition, Section 1905(r)(5) of the Social Security Act (the Act) requires that any medically necessary health care service listed at Section 1905(a) of the Act be provided to an EPSDT member even if the service is not available under the state's Medicaid plan to the rest of the Medicaid population. See also, 42 CFR § 441 Subpart B (Sections 50-62).

Excluded Services: Health care services that the health insurance or plan doesn't pay for or cover.

Grievance: In accordance with 42 CFR § 438.400, a grievance means an expression of dissatisfaction about any matter other than an "action." A "grievance" is any complaint or dispute expressing dissatisfaction with any aspect of MCC's or provider's operations, activities, or behavior. Possible subjects for grievances include, but are not limited to, quality of care or services provided, aspects of interpersonal relationships such as rudeness of a PCP or employee of MCC, or failure to respect the member's rights, as provided for in 42 CFR § 438.400 et seq.

Home Health Care: Includes intermittent or part-time nursing services (R.N. or L.P.N.), personal care services by a home health aide, and medical items (limited to approved types of supplies and equipment, suitable for use in the home).

Hospitalization: Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care: Outpatient services provided in an outpatient hospital setting. Your PCP can obtain prior notification for health care services that may require notification.

Medically Necessary: Per DMAS, an item or service provided for the diagnosis or treatment of a member's condition consistent with standards of medical practice and in accordance with Virginia Medicaid policy (12 VAC 30-130-600) and EPSDT criteria (for qualifying members under age 21) and Federal regulations as defined in 42 CFR § 438.210 and 42 CFR § 440.230.

Member: A person eligible for and enrolled in the plan to receive covered services.

Non-covered Services: Services, supplies, products and accommodations that plan is not required to provide to members.

Participating Provider: Any duly licensed physician, hospital, ancillary, or other health care provider that has contracted directly or indirectly with MCC to provide covered services to plan members and is credentialed in accordance with the plan's credentialing criteria.

Physician Services: Includes all services and procedures rendered by a participating provider when needed for preventive, diagnostic, or therapeutic care, or to treat a particular injury, illness or disease. Excludes experimental procedures and cosmetic surgery. These physicians include: advanced registered nurse practitioner, physician assistant, podiatrist, ambulatory surgical centers, community health departments, rural health clinic services, federally qualified health centers, birthing centers, certified nurse midwives, chiropractic, psychiatrist and nursing care.

Prior Authorization (Preauthorization): Prior authorization verifies the medical necessity of certain treatments, as well as the setting where medical services are provided. For pharmacy benefits, prior authorization helps determine cost-effective alternatives for certain prescription drugs.

Prescription Drugs: Includes prescribed drugs currently covered by the Medicaid program, when ordered by a participating provider and supplied by a licensed participating pharmacy.

Primary Care Provider (PCP): A practitioner who provides preventive and primary medical care for eligible members and who certifies service authorizations and referrals for all medically necessary specialty services. PCPs may include pediatricians, family and general practitioners, internists, and specialists who perform primary care functions such as surgeons; and, clinics including, but not limited to, health departments, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), etc.

Reconsideration: A request to MCC from a member or their authorized representative to re- review

a service that was previously denied, terminated, or reduced.

Specialist: A doctor who specializes in treating certain diseases, health problems, or conditions; for the purposes of this contract, not primary care or pediatric doctor.

Urgent Care: Medical services required promptly to prevent impairment of health due to symptoms that do not constitute an emergency medical condition, but that are the result of an unforeseen illness, injury, or condition for which medical services are immediately required. Urgent care is appropriately provided in a clinic, physician's office, or in a hospital emergency department if a clinic or physician's office is inaccessible. Urgent care does not include primary care services or services provided to treat an emergency medical condition.

MCC CustomerCare

CALL	**CCC Plus:** 1-800-424-4524 **Medallion 4.0:** 1-800-424-4518 Hours of operation are 8 a.m. to 6 p.m. local time, Monday through Friday.
FAX	1-855-472-8574
WRITE	Molina Complete Care 3829 Gaskins Rd Richmond, VA 23233-1437
EMAIL	MCCVA-Provider@molinahealthcare.com
WEBSITE	www.MCCofVA.com

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