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Molina Complete Care

Member Handbook

COMMONWEALTH COORDINATED CARE PLUS PROGRAM (CCC PLUS)

Virginia Department of Medical Assistance Services (DMAS)

MOLINA® HEALTHCARE | Molina Complete Care

Effective December 1, 2021

Table of contents

Help in Other Languages or Alternate Formats 1

Help in Other Languages 2

1. Commonwealth Coordinated Care Plus (CCC Plus) 5

Welcome to Molina Complete Care 5

How to Use This Handbook 6

Other Information We Will Send to You 6

MCC Member ID Card 6

Provider and Pharmacy Directory 7

Important Phone Numbers 8

2. What is Commonwealth Coordinated Care Plus 10

What Makes You Eligible to be a CCC Plus Member 10

CCC Plus Enrollment 10

Reasons You Would Not be Eligible to Participate in CCC Plus 11

What if I Am Pregnant 11

Special care for pregnant members 11

When you become pregnant 12

During your pregnancy 12

When you have a new baby 12

Coverage for Newborns Born to Moms Covered Under CCC Plus 13

Medicaid Eligibility 14

Choosing or Changing Your Health Plan 14
Health Plan Assignment 14
You Can Change Your Health Plan Through the CCC Plus Helpline 14
Automatic Re-Enrollment 15
What is MCC's Service Area? 15
If You Have Medicare and Medicaid 16
Types of Services Under Medicare 16
Types of Services Under CCC Plus (Medicaid) 16
You Can Choose the Same Health Plan for Medicare and Medicaid 17
How to Contact the Medicare State Health Insurance Assistance Program (SHIP) 18
3. How CCC Plus Works 19
What are the Advantages of CCC Plus 19
What are the Advantages of Choosing MCC? 20
We're all about YOU 20
Your care team, in your neighborhood 20
Transition of Care Policy: Continuity of Care Period 24
If You Have Other Coverage 25
4. Your Care Coordinator 26
How Your Care Coordinator Can Help 26
Eligibility for Long-Term Services and Supports 27
What is a Health Screening 27
What is a Health Risk Assessment 28

What is an Individualized Care Plan 28
How to Contact Your Care Coordinator 29
Changing Care Coordinators 29
5. Help From Member Services 32
How to Contact MCC Member Services 32
How Member Services Can Help 33
NurseLine 33
Behavioral Health Crisis Line 34
Addiction and Recovery Treatment Services (ARTS) Advice Line 35
If You Do Not Speak English 35
If You Have a Disability and Need Assistance in Understanding Information or Working with Your Care Coordinator 36
If You Have Questions About Your Medicaid Eligibility 36
6. How to Get Care and Services 37
How to Get Care from Your Primary Care Physician 37
Your Primary Care Physician 37
Choosing Your PCP 37
If You have Medicare, Tell us About Your PCP 38
If Your Current PCP is not in Our Network 38
Changing Your PCP 38
Getting an Appointment with Your PCP 39
Appointment Standards 39

Services That Do Not Require an Approval 39
How to Get Care From Network Providers 40
Travel Time and Distance Standards 40
Accessibility 41
Telehealth Visits 42
What are "Network Providers" 42
What are "Network Pharmacies" 42
What are Specialists 43
If Your Provider Leaves Our Plan 43
How to Get Care from Out-of-Network Providers 44
Care From Out-of-State Providers 45
Network Providers Cannot Bill You Directly 45
If You Receive a Bill for Covered Services 45
If You Receive Care From Providers Outside of the United States 45
7. How to Get Care for Emergencies 46
What is an Emergency 46
What to do in an Emergency 46
What is a Medical Emergency 46
What is a Behavioral Health Emergency 47
Examples of Non-Emergencies 47
If You Have an Emergency When Away From Home 47
What is Covered if You Have an Emergency 47

Notifying MCC About Your Emergency 47
After an Emergency 48
If You Are Hospitalized 48
If it Wasn't a Medical Emergency 48
8. How to Get Urgently Needed Care 49
What is Urgently Needed Care 49
9. How to Get Your Prescription Drugs 50
Getting Your Prescriptions Filled 50
List of Covered Drugs 51
Limits for Coverage of Some Drugs 51
Getting Approval in Advance 52
Trying a Different Drug First 52
Quantity Limits 52
Emergency Supply 53
Non-Covered Drugs 53
Changing Pharmacies 54
What if You Need a Specialized Pharmacy 54
Can You Use Mail-Order Services to Get Your Drugs 55
Can You Get a Long-Term Supply of Drugs 55
Can You Use a Pharmacy That is Not in MCC's Network 55
What is the Patient Utilization Management and Safety (PUMS) Program 56

10. How to Access Your CCC Plus Benefits.....57
CCC Plus Benefits 57
General Coverage Rules.....57
Benefits Covered Through MCC.....58
Extra Benefits We Provide that are not Covered by Medicaid 63
How to Access Early and Periodic Screening, Diagnostic, and Treatment Services 68
What is EPSDT.....68
Getting EPSDT Services.....68
Getting Early Intervention Services.....69
How to Access Behavioral Health Services.....70
How to Access Addiction and Recovery Treatment Services (ARTS).....72
How to Access Long-Term Services and Supports (LTSS).....73
Commonwealth Coordinated Care Plus Waiver.....73
How to Self-Direct Your Care.....74
Nursing Facility Services.....74
Screening for Long-Term Services and Supports 75
Freedom of Choice.....75
How to Get Services if You are in a Developmental Disability Waiver.....76
How to Get Non-Emergency Transportation Services 77
Non-Emergency Transportation Services Covered by MCC.....77
Transportation to and From DD Waiver Services.....77

11. Services Covered Through the DMAS Medicaid Fee-For-Service Program 78
Carved-Out Services 78
Services That Will End Your CCC Plus Enrollment 80
12. Services Not Covered by CCC Plus 81
If You Receive Non-Covered Services 82
13. Member Cost Sharing 83
Member Patient Pay Toward Long-Term Services and Supports 83
Medicare Members and Part D Drugs 83
14. Service Authorization and Benefit Determination 84
Service Authorization 84
Service Authorizations and Continuity of Care 87
How to Submit a Service Authorization Request 88
What Happens After We Get Your Service Authorization Request 88
Timeframes for Service Authorization Review 88
Benefit Determination 90
Advance Notice 90
Post Payment Review 90
15. Appeals, State Fair Hearings, and Grievances 91
Your Right to Appeal 91
Authorized Representative 91
Adverse Benefit Determination 91

How to Submit Your Appeal 92
Continuation of Benefits 92
What Happens After We Get Your Appeal 93
Timeframes for Appeals 93
Written Notice of Appeal Decision 94
Your Right to a State Fair Hearing 94
Standard or Expedited Review Requests 95
Authorized Representative 95
Where to Send the State Fair Hearing Request 95
After You File Your State Fair Hearing Appeal 96
State Fair Hearing Timeframes 96
Continuation of Benefits 96
If the State Fair Hearing Reverses the Denial 97
If You Disagree with the State Fair Hearing Decision 97
Your Right to File a Grievance 97
Timeframe for Grievances 97
What Kinds of Problems Should be Grievances 98
There Are Different Types of Grievances 99
Internal Grievances 99
External Grievances 100
16. Member Rights 102
Your Rights 102
Your Right to be Safe 104
Your Right to Confidentiality 105

Your Right to Privacy 105
How to Join the Member Advisory Committee 106
We Follow Non-Discrimination Policies 106
17. Member Responsibilities 109
Your Responsibilities 109
Advance Directives 110
Where to Get the Advance Directives Form 111
Completing the Advance Directives Form 111
Share the Information with People You Want to Know About It 111
We Can Help You Get or Understand Advance Directives Documents 111
Other Resources 112
If Your Advance Directives Are Not Followed 112
18. Fraud, Waste, and Abuse 114
What is Fraud, Waste, and Abuse 114
How Do I Report Fraud, Waste, or Abuse 115
19. Other Important Resources 117
20. Information for Medicaid Expansion Members 118
What Makes You Eligible to be a Medicaid Expansion Member 118
Enrollment for a Medicaid Expansion Member 118
Medicaid Expansion Benefits and Services 119
21. Important Words and Definitions Used in this Handbook 121
MCC Member Services 129

Help in Other Languages or Alternate Formats

This handbook is available for free in other languages and formats including online, in large print, Braille or Audio CD. To request the handbook in an alternate format and or language, call Member Services toll free at 1-800-424-4524 (TTY 711).

Our bilingual staff and interpreters are trained professionals. They understand medical and treatment information. They can help you communicate with your health care professionals, your family members or your friends about setting up a visit with your doctor. And they can provide health education.

If you have any problems reading or understanding this information, please contact our Member Services staff at 1-800-424-4524 (TTY 711) for help at no cost to you.

We provide reasonable accommodations and communications access to persons with disabilities. Individuals who are deaf or hard of hearing or who are speech-impaired, who want to speak to a Member Services representative, and who have a TTY or other assistive device can dial 711 to reach a relay operator. They will help you reach our Member Services staff. The Virginia Relay (711) service provides:

TTY (text telephone)—A TTY looks much like a phone, except it has a keyboard and text screen.

Voice Carry-Over (VCO)—For people who can speak clearly, yet have hearing loss significant enough to keep them from understanding what is being said over a standard telephone.

Speech-To-Speech (STS)—For people with mild to moderate difficulty speaking who can hear clearly over the phone.

Hearing Carry-Over (HCO)—For people with significant difficulty speaking.

You can also email questions to MCCVA@molinahealthcare.com. We will reply in one business day.

Help in Other Languages

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-800-424-4524 (TTY 711).

Spanish
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-424-4524 (TTY 711).

Korean
영어로 말할 수 없다면1-800-424-4524 (TTY 711). 로 전화하십시오. 저희는 통역 서비스를 이용할 수 있으며 귀하의 언어로 된 질문에 무료로 답변 할 수 있습니다. 우리는 또한 귀하의 언어로 의사 소통 할 수있는 의료 서비스 제공자를 찾도록 도울 수 있습니다.

Vietnamese
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-424-4524 (TTY 711)

Chinese
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-424-4524 (TTY 711)

Arabic
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم
1-800-424-4524 (711 رقم هاتف الصم والبكم).

Tagalog
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-424-4524 (TTY 711).

Farsi
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما
فراهم می باشد. با 1-800-424-4524 (TTY 711) تماس بگیرید.

Amharic
ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ
1-800-424-4524 (መስማት ለተሳናቸው 711).

Urdu
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں
1-800-424-4524 (TTY 711).

French
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-424-4524 (ATS 711).

Russian
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-424-4524 (телетайп 711).

Hindi
ध्यान द: यद आप हदी बोलते ह तो आपके लिए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह। 1-800-424-4524 (TTY 711) पर कॉल कर।

German
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-424-4524 (TTY 711).

Bengali
লয্ করনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপল আছে। ফোন করন ১-1-800-424-4524 (TTY 711)।

Bassa
Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jŭ ké m̀ Ɓàsɔ́ ɔ̀ -wùɖù-po-nyɔ̀ jŭ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ ìn m̀ gbo kpáa. Đá 1-800-424-4524 (TTY 711)

1. Commonwealth Coordinated Care Plus (CCC Plus)

Welcome to Molina Complete Care

Thank you for being a member of Molina Complete Care (MCC), a Commonwealth Coordinated Care Plus (CCC Plus) plan. If you are a new member, we will get in touch with you in the next few weeks to go over some very important information with you. You will be assigned a Care Coordinator who will help you get the care and services you need. You can ask us any questions you have, or get help making appointments. If you need to speak with us right away or before we contact you, call us at 1-800-424-4524 (TTY 711).

We want you to get the care you need, as soon as possible. We also want to make sure you understand your benefits. Start with these easy steps:

1. **Call your primary care provider (PCP) to make an appointment.** Once you've chosen a PCP, it's important to schedule an appointment as soon as possible – even if you're not sick. If your doctor gets to know you when you're well, he or she is better able to treat you when you're not. Regular checkups help you stay healthy. We'll send the name and telephone number of your PCP in a separate mailing. Call us at 1-800-424-4524 (TTY 711) to choose or change your PCP at any time, or to get help making an appointment. We are here for you.

2. **Take your Health Screening.** Complete the Health Screening form and return it to us. It helps to give us a picture of your overall health. It helps us match you with the best Care Coordination Team for you. You can find the form at www.MCCofVA.com. If you need help with the Health Screening form, call Member Services. We can also assist with other forms that may help us assess your needs.

3. **Get to know your plan.** Start by reading the "How to Get Care and Services" and "How to Access Your CCC Plus Benefits" parts of this handbook. They give you information about your new plan. Be sure to keep your handbook close by. You can also visit our website at www.MCCofVA.com.

Please call us if you have any questions. We're here to help you. We are available 24 hours a day and seven days a week. You can reach us at our toll-free number 1-800-424-4524 (TTY 711).

How to Use This Handbook

This handbook will help you understand your CCC Plus benefits and how you can get help from MCC. This handbook is your guide to health services. It explains your health care, behavioral health, prescription drug, and long-term services and supports coverage under the CCC Plus program. It tells you the steps you can take to make your health plan work for you.

Feel free to share this handbook with a family member or someone who knows your health care needs. When you have a question, check this handbook, call Member Services at 1-800-424-4524 (TTY 711), visit our website at www.MCCofVA.com or call your Care Coordinator.

Member Services, our website and your Care Coordinator can also provide the latest information related to COVID-19.

Other Information We Will Send to You

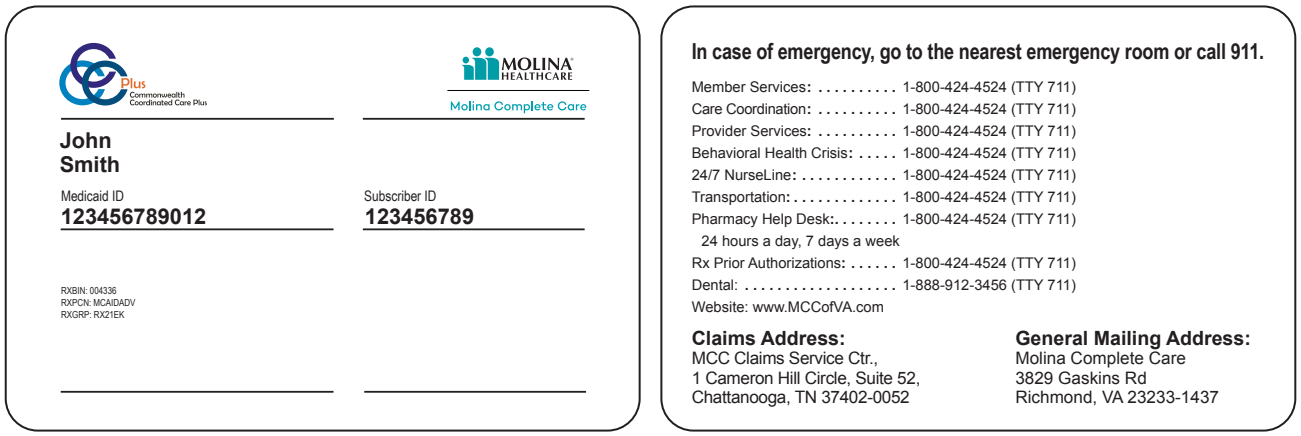
With this handbook, you should have already received your MCC welcome letter, information on how to access your Provider and Pharmacy Directory and a List of Covered Drugs. In separate mailings, we'll send you:

- Your Member ID Card.
- The name and telephone number of your primary care provider (PCP). (You may call us to change your PCP at any time.)
- The name and telephone number of your Care Coordinator.

MCC Member ID Card

Show your MCC ID card when you receive Medicaid services, including when you get long term services and supports, at doctor visits, and when you pick up prescriptions. You must show this card when you get any

services or prescriptions. If you have Medicare and Medicaid, show your Medicare and MCC ID card when you receive services. Below is a sample card to show you what yours will look like:



If you haven't received your card, or if your card is damaged, lost, or stolen, call Member Services at the number at the bottom of the page right away, and we will send you a new card.

In addition to your MCC card, keep your Commonwealth of Virginia Medicaid ID card to access services that are covered by the State, under the Medicaid fee-for-service program. These services are described in ***Services Covered through Medicaid Fee-For-Service,*** in Section 11 of this handbook.

Provider and Pharmacy Directory

You can ask for an annual Provider and Pharmacy Directory by calling Member Services at the number on the bottom of this page. You can also see the Provider and Pharmacy Directory at www.MCCofVA.com.

The Provider and Pharmacy Directory provides information on health care professionals (such as doctors, nurse practitioners, psychologists, etc.), facilities (hospitals, clinics, nursing facilities, etc.), support providers (such as adult day health, home health providers, etc.), and pharmacies in the MCC network. While you are a member of our plan, you generally must use one of our network providers and pharmacies to get covered services. There are some exceptions, however, including:

- When you first join our plan (see *Continuity of Care Period* in Section 3 of this handbook),
- If you have Medicare (see *How to Get Care From Your Primary Care Physician* in Section 6 of this handbook, and
- In several other circumstances (see *How to Get Care From Out-of-Network Providers* in Section 6 of this handbook.)

You can ask for a paper copy of the *Provider and Pharmacy Directory* or *List of Covered Drugs* by calling Member Services at the number at the bottom of the page. You can also see the *Provider and Pharmacy Directory* and *List of Covered Drugs* at www.MCCofVA.com or download it from this website. Refer to *List of Covered Drugs* in Section 9 of this handbook.

Your Provider Directory lists doctors, hospitals, pharmacies and other services and supports providers that are part of our network. You can find the names, addresses, phone numbers, provider qualifications, specialties, board certification status (if applicable), new patient acceptance (open or closed panels), and other important information about our network providers in this directory. You can also call Member Services to learn other details about your provider such as which medical school they attended and residency completion information.

Important Phone Numbers

Your Care Coordinator	1-800-424-4524 (TTY 711)
MCC Member Services	1-800-424-4524 (TTY 711)
MCC Behavioral Health Crisis Line (24/7)	1-800-424-4524 (TTY 711)
Medical/Behavioral Health Advice Line (24/7)	1-800-424-4524 (TTY 711)
Veyo Non-Emergency Transportation	1-800-424-4524 (TTY 711)

DMAS Dental Benefits Administrator	For questions or to find a dentist in your area, call the DMAS Dental Benefits Administrator at 1-888-912-3456. Information is also available on the DMAS website at: https://www.dmas.virginia.gov/for-members/benefits-and-services/dental/ or the DentaQuest website at: http://www.dentaquestgov.com/
DMAS Transportation Contractor for transportation to and from DD Waiver Services	1-866-386-8331 TTY: 1-866-288-3133 Or dial 711 to reach a relay operator
CCC Plus Helpline	1-844-374-9159 TDD: 1-800-817-6608 Or visit the website at cccplusva.com
Department of Health and Human Services' Office for Civil Rights	1-800-368-1019 or visit the website at www.hhs.gov/ocr
Office of the State Long-Term Care Ombudsman	1-800-552-5019 TTY: 1-800-464-9950

2. What is Commonwealth Coordinated Care Plus

The Commonwealth Coordinated Care Plus (CCC Plus) program is a Medicaid managed care program through the Department of Medical Assistance Services (DMAS). MCC was approved by DMAS to provide care coordination and health care services. Our goal is to help you improve your quality of care and quality of life.

What Makes You Eligible to be a CCC Plus Member

You are eligible for CCC Plus when you have full Medicaid benefits, and meet one of the following categories:

- You are age 65 and older,
- You are an adult or child with a disability,
- You reside in a nursing facility (NF),
- You receive services through the CCC Plus home and community-based services waiver formerly referred to as the Technology Assisted and Elderly or Disabled with Consumer Direction (EDCD) Waivers,
- You receive services through any of the three waivers serving people with developmental disabilities (Building Independence, Family & Individual Supports, and Community Living Waivers), also known as the DD Waivers.

CCC Plus Enrollment

Eligible individuals must enroll in the CCC Plus program. DMAS and the CCC Plus Helpline manage the enrollment for the CCC Plus program. To participate in CCC Plus, you must be eligible for Medicaid.

Reasons You Would Not be Eligible to Participate in CCC Plus

You would not be able to participate in CCC Plus if any of the following apply to you:

- You lose/lost Medicaid eligibility.
- You do not meet one of the eligible categories listed above.
- You are enrolled in hospice under the regular fee-for-service Medicaid program prior to any CCC Plus benefit assignment.
- You enroll in the Medicaid Health Insurance Premium Payment (HIPP) program.
- You enroll in PACE (Program of All-Inclusive Care for the Elderly). *For more information about PACE, talk to your Care Coordinator or visit:* http://www.pace4you.org/.
- You reside in an Intermediate Care Facility for Individuals with Intellectual and Developmental Disabilities (ICF/IDD).
- You are receiving care in a Psychiatric Residential Treatment Facility (children under age 21).
- You reside in a Veteran's Nursing Facility.
- You reside in one of these State long term care facilities: Piedmont, Catawba, Hiram Davis, or Hancock.
- You are currently incarcerated.
- You live on Tangier Island.

What if I Am Pregnant

Special care for pregnant members

When you become pregnant and during your pregnancy, it is very important to see your primary care provider (PCP), obstetrician or gynecologist (OB/GYN) for care. This kind of care is called prenatal care. It can help you have a healthy baby. Prenatal care is always important even if this is not your first time having a baby.

Our program helps pregnant members with complicated healthcare needs. A care coordinator with the appropriate clinical background will work closely with pregnant members to provide:

- Education
- Emotional support
- Help in following your doctor's care plan
- Information on services and resources in your community, such as transportation; the Women, Infants, and Children program (WIC); breastfeeding and counseling

Your Care Coordinator will also work with your doctors and help with other services you may need. The goal is to help you stay healthy during your pregnancy and to help you to deliver a healthy baby.

When you become pregnant

If you think you are pregnant: Call your PCP or OB/GYN right away. You do not need a referral from your PCP to see an OB/GYN. Call Member Services if you need help finding an OB/GYN in the MCC network.

During your pregnancy

While you are pregnant, you need to take good care of your health. You may be able to get healthy food from WIC. Your Care Coordinator or Member Services can give you the phone number for the WIC program close to you.

When you are pregnant, you must go to your PCP or OB/GYN at least:

- Every four weeks for the first six months
- Every two weeks for the seventh and eighth months
- Every week during the last month

Your PCP or OB/GYN may want you to visit more than this based on your health needs.

When you have a new baby

When you deliver your baby, you and your baby may stay in the hospital at least:

- 48 hours after a vaginal delivery
- 72 hours after a Cesarean section (C-section)

You may stay in the hospital for less time if your PCP or OB/GYN and the baby's provider sees that you and your baby are doing well. If you and your baby leave the hospital early, your PCP or OB/GYN may ask you to have an office or in-home nurse visit within 48 hours.

It's important to set up a visit with your PCP or OB/GYN after you have your baby for a postpartum checkup. You may feel well and think you are healing, but it takes the body at least six weeks to heal after delivery.

- The visit should be done between 21 and 56 days after you deliver
- If you delivered by C-section, your PCP or OB/GYN may ask you to come back for a one or two-week post-surgery checkup. This is not considered a postpartum checkup. You will still need to go back and see your provider within 21 to 56 days after your delivery for your postpartum checkup.

If you are within your first ninety (90) days of initial enrollment, and in your third trimester of pregnancy, and your provider is not participating with MCC, you may request to move to another MCO where your provider participates. If your provider does not participate with any of the CCC Plus health plans, you may request to receive coverage through fee-for-service Medicaid until after delivery of your baby. Contact the CCC Plus Helpline at 1-844-374-9159 or TDD: 1-800-817-6608 to make this request.

Coverage for Newborns Born to Moms Covered Under CCC Plus

If you have a baby, you will need to report the birth of your child as quickly as possible to enroll your baby in Medicaid. You can do this by:

- Calling the Cover Virginia Call Center at 833-5CALLVA (TDD: 1-888-221-1590) to report the birth of your child over the phone, or
- Contacting your local Department of Social Services to report the birth of your child.

You will be asked to provide your information and your baby's:

- Name
- Date of Birth
- Race
- Gender
- The baby's mother's name and Medicaid ID number

When first enrolled in Medicaid, your baby will be able to access health care through the Medicaid fee-for-service program. This means that you can take your baby to any provider in the Medicaid fee-for-service network for covered services. Look for additional information in the mail about how your baby will receive Medicaid coverage from DMAS.

Medicaid Eligibility

Medicaid eligibility is determined by your local Department of Social Services (DSS) or the Cover Virginia Central Processing Unit. Contact your local DSS eligibility worker or call Cover Virginia at 833-5CALLVA (TDD: 1-888-221-1590) about any Medicaid eligibility questions. The call is free. For more information you can visit Cover Virginia at www.coverva.org.

Choosing or Changing Your Health Plan

Health Plan Assignment

You received a notice from DMAS that included your initial health plan assignment. With that notice DMAS included a comparison chart of health plans in your area. The assignment notice provided you with instructions on how to make your health plan selection.

You may have chosen us to be your health plan. If not, DMAS may have assigned you to our health plan based upon your history with us as your managed care plan. For example, you may have been enrolled with us before either through Medicare or Medicaid. You may also have been assigned to us if certain providers you see are in our network. These include nursing facilities, adult day health care, and private duty nursing providers.

You Can Change Your Health Plan Through the CCC Plus Helpline

The CCC Plus Helpline can help you choose the health plan that is best for you. For assistance, call the CCC Plus Helpline at 1-844-374-9159 or TDD 1-800-817-6608, or visit the website at cccplusva.com. The CCC Plus Helpline is available Monday through Friday (except on State Holidays) from 8:30 a.m. to 6:00 p.m. The CCC Plus Helpline can help you understand your health plan choices and answer your questions about which doctors and other providers participate with each health plan. The CCC Plus Helpline services are free and are not connected to any CCC Plus health plan.

You can change your health plan during the first 90 days of your CCC Plus program enrollment for any reason. You can also change your health plan once a year during open enrollment for any reason. Open enrollment occurs each year between October and December. You will get a letter from DMAS during open enrollment with more information. You may also ask to change your health plan at any time for "good cause," which can include:

- You move out of the health plan's service area,
- You need multiple services provided at the same time but cannot access them within the health plan's network,
- Your residency or employment would be disrupted as a result of your residential, institutional, or employment supports provider changing from an in-network to an out-of-network provider, and
- Other reasons determined by DMAS, including poor quality of care and lack of access to appropriate providers, services, and supports, including specialty care.

The CCC Plus Helpline handles "good cause" requests and can answer any questions you may have. Contact the CCC Plus Helpline at 1-844-374-9159 or TDD 1-800-817-6608, or visit the website at cccplusva.com.

Automatic Re-Enrollment

If your enrollment ends with us and you regain eligibility for the CCC Plus program within 60 days or less, you will automatically be reenrolled with MCC. You will also be sent a re-enrollment letter from DMAS.

What is MCC's Service Area?

MCC covers the entire Commonwealth of Virginia. Only people who live in our service area can enroll with MCC. If you move outside of our service area, you cannot stay in this plan. If this happens, you will receive a letter from DMAS asking you to choose a new plan. You can also call the CCC Plus Helpline if you have any questions about your health plan enrollment. Contact the CCC Plus Helpline at 1-844-374-9159 or TDD 1-800-817-6608 or visit the website at cccplusva.com.

If You Have Medicare and Medicaid

If you have Medicare and Medicaid, some of your services will be covered by your Medicare plan and some will be covered by MCC. We are your CCC Plus Medicaid Plan.

Types of Services Under Medicare

- Inpatient Hospital Care (Medical and Psychiatric)
- Outpatient Care (Medical and Psychiatric)
- Physician and Specialists Services
- X-Ray, Lab Work and Diagnostic Tests
- Skilled Nursing Facility Care
- Home Health Care
- Hospice Care
- Prescription Drugs
- Durable Medical Equipment

For more information, contact your Medicare Plan, visit Medicare.gov, or call Medicare at 1-800-633-4227.

Types of Services Under CCC Plus (Medicaid)

- Medicare Copayments
- Hospital and Skilled Nursing when Medicare Benefits are Exhausted
- Long term nursing facility care (custodial)
- Home and Community Based Waiver Services like personal care and respite care, environmental modifications, and assistive technology services
- Community-based Behavioral Health Services
- Medicare non-covered services, like some over the counter medicines, medical equipment and supplies, and incontinence products.

You Can Choose the Same Health Plan for Medicare and Medicaid

You have the option to choose the same health plan for your Medicare and CCC Plus Medicaid coverage. The Medicare plan is referred to as a *Dual Special Needs Plan (DSNP).* Having the same health plan for Medicare and Medicaid will enhance and simplify the coordination of your Medicare and Medicaid benefits. There are benefits to you if you are covered by the same health plan for Medicare and Medicaid. Some of these benefits include:

- You receive better coordination of care through the same health plan
- You have one health plan and one number to call for questions about all of your benefits
- You work with the same Care Coordinator for Medicare and Medicaid. This person will work with you and your providers to make sure you get the care you need

We offer all the traditional Medicare services at no cost to you, plus:

- No plan premiums, no deductibles, and low copays for prescription drugs
- Annual physical exam at no cost
- Annual hearing exam and hearing aids fitting at no cost, plus $1,250 every 3 years for hearing aids
- Dental services: $500 benefit every 2 years for dentures
- Over-the-counter (OTC) card with $210 every 3 months or $840 per year
- Non-medical transportation up to 30 miles (24 one-way trips, prior authorization required)
- A nurse care manager to coordinate your health care needs
- Services to help you stay in your own home
- Access to staff pharmacists when you need help with your prescriptions
- Phone access to MCC of VA (HMO SNP) team members who speak your language

You can change your Medicaid health plan enrollment to match your Medicare health plan choice, or you can change your Medicare health plan enrollment to match your Medicaid health plan choice. This is called aligned enrollment. Aligned enrollment is voluntary at this time.

If you choose Medicare fee-for-service or a Medicare plan other than our Medicare DSNP plan, we will work with your Medicare plan to coordinate your benefits.

How to Contact the Medicare State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) gives free health insurance counseling to people with Medicare. In Virginia, the SHIP is called the Virginia Insurance Counseling and Assistance Program (VICAP). You can contact the Virginia Insurance Counseling Assistance Program if you need assistance with your Medicare health insurance options. VICAP can help you understand your Medicare plan choices and answer your questions about changing to a new Medicare plan. VICAP is an independent program that is free and not connected to any CCC Plus health plans.

CALL	1-800-552-3402 This call is free.
TTY	TTY users dial 711
WRITE	Virginia Insurance Counseling and Assistance Program 1610 Forest Avenue, Suite 100 Henrico, Virginia 23229
EMAIL	aging@dars.virginia.gov
WEBSITE	https://www.vda.virginia.gov/vicap.htm

3. How CCC Plus Works

MCC contracts with doctors, specialists, hospitals, pharmacies, providers of long-term services and supports, and other providers. These providers make up our provider network. You will also have a Care Coordinator. Your Care Coordinator will work closely with you and your providers to understand and meet your needs. Your Care Coordinator will also provide you with information about your covered services and the choices that are available to you. Refer to *Your Care Coordinator* in Section 4 of this handbook.

What are the Advantages of CCC Plus

CCC Plus provides person-centered supports and coordination to meet your individual needs. Some of the advantages of CCC Plus include:

- You will have a care team that you help put together. Your care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need
- You will have a Care Coordinator. Your Care Coordinator will work with you and with your providers to make sure you get the care you need
- You will be able to direct your own care with help from your care team and Care Coordinator
- Your care team and Care Coordinator will work with you to come up with a care plan specifically designed to meet your health and/or long-term support needs. Your care team will be in charge of coordinating the services you need. This means, for example:
  - Your care team will make sure your doctors know about all medicines you take so they can reduce any side effects
  - Your care team will make sure your test results are shared with all your doctors and other providers so they can be kept informed of your health status and needs
- Treatment choices that include preventive, rehabilitative, and community-based care
- An on-call nurse or other licensed staff is available 24 hours per day, 7 days per week to answer your questions. We are here to help you. You can reach us by calling the number at the bottom of this page. Also refer to *NurseLine Available 24 Hours a Day, 7 Days a Week* in Section 5 of this handbook

What are the Advantages of Choosing MCC?

We're all about YOU

We're about helping you live a vibrant, healthy life as independently as possible. MCC is here to help you exercise choice and control over the decisions affecting your life and to help you do the things you love.

Our **person-centered culture**, which is woven into everything we do, and our **dedication to offering you choices** are what set us apart. We offer a model of care that places **you** at the center of your care team.

Your Care Coordinator will chat with you first, along with your family and friends if you wish, just to get to know you. He or she always puts your needs first, creating a care plan based on your desires and goals – and working with your health care providers to make sure they understand your needs, too.

Your care team, in your neighborhood

At MCC, we understand that it is important for you to stay connected to your family, friends, neighbors, health care providers and other connections. This can include work, school, faith communities and social support groups and services. That's why we created **Integrated Health Neighborhoods℠**, to work behind the scenes to support your relationship with your Care Coordinator and your care team by facilitating these connections for you in your own community.

Our teams include individuals who live and work within the same neighborhood that you do. They know firsthand about the local resources and services that could benefit you the most. They come to you to provide you with choices in your neighborhood or community. And they work together to help you stay comfortable, wherever you call home.

With the help of your care coordinator and your care team, you'll be on the road to achieving your goals and can share your experiences, challenges and triumphs along the way.

We offer added benefits that go beyond the standard offerings

Service	CCC Plus Program–MCC	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 care coordinator • 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 – $50 per year	Available to all members

Service	CCC Plus Program–MCC	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 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.
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 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.

Service	CCC Plus Program–MCC	Eligibility
Smart phone program We offer smartphones with 350 free minutes, 4.5 GB of data and unlimited texting each month. We also provide text messaging programs to remind members of appointments and more.	Covered	All members
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.
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.

Service	CCC Plus Program–MCC	Eligibility
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.

If you have any questions about these benefits, please call our Member Services Department at 1-800-424-4524 (TTY 711) 8 a.m. to 8 p.m. local time, Monday-Friday.

Transition of Care Policy: Continuity of Care Period

The continuity of care period is 30 days. If MCC is new for you, you can keep seeing the doctors you go to now for the first 30 days if they are not in our network. You can also keep getting your authorized services for the duration of the authorization or for 30 days after you first enroll, whichever is sooner. After 30 days in our plan, you will need to see doctors and other providers in the MCC network. A network provider is a provider who contracts and works with our health plan. You can call your Care Coordinator or Member Services for help finding a network provider. Your new provider can get a copy of your medical records from your previous provider, if needed.

If you are in a nursing facility at the start of the CCC Plus program, you may choose to:

- Remain in the facility as long as you continue to meet the Virginia DMAS' criteria for nursing facility care,
- Move to a different nursing facility, or
- Receive services in your home or other community-based setting.

The continuity of care period may be longer than 30 days. MCC may extend this time frame until the health risk assessment is completed. MCC will also extend this time frame for you to have a safe and effective transition to a qualified provider within our network. Talk to your Care Coordinator if you want to learn more about these options.

If You Have Other Coverage

Medicaid is the payer of last resort. This means that if you have another insurance, are in a car accident, or if you are injured at work, your other insurance or Workers Compensation has to pay first.

We have the right and responsibility to collect payment for covered Medicaid services when Medicaid is not the first payer. We will not attempt to collect any payment directly from you. Contact Member Services if you have other insurance so that we can best coordinate your benefits. Your Care Coordinator will also work with you and your other health plan to coordinate your services.

4. Your Care Coordinator

You have a dedicated Care Coordinator who can help you to understand your covered services and how to access these services when needed. Your Care Coordinator will also help you to work with your doctor and other health care professionals (such as nurses and physical therapists), to provide a health risk assessment, and develop a care plan that considers your needs and preferences. We provide more information about the health risk assessment and the care plan below.

How Your Care Coordinator Can Help

Your Care Coordinator can:

- Answer questions about your health care
- Provide assistance with appointment scheduling
- Answer questions about getting any of the services you need. For example: behavioral health services, transportation, and long-term services and supports (LTSS)
  - Long-term services and supports (LTSS) are a variety of services and supports that help older individuals and individuals with disabilities meet their daily needs for assistance, improve the quality of their lives, and facilitate maximum independence. Examples include personal assistance services (assistance with bathing, dressing, and other basic activities of daily life and self-care), as well as support for everyday tasks such as meal preparation, laundry, and shopping. LTSS are provided over a long period of time, usually in homes and communities, but also in nursing facilities
- Help with arranging transportation to your appointments when necessary. If you need a ride to receive a Medicaid covered service and cannot get there, non-emergency transportation is covered. Just call Veyo at 1-877-790-9472 or call your Care Coordinator for assistance
- Answer questions you may have about your daily health care and living needs including these services:
  - Skilled nursing care
  - Physical therapy
  - Occupational therapy

- Speech therapy
- Home health care
- Personal care services
- Mental health services
- Services to treat addiction
- Other services that you need

Eligibility for Long-Term Services and Supports

The Commonwealth decides who can receive long-term services and supports (LTSS). These include:

- LTSS that are based in a person's home or in the community
- LTSS that are based in various types of facilities, including a nursing facility

Individuals who are eligible for LTSS usually:

- Have disabilities and chronic illnesses. This might include needing help with personal care, respite care, activities of daily living or a variety of services and supports that assist individuals with health or personal needs and activities over a period of time. This also may include needing help with tasks in the home or home modifications
- Permanently live in a nursing facility or need hospice services

What is a Health Screening

Within three months after you enroll with MCC, an MCC representative will contact you or your authorized representative via telephone, mail or in person to ask you some questions about your health and social needs. These questions will make up what is called the "Health Screening." The representative will ask about any medical conditions you currently have or have had in the past, your ability to do everyday things, and your living conditions.

Your answers will help MCC understand your needs, identify whether or not you have medically complex needs, and to determine when your Health Risk Assessment is required. MCC will use your answers to develop your Care Plan (for more information on your Care Plan, see below).
Please contact MCC if you need accommodations to participate in the health screening.

If you have questions about the health screening, please contact 1-800-424-4524 (TTY 711)
8 a.m. to 8 p.m. local time, Monday-Friday. This call is free.

What is a Health Risk Assessment

After you enroll with MCC, your Care Coordinator will meet with you to ask you some questions about your health, needs and choices. Your Care Coordinator will talk with you about any medical, behavioral, physical, and social service needs that you may have. This meeting may be in-person or by phone and is known as a health risk assessment (HRA). A HRA is a complete, detailed assessment of your medical, behavioral, social, emotional, and functional status. The HRA is typically completed by your Care Coordinator. This health risk assessment will enable your Care Coordinator to understand your needs and help you get the care that you need.

What is an Individualized Care Plan

An individualized care plan includes the types of health services that are needed and how you will get them. It is based on your health risk assessment and individual needs. After you and your Care Coordinator complete your health risk assessment, your care team will meet with you to talk about what health and/or long term services and supports you need and want as well as your goals and preferences. Together, you and your care team will make a personalized care plan, specific to your needs. (This is also referred to as a person-centered or individualized care plan.) Your care team will work with you to update your care plan when the health services you need or choose change, and at least once per year.

How to Contact Your Care Coordinator

We will send you the name and telephone number of your Care Coordinator in the mail. Your Care Coordinator will help you:

- Find your way through the health care and long-term services and supports system
- Make sure all your providers have a copy of your medical records
- Make appointments
- Complete health and wellness forms
- Connect you with support services in your community

As an MCC member, you are at the center of the Care Coordination Team with your Care Coordinator. Care Coordinators are registered nurses or social workers. They are experienced in caring for individuals with acute and chronic medical needs. The Care Coordination team also includes your primary care provider, your primary behavioral health provider, your family or support system, and others. Your Care Coordinator will have other team members, such as Peer Specialists, who can support you by being actively engaged in your treatment and recovery. The team lives and works within the same communities that our members live in, allowing for quick and easy access to the team, care and services.

The Care Coordination Team works with your provider and other health care professionals, including nurses, physical therapists or community agencies. All Care Coordination Team members work to ensure you receive the services you need. We believe it is important to work with each member's existing community supports and providers on an ongoing basis. (See *What are the Advantages of Choosing MCC?* in Section 3 of this handbook.)

Changing Care Coordinators

Please let us know if someone on your Care Coordination Team is not a good fit. A member can change their Care Coordinator at any time. You can choose a different Care Coordinator if available. Call us at 1-800-424-4524 (TTY 711).

Your Care Coordination Team

**Lead the team*

CALL	1-800-424-4524. This call is free. Our office hours are Monday through Friday from 8 a.m. to 8 p.m. Our NurseLine can be reached 24 hours a day, seven days a week. They can answer your health care questions and help with your long-term services and support needs. We have free interpreter services for people who do not speak English and 711 for people who have hearing or speaking problem 24 hours a day, seven days a week.
TTY	711. This call is free and available 24 hours a day, 7 days a week. This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
WRITE	Molina Complete Care 3829 Gaskins Rd Richmond, VA 23233-1437
EMAIL	MCCVA@molinahealthcare.com
WEBSITE	www.MCCofVA.com

5. Help From Member Services

Our Member Services Staff are available to help you if you have any questions about your benefits, services or procedures, or have a concern about MCC. Member Services is available Monday through Friday from 8 a.m. to 8 p.m. local time. You can leave a voice message at other times. We suggest you leave a voice message if your question can wait until the next business day.

Our NurseLine can be reached 24 hours a day, seven days a week. They can answer your health care questions. They can help with your long-term services and support needs.

How to Contact MCC Member Services

CALL	1-800-424-4524. This call is free. Our office hours are Monday through Friday from 8 a.m. to 8 p.m. We have free interpreter services for people who do not speak English and 711 for people who have hearing or speaking problems.
TTY	711. This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	Molina Complete Care 3829 Gaskins Rd Richmond, VA 23233-1437
EMAIL	MCCVA@molinahealthcare.com
WEBSITE	www.MCCofVA.com

How Member Services Can Help

Member Services can:

- Answer questions you have about MCC
- Answer questions you have about claims and how to submit them, billing or your Member ID Card
- Help you find a doctor or see if a doctor is in MCC's network
- Help you change your Primary Care Physician (PCP)
- Provide information on coverage decisions about your health care services (including medications)
  - A coverage decision about your health care is a decision about:
    - your benefits and covered services, or
    - the amount we will pay for your health services
- Provide information on how you can submit an appeal about a coverage decision on your health care services (including medications). An appeal is a formal way of asking us to review a decision we made about your coverage and asking us to change it if you think we made a mistake. (See *Your Right to Appeal* in Section 15 of this handbook)
- Grievances about your health care services (including medications). You can make a grievance about us or any provider (including a non-network or network provider). A network provider is a provider who contracts and works with the health plan. You can also make a grievance about the quality of the care you received to us or to the CCC Plus Helpline at 1-844-374-9159 or TDD 1-800-817-6608. (See *Your Right to File a Grievance* in Section 15 of this handbook)

NurseLine

Available 24 Hours a Day, 7 Days a Week

If you are unable reach your Care Coordinator, you can reach a nurse or behavioral health professional 24 hours a day, 7 days a week to answer your questions toll-free at: 1-800-424-4524 (TTY 711).

CALL	1-800-424-4524. This call is free. Available 24 hours a day, 7 days a week We have free interpreter services for people who do not speak English and 711 for people who have hearing or speaking problems.
TTY	711. This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.

Behavioral Health Crisis Line

Available 24 Hours a Day, 7 Days a Week

Contact MCC if you do not know how to get services during a crisis. We will help find a crisis provider for you. Call 1-800-424-4524 (TTY 711). If you have thoughts about harming yourself or someone else, you should:

- Get help right away by calling 911
- Go to the closest hospital for emergency care
- Call a crisis hotline like the National Suicide Prevention Lifeline at 1-800-273-8255

CALL	1-800-424-4524. This call is free. Available 24 hours a day, 7 days a week We have free interpreter services for people who do not speak English and 711 for people who have hearing or speaking problems.
TTY	711. This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.

Addiction and Recovery Treatment Services (ARTS) Advice Line

Available 24 Hours a Day, 7 Days a Week

MCC Care Coordinators can help you decide what kind of services would be most helpful to you if you are having issues with drugs or alcohol.

If you are unable reach your Care Coordinator, you can reach an ARTS health professional 24 hours a day, 7 days a week to answer your questions at: 1-800-424-4524. The call is free.

CALL	1-800-424-4524. This call is free. Available 24 hours a day, 7 days a week We have free interpreter services for people who do not speak English and 711 for people who have hearing or speaking problems.
TTY	711. This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.

If You Do Not Speak English

We can provide you with translation services. MCC Member Services has employees who speak your language and we are able to access interpreter services. We also have written information in many languages for our members. Currently written materials are available in English and Spanish. If you need interpretation, please call Member Services (at no charge) at 1-800-424-4524 (TTY 711) and request to speak to an interpreter or request written materials in your language.

If You Have a Disability and Need Assistance in Understanding Information or Working with Your Care Coordinator

We provide reasonable accommodations to people with disabilities in compliance with the Americans with Disabilities Act. This includes but is not limited to accessible communications (such as a qualified sign language interpreter), braille or large print materials, etc. If you need a reasonable accommodation please call Member Services (at no charge) at 1-800-424-4524 (TTY 711) to ask for the help you need.

If You Have Questions About Your Medicaid Eligibility

If you have questions about your Medicaid eligibility, contact your Medicaid eligibility worker at the Department of Social Services in the city or county where you live. If you have questions about the services you get under MCC, call Member Services at 1-800-424-4524 (TTY 711).

6. How to Get Care and Services

How to Get Care from Your Primary Care Physician

Your Primary Care Physician

A Primary Care Physician (PCP) is a doctor selected by you who meets state requirements and is trained to give you basic medical care. You will usually see your PCP for most of your routine health care needs. Your PCP will work with you and your Care Coordinator to coordinate most of the services you get as a member of our plan. Coordinating your services or supplies includes checking or consulting with other plan providers about your care. If you need to see a doctor other than your PCP, you may need a referral (authorization) from your PCP. You may also need to get approval in advance from your PCP before receiving certain types of covered services or supplies. In some cases, your PCP will need to get authorization (prior approval) from us. Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your PCP's office. Contact Member Services or your Care Coordinator with any questions you have about getting your medical records transferred to your PCP or about your care and services.

Choosing Your PCP

New members have the right to choose a PCP in our network soon after joining MCC during our Welcome Call or by calling us at 1-800-424-4524 (TTY 711). If you do not already have a PCP you must request one prior to the 25th day of the month before your effective enrollment date, or else MCC may assign you a PCP. You have the right to change your PCP at any time by calling Member Services at the number listed at the bottom of this page. If you would like more information about a doctor, including physician incentive plans please call Member Services at 1-800-424-4524 (TTY 711).

If you do not have a PCP in our network, we can help you find a highly qualified PCP in your community. For help locating a provider you can use our on-line provider directory at: www.MCCofVA.com. The provider directory includes a list of all of the doctors, clinics, hospitals, labs, specialists, long term services and supports providers, and other providers who work with MCC. The directory also includes information on the accommodations each provider has for individuals who have disabilities or who do not speak English. We can also provide you with a paper copy of the provider directory. You can also call Member Services at the number on the bottom of this page or call your Care Coordinator for assistance.

You may want to find a doctor:

- Who knows you and understands your health condition
- Who is taking new patients
- Who can speak your language
- Who has appropriate accommodations for people with physical or other disabilities

If you have a disability or a chronic illness you can ask us if your specialist can be your PCP. We also contract with Federally Qualified Health Centers (FQHC) that provide primary and specialty care. Another clinic can also act as your PCP if the clinic is a network provider.

Women can also choose an OB/GYN for women's health issues. These include routine check-ups, follow-up care if there is a problem, and regular care during a pregnancy. Women do not need a PCP referral to see an OB/GYN provider in our network.

If You have Medicare, Tell us About Your PCP

If you have Medicare, you do not have to choose a PCP in MCC's network. Simply call Member Services or your Care Coordinator to let us know the name and contact information for your PCP. We will coordinate your care with your Medicare assigned PCP.

If Your Current PCP is not in Our Network

If you do not have Medicare, you need to choose a PCP that is in MCC's network. You can continue to see your current PCP during the continuity of care period even if they are not in MCC's network. The continuity of care period is 30 days. Your Care Coordinator can help you find a PCP in our network. At the end of the continuity of care period, if you do not choose a PCP in the MCC network, we will assign a PCP to you.

Changing Your PCP

You may call Member Services to change your PCP at any time to another PCP in our network. Also, it is possible that your PCP might leave our network. We will tell you within 15 days from when we know about this. We can help you find a new PCP. The change is effective immediately upon receipt of the request.

Getting an Appointment with Your PCP

Your PCP will take care of most of your health care needs. Call your PCP to make an appointment. If you need care before your first appointment, call your PCP's office to ask for an earlier appointment. We encourage providers to let you make appointments electronically on their websites. If you need help making an appointment, call Member Services at 1-800-424-4524 (TTY 711).

Appointment Standards

You should be able to get an appointment with your PCP within the same amount of time as any other patient seen by the PCP. Expect the following times to see a provider:

- For an emergency—immediately
- For urgent care and office visits with symptoms—within 24 hours of request
- For routine primary care visit—within 30 calendar days

If you are pregnant, you should be able to make an appointment to see an OB/GYN as follows:

- First trimester (first 3 months)—Within 14 calendar days of request
- Second trimester (3 to 6 months)—Within 7 calendar days of request
- Third trimester (6 to 9 months)—Within 5 business days of request
- High Risk Pregnancy—Within 3 business days or immediately if an emergency exists

If you are unable to receive an appointment within the times listed above, call Member Services at 1-800-424-4524 (TTY 711) and they will help you get the appointment.

Services That Do Not Require an Approval

Some services you will receive and providers you will see do not require a PCP approval or a referral. Your Care Coordinator can help you with this process and will make sure you receive the medical and behavioral care you need in a timely way. We want you to get the care you need regardless of obtaining a referral. It is always a good idea to let your PCP know which providers you're seeing and which services you're receiving. You can get services like the ones listed below without first getting approval from your PCP:

- Emergency services from network providers or out-of-network providers
- Urgently needed care from network providers
- Family Planning Services and Supplies
- Preventive health screenings or services, such as screening lab work, immunizations, or colonoscopy
- Routine women's health care services. This includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider
- Some mental health or substance abuse services/providers
- Additionally, if you are eligible to get services from Indian health providers, you may see these providers without a referral

MCC will make sure that you receive the same access to mental health services as to physical health services.

How to Get Care From Network Providers

Our provider network includes access to care 24 hours a day 7 days per week and includes hospitals, doctors, specialists, urgent care facilities, nursing facilities, home and community based service providers, early intervention providers, rehabilitative therapy providers, addiction and recovery treatment services providers, home health and hospice providers, durable medical equipment providers, and other types of providers. MCC provides you with a choice of providers and they are located so that you do not have to travel very far to see them. There may be special circumstances where longer travel time is required; however, that should be only on rare occasions.

Travel Time and Distance Standards

MCC will provide you with the services you need within the travel time and distance standards described in the table below. These standards apply for services that you travel to in order to receive care from network providers. These standards do not apply to providers who provide services to you at home. If you live in an urban area, you should not have to travel more than 30 miles or 45 minutes to receive services. If you live in a rural area, in the Roanoke/Alleghany Region, or the Southwest Region, you should not have to travel more than 60 miles or 75 minutes to receive services.

Member Travel Time & Distance Standards		
Standard	**Distance**	**Time**
Urban		
• PCP	15 Miles	30 Minutes
• Specialists and other providers	30 Miles	45 Minutes
Rural		
• PCP	30 Miles	45 Minutes
• Specialists and other providers	60 Miles	75 Minutes

Roanoke/Alleghany & Southwest Regions		
Standard	**Distance**	**Time**
Urban and Rural		
• PCPs	30 Miles	45 Minutes
• Specialists and other providers	60 Miles	75 Minutes

Accessibility

MCC wants to make sure that all providers and services are as accessible (including physical and geographic access) to individuals with disabilities as they are to individuals without disabilities. If you have difficulty getting an appointment with a provider, or accessing services because of a disability, contact Member Services at 1-800-424-4524 (TTY 711) for assistance.

Telehealth Visits

MCC supports the use of telehealth visits. A telehealth visit is when you see your doctor over phone or video chat instead of going into their office. Please ask your doctor if they do telehealth visits and what you can do to schedule one. Call Member Services if you need help making an appointment.

Your regular doctor may be able to prescribe certain medications via telehealth visit. Check with your doctor to see if your medications can be prescribed this way.

What are "Network Providers"

MCC network providers include:

- Doctors, nurses, and other health care professionals that you can go to as a member of our plan
- Clinics, hospitals, nursing facilities, and other places that provide health services in our plan
- Early intervention providers, home health agencies and durable medical equipment suppliers
- Long-term services and supports (LTSS) providers including nursing facilities, hospice, adult day health care, personal care, respite care, and other LTSS providers

Network providers have agreed to accept payment from our plan for covered services as payment in full.

What are "Network Pharmacies"

Network pharmacies are pharmacies (drug stores) that have agreed to fill prescriptions for our members. Use the Provider and Pharmacy Directory to find the network pharmacy you want to use.

Except during an emergency, you must fill your prescriptions at one of our network pharmacies if you want our plan to help you pay for them. Call Member Services at the number at the bottom of the page for more information. Both Member Services and MCC's website can give you the most up-to-date information about changes in our network pharmacies and providers. Call us at 1-800-424-4524 (TTY 711) or visit www.MCCofVA.com.

What are Specialists

If you need care that your PCP cannot provide, your PCP may refer you to a specialist. Most of the specialists are in MCC's network. A specialist is a doctor who provides health care for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples:

- *Oncologists* care for patients with cancer
- *Cardiologists* care for patients with heart problems
- *Orthopedists* care for patients with bone, joint, or muscle problems

If you need to see a specialist for ongoing care, your PCP may be able to refer you for a specified number of visits or length of time (known as a standing referral). If you have a standing referral, you will not need a new referral each time you need care. If you have a disabling condition or chronic illnesses you can ask us if your specialist can be your PCP.

We have a team of nurses and behavioral health clinicians who review your provider's request. They use notes from your providers along with a set of guidelines to decide if the service is needed. Call us at 1-800-424-4524 (TTY 711) if you need more information. We can help you obtain a referral or provide details about how we approve your service. We will send you and your provider a letter if we do not approve the service. We will tell you how to appeal if you don't agree with us.

Decisions for approving services are based on making sure the service is what you need, and that it is a covered benefit. We do not encourage our staff to make decisions that result in less care than what you need. We also do not reward doctors or others for denying services.

If Your Provider Leaves Our Plan

A network provider you are using might leave our plan. If one of your providers does leave our plan, you have certain rights and protections that are summarized below:

1. Even though our network of providers may change during the year, we must give you uninterrupted access to qualified providers
2. When possible, we will give you at least 15 days' notice so that you have time to select a new provider
3. We will help you select a new qualified provider to continue managing your health care needs

4. If you are undergoing medical treatment, you have the right to ask, and we will work with you to ensure, that the medically necessary treatment you are getting is not interrupted
5. If you believe we have not replaced your previous provider with a qualified provider or that your care is not being appropriately managed, you have the right to file a grievance or request a new provider
6. If you find out one of your providers is leaving our plan, please contact your Care Coordinator so we can assist you in finding a new provider and managing your care

How to Get Care from Out-of-Network Providers

If we do not have a specialist in the MCC network to provide the care you need, we will get you the care you need from a specialist outside of our network. If at any time you are having trouble finding an in- or out-of-network provider, your Care Coordinator will work with other members of our team to find you a provider. We will also get you care outside of our network in any of the following circumstances:

- When MCC has approved a doctor out of its established network
- When emergency and family planning services are rendered to you by an out of network provider or facility
- When you receive emergency treatment by providers not in the network
- When the needed medical services are not available in MCC's network
- When MCC cannot provide the needed specialist within the distance standard of more than 30 miles in urban areas or more than 60 miles in rural areas
- When the type of provider needed and available in MCC's network does not, because of moral or religious objections, furnish the service you need
- Within the first 30 days of your enrollment when your provider is not part of MCC's network but has treated you in the past
- If you are in a nursing facility when you enroll with MCC, and the nursing facility is not in our network

If your PCP or MCC refer you to a provider outside of our network, you are not responsible for any of the costs, except for your patient pay toward long term services and supports. See Section 13 of this handbook for information about what a patient pay is and how to know if you have one.

Care From Out-of-State Providers

MCC is not responsible for services you obtain outside Virginia except under the following circumstances:

- Necessary emergency or post-stabilization services
- Where it is a general practice for those living in your locality to use medical resources in another State
- The required services are medically necessary and not available in-network and within the Commonwealth of Virginia

Network Providers Cannot Bill You Directly

Network providers must always bill MCC. Doctors, hospitals, and other providers in our network cannot make you pay for covered services. They also cannot charge you if we pay for less than the provider charged us; this is known as "balanced billing." This is true even if we pay the provider less than the provider charged for a service. If we decide not to pay for some charges, you still do not have to pay them.

If You Receive a Bill for Covered Services

If you are billed for any of the services covered by our plan, you should not pay the bill. If you do pay the bill, MCC may not be able to pay you back.

Whenever you get a bill from a network provider or for services that are covered outside of the network (example emergency or family planning services), send us the bill. We will contact the provider directly and take care of the bill for covered services.

If You Receive Care From Providers Outside of the United States

Our plan does not cover any care that you get outside the United States.

7. How to Get Care for Emergencies

What is an Emergency

An emergency is a sudden or unexpected illness, severe pain, accident or injury that could cause serious injury or death if it is not treated immediately. You are always covered for emergencies.

What to do in an Emergency

Call 911 at once! You do not need to call MCC first. You do not need an authorization or a referral for emergency services. Calling 911 will help you get to a hospital. You can use any hospital for emergency care, even if you are in another city or state. If you are helping someone else, try to stay calm.

Tell the hospital that you are a MCC member. Ask them to call us at the number on the back of your CCC Plus ID Card.

What is a Medical Emergency

This is when a person thinks he or she must act quickly to prevent serious health problems. It includes symptoms such as severe pain or serious injury. The condition is so serious that, if it doesn't get immediate medical attention, you believe that it could cause:

- serious risk to your health; or
- serious harm to bodily functions; or
- serious dysfunction of any bodily organ or part; or
- in the case of a pregnant woman in active labor, meaning labor at a time when either of the following would occur:
  - There is not enough time to safely transfer you to another hospital before delivery, or
  - The transfer may pose a threat to your health or safety or to that of your unborn child.

What is a Behavioral Health Emergency

A behavioral health emergency is when a person thinks about or fears they might hurt themselves or hurt someone else. Our 24/7 Behavioral Health Crisis Line can be accessed at any time to help with any type of behavioral health crises.

Examples of Non-Emergencies

Examples of non-emergencies are: colds, sore throat, upset stomach, minor cuts and bruises, or sprained muscles. If you are not sure, call your Care Coordinator first. You can also call your PCP or MCC's 24/7 NurseLine at 1-800-424-4524 (TTY 711).

If You Have an Emergency When Away From Home

You or a family member may have a medical or a behavioral health emergency away from home. You may be visiting someone outside Virginia. While traveling, your symptoms may suddenly get worse. If this happens, go to the closest hospital emergency room. You can use any hospital for emergency care. Show them your MCC card. Tell them you are in MCC's program.

What is Covered if You Have an Emergency

You may receive covered emergency care whenever you need it, anywhere in the United States. Prior authorization is not required for emergency services. If you need an ambulance to get to the emergency room, our plan covers the ambulance transportation. If you have an emergency, we will talk with the doctors who give you emergency care. Those doctors will tell us when your medical emergency is complete.

Notifying MCC About Your Emergency

Notify your doctor and MCC as soon as possible about the emergency within 48 hours if you can. However, you will not have to pay for emergency services because of a delay in telling us. We need to follow up on your emergency care. Your Care Coordinator and other care team members will assist you in getting the correct services in place before you are discharged to ensure that you get the best care possible. Our after-hours NurseLine staff and managers are also available to assist you with discharge planning. Please call 1-800-424-4524 (TTY 711) 24 hours a day, 7 days a week. This number is also listed on the back of your MCC member ID card.

After an Emergency

MCC will provide necessary follow-up care, including through out of network providers if necessary, until your physician says that your condition is stable enough for you to transfer to an in-network provider, or for you to be discharged. If you get your emergency care from out-of-network providers, we will try to get network providers to take over your care as soon as possible after your physician says you are stable. You may also need follow-up care to be sure you get better. Your follow-up care will be covered by our plan.

If You Are Hospitalized

If you are hospitalized, a family member or a friend should contact MCC as soon as possible. By keeping us informed, your Care Coordinator can work with the hospital team to organize the right care and services for you before you are discharged. Your Care Coordinator will also keep your medical team including your home care services providers informed of your hospital and discharge plans.

If it Wasn't a Medical Emergency

Sometimes it can be hard to know if you have a medical emergency. You might go in for emergency care, and the doctor may say it wasn't really a medical emergency. As long as you reasonably thought your health was in serious danger, we will cover your care. However, after the doctor says it was not an emergency, we will cover your additional care only if you follow the *General Coverage Rules* described in Section 10 of this handbook.

8. How to Get Urgently Needed Care

What is Urgently Needed Care

Urgently needed care is care you get for a non-life threatening, sudden illness, injury, or condition that isn't an emergency but needs care right away. For example, you might have an existing condition that worsens and you need to have it treated right away. Other examples of urgently needed care include sprains, strains, skin rashes, infection, fever, flu, etc. In most situations, we will cover urgently needed care only if you get this care from a network provider. We always recommend that you seek care from your primary care provider for non-emergency medical needs. However, if you are unable to be seen by your primary care provider, you can seek care from one of our in-network Urgent Care Centers. This includes urgently needed care when you are outside our service area.

You can find a list of Urgent Care Centers we work with in our Provider and Pharmacy Directory, available on our website at www.MCCofVA.com.

9. How to Get Your Prescription Drugs

This section explains rules for getting your outpatient prescription drugs. These are drugs that your provider orders for you that you get from a pharmacy or drug store.

MCC will usually cover your drugs as long as you follow the rules in this Section.

- You must have a doctor or other authorized provider write your prescription. This person often is your primary care physician (PCP). It could also be another provider if your primary care physician has referred you for care. Prescriptions for controlled substances must be written by an in-network doctor or provider
- You generally must use a network pharmacy to fill your prescription
- Your prescribed drug must be on MCC's List of Covered Drugs. If it is not on the List of Covered Drugs, we may be able to cover it by giving you a service authorization
- Your drug must be used for a medically accepted indication. This means that the use of the drug is either approved by the Food and Drug Administration or supported by certain medical reference books
- If you have Medicare, most of your drugs are covered through your Medicare carrier. We cannot pay for any drugs that are covered under Medicare Part D, including copayments
- MCC can provide coverage for coinsurance and deductibles on Medicare Part B drugs. These include some drugs given to you while you are in a hospital or nursing facility

Getting Your Prescriptions Filled

In most cases, MCC will pay for prescriptions only if they are filled at our network pharmacies. A network pharmacy is a drug store that has agreed to fill prescriptions for our members. You may go to any of our network pharmacies.

To find a network pharmacy, you can look in the Provider and Pharmacy Directory, visit our website, or contact Member Services at the number at the bottom of the page or your Care Coordinator.

To fill your prescription, show your Member ID Card at your network pharmacy. If you have Medicare, show your Medicare Part D and MCC ID cards. The network pharmacy will bill MCC for the cost of your covered prescription drug when necessary. If you do not have your Member ID Card with you when you fill your prescription, ask the pharmacy to call MCC to get the necessary information.

If you need help getting a prescription filled, you can contact Member Services at the number at the bottom of the page or call your Care Coordinator.

List of Covered Drugs

MCC has a List of Covered Drugs that are selected by us with the help of a team of doctors and pharmacists. The MCC List of Covered Drugs also includes all of the drugs on the DMAS Preferred Drug List (PDL). The List of Covered Drugs can be found at www.MCCofVA.com. The List of Covered Drugs tells you which drugs are covered by us and also tells you if there are any rules or restrictions on any drugs, such as a limit on the amount you can get.

You can call Member Services to find out if your drugs are on the List of Covered Drugs or check online at www.MCCofVA.com. If you would like a paper copy of the List of Covered Drugs, please call our Member Services number and we can arrange to have a copy mailed to you. The list may change during the year. If you are on a drug that is impacted by a change to the List of Covered Drugs, you and your provider will be notified in writing 30 days prior to the change taking effect. To get the most up-to-date List of Covered Drugs, visit www.MCCofVA.com or call 1-800-424-4524 (TTY 711). Member Services is available from 8 a.m. to 8 p.m. local time, Monday through Friday.

We will generally cover a drug on MCC's List of Covered Drugs as long as you follow the rules explained in this Section. You can also get drugs that are not on the list when medically necessary. Your physician may have to obtain a service authorization from us in order for you to receive some drugs.

Limits for Coverage of Some Drugs

For certain prescription drugs, special rules limit how and when we cover them. In general, our rules encourage you to get a drug that works for your medical condition and that is safe and effective, and cost effective.

If there is a special rule for your drug, it usually means that you or your provider will have to take extra steps for us to cover the drug. For example, your provider may need to request a service authorization for you to receive the drug. We may or may not agree to approve the request without taking extra steps. Refer to ***Service Authorization and Benefit Determination and Service Authorizations and Continuity of Care*** in Section 14 of this handbook.

If MCC is new for you, you can keep getting your authorized drugs for the duration of the authorization or during the continuity of care period after you first enroll, whichever is sooner. The continuity of care period is 30 days. Refer to ***Continuity of Care Period*** in Section 3 of this handbook.

If we deny or limit coverage for a drug, and you disagree with our decision, you have the right to appeal our decision. The continuity of care period is 30 days. Refer to ***Your Right to Appeal*** in Section 15 of this handbook. If you have any concerns, contact your Care Coordinator. Your Care Coordinator will work with you and your PCP to make sure that you receive the drugs that work best for you.

Getting Approval in Advance

For some drugs, you or your doctor must get a service authorization approval from MCC before you fill your prescription. If you don't get approval, we may not cover the drug.

Trying a Different Drug First

We may require that you first try one (usually less-expensive) drug (before we will cover another (usually more-expensive) drug for the same medical condition. For example, if Drug A and Drug B treat the same medical condition, the plan may require you to try Drug A first. If Drug A does not work for you, then we will cover Drug B. This is called step therapy.

Quantity Limits

For some drugs, we may limit the amount of the drug you can have. This is called a quantity limit. For example, the plan might limit how much of a drug you can get each time you fill your prescription.

To find out if any of the rules above apply to a drug your physician has prescribed, check the List of Covered Drugs. For the most up-to-date information, call Member Services or check our website at www.MCCofVA.com.

Emergency Supply

There may be an instance where your medication requires a service authorization, and your prescribing physician cannot readily provide authorization information to us, for example over the weekend or on a holiday.

If your pharmacist believes that your health would be compromised without the benefit of the drug, we may authorize a 72-hour emergency supply of the prescribed medication. This process provides you with a short-term supply of the medications you need and gives time for your physician to submit a service authorization request for the prescribed medication.

Non-Covered Drugs

By law the types of drugs listed below are not covered by Medicare or Medicaid:

- Drugs used to promote fertility
- Drugs used for cosmetic purposes or to promote hair growth
- Drugs used for the treatment of sexual or erectile dysfunction, such as Viagra®, Cialis®, Levitra®, and Caverject®, 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
- Drugs used for treatment of anorexia, weight loss, or weight gain
- All DESI (Drug Efficacy Study Implementation) drugs as defined by the FDA to be less than effective, including prescriptions that include a DESI drug
- Drugs that have been recalled
- Experimental drugs or non-FDA-approved drugs
- Any drugs marketed by a manufacturer who does not participate in the Virginia Medicaid Drug Rebate program

Changing Pharmacies

If you need to change pharmacies and need a refill of a prescription, you can ask your pharmacy to transfer the prescription to the new pharmacy. If you need help changing your network pharmacy, you can contact Member Services at the number at the bottom of the page or your Care Coordinator.

If the pharmacy you use leaves MCC's network, you will have to find a new network pharmacy. To find a new network pharmacy, you can look in the Provider and Pharmacy Directory, visit our website, or contact Member Services at the number at the bottom of the page or your Care Coordinator. Member Services can tell you if there is a network pharmacy nearby.

What if You Need a Specialized Pharmacy

Sometimes prescriptions must be filled at a specialized pharmacy. Specialty drugs are used for treatment of complex diseases and when prescribed the medications required special handling or clinical care support prior to dispensing. Only a limited number of pharmacies are contracted by each MCO to provide these drugs. These medications will be shipped directly to the member's home or the prescriber office and cannot be picked up at all retail outlets. Also these drugs usually require a service authorization prior to dispensing. Be sure to check with the formulary of your plan regarding coverage of these specialty drugs and allow time for shipment deliveries.

CVS Caremark Specialty Pharmacy is our **preferred specialty pharmacy**. We would like you to get your specialty medicine sent through the mail from CVS Caremark Specialty Pharmacy. CVS Caremark Specialty Pharmacy will work closely with you and your provider to give you what you need to effectively manage your condition. MCC limits the days-supply on specialty prescriptions to 31 days.

CVS Caremark Specialty Pharmacy makes it easy for you to get your specialty medicine with services to help you including:

- Coaching programs to help manage your condition
- Free delivery to your 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 you get the most out of your benefits
- Online member portal where you can request refills and learn more

If you have a new prescription or if you are requesting a refill from another pharmacy, please call CVS Caremark Specialty Pharmacy to get your medicine delivered to you at no cost. If you do not want to use CVS Caremark Specialty Pharmacy, tell the pharmacy team member at the time of the call and they will make a change that will allow you to continue to get your specialty medicine at your current pharmacy. For questions about our Specialty Pharmacy program, please call 1-800-237-2767.

Can You Use Mail-Order Services to Get Your Drugs

MCC understands that picking up your medications can be challenging at times. If you are having trouble getting your medications from your local pharmacy, we can help by providing them through mail-order service. Most medications can be mailed to you quickly and securely. For questions about our pharmacy mail order service, please call 1-844-285-8668.

Can You Get a Long-Term Supply of Drugs

MCC allows long-term supplies of maintenance medications. Examples of maintenance medications include those used daily and for diseases such as heart disease, high blood pressure, depression, or asthma. You may obtain long-term supplies from your retail pharmacy or through mail order. Contact Member Services if you think you qualify for this.

Can You Use a Pharmacy That is Not in MCC's Network

In most cases, we will pay for prescriptions only if they are filled in a network pharmacy. This is a drug store that has agreed to fill prescriptions for our plan members. You may go to any of our network pharmacies. Please visit our website to locate a Pharmacy near you. Or call Member Services at 1-800-424-4524 (TTY 711). If you choose to fill your prescriptions at a pharmacy out of the MCC network, you may be responsible for the full cost of the medication.

What is the Patient Utilization Management and Safety (PUMS) Program

Some members who require additional monitoring may be enrolled in the Patient Utilization Management and Safety (PUMS) program. The PUMS program is required by DMAS and helps make sure your drugs and health services work together in a way that won't harm your health. As part of this program, we may check the Prescription Monitoring Program (PMP) tool that the Virginia Department of Health Professions maintains to review your drugs. This tool uses an electronic system to monitor the dispensing of controlled substance prescription drugs.

If you are chosen for PUMS, you may be restricted to or locked into only using one pharmacy or only going to one provider to get certain types of medicines. We will send you a letter to let you know how PUMS works. The lock-in period is for 12 months. At the end of the lock in period, we'll check in with you to see if you should continue the program. If you are placed in PUMS and don't think you should be in the program, you can appeal. You must appeal to us within 60 days of when you get the letter saying that you have been put into PUMS. You can also request a State Fair Hearing. Refer to *Appeals, State Fair Hearings, and Grievances* in Section 15 of this handbook.

If you're in the PUMS program, you can get prescriptions after hours if your selected pharmacy doesn't have 24-hour access. You'll also be able to pick a PCP, pharmacy or other provider where you want to be locked in. If you don't select providers for lock in within 15 days, we'll choose them for you.

Members who are enrolled in PUMS will receive a letter from MCC that provides additional information on PUMS including all of the following information:

- A brief explanation of the PUMS program
- A statement explaining the reason for placement in the PUMS program
- Information on how to appeal to MCC if placed in the PUMS program
- Information regarding how request a State Fair Hearing after first exhausting MCC's appeals process
- Information on any special rules to follow for obtaining services, including for emergency or after-hours services
- Information on how to choose a PUMS provider

Contact Member Services at 1-800-424-4524 (TTY 711) or your Care Coordinator if you have any questions on PUMS.

10. How to Access Your CCC Plus Benefits

CCC Plus Benefits

As an MCC member, you have a variety of health care benefits and services available to you. We also regularly assess new technology, which includes medical and behavioral health procedures, medications, and devices to add as benefits and services. You will receive most of your services through us, but may receive some through DMAS or a DMAS Contractor.

- Services provided through MCC are described in this Section 10 of the handbook
- Services covered by DMAS or a DMAS Contractor are described in Section 11 of this handbook
- Services that are not covered through MCC or DMAS are described in Section 12 of this handbook

Services you receive through us or through DMAS will not require you to pay any costs other than your "patient pay" toward long term services and supports. Section 13 of this handbook provides information on what a "patient pay" is and how you know if you have one.

General Coverage Rules

To receive coverage for services you must meet the general coverage requirements described below.

- Your services (including medical care, services, supplies, equipment, and drugs) must be medically necessary. Medically necessary generally means you need the service or supplies to prevent, diagnose, or treat a medical condition or its symptoms based on accepted standards of medical practice
- In most cases, you must get your care from a network provider. A network provider is a provider who works with MCC. In most cases, we will not pay for care you get from an out- of-network provider unless the service is authorized by us. Section 6 has more information about using network and out-of-network providers, including *Services You Can Get Without First Getting Approval From Your PCP*
- Some of your benefits are covered only if your doctor or other network provider gets approval from us first. This is called a service authorization. Section 14 includes more information about service authorizations

- If MCC is new for you, you can keep seeing the doctors you go to now during the 30-day continuity of care period. You can also keep getting your authorized services for the duration of the authorization or during the continuity of care period after you first enroll, whichever is sooner. Also see *Continuity of Care Period* in Section 3 of this handbook.

Benefits Covered Through MCC

MCC covers all the following services for you when they are medically necessary. If you have Medicare or another insurance plan, we will coordinate these services with your Medicare or other insurance plan. Refer to Section 11 of this handbook for *Services Covered Through the DMAS Medicaid Fee-For-Service Program*.

- Regular medical care, including office visits with your PCP, referrals to specialists, exams, etc. *See Section 6 of this handbook for more information about PCP services*
- Preventive care, including regular check-ups, screenings, and well-baby/child visits. *See Section 6 of this handbook for more information about PCP services*
- Addiction and Recovery Treatment Services (ARTS), including inpatient, outpatient, community-based, medication assisted treatment, peer services, and case management. Services may require authorization. *Additional information about ARTS services is provided below in this Section of the handbook*
- Adult day health Care services (see CCC Plus Waiver)
- Care coordination services, including assistance connecting to CCC Plus covered services and to housing, food, and community resources. *See Section 4 of this handbook for more information about your Care Coordinator*
- Clinic services, including renal dialysis
- CCC Plus Home and Community Based Waiver services, (formerly known as the EDCD and Technology Assisted Waivers), including: adult day health care, assistive technology, environmental modifications, personal care services, personal emergency response systems (PERS), private duty nursing services, respite services, services facilitation, transition services. *Additional information about CCC Plus Waiver services is provided later in this Section. Section 11 of this handbook provides information about DD Waiver Services*

- Colorectal cancer screening
- Court ordered services
- Durable medical equipment (DME) and supplies including medically necessary respiratory, oxygen, and ventilator equipment and supplies, wheelchairs and accessories, hospital beds, diabetic equipment and supplies, incontinence products, assistive technology, communication devices, and rehabilitative equipment and devices and other necessary equipment and supplies
- Early and Periodic Screening Diagnostic and Treatment services (EPSDT) for children under age 21. *Additional information about EPSDT services is provided later in this Section of the handbook*
- Early Intervention services for children from birth to age 3. *Additional information about early intervention services is provided later in this Section of the handbook*.
- Electroconvulsive therapy (ECT)
- Emergency custody orders (ECO)
- Emergency services including emergency transportation services (ambulance, etc.)
- Emergency and post stabilization services. Additional information about emergency and post stabilization services is provided in Section 7 of this handbook
- End stage renal disease services
- Eye examinations
- Family planning services, including services, devices, drugs (including long acting reversible contraception) and supplies for the delay or prevention of pregnancy. You are free to choose your method for family planning including through providers who are in/out of MCC's network. We do not require you to obtain a service authorization or a PCP referral for family planning services
- Gender Dysphoria treatment services
- Glucose test strips
- Hearing (audiology) services
- Home health services
- Hospice services
- Hospital care—inpatient/outpatient

- Human Immunodeficiency Virus (HIV) testing and treatment counseling
- Immunizations
- Inpatient psychiatric hospital services
- Laboratory, Radiology and Anesthesia Services
- Lead investigations
- Mammograms
- Maternity care—includes pregnancy care, doctors/certified nurse-midwife services. *Additional information about maternity care is provided in Section 6 of this handbook*
- 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
  - Crisis Intervention and Stabilization
  - Mental Health Skill-building Services (MHSS)
  - Intensive In-Home
  - Psychosocial Rehabilitation
  - Applied Behavior Analysis
  - 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
- Nursing facility—includes skilled, specialized care, long stay hospital, and custodial care. *Additional information about nursing facility services is provided later in this Section of the handbook*
- Nurse Midwife Services through a Certified Nurse Midwife provider
- Organ transplants
- Orthotics, including braces, splints and supports—for children under 21, or adults through an intensive rehabilitation program
- Outpatient hospital services
- Pap smears
- Personal care or personal assistance services (through EPSDT or through the CCC Plus Waiver)
- Physician's services or provider services, including doctor's office visits.
- Physical, occupational, and speech therapies
- Podiatry services (foot care)
- Prenatal and maternal services
- Prescription drugs. *See Section 9 of this handbook for more information on pharmacy services*
- Private duty nursing services (through EPSDT and through the CCC Plus HCBS Waiver)
- Prostate specific antigen (PSA) and digital rectal exams
- Prosthetic devices including arms, legs and their supportive attachments, breasts, and eye prostheses)
- Psychiatric or psychological services
- Radiology services
- Reconstructive breast surgery
- Rehabilitation services—inpatient and outpatient (including physical therapy, occupational therapy, speech pathology and audiology services)
- Renal (kidney) dialysis services

- Second opinion services from a qualified health care provider within the network or we will arrange for you to obtain one at no cost outside the network. The doctor providing the second opinion must not be in the same practice as the first doctor. Out of network referrals may be approved when no participating provider is accessible or when no participating provider can meet your individual needs
- Surgery services when medically necessary and approved by MCC
- Telemedicine services
- Temporary detention orders (TDO)
- Tobacco Cessation Services education and pharmacotherapy for all members
- Transportation services, including emergency and non-emergency (air travel, ground ambulance, stretcher vans, wheelchair vans, public bus, volunteer/ registered drivers, taxi cabs). MCC will also provide transportation to/from most "carved-out" and added benefits. *Additional information about transportation services is provided later in this Section of the handbook. Transportation services for DD Waiver services are covered through DMAS, as described in Section 11 of this handbook*
- Vision services
- Well Visits. We promote wellness visits for both adults and children. Our Care Coordination Team will work with you to help you understand and access important preventive health and wellness visits. We offer health screenings at community events to further identify your specific health and wellness visit needs. We follow current and nationally recognized well visit guidelines and follow the same for health screenings, such as mammograms, immunizations, colorectal, pregnancy, and women and men's health
  - For children, the well visits are known as Early and Periodic Screening, Diagnosis and Treatment visits. They are also known as EPSDT visits. They are an important part of our wellness program. These visits include preventive screenings and other services to keep your child healthy. More detail on these services is covered later under the EPSDT program section. Abortion services coverage is only available in cases where there would be a substantial danger to the life of the mother

Extra Benefits We Provide that are not Covered by Medicaid

As a member of MCC you have access to services that are not generally covered through Medicaid fee-for-service. These are known as "added benefits." We provide the following added benefits:

Service	CCC Plus Program–MCC	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 care coordinator • 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 – $50 per year	Available to all members
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 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.
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 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, 4.5 GB of data and unlimited texting each month. We also provide text messaging programs to remind members of appointments and more.	Covered	All members
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.

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.

How to Access Early and Periodic Screening, Diagnostic, and Treatment Services

What is EPSDT

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is a federally mandated Medicaid benefit that provides comprehensive and preventive health care services for children under age 21. If you have a child that is under age 21, EPSDT provides coverage for all medically necessary preventive, dental, behavioral health, developmental, and specialty services. It includes coverage for immunizations, well child visits, lead investigations, private duty nursing, personal care, and other services and therapies that treat or make a condition better. It will also cover services that keep your child's condition from getting worse. EPSDT can provide coverage for medically necessary services even if these are not normally covered by Medicaid.

- EPSDT screenings are conducted by a qualified provider such as but not limited to a Physician, Nurse Practitioner, Physician Assistant, Rural Health Clinics, Local Health Departments, Federally Qualified Health Centers and school based health clinics and can occur during the following:
  - Screening/well child check-ups (EPSDT/Periodic screenings)—Checkups that occur at regular intervals.
  - Vision and hearing screenings
  - Age appropriate immunization appointments
  - Important routine lab test, such as testing for lead levels in children- this should be done on all children at 12 and 24 months, or at 24 and 72 months for children not previously tested.
  - Sick visits (EPSDT/Inter-periodic Screenings)—unscheduled check-ups or problem focused assessments that can happen at any time because of child's illness or a change in condition.

Getting EPSDT Services

MCC provides most of the Medicaid EPSDT covered services. However, some EPSDT services, like pediatric dental care, are not covered by us. For any services not covered by us, you can get these through the Medicaid fee-for-service program. Additional information about services provided through Medicaid fee-for-service is provided in Section 11 of this handbook.

We promote wellness visits for children under EPSDT. They are an important part of our wellness program. These visits include preventive screenings and other services to keep your child healthy. We expect the following check-ups:

- Birth
- 2 – 4 days for newborns discharged less than 48 hours after delivery
- 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months
- 24 months
- 30 months
- Once every year for ages 3–20

Getting Early Intervention Services

If you have a baby under the age of three, and you believe that he or she is not learning or developing like other babies and toddlers, your child may qualify for early intervention services. Early intervention includes services such as speech therapy, physical therapy, occupational therapy, service coordination, and developmental services to help families support their child's learning and development during everyday activities and routines. Services are generally provided in your home.

The first step is meeting with the local Infant and Toddler Connection program in your community to see if your child is eligible. A child from birth to age three is eligible if he or she has (1) a 25% developmental delay in one or more areas of development; (2) atypical development; or, (3) a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay.

For more information, call your Care Coordinator. Your Care Coordinator can help. If your child is enrolled in MCC we provide coverage for early intervention services. Your Care Coordinator will work closely with you and the Infant and Toddler Connection program to help you access these services and any other services that your child may need. Information is also available at https://itcva.online or by calling 1-800-234-1448.

How to Access Population Health Programs

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

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

To find out more about these educational and interactive programs, please speak with your assigned care coordinator or call Member Services.

How to Access Complex Case Management

If you have more than one medical condition you are trying to take care of or have recently had a hospitalization or a change in your current health, MCC is here to help. MCC offers a no-cost Complex Case Management program to help you get the medical care and services you need. If you would like help managing your health, you can call Member Services to refer yourself to the Complex Case Management program.

How to Access Behavioral Health Services

Behavioral health services offer a wide range of treatment options for individuals with a mental health or substance use disorder. Many individuals struggle with mental health conditions such as depression, anxiety, or other mental health issues as well as using substances at some time in their lives. These behavioral health services aim to help individuals live in the community and maintain the most independent and satisfying lifestyle possible. Services range from outpatient counseling to hospital care, including day treatment and crisis services. These services can be provided in your home or in the community, for a short or long timeframe, and all are performed by qualified individuals and organizations.

Contact your Care Coordinator if you are having trouble coping with thoughts and feelings. Your Care Coordinator will help you make an appointment to speak with a behavioral healthcare professional. Your Care Coordinator can assist with referring you to any behavioral health services that would be appropriate for your needs. If authorization is required for those services, your provider will request authorization for you.

The following Behavioral Health services are covered for you through Magellan of Virginia, the DMAS Behavioral Health Services Administrator (BHSA): Psychiatric Residential Treatment Services, Therapeutic Group Home Services, and Treatment Foster Care-Case Management. Your Care Coordinator will work closely with the BHSA to coordinate the services you need, including those that are provided through the BHSA.

We are here to make sure that you get the care you need to feel better. Your Care Coordinator and our NurseLine nurses can make sure you see your provider quickly. Please call us at 1-800-424-4524 (TTY 711) if you need help.

You can get help in finding a behavioral health or substance abuse provider by calling 1-800-424-4524 (TTY 711). Someone is available to help you 24 hours a day and seven days a week. You can also look in our provider directory. Or you can look on our website at www.MCCofVA.com.

You will be given the names of providers in your local area if you call. You can choose to call one of these providers for an appointment. You do not need to call your PCP for a referral for substance abuse appointments. Some services do require an okay from us. Your provider will ask for an okay when it is needed.

The services you can get include inpatient and outpatient hospital services and psychiatric services. You can also get a range of behavioral health services. Sometimes you can get these services in your community. Sometimes you can get them in your home or in schools. Some of the behavioral health services you may need for you or a family member include:

- Individual, family and group therapy
- Day treatment for adults and children
- Individual and family assessments
- Evaluations

- Treatment planning
- Psychosocial rehabilitation
- Targeted case management
- Therapeutic behavioral on-site services for children and adolescents

How to Access Addiction and Recovery Treatment Services (ARTS)

MCC offers a variety of services that help individuals who are struggling with using substances, including drugs and alcohol. Addiction is a medical illness, just like diabetes, that many people deal with and can benefit from treatment no matter how bad the problem may seem. If you need treatment for addiction, we provide coverage for services that can help you. These services include settings in inpatient, outpatient, residential, and community-based treatment. Medication assisted treatment options, counseling services and behavioral therapy options are also available if you are dealing with using prescription or non-prescription drugs. Other options that are helpful include peer recovery services (someone who has experience similar issues and in recovery), as well as case management services. Talk to your PCP or call your Care Coordinator to determine the best option for you and how to get help in addiction and recovery treatment services. To find an ARTS provider, you can look in the Provider and Pharmacy Directory, visit our website, call your Care Coordinator, or contact Member Services at 1-800-424-4524 (TTY 711).

Our ARTS Care Coordinators have a lot of experience. They manage substance use benefits, coordinate ARTS services and assess all requests for residential and inpatient treatment. The ARTS Care Coordinators work with providers and internal MCC staff to complete service requests and authorizations. These authorizations are communicated to providers in a timely way and are documented in our clinical system.

These Care Coordinators also know about telehealth services. Some members may live in areas that are hard to get to. The Care Coordinators might recommend telehealth services in these cases. They may also schedule assessments in members' homes if telehealth or other services are not possible.

How to Access Long-Term Services and Supports (LTSS)

MCC provides coverage for long-term services and supports (LTSS) including a variety of services and supports that help older individuals and individuals with disabilities meet their daily needs and maintain maximum independence. We have Care Coordination team staff who live and work in the same community you live in. The team helps you coordinate local LTSS providing assistance that helps you live in your own home or other setting of your choice and improves your quality life. Examples services include personal assistance services (assistance with bathing, dressing, and other basic activities of daily life and self-care), as well as support for everyday tasks such as laundry, shopping, and transportation. LTSS are provided over a long period of time, usually in homes and communities (through a home and community-based waiver), but also in nursing facilities. If you need help with these services, please call your Care Coordinator who will help you in the process to find out if you meet the Virginia eligibility requirements for these services. Also see the Sections: *Commonwealth Coordinated Care Plus Waiver, Nursing Facility Services, and How to Get Services* if you are in a DD Waiver described later in this Section of the handbook.

Commonwealth Coordinated Care Plus Waiver

Some members may qualify for home and community-based care waiver services through the Commonwealth Coordinated Care Plus Waiver (formerly known as the Elderly or Disabled with Consumer Direction and Technology Assistance Waivers).

The Commonwealth Coordinated Care Plus (CCC Plus) Waiver is meant to allow a member who qualifies for nursing facility level of care to remain in the community with help to meet their daily needs. If determined eligible for CCC Plus Waiver services, you may choose how to receive personal assistance services. You have the option to receive services through an agency (known as agency directed) or you may choose to serve as the employer for a personal assistance attendant (known as self-directed.) Information on self-directed care is described in more detail below, in this Section of the handbook.

CCC Plus Waiver Services may include:

- Private duty nursing services (agency directed)
- Personal care (agency or self-directed)
- Respite care (agency or self-directed)

- Adult day health care
- Personal emergency response system (with or without medication monitoring)
- Transition coordination/services for members transitioning to the community from a nursing facility or long stay hospital
- Assistive technology
- Environmental modifications

Individuals enrolled in a DD Waiver should see *How to Get Services if you are in a DD Waiver* described later in this Section.

How to Self-Direct Your Care

Self-directed care (also called consumer-directed care) refers to personal care and respite care services provided under the CCC Plus Waiver. These are services in which the member or their family/caregiver is responsible for hiring, training, supervising, and firing of their attendant. You will receive financial management support in your role as the employer to assist with enrolling your providers, conducting provider background checks, and paying your providers.

If you have been approved to receive CCC Plus Waiver services and would like more information on the self-directed model of care, please contact your Care Coordinator who will assist you with these services.

Your Care Coordinator will also monitor your care as long as you are receiving CCC Plus Waiver services to make sure the care provided is meeting your daily needs.

Nursing Facility Services

If you are determined to meet the coverage criteria for nursing facility care, and choose to receive your long term services and supports in a nursing facility, MCC will provide coverage for nursing facility care. If you have Medicare, we will provide coverage for nursing facility care after you exhaust your Medicare covered days in the nursing facility, typically referred to as skilled nursing care.

If you are in a nursing facility, you may be able to move from your nursing facility to your own home and receive home and community-based services if you would like to. If you are interested in moving out of the nursing facility into the community, talk with your Care Coordinator. Your Care Coordinator is available to work with you, your family, and the discharge planner at the nursing facility if you are interested in moving from the nursing facility to a home or community setting.

If you choose not to leave the nursing facility, you can remain in the nursing facility for as long as you are determined to meet the coverage criteria for nursing facility care.

MCC provides Care Coordinators who work on site at the various nursing facilities. The Care Coordinators can assist you or the nursing facility staff in getting any type of nursing facility information, services, approvals and authorizations. Our Transition Coordinators help the Care Coordinators with any transitions to and from nursing facilities, the community or hospital whenever necessary.

Screening for Long-Term Services and Supports

Before you can receive long-term services and supports (LTSS) you must be screened by a community based or hospital screening team. A screening is used to determine if you meet the level of care criteria for LTSS. Contact your Care Coordinator to find out more about the screening process in order to receive LTSS.

Freedom of Choice

If you are approved to receive long term services and supports, you have the right to receive care in the setting of your choice:

- In your home
- In another place in the community
- In a nursing facility

You can choose the doctors and health professionals for your care from our network. If you prefer to receive services in your home under the CCC Plus Waiver, for example, you can choose to directly hire your own personal care attendant(s), known as self-directed care. Another option you have is to choose a personal care agency in our network, where the agency will hire, train, and supervise personal assistance workers on your behalf, known as agency direction. You also have the option to receive services in a nursing facility from our network of nursing facility providers.

How to Get Services if You are in a Developmental Disability Waiver

If you are enrolled in one of the DD waivers, you will be enrolled in CCC Plus for your non-waiver services. The DD waivers include:

- The Building Independence (BI) Waiver,
- The Community Living (CL) Waiver, and
- The Family and Individual Supports (FIS) Waiver.

MCC will only provide coverage for your non-waiver services. Non-waiver services include all of the services listed in Section 10, *Benefits Covered through MCC*. **Exception**: If you are enrolled in one of the DD Waivers, you would not also be eligible to receive services through the CCC Plus Waiver.

DD Waiver services, DD and ID targeted case management services, and transportation to/from DD waiver services, will be paid through Medicaid fee-for-service as "carved-out" services. The carve-out also includes any DD waiver services that are covered through EPSDT for DD waiver enrolled individuals under the age of 21.

If you have a developmental disability and need DD waiver services, you will need to have a diagnostic and functional eligibility assessment completed by your local Community Services Board (CSB). All individuals enrolled in one of the DD waivers follow the same process to qualify for and access BI, CL and FIS services and supports. Services are based on assessed needs and are included in your person-centered individualized service plan.

The DD waivers have a wait list. Individuals who are on the DD waiver waiting list may qualify to be enrolled in the CCC Plus Waiver until a BI, CL or FIS DD waiver slot becomes available and is assigned to the individual. The DD waiver waiting list is maintained by the CSBs in your community.

For more information on the DD Waivers and the services that are covered under each DD Waiver, visit the Department of Behavioral Health and Developmental Services (DBHDS) website at: www.mylifemycommunityvirginia.org/ or call 1-844-603-9248. Your Care Coordinator will work closely with you and your DD or ID case manager to help you get all of your covered services. Contact your Care Coordinator if you have any questions or concerns.

How to Get Non-Emergency Transportation Services

Non-Emergency Transportation Services Covered by MCC

Non-Emergency transportation services are covered by MCC for covered services, carved out services, and added benefits. Exception: If you are enrolled in a DD Waiver, we only cover transportation to/from non-waiver services. (Refer to *Transportation to/from DD Waiver Services* below.)

Transportation may be provided if you have no other means of transportation and need to go to a doctor or a health care facility for a covered service. For urgent or non-emergency medical appointments, call the reservation line at 1-877-790-9472. If you are having problems getting transportation to your appointments, call your Care Coordinator or MCC Member Services at 1-800-424-4524 (TTY 711). We require 72 hours advanced notice for transportation requests for routine appointments.

In case of a life-threatening emergency, call 911. Refer to *How to Get Care for Emergencies* in Section 7 of this handbook.

Transportation to and From DD Waiver Services

If you are enrolled in a DD Waiver, MCC only provides coverage for your transportation to and from your non-waiver services. (Call Veyo at 1-877-790-9472 for transportation to your non-waiver services.)

Transportation to your DD Waiver services is covered by the DMAS Transportation Contractor. You can find out more about how to access transportation services through the DMAS Transportation Contractor on the website at: http://transportation.dmas.virginia.gov/ or by calling the Transportation Contractor. Transportation for routine appointments are taken Monday through Friday between the hours of 6 a.m. to 8 p.m. The DMAS Transportation Contractor is available 24 hours a day, 7 days a week to schedule urgent reservations, at: 1-866-386-8331 or TTY 1-866-288-3133 or 711 to reach a relay operator.

If you have problems getting transportation to your DD waiver services, you may call your DD Case Manager or the DMAS Transportation Contractor at the number above. You can also call your Care Coordinator. Your Care Coordinator will work closely with you and your DD Case Manager to help get the services that you need. MCC Member Services is also available to help at 1-800-424-4524 (TTY 711).

11. Services Covered Through the DMAS Medicaid Fee-For-Service Program

Carved-Out Services

The Department of Medical Assistance Services (DMAS) will provide you with coverage for the services listed below. These services are known as "carved-out services." Your provider bills fee-for-service Medicaid (or a DMAS Contractor) for these services.

Your Care Coordinator can also help you to access these services if you need them.

- Dental Services are provided through the DMAS Dental Benefits Administrator. DMAS has contracted with its Dental Benefits Administrator to coordinate the delivery of all Medicaid dental services. The dental program provides coverage for the following populations and services:
  - For children under age 21: diagnostic, preventive, restorative/surgical procedures, as well as orthodontia services
  - For pregnant women: x-rays and examinations, cleanings, fillings, root canals, gum related treatment, crowns, partials, and dentures, tooth extractions and other oral surgeries, and other appropriate general services Orthodontic treatment is not included. The dental coverage ends 60 days after the baby is born
  - For adults age 21 and over: coverage will include cleanings, x-rays, exams, fillings, dentures, root canals, gum-related treatment, oral surgery and more

  If you have any questions about your dental coverage through ***the DMAS Dental Benefits Administrator***, you can reach DentaQuest Member Services at 1-888-912-3456, Monday through Friday, 8:00 AM - 6:00 PM EST. The TTY/TDD number is 1-800-466-7566. Additional information is provided at: https://www.dmas.virginia.gov/for-members/benefits-and-services/dental/

MCC provides coverage for non-emergency transportation for any dental services covered through the DMAS Dental Benefits Administrator, as described above. Contact Member Services if you need assistance.

MCC provides coverage for oral services such as hospitalizations, surgeries or services billed by a medical doctor not a dentist.

- Developmental Disability (DD) Waiver Services, including Case Management for DD Waiver Services, are covered through DBHDS. The carve-out includes any DD Waiver services that are covered through EPSDT for DD waiver enrolled individuals and transportation to/from DD Waiver services. Also see ***How to Get Services if you are in a Developmental Disability Waiver*** in Section 10 of this handbook
- School health services including certain medical, mental health, hearing, or rehabilitation therapy services that are arranged by your child's school. The law requires schools to provide students with disabilities a free and appropriate public education, including special education and related services according to each student's Individualized Education Program (IEP). While schools are financially responsible for educational services, in the case of a Medicaid-eligible student, part of the costs of the services identified in the student's IEP may be covered by Medicaid. When covered by Medicaid, school health services are paid by DMAS. Contact your child's school administrator if you have questions about school health services
- Therapeutic Group Home Services for children and adolescents younger than the age of 21. This is a place where children and adolescents live while they get treatment. Children under this level of care have serious mental health concerns. These services provide supervision and behavioral health care toward therapeutic goals. These services also help the member and their family work towards discharge to the member's home. Additional information about Therapeutic Group Home Services is available on the Magellan website at: www.magellanofvirginia.com or by calling: 1-800-424-4046 (TTY 711). You can also call your Care Coordinator for assistance
- For members age twenty-one (21) through sixty-four (64), where the member goes into private freestanding Institution for Mental Disease (IMD) or a State freestanding IMD for a Temporary Detention Order (TDO), the state TDO program will pay for the service

Services That Will End Your CCC Plus Enrollment

If you receive any of the services below, your enrollment with MCC will end. You will receive these services through DMAS or a DMAS Contractor.

- PACE (Program of All-Inclusive Care for the Elderly). For more information about PACE, talk to your Care Coordinator or visit: http://www.pace4you.org/
- You reside in an Intermediate Care Facility for Individuals with Intellectual and Developmental Disabilities (ICF/IID)
- You are receiving care in a Psychiatric Residential Treatment Facility (children under 21). Additional information about Psychiatric Residential Treatment Facility Services is available on the Magellan website at: www.magellanofvirginia.com or by calling: 1-800-424-4046 (TTY 711). You can also call your Care Coordinator for assistance
- You reside in a Veteran's Nursing Facility
- You become incarcerated
- You reside in one of these State long term care facilities: Piedmont, Catawba, Hiram Davis, or Hancock

12. Services Not Covered by CCC Plus

The following services are not covered by Medicaid or MCC. If you receive any of the following non-covered services you will be responsible for the cost of these services.

- Acupuncture
- Administrative expenses, such as completion of forms and copying records
- Artificial insemination, in-vitro fertilization, or other services to promote fertility
- Certain drugs not proven effective
- Certain experimental surgical and diagnostic procedures
- Chiropractic services
- Cosmetic treatment or surgery
- Daycare, including companion services for the elderly (except in some home- and community-based service waivers)
- Drugs prescribed to treat hair loss or to bleach skin
- Immunizations if you are age 21 or older (except for flu and pneumonia for those at risk and as authorized by MCC)
- Medical care other than emergency services, urgent care services, or family planning services, received from providers outside of the network unless authorized by MCC
- Personal care services (except through some home and community-based service waivers or under EPSDT)
- Prescription drugs covered under Medicare Part D, including the Medicare copayment.
- Private duty nursing (except through some home and community-based service waivers or under EPSDT)
- Weight loss clinic programs unless authorized
- Care outside of the United States

If You Receive Non-Covered Services

We cover your services when you are enrolled with our plan and:

- Services are medically necessary, and
- Services are listed as *Benefits Covered Through MCC* in Section 10 of this handbook, and
- You receive services by following plan rules.

If you get services that aren't covered by our plan or covered through DMAS, you must pay the full cost yourself. If you are not sure and want to know if we will pay for any medical service or care, you have the right to ask us. You can call Member Services or your Care Coordinator to find out more about services and how to obtain them. You also have the right to ask for this in writing. If we say we will not pay for your services, you have the right to appeal our decision.

Section 15 provides instructions for how to appeal MCC's coverage decisions. You may also call Member Services to learn more about your appeal rights or to obtain assistance in filing an appeal.

13. Member Cost Sharing

There are no copayments for services covered through the CCC Plus Program. This includes services that are covered through MCC or services that are carved-out of the CCC Plus contract. The services provided through MCC or through DMAS will not require you to pay any costs other than your patient pay toward long term services and supports. See the *Member Patient Pay* Section below.

CCC Plus does not allow providers to charge you for covered services. MCC pays providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges for a service. If you receive a bill for a covered service, contact Member Services and they will help you.

If you get services that aren't covered by our plan or covered through DMAS, you must pay the full cost yourself. If you are not sure and want to know if we will pay for any medical service or care, you have the right to ask us. You can call Member Services or your Care Coordinator to find out more about services and how to obtain them. You also have the right to ask for this in writing. If we say we will not pay for your services, you have the right to appeal our decision. See Section 12 of this handbook for a list of non-covered services.

Member Patient Pay Toward Long-Term Services and Supports

You may have a *patient pay* responsibility toward the cost of nursing facility care and home and community-based waiver services. A patient pay is required to be calculated for all members who get nursing facility or home and community-based waiver services. When your income exceeds a certain amount, you must contribute toward the cost of your long-term services and supports. If you have a patient pay amount, you will receive notice from your local Department of Social Services (DSS) of your patient pay responsibility. DMAS also shares your patient pay amount with MCC if you are required to pay toward the cost of your long-term services and supports. If you have questions about your patient pay amount, contact your Medicaid eligibility worker at the local Department of Social Services.

Medicare Members and Part D Drugs

If you have Medicare, you get your prescription medicines from Medicare Part D; not from the CCC Plus Medicaid program. CCC Plus does not pay the copayment for the medicines that Medicare Part D covers.

14. Service Authorization and Benefit Determination

Service Authorization

There are some treatments, services, and drugs that you need to get approval for before you receive them or in order to be able to continue receiving them. This is called a service authorization. You, your doctor, or someone you trust can ask for a service authorization.

If the services you require are covered through Medicare then a service authorization from MCC is not required. If you have questions regarding what services are covered under Medicare, please contact your Medicare health plan. You can also contact your MCC Care Coordinator.

A service authorization helps to determine if certain services or procedures are medically needed and covered by the plan. Decisions are based on what is right for each member and on the type of care and services that are needed.

We look at standards of care based on:

- Medical policies
- National clinical guidelines
- Medicaid guidelines
- Your health benefits

MCC does not reward employees, consultants, or other providers to:

- Deny care or services that you need
- Support decisions that approve less than what you need
- Say you don't have coverage

Service authorizations are not required for early intervention services, emergency care, family planning services (including access to or quantity limits for long acting reversible contraceptives), preventive services, and basic prenatal care.

The following treatments and services must be authorized before you get them:

- Physical health – acute care
  - Inpatient hospital – elective procedures
  - Non-emergency transportation
- Outpatient services (typically delivered in an outpatient clinic/setting)
  - Abortions, induced (limited to danger of life to mother)
  - Chiropractic services under age 21
  - Cosmetic procedures (limited to medical necessity)
  - Dental (excluding routine dental care)
  - Genetic testing
  - Hospital or ambulatory care center-based outpatient surgeries
  - IV infusion or injectable medications (provider-administered – see pharmacy benefits)
- Non-emergent referral to a non-contracted provider
  - Non-urgent – ambulance
  - Pain management procedures
  - Therapy (physical, occupational, speech therapy, and hyperbaric)
  - Transplant evaluation and services
- Outpatient diagnostic services
  - Radiation therapy
  - Some cardiac testing
  - High tech radiology (PETs, MRIs and MRAs)
  - Sleep studies

- Rehabilitation services
  - Inpatient rehabilitation
  - Cardiac rehabilitation
  - Pulmonary rehabilitation
- Long term services and supports (LTSS)
  - Adult day health care (ADHC)
  - Assistive technology
  - Environmental modification
  - Long-stay hospital
  - Personal care services (consumer directed and agency directed)
  - Personal emergency response system (PERS)
  - Respite care
  - Private duty nursing
  - Specialized care
  - Transition services
- Home health care
  - Home health care – nursing, social work and home health aide
  - Occupational, physical or speech therapy
- Behavioral health services
  - Addiction, Recovery, Treatment Services (ARTS)
  - Behavioral health mid-level rehab services
  - Behavioral health services inpatient
  - Community Mental Health and Rehabilitative Services (CMHRS)

- Vision
- Hearing services – screenings, exams and hearing aids
- Inpatient skilled nursing facility
- Durable medical equipment (DME)/medical supplies
  - CPAP/apnea monitors
  - Hospital beds
  - Nutritional supplements and supplies
  - Over $500 annually (including prosthetics and orthotics)
  - Oxygen therapy
  - Replacement DME
  - Wheelchairs
  - Wound care supplies/devices
- Medical devices
- Pharmacy
  - Refer to Molina Complete Care pharmacy guidelines
  - Specialty drugs
- Experimental and investigational procedures

To find out more about how to request approval for these treatments or services you can contact Member Services at 1-800-424-4524 (TTY 711) or call your Care Coordinator.

Service Authorizations and Continuity of Care

If you are new to MCC we will honor any service authorization approvals made by DMAS or issued by another CCC Plus plan during the continuity of care period (or until the authorization ends if that is sooner. The continuity of care period is 30 days. Refer to *Continuity of Care Period* in Section 3 of this handbook).

How to Submit a Service Authorization Request

Service authorizations can be obtained by calling the Member Services line at 1-800-424-4524 (TTY 711). The Member Services representative will assist you in speaking with the Support Center, or your assigned Care Coordinator or Utilization Management team member can help you to obtain your service authorization.

What Happens After We Get Your Service Authorization Request

MCC has a review team to be sure you receive medically necessary services. Doctors, nurses and licensed clinicians are on the review team. Their job is to be sure the treatment or service you asked for is medically needed and right for you. They do this by checking your treatment plan against medically acceptable standards. The standards we use to determine what is medically necessary are not allowed to be more restrictive than those that are used by DMAS.

Any decision to deny a service authorization request or to approve it for an amount that is less than requested is called an adverse benefit determination (decision). These decisions will be made by a qualified health care professional. If we decide that the requested service is not medically necessary, the decision will be made by a medical or behavioral health professional, who may be a doctor or other health care professional who typically provides the care you requested. You can request the specific medical standards, called clinical review criteria, used to make the decision for actions related to medical necessity.

Timeframes for Service Authorization Review

MCC follows National Committee for Quality Assurance service authorization standards and timeframes. MCC is responsible for deciding how quickly the authorization is needed depending on the urgency and type of service requested. For standard authorization decisions, MCC will provide written notice as quickly as needed, and within fourteen (14) calendar days. For urgent decisions, MCC will provide written notice within three (3) calendar days.

Urgent requests include requests for medical or behavioral health care or services where waiting 14 days could seriously harm your health or ability to function in the future. Care or services to help with transitions from inpatient hospital or institutional setting to home are also urgent requests. You or your doctor can ask for an urgent request if you believe that a delay will cause serious harm to your health. For standard or urgent decisions, if MCC, you or your provider request an extension, or more information is needed, an extension of up to fourteen (14) additional calendar days is allowed.

For pharmacy services, we must provide decisions by telephone or other telecommunication device within 24 hours.

There may be an instance where your medication requires a service authorization, and your prescribing physician cannot readily provide authorization information to us, for example over the weekend or on a holiday. If your pharmacist believes that your health would be compromised without the benefit of the drug, we may authorize a 72-hour emergency supply of the prescribed medication. This process provides you with a short-term supply of the medications you need and gives time for your physician to submit an authorization request for the prescribed medication.

If we need more information to make a decision about your service request, we will:

- Write and tell you and your provider what information is needed. If your request is in an urgent request, we will call you or your provider right away and send a written notice later
- Tell you why the delay is in your best interest
- Make a decision no later than 14 days from the day we asked for more information

You, your provider, or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give MCC to help decide your case. This can be done by calling 1-800-424-4524 (TTY 711) or contacting us by mail at:

Molina Complete Care
3829 Gaskins Rd
Richmond, VA 23233-1437

You or someone you trust can file a grievance with MCC if you don't agree with our decision to take more time to review your request. You or someone you trust can also file a grievance about the way MCC handled your service authorization request to the State through the CCC Plus Helpline at 1-844-374-9159 or TDD 1-800-817-6608. Also see *Your Right to File a Grievance,* in Section 15 of this handbook.

Benefit Determination

We will notify you with our decision by the date our time for review has expired. But if for some reason you do not hear from us by that date, it is the same as if we denied your service authorization request. If you disagree with our decision, you have the right to file an appeal with us. Also see *Your Right to Appeal,* in Section 15 in this handbook.

We will tell you and your provider in writing if your request is denied. A denial includes when the request is approved for an amount that is less than the amount requested. We will also tell you the reason for the decision and the name of the person responsible for making the adverse determination. We will explain what options for appeals you have if you do not agree with our decision. Also see *Your Right to Appeal*, in Section 15 of this handbook.

Advance Notice

In most cases, if we make a benefit determination to reduce, suspend or end a service we have already approved and that you are now getting, we must tell you at least 10 days before we make any changes to the service. Also see *Continuation of Benefits* in Section 15 of this handbook.

Post Payment Review

If we are checking on care or services that you received in the past, we perform a provider post payment review. If we deny payment to a provider for a service, we will send a notice to you and your provider the day the payment is denied. You will not have to pay for any care you received that was covered by MCC even if we later deny payment to the provider.

15. Appeals, State Fair Hearings, and Grievances

Your Right to Appeal

You have the right to appeal any adverse benefit determination (decision) by MCC that you disagree with that relates to coverage or payment of services.

For example, you can appeal if MCC denies:

- A request for a health care service, supply, item or drug that you think you should be able to get, or
- A request for payment of a health care service, supply, item, or drug that MCC denied

You can also appeal if MCC stops providing or paying for all or a part of a service or drug you receive through CCC Plus that you think you still need.

Authorized Representative

You may wish to authorize someone you trust to appeal on your behalf. This person is known as your authorized representative. You must inform MCC of the name of your authorized representative. You can do this by calling Member Services at 1-800-424-4524 (TTY 711). We will provide you with a form that you can fill out and sign stating who your representative will be.

Adverse Benefit Determination

There are some treatments and services that you need to get approval for before you receive them or in order to be able to continue receiving them. Asking for approval of a treatment or service is called a service authorization request. This process is described earlier in this handbook. Any decision we make to deny a service authorization request or to approve it for an amount that is less than requested is called an adverse benefit determination. Refer to *Service Authorization and Benefit Determinations* in Section 14 of this handbook.

How to Submit Your Appeal

If you are not satisfied with a decision we made about your service authorization request, you have 60 calendar days after hearing from us to file an appeal. You can do this yourself or ask someone you trust to file the appeal for you. You can call Member Services at 1-800-424-4524 (TTY 711) if you need help filing an appeal or if you need assistance in another language or require an alternate format. We will not treat you unfairly because you file an appeal.

You can file your appeal by phone or in writing. You can send the appeal as a standard appeal or an expedited (fast) appeal request.

You or your doctor can ask to have your appeal reviewed under the expedited process if you believe your health condition or your need for the service requires an expedited review. Your doctor will have to explain how a delay will cause harm to your physical or behavioral health. If your request for an expedited appeal is denied, we will tell you and your appeal will be reviewed under the standard process.

Send your Appeal request to:

Appeals & Grievance
Molina Healthcare, Inc.
PO Box 36030
Louisville, KY 40233-6030

or 1-800-424-4524 (TTY 711) from 8 a.m. to 8 p.m. local time, Monday through Friday. Expedited process appeals submitted by phone do not require you to submit a written request.

Continuation of Benefits

In some cases you may be able to continue receiving services that were denied by us while you wait for your appeal to be decided. You may be able to continue the services that are scheduled to end or be reduced if you ask for an appeal:

- Within ten days from being told that your request is denied or care is changing; or
- By the date the change in services is scheduled to occur

If your appeal results in another denial you may have to pay for the cost of any continued benefits that you received if the services were provided solely because of the requirements described in this Section.

What Happens After We Get Your Appeal

We will send you a letter to let you know we have received and are working on your appeal.

Appeals of clinical matters will be decided by qualified health care professionals who did not make the first decision and who have appropriate clinical expertise in treatment of your condition or disease.

Before and during the appeal, you or your authorized representative can see your case file, including medical records and any other documents and records being used to make a decision on your case. This information is available at no cost to you.

You can also provide information that you want to be used in making the appeal decision

In writing:

Appeals & Grievance
Molina Healthcare, Inc.
PO Box 36030
Louisville, KY 40233-6030

In person:

Appeals & Grievance
Molina Healthcare, Inc.
3829 Gaskins Road
Richmond, VA 23233

You can also call Member Services at 1-800-424-4524 (TTY 711) if you are not sure what information to give us.

Timeframes for Appeals

Standard Appeals
If we have all the information we need we will respond in writing as quickly as possible, not to exceed 30 days of when we receive your appeal request. We will tell you within 2 calendar days after receiving your appeal if we need more information.

Expedited Appeals
If we have all the information we need, expedited appeal decisions will be made within 72 hours receipt of your appeal. We will tell you our decision by phone and send a written notice within 2 calendar days from when we make the decision.

If We Need More Information
If we can't make the decision within the needed timeframes because we need more information we will:

- Write you and tell you what information is needed. If your request is in an expedited review, we will call you right away and send a written notice later
- Tell you why the delay is in your best interest; and
- Make a decision no later than 14 additional days from the timeframes described above

You, your provider, or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give MCC to help decide your case. This can be done by calling or writing to:

Appeals & Grievance
Molina Healthcare, Inc.
PO Box 36030
Louisville, KY 40233-6030

or 1-800-424-4524 (TTY 711), from 8 a.m. to 8 p.m. local time, Monday through Friday.

You or someone you trust can file a grievance with MCC if you do not agree with our decision to take more time to review your appeal by calling at 1-800-424-4524 (TTY 711). You or someone you trust can also file a grievance about the way MCC handled your appeal to the State through the CCC Plus Help Line at 1-844-374-9159 or TDD 1-800-817-6608.

If we do not tell you our decision about your appeal on time, you have the right to appeal to the State through the State Fair Hearing process. An untimely response by us is considered a valid reason for you to appeal further through the State Fair Hearing process.

Written Notice of Appeal Decision

We will tell you and your provider in writing if your request is denied or approved in an amount less than requested. We will also tell you the reason for the decision and the name of the person responsible for making the adverse determination. We will explain your right to appeal through the State Fair Hearing Process if you do not agree with our decision.

Your Right to a State Fair Hearing

If you disagree with our decision on your appeal request, you can appeal directly to DMAS. This process is known as a State Fair Hearing. You may also submit a request for a State Fair Hearing if we deny payment for covered services or if we do not respond to an appeal request for services within the times described in this handbook. The State requires that you first exhaust (complete) MCC's appeals process before you can file an appeal request through the State Fair Hearing process. If we do not respond to your appeal request timely DMAS will count this as an exhausted appeal.

State fair hearings can be requested for an adverse benefit decision related to Medicaid covered services. You cannot appeal to DMAS for an adverse benefit decision related to extra benefits we provide that are not covered by Medicaid (see Section 10 for a list of extra benefits).

Standard or Expedited Review Requests

For standard requests, appeals will be heard and DMAS will give you an answer generally within 90 days from the date you filed your appeal. If you want your State Fair Hearing to be handled quickly, you must write "EXPEDITED REQUEST" on your appeal request. You must also ask your doctor to send a letter to DMAS that explains why you need an expedited appeal. DMAS will tell you if you qualify for an expedited appeal within 72 hours of receiving the letter from your doctor.

Authorized Representative

You can give someone like your PCP, provider, or friend or family member written permission to help you with your State Fair Hearing request. This person is known as your authorized representative.

Where to Send the State Fair Hearing Request

There are a few ways to ask for an appeal with DMAS. Your deadline to ask for an appeal with DMAS is 120 calendar days from when we issue our final MCO internal appeal decision.

1. **Electronically.** Online at www.dmas.virginia.gov/#/appealsresources or email to appeals@dmas.virginia.gov
2. **By fax.** Fax your appeal request to DMAS at 1-804-452-5454
3. **By mail or in person.** Send or bring your appeal request to Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219
4. **By phone.** Call DMAS at 1-804-371-8488 (TTY 1-800-828-1120)

To help you, an appeal request form is available from DMAS at www.dmas.virginia.gov/#/appealsresources. You can also write your own letter. Include a full copy of our final denial letter when you file your appeal with DMAS. Also include any documents you would like DMAS to review during your appeal. All information submitted during the initial request and during the DMAS appeal process will be considered to determine if the individual meets the criteria for approval of the requested eligibility/service(s).

After You File Your State Fair Hearing Appeal

DMAS will notify you of the date, time, and location of the scheduled hearing. Most hearings can be done by telephone.

State Fair Hearing Timeframes

Expedited Appeal

If you qualify for an expedited appeal, DMAS will give you an answer to your appeal within 72 hours of receiving the letter from your doctor. If DMAS decides right away that you win your appeal, they will send you their decision within 72 hours of receiving the letter from your doctor. If DMAS does not decide right away, you will have an opportunity to participate in a hearing to present your position. Hearings for expedited decisions are usually held within one or two days of DMAS receiving the letter from your doctor. DMAS still has to give you an answer within 72 hours of receiving your doctor's letter.

Standard Appeal

If your request is not an expedited appeal, or if DMAS decides that you do not qualify for an expedited appeal, DMAS will generally give you an answer within 90 days from the date you filed your appeal. You will have an opportunity to participate in a hearing to present your position before a decision is made.

Continuation of Benefits

In some cases you may be able to continue receiving services that were denied by us while you wait for your State Fair Hearing appeal to be decided. You may be able to continue the services that are scheduled to end or be reduced if you ask for an appeal:

- Within ten days from being told that your request is denied or care is changing;
- By the date the change in services is scheduled to occur

Your services will continue until you withdraw the appeal, the original authorization period for your service ends, or the State Fair Hearing Officer issues a decision that is not in your favor. You may, however, have to repay MCC for any services you receive during the continued coverage period if MCC's adverse benefit determination is upheld and the services were provided solely because of the requirements described in this Section.

If the State Fair Hearing Reverses the Denial

If services were not continued while the State Fair Hearing was pending

If the State Fair Hearing decision is to reverse the denial, MCC must authorize or provide the services under appeal as quickly as your condition requires and no later than 72 hours from the date MCC receives notice from the State reversing the denial.

If services were provided while the State Fair Hearing was pending

If the State Fair hearing decision is to reverse the denial and services were provided while the appeal is pending, MCC must pay for those services, in accordance with State policy and regulations.

If You Disagree with the State Fair Hearing Decision

The State Fair Hearing decision is the final administrative decision rendered by the Department of Medical Assistance Services. If you disagree with the Hearing Officer's decision you may appeal it to your local circuit court.

Your Right to File a Grievance

MCC will try its best to deal with your concerns as quickly as possible to your satisfaction. Depending on what type of concern you have, it will be handled as a grievance or as an appeal.

Timeframe for Grievances

You can file a grievance with us at any time.

What Kinds of Problems Should be Grievances

The grievance process is used for concerns related to quality of care, waiting times, and customer service. Here are examples of the kinds of problems handled by the MCC grievance process.

Grievances about quality

- You are unhappy with the quality of care, such as the care you got in the hospital

Grievances about privacy

- You think that someone did not respect your right to privacy or shared information about you that is confidential or private

Grievances about poor customer service

- A health care provider or staff was rude or disrespectful to you
- MCC staff treated you poorly
- MCC is not responding to your questions
- You are not happy with the assistance you are getting from your Care Coordinator

Grievances about accessibility

- You cannot physically access the health care services and facilities in a doctor or provider's office
- You were not provided requested reasonable accommodations that you needed in order to participate meaningfully in your care

Grievances about communication access

- Your doctor or provider does not provide you with a qualified interpreter for the deaf or hard of hearing or an interpreter for another language during your appointment

Grievances about waiting times

- You are having trouble getting an appointment, or waiting too long to get it.
- You have been kept waiting too long by doctors, pharmacists, or other health professionals or by Member Services or other MCC staff

Grievances about cleanliness

- You think the clinic, hospital or doctor's office is not clean

Grievances about communications from us

- You think we failed to give you a notice or letter that you should have received
- You think the written information we sent you is too difficult to understand
- You asked for help in understanding information and did not receive it

There Are Different Types of Grievances

You can make an internal grievance and/or an external grievance at any time. An internal grievance is filed with and reviewed by MCC. An external grievance is filed with and reviewed by an organization that is not affiliated with MCC.

Internal Grievances

To make an internal grievance, call Member Services at 1-800-424-4524 (TTY 711). You or someone who can act for you can tell us if you have a grievance. You can also write your grievance and send it to us. If you put your grievance in writing, we will respond to your grievance in writing. You can file a grievance in writing by mailing it to us at

Appeals & Grievance
Molina Healthcare, Inc.
PO Box 36030
Louisville, KY 40233-6030

or 1-800-424-4524 (TTY 711) from 8 a.m. to 8 p.m. local time, Monday through Friday.

So that we can best help you, include details on who or what the grievance is about and any information about your grievance. Someone from MCC who was not involved in your case before will review your grievance and ask you for any additional information. You can call Member Services at 1-800-424-4524 (TTY 711) if you need help filing a grievance or if you need assistance in another language or format.

If you call us, we will tell you if we have received your grievance and how we will resolve it. If you write your grievance and send it to us, we will send you a letter telling you we received it and the next steps.
We will notify you of the outcome of your grievance within a reasonable time, but no later than 90 calendar days after we receive your grievance. The time can be extended by 14 more days if you ask us for more time or if we need to get more information to resolve your grievance.

If your grievance is related to your request for an expedited appeal, we will respond within 72 hours after the receipt of the grievance.

External Grievances

You Can File a Grievance with the CCC Plus Helpline
You can make a grievance about MCC to the CCC Plus Helpline. Contact the CCC Plus Helpline at 1-844-374-9159 or TDD 1-800-817-6608.

You Can File a Complaint with the Office for Civil Rights
You can make a complaint to the Department of Health and Human Services' Office for Civil Rights if you think you have not been treated fairly. For example, you can make a complaint about disability access or language assistance. You can also visit www.hhs.gov/ocr for more information.

You may contact the local Office for Civil Rights office at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019
TDD: 1-800-537-7697

You Can File a Grievance with the Office of the State Long-Term Care Ombudsman
The State Long-Term Care Ombudsman serves as an advocate for older persons receiving long-term care services. Local Ombudsmen provide older Virginians and their families with information, advocacy, grievance counseling, and assistance in resolving care problems.

The State's Long-Term Care Ombudsman program offers assistance to persons receiving long term care services, whether the care is provided in a nursing facility or assisted living facility, or through community-based services to assist persons still living at home. A Long-Term Care Ombudsman does not work for the facility, the State, or MCC. This helps them to be fair and objective in resolving problems and concerns.

The program also represents the interests of long-term care consumers before state and federal government agencies and the General Assembly.

The State Long-Term Care Ombudsman can help you if you are having a problem with MCC or a nursing facility. The State Long-Term Care Ombudsman is not connected with us or with any insurance company or health plan. The services are free.

Office of the State Long-Term Care Ombudsman
1-800-552-5019 This call is free.

This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.

Virginia Office of the State Long-Term Care Ombudsman
Virginia Department for Aging and Rehabilitative Services
8004 Franklin Farms Drive
Henrico, Virginia 23229
1-804-662-9140
www.ElderRightsVA.org

16. Member Rights

Your Rights

It is the policy of MCC to treat you with respect. We also care about keeping a high level of confidentiality with respect for your dignity and privacy. As a CCC Plus member you have certain rights. You 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 your medical services and care
- Know what services are available to you. This includes if you need an interpreter because you don't speak English
- Make recommendations regarding MCC member rights and responsibilities policy. Choose to receive long-term services and supports in your home or community or in a nursing facility
- Have confidentiality and privacy about your medical records and when you get treatment
- Receive information on available treatment options and alternatives presented in a manner appropriate to your condition and ability to understand
- Have a candid discussion of appropriate or medically necessary treatment options for your 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 the purpose of experimental research. If it is, the member can refuse or accept the services
- Get information in a language you understand—you can get oral translation services free of charge
- Receive reasonable accommodations to ensure you can effectively access and communicate with providers, including auxiliary aids, interpreters, flexible scheduling, and physically accessible buildings and services

- Receive information necessary for you to give informed consent before the start of treatment
- Be treated with respect and recognition for your dignity and right to privacy;
- Request and receive a copy of your 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 about your healthcare, 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 you need from MCC, including how you can receive benefits from out-of-network providers if the services are not available in the MCC network
- Receive full information and counseling on the availability of known financial resources for your care
- Know whether a healthcare 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 you will be liable for the cost of the service(s)
  - the cost of the service(s)

  If requested, please 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 your rights in a way that does not adversely affect the way the provider treats you
- Voice complaints or file appeals to the State about MCC or the care it provides. You can call the CCC Plus Helpline at 1-844-374-9159 or TDD 1-800-817-6608 to make a complaint about us.
- Appoint someone to speak for you about your care and treatment and to represent you in an Appeal

- Make advance directives and plans about your care in the instance that you are not able to make your own health care decisions. See Section 17 of this handbook for information about Advance Directives
- Change your CCC Plus health plan once a year for any reason during open enrollment or change your MCO after open enrollment for an approved reason. Reference Section 2 of this handbook or call the CCC Plus Helpline at 1-844-374-9159 or TDD 1-800-817-6608 or visit the website at cccplusva.com for more information
- Appeal any adverse benefit determination (decision) by Molina that you disagree with that relates to coverage or payment of services. See *Your Right to Appeal* in this Section 15 of the handbook
- File a grievance about any concerns you have with our customer service, the services you have received, or the care and treatment you have received from one of our network providers. See *Your Right to File a Grievance* in Section 15 of this handbook
- Receive information about MCC, its services, its practitioners and providers and member rights and responsibilities
- Make recommendations regarding our member rights and responsibility policy, for example by joining our Member Advisory Committee (as described later in this section of the handbook)
- Exercise your rights and to know that you will not have any retaliation against you by MCC, any of our doctors/providers or state agencies

Your Right to be Safe

Everyone has the right to live a safe life in the home or setting of their choice. Each year, many older adults and younger adults who are disabled are victims of mistreatment by family members, by caregivers and by others responsible for their well-being. If you, or someone you know, is being abused, physically, is being neglected, or is being taken advantage of financially by a family member or someone else, you should call your local department of social services or the Virginia Department of Social Services' 24-hour, toll-free hotline at: 1-888 832-3858. You can make this call anonymously; you do not have to provide your name. The call is free.

They can also provide a trained local worker who can assist you and help you get the types of services you need to assure that you are safe.

Your Right to Confidentiality

MCC will only release information if it is specifically permitted by state and federal law or if it is required for use by programs that review medical records to monitor quality of care or to combat fraud or abuse. Information about your behavioral health and substance abuse treatment is kept very safe and is only shared with others when you tell us it is okay to do so. If you would like for us to share this information with your family or other providers, you will need to sign a release form.

MCC staff will ask questions to confirm your identity before we discuss or provide any information regarding your health information.

Your Right to Privacy

We follow all Commonwealth and federal laws and regulations relating to privacy. This includes the Health Insurance Portability and Accountability Act of 1996 (HIPAA). We have rules to protect your health information. This includes oral, written and electronic Protected Health Information (PHI). Information we protect:

- Member name
- Member ID number
- Member address
- Member telephone number
- Social security number
- Date of birth
- Health status
- Names of your doctors

The Notice of Privacy Practices lists your rights under HIPAA. You have the right to see, correct and get copies of your PHI. We can use PHI for health plan activities. This includes paying doctor bills or providing care. We may have to share this information if required by state or federal law.

Your Health Guide will give you an Authorization, Use and Disclosure form and will go over it with you. This form asks if you want to share your information with others involved in your care. This helps to coordinate your health care. Member Services can also give you the form. You can cancel your permission at any time.

How to Join the Member Advisory Committee

MCC would like you to help us improve our health plan. We invite you to join our Member Advisory Committee. On the committee, you can let us know how we can better serve you. Going to these meetings will give you and your caregiver or family member the chance to help plan meetings and meet other members in the community. These educational meetings are held once every three months. If you would like to attend or would like more information, please contact MCC Member Services at 1-800-424-4524 (TTY 711).

We Follow Non-Discrimination Policies

You cannot be treated differently because of your race, color, national origin, disability, age, religion, gender, marital status, pregnancy, childbirth, sexual orientation, or medical conditions.

If you think that you have not been treated fairly for any of these reasons, call the Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800-537-7697. You can also visit www.hhs.gov/ocr for more information.

Molina Complete Care complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Spanish
Molina Complete Care cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

Korean
Molina Complete Care 은(는) 관련 연방 공민권법을 준수하며 인종, 피부색, 출신 국가, 연령, 장애 또는 성별을 이유로 차별하지 않습니다.

Vietnamese
Molina Complete Care tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính.

Chinese
Molina Complete Care 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障 或性別而歧視任何人。

Arabic
يلتزم Molina Complete Care بقوانين الحقوق المدنية الفدرالية المعمول بها ولا يميز على أساس العرق أو اللون أو الأصل الوطني أو السن أو الإعاقة أو الجنس.

Tagalog
Sumusunod ang Molina Complete Care sa mga naaangkop na Pederal na batas sa karapatang sibil at hindi nandidiskrimina batay sa lahi, kulay, bansang pinagmulan, edad, kapansanan o kasarian.

Farsi
Molina Complete Care از قوانین حقوق مدنی فدرال مربوطه تبعیت می کند و هیچگونه تبعیضی بر اساس نژاد، رنگ پوست، اصلیت ملیتی، سن، ناتوانی ای جنسیت افراد قایل نمی شود.

Amharic
ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-424-4524 (መስማት ለተሳናቸው 711).

Urdu
Molina Complete Care قابِل اطلاق وفاقی شہری حقوق کے قوانین کی تعمیل کرتا ہے اور یہ کہ نسل، رنگ ، قومیت، عمر، معذوری ای جنس کی بنیاد پر امتیاز نہیں کرتا۔

French
Molina Complete Care respecte les lois fédérales en vigueur relatives aux droits civiques et ne pratique aucune discrimination basée sur la race, la couleur de peau, l’origine nationale, l’âge, le sexe ou un handicap.

Russian
Molina Complete Care соблюдает применимое федеральное законодательство в области гражданских прав и не допускает дискриминации по признакам расы, цвета кожи, национальной принадлежности, возраста, инвалидности или пола.

Hindi
Molina Complete Care लागू होने योग्य संघीय नागरिक अधिकार कानून का पालन करता है और जाति, रंग, राय मूल, आयु, विकलांगता, या लिंग के आधार पर भेदभाव नहीं करता है।

German
Molina Complete Care erfüllt geltenden bundesstaatliche Menschenrechtsgesetze und lehnt jegliche Diskriminierung aufgrund von Rasse, Hautfarbe, Herkunft, Alter, Behinderung oder Geschlecht ab.

Bengali
Molina Complete Care প্রযোজ্য ফেডারেল নাগরিক অধিকার আইন মেনে চলে এবং জাতি, রঙ, জাতীয় উৎপত্তি, বয়স, অক্ষমতা, বা লিঙ্গের ভিত্তিতে বৈষম্য করে না।

Bassa
Molina Complete Care Nyɔ bɛ̌ɛ̀ kpɔ̃ nyɔ̌ŭn-dyù gbo-gmɔ̀ -gmà bɛ̌ɔ̀ dyi ké wa ní ge nyɔ̌ŭn-dyù mú dyìîn ɖé bóɖó-dù nyɔɔ̀ sɔ̀ kɔ̃ ɛ mú, mɔɔ kà nyɔɔ̀ dyɔɔ̀ -kù nyu nìɛ̀ kɛ mú, mɔɔ bóɖó bé nyɔɔ̀ sɔ̀ kɔ̃ ɛ mú, mɔɔ zɔ̃jĩ̈ kà nyɔɔ̀ ɖă nyuɛ mú, mɔɔ nyɔɔ̀ mɛ kɔ́ dyíɛ mú, mɔɔ nyɔɔ̀ mɛ mɔ̀ gàa, mɔɔ nyɔɔ̀ mɛ mɔ̀ màa kɛɛ mú.

17. Member Responsibilities

Your Responsibilities

As a member, you also have some responsibilities. These include:

- Present your MCC membership card whenever you seek medical care.
- Provide complete and accurate information to the best of your ability on your health and medical history to MCC and its practitioners and providers need in order to provide care
- Report unexpected changes in your health status
- Participate in your care team meetings, develop an understanding of your health problems, and provide input in developing mutually agreed upon treatment goals to the degree possible
- Follow plans and instructions for care that you have agreed to with your practitioners and keep your doctor appointments. If you must cancel, call as soon as you can
- Follow your provider's conduct rules and regulations
- Receive all of your covered services from MCC's network
- Obtain authorization from MCC prior to receiving services that require a service authorization review (see Section 14)
- Call MCC whenever you have a question regarding your membership or if you need assistance toll-free at 1-800-424-4524 (TTY 711)
- Tell MCC when you plan to be out of town so we can help you arrange your services
- Use the emergency room only for real emergencies
- Call your PCP when you need medical care, even if it is after hours
- Tell MCC when you believe there is a need to change your plan of care
- Tell us if you have problems with any healthcare staff. Call Member Services at 1-800-424-4524 (TTY 711)

- Call Member Services at 1-800-424-4524 (TTY 711) about any of the following:
  - If you have any changes to your name, your address, or your phone number. Report these also to your case worker at your local Department of Social Services
  - If you have any changes in any other health insurance coverage, such as from your employer, your spouse's employer, or workers' compensation
  - If you have any liability claims, such as claims from an automobile accident
  - If you are admitted to a nursing facility or hospital
  - If you get care in an out-of-area or out-of-network hospital or emergency room
  - If your caregiver or anyone responsible for you changes
  - If you are part of a clinical research study

Advance Directives

You have the right to say what you want to happen if you are unable to make health care decisions for yourself. There may be a time when you are unable to make health care decisions for yourself. Before that happens to you, you can:

- Fill out a written form to give someone the right to make health care decisions for you if you become unable to make decisions for yourself
- Give your doctors written instructions about how you want them to handle your health care if you become unable to make decisions for yourself

The legal document that you can use to give your directions is called an advance directive. An advance directive goes into effect only if you are unable to make health care decisions for yourself. Any person age 18 or over can complete an advance directive. There are different types of advance directives and different names for them. Examples are a living will, a durable power of attorney for health care, and advance care directive for health care decisions.

You do not have to use an advance directive, but you can if you want to. Here is what to do:

Where to Get the Advance Directives Form

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

You can also get the form from your doctor, a lawyer, a legal services agency, or a social worker. Organizations such as local community agencies, the Area Agencies on Aging, Centers for Independent Living, Virginia Department of Health, health clinics, community service boards, hospitals, and the Virginia county welfare offices may also have advance directive forms. You can also contact Member Services or your assigned Care Coordinator for help in obtaining advance directive information and forms.

Completing the Advance Directives Form

Fill it out and sign the form. The form is a legal document. You may want to consider having a lawyer help you prepare it. There may be free legal resources available to assist you.

Share the Information with People You Want to Know About It

Give copies to people who need to know about it. You should give a copy of the Living Will, Advance Care Directive, or Power of Attorney form to your doctor. You should also give a copy to the person you name as the one to make decisions for you. You may also want to give copies to close friends or family members. Be sure to keep a copy at home.

If you are going to be hospitalized and you have signed an advance directive, take a copy of it to the hospital. The hospital will ask you whether you have signed an advance directive form and whether you have it with you. If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

We Can Help You Get or Understand Advance Directives Documents

Your Care Coordinator can help you understand or get these documents. They do not change your right to quality health care benefits. The only purpose is to let others know what you want if you can't speak for yourself.

Remember, it is your choice to fill out an advance directive or not. You can revoke or change your advance care directive or power of attorney if your wishes about your health care decisions or authorized representative change.

Other Resources

You may also find information about advance directives in Virginia at: www.virginiaadvancedirectives.org.

You can store your advance directive at the Virginia Department of Health Advance Healthcare Directive Registry: https://connectvirginia.org/adr/.

If Your Advance Directives Are Not Followed

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the following organizations.

For complaints about doctors and other providers, contact the Enforcement Division at the Virginia Department of Health Professions:

CALL	Virginia Department of Health Professions: Toll-Free Phone: 1-800-533-1560 Local Phone: 804-367-4691
WRITE	Virginia Department of Health Professions Enforcement Division 9960 Mayland Drive, Suite 300 Henrico, Virginia 23233-1463
FAX	804-527-4424
EMAIL	enfcomplaints@dhp.virginia.gov
WEBSITE	http://www.dhp.virginia.gov/PractitionerResources/Enforcement/

For complaints about nursing facilities, inpatient and outpatient hospitals, abortion facilities, home care organizations, hospice programs, dialysis facilities, clinical laboratories, and health plans (also known as managed care organizations), contact the Office of Licensure and Certification at the Virginia Department of Health:

CALL	Toll-Free Phone: 1-800-955-1819 Local Phone: 804-367-2106
WRITE	Virginia Department of Health Office of Licensure and Certification 9960 Mayland Drive, Suite 401 Henrico, Virginia 23233-1463
FAX	804-527-4503
EMAIL	OLC-Complaints@vdh.virginia.gov
WEBSITE	http://www.vdh.virginia.gov/licensure-and-certification/

18. Fraud, Waste, and Abuse

What is Fraud, Waste, and Abuse

Fraud is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

Waste includes overutilization, underutilization, or misuse of resources. Waste typically is not an intentional act, but does result in spending that should not have occurred. As a result, waste should be reported so that improper payments can be identified and corrected.

Abuse includes practices that are inconsistent with sound fiscal, business, or medical practice, and result in unnecessary cost to the Medicaid program, payment for services that are not medically necessary, or fail to meet professionally recognized health care standards.

Common types of health care fraud, waste, and abuse include:

- Medical identity theft
- Billing for unnecessary items or services
- Billing for items or services not provided
- Billing a code for a more expensive service or procedure than was performed (known as up-coding)
- Charging for services separately that are generally grouped into one rate (Unbundling)
- Items or services not covered
- When one doctor receives a form of payment in return for referring a patient to another doctor. These payments are called “kickbacks”

How Do I Report Fraud, Waste, or Abuse

If you think someone or a provider is committing fraud, waste and abuse, please report it. Our Corporate Compliance hotline is available 24 hours a day, seven days a week. It is handled by an outside company. Callers do not have to give their names. All calls will be looked into. All calls are confidential.

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

If you would prefer to refer your fraud, waste, or abuse concerns directly to the State, you can report to the contacts listed below.

Department of Medical Assistance Services Fraud Hotline

Phone: 1-800-371-0824 or
1-866-486-1971 or
1-804-786-1066

Virginia Medicaid Fraud Control Unit (Office of the Attorney General)

Email: MFCU_mail@oag.state.va.us
Fax: 1-804-786-3509
Mail: Office of the Attorney General
Medicaid Fraud Control Unit
202 North Ninth Street
Richmond, VA 23219

Virginia Office of the State Inspector General Fraud, Waste, and Abuse Hotline

Phone: 1-800-723-1615
Fax: 1-804-371-0165
Email: covhotline@osig.virginia.gov
Mail: State FWA Hotline
101 N. 14th Street
The James Monroe Building 7th Floor
Richmond, VA 23219

You can also contact the U.S. Department of Health & Human Services Office of Inspector General at:

Office of Inspector General
Department of Health & Human Services
Attn: Hotline
P.O. Box 23489
Washington, DC 20026
Phone: 1-800-HHS-TIPS / TTY: 1-800-377-4950
Website: https://oig.hhs.gov/fraud/report-fraud/

You may get a form asking if you received the services your provider was paid to give you. There will be an envelope to use to return your answers. An address will already be written on the envelope. The postage on the envelope will be paid. We will look into it if you tell us that you did not get the services. We will also report it to DMAS.

19. Other Important Resources

Centers for Independent Living
www.vadrs.org/cbs/cils.htm
Centers for Independent Living, often referred to as "CILs," are non-residential places of action and coalition designed and operated by people with disabilities. CILs work with individuals to promote leadership and independence as well as with local communities to remove barriers to independence. In Virginia, most CILs serve a planning district comprising several counties.

Virginia Association of Area Agencies on Aging (V4A)
www.vaaaa.org
V4A's primary mission is to build the capacity of its members to help older persons to live with dignity and choices in their homes and communities for as long as possible, and to enhance elder rights.

Virginia Department for the Deaf and Hard of Hearing (VDDHH)
The Technology Assistance Program (TAP) provides telecommunication equipment to qualified applicants whose disabilities prevent them from using a standard telephone. VDDHH outreach specialists can also provide information and referral for assistive technology devices.

1-804-662-9502 (Voice / TTY)
1-800-552-7917 (Voice / TTY)
1-804-662-9718 (Fax)
1602 Rolling Hills Drive, Suite 203
Richmond, VA 23229-5012
www.vddhh.org

Virginia Department of Health
www.vdh.virginia.gov

20. Information for Medicaid Expansion Members

What Makes You Eligible to be a Medicaid Expansion Member

You are eligible for Medicaid Expansion if you are 19 years of age to 64 years of age and you meet all of the following categories:

- You are not already eligible for Medicare coverage,
- You are not already eligible for Medicaid coverage through a mandatory coverage group (you are pregnant or disabled, for example)
- Your income does not exceed 138% of the Federal Poverty Limit (FPL), and
- You indicated in your application that you have complex medical needs.

Medicaid eligibility is determined by your local Department of Social Services (DSS) or the Cover Virginia Central Processing Unit. Contact your local DSS eligibility worker or call Cover Virginia at 833-5CALLVA (TDD: 1-888-221-1590) about any Medicaid eligibility questions. The call is free. For more information you can visit Cover Virginia at http://www.coverva.org.

Enrollment for a Medicaid Expansion Member

Within three months after you enroll with MCC, a health plan representative will contact you or your authorized representative via telephone, mail or in person to ask you some questions about your health and social needs.

If you do not meet the medically complex criteria, you may transfer from CCC Plus to the Medicaid Managed Care Medallion 4.0 program. If MCC is unable to contact you, or you refuse to participate in the entire health screening, you will be transferred to the Medallion program. You will stay with MCC no matter which program you are in. If you prefer to change health plans, you can change within the first 90 days of enrolling into the Medallion 4.0 program. For more information on the Health Screening, see section 4.

If you do not meet medically complex criteria and do not agree, you have a right to submit a grievance to MCC. See the *Your Right to File a Grievance* section for details.

You can change your health plan during the first 90 days of your CCC Plus program enrollment for any reason. You can also change your health plan once a year during open enrollment for any reason. Open enrollment occurs each year between November 1st and December 31st. You will get a letter from DMAS during open enrollment with more information.

You may also ask to change your health plan at any time for "good cause," which can include:

- You move out of the health plan's service area,
- You need multiple services provided at the same time but cannot access them within the health plan's network,
- Your residency or employment would be disrupted as a result of your residential, institutional, or employment supports provider changing from an in-network to an out-of-network provider, and
- Other reasons determined by DMAS, including poor quality of care and lack of access to appropriate providers, services, and supports, including specialty care.
- You do not meet medically complex criteria and transfer to the Medallion 4.0 Medicaid Managed Care program

The CCC Plus Helpline handles "good cause" requests and can answer any questions you may have. Contact the CCC Plus Helpline at 1-844-374-9159 or TDD 1-800-817-6608, or visit the website at cccplusva.com.

Medicaid Expansion Benefits and Services

As a Medicaid expansion member, you have a variety of health care benefits and services available to you. You will receive most of your services through MCC, but may receive some through DMAS or a DMAS Contractor.

- Services provided through MCC are described in the Commonwealth Coordinated Care Plus Program Member Handbook, Section 10.
- Services covered by DMAS or a DMAS Contractor are described in the Commonwealth Coordinated Care Plus Program Member Handbook, Section 11.
- Services that are not covered through MCC or DMAS are described in the Commonwealth Coordinated Care Plus Program Member Handbook, Section 12.

If you are an eligible Medicaid expansion member, in addition to the services listed above (in the same amount, duration, and scope of services as other CCC Plus Program members) you will also receive the following four additional health benefits:

- Annual adult wellness exams
- Nutritional counseling if you are diagnosed with obesity or chronic medical diseases
- Recommended adult vaccines or immunizations

MCC will also encourage you to take an active role in your health. For example, you could get up to $50 in gift cards each year when you do things that help your health, like quitting smoking, getting annual physicals or going to regular doctor visits if you are pregnant.

If you frequently visit the emergency room, MCC will reach out to you to help you address your needs. There may be opportunities to address your needs outside of the emergency room, like in physician offices and clinics.

MCC may also discuss with you several opportunities to take advantage of job training, education and job placement assistance to help you find the work situation that is right for you.

21. Important Words and Definitions Used in this Handbook

Adverse benefit determination: Any decision to deny a service authorization request or to approve it for an amount that is less than requested.

Appeal: A way for you to challenge an adverse benefit determination (such as a denial or reduction of benefits) made by MCC if you think we made a mistake. You can ask us to change a coverage decision by filing an appeal.

Activities of daily living: The things people do on a normal day, such as eating, using the toilet, getting dressed, bathing, or brushing the teeth.

Balance billing: A situation when a provider (such as a doctor or hospital) bills a person more than MCC's cost-sharing amount for services. We do not allow providers to "balance bill" you. Call Member Services if you get any bills that you do not understand.

Brand name drug: A prescription drug that is made and sold by the company that originally made the drug. Brand name drugs have the same ingredients as the generic versions of the drugs. Generic drugs are made and sold by other drug companies.

Care Coordinator: One main person from our MCC who works with you and with your care providers to make sure you get the care you need.

Care coordination: A person-centered individualized process that assists you in gaining access to needed services. The Care Coordinator will work with you, your family members, if appropriate, your providers and anyone else involved in your care to help you get the services and supports that you need.

Care plan: A plan for what health and support services you will get and how you will get them.

Care team: A care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need. Your care team will also help you make a care plan.

CCC Plus Helpline: an Enrollment Broker that DMAS contracts with to perform choice counseling and enrollment activities.

Centers for Medicare & Medicaid Services (CMS): The federal agency in charge of Medicare and Medicaid programs.

Coinsurance: See the definition for cost sharing.

Copayment: See the definition for cost sharing.

Cost sharing: the costs that members may have to pay out of pocket for covered services. This term generally includes deductibles, coinsurance, and copayments, or similar charges. Also see the definition for patient pay.

Coverage decision: A decision about what benefits we cover. This includes decisions about covered drugs and services or the amount we will pay for your health services.

Covered drugs: The term we use to mean all of the prescription drugs covered by MCC.

Covered services: The general term we use to mean all of the health care, long-term services and supports, supplies, prescription and over-the-counter drugs, equipment, and other services covered by MCC.

Durable medical equipment: Certain items your doctor orders for you to use at home. Examples are walkers, wheelchairs, or hospital beds.

Emergency medical condition: An emergency means your life could be threatened or you could be hurt permanently (disabled) if you don't get care quickly. If you are pregnant, it could mean harm to the health of you or your unborn baby.

Emergency medical transportation: Your condition is such that you are unable to go to the hospital by any other means but by calling 911 for an ambulance.

Emergency room care: A hospital room staffed and equipped for the treatment of people that require immediate medical care and/or services.

Emergency services: Services provided in an emergency room by a provider trained to treat a medical or behavioral health emergency.

Excluded services: Services that are not covered under the Medicaid benefit.

Fair hearing: See State Fair Hearing. The process where you appeal to the State on a decision made by us that you believe is wrong.

Fee-for-service: The general term used to describe Medicaid services covered by the Department of Medical Assistance Services (DMAS).

Generic drug: A prescription drug that is approved by the federal government to use in place of a brand name drug. A generic drug has the same ingredients as a brand name drug. It is usually cheaper and works just as well as the brand name drug.

Grievance: A complaint you make about us or one of our network providers or pharmacies. This includes a complaint about the quality of your care.

Habilitation services and devices: Services and devices that help you keep, learn, or improve skills and functioning for daily living.

Health insurance: Type of insurance coverage that pays for health, medical and surgical expenses incurred by you.

Health plan: An organization made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has Care Coordinators to help you manage all your providers and services. They all work together to provide the care you need.

Health risk assessment: A review of a patient's medical history and current condition. It is used to figure out the patient's health and how it might change in the future.

Home health aide: A person who provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care (like bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

Home health care: Health care services a person receives in the home including nursing care, home health aide services and other services.

Hospice services: A program of care and support to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has a terminal illness and is expected to have six months or less to live. An enrollee who has a terminal prognosis has the right to elect hospice. A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.

Hospitalization: The act of placing a person in a hospital as a patient.

Hospital outpatient care: Care or treatment that does not require an overnight stay in a hospital.

List of Covered Drugs (Drug List): A list of prescription drugs covered by MCC. MCC chooses the drugs on this list with the help of doctors and pharmacists. The Drug List tells you if there are any rules you need to follow to get your drugs. The Drug List is sometimes called a "formulary."

Long-term services and supports (LTSS): A variety of services and supports that help elderly individuals and individuals with disabilities meet their daily needs for assistance, improve the quality of their lives, and maintain maximum independence. Examples include assistance with bathing, dressing, toileting, eating, and other basic activities of daily life and self-care, as well as support for everyday tasks such as laundry, shopping, and transportation. LTSS are provided over a long period of time, usually in homes and communities, but also in facility-based settings such as nursing facilities. Most of these services help you stay in your home so you don't have to go to a nursing facility or hospital.

Medically Necessary: This describes the needed services to prevent, diagnose, or treat your medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice or as necessary under current Virginia Medicaid coverage rules.

Medicaid (or Medical Assistance): A program run by the federal and the state government that helps people with limited incomes and resources pay for long-term services and supports and medical costs. It covers extra services and drugs not covered by Medicare. Most health care costs are covered if you qualify for both Medicare and Medicaid.

Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare or a managed care plan (see "Health plan").

Medicare-covered services: Services covered by Medicare Part A and Part B. All Medicare health plans must cover all of the services that are covered by Medicare Part A and Part B.

Medicare-Medicaid enrollee: A person who qualifies for Medicare and Medicaid coverage. A Medicare-Medicaid enrollee is also called a "dual eligible beneficiary."

Medicare Part A: The Medicare program that covers most medically necessary hospital, skilled nursing facility, home health, and hospice care.

Medicare Part B: The Medicare program that covers services (like lab tests, surgeries, and doctor visits) and supplies (like wheelchairs and walkers) that are medically necessary to treat a disease or condition. Medicare Part B also covers many preventive and screening services.

Medicare Part C: The Medicare program that lets private health insurance companies provide Medicare benefits through a Medicare Advantage Plan.

Medicare Part D: The Medicare prescription drug benefit program. (We call this program "Part D" for short.) Part D covers outpatient prescription drugs, vaccines, and some supplies not covered by Medicare Part A or Part B or Medicaid.

Member Services: A department within MCC is responsible for answering your questions about your membership, benefits, grievances, and appeals.

Model of care: A way of providing high-quality care. The CCC Plus model of care includes care coordination and a team of qualified providers working together with you to improve your health and quality of life.

Network: "Provider" is the general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that provide your health care services, medical equipment, and long-term services and supports. They are licensed or certified by Medicaid and by the state to provide health care services. We call them "network providers" when they agree to work with MCC and accept our payment and not charge our members an extra amount. While you are a member of MCC, you must use network providers to get covered services. Network providers are also called "plan providers."

Network pharmacy: A pharmacy (drug store) that has agreed to fill prescriptions for MCC members. We call them "network pharmacies" because they have agreed to work with MCC. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Non-participating provider: A provider or facility that is not employed, owned, or operated by MCC and is not under contract to provide covered services to members of MCC.

Nursing facility: A medical care facility that provides care for people who cannot get their care at home but who do not need to be in the hospital. Specific criteria must be met to live in a nursing facility.

Ombudsman: An office in your state that helps you if you are having problems with MCC or with your services. The ombudsman's services are free.

Out-of-network provider or Out-of-network facility: A provider or facility that is not employed, owned, or operated by MCC and is not under contract to provide covered services to members of MCC.

Participating provider: Providers, hospitals, home health agencies, clinics, and other places that provide your health care services, medical equipment, and long-term services and supports that are contracted with MCC. Participating providers are also "in-network providers" or "plan providers."

Patient Pay: The amount you may have to pay for long term care services based on your income. The Department of Social Services (DSS) must calculate your patient pay amount if you live in a nursing facility or receive CCC Plus Waiver services and have an obligation to pay a portion of your care. DSS will notify you and MCC if you have a patient pay, including the patient pay amount (if any).

Physician services: Care provided to you by an individual licensed under state law to practice medicine, surgery, or behavioral health.

Plan: An organization made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has Care Coordinators to help you manage all your providers and services. They all work together to provide the care you need.

Prescription drug coverage: Prescription drugs or medications covered (paid) by your MCC. Some over-the -counter medications are covered.

Prescription drugs: A drug or medication that, by law, can be obtained only by means of a physician's prescription.

Primary Care Physician (PCP): Your primary care physician (also referred to as your primary care provider) is the doctor who takes care of all of your health needs. They are responsible to provide, arrange, and coordinate all aspects of your health care. Often they are the first person you should contact if you need health care. Your PCP is typically a family practitioner, internist, or pediatrician. Having a PCP helps make sure the right medical care is available when you need it.

Prosthetics and Orthotics: These are medical devices ordered by your doctor or other health care provider. Covered items include, but are not limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function.

Provider: A person who is authorized to provide your health care or services. Many kinds of providers participate with MCC, including doctors, nurses, behavioral health providers and specialists.

Premium: A monthly payment a health plan receives to provide you with health care coverage.

Private duty nursing services: skilled in-home nursing services provided by a licensed RN, or by an LPN under the supervision of an RN, to waiver members who have serious medical conditions or complex health care needs.

Referral: In most cases you PCP must give you approval before you can use other providers in MCC's network. This is called a referral.

Rehabilitation services and devices: Treatment you get to help you recover from an illness, accident, injury, or major operation.

Service area: A geographic area where MCC is allowed to operate. It is also generally the area where you can get routine (non-emergency) services.

Service authorization: Also known as preauthorization. Approval needed before you can get certain services or drugs. Some network medical services are covered only if your doctor or other network provider gets an authorization from MCC.

Skilled nursing care: care or treatment that can only be done by licensed nurses. Examples of skilled nursing needs include complex wound dressings, rehabilitation, tube feedings or rapidly changing health status.

Skilled Nursing Facility (SNF): A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

Specialist: A doctor who provides health care for a specific disease, disability, or part of the body.

Urgently needed care (urgent care): Care you get for a non-life threatening sudden illness, injury, or condition that is not an emergency but needs care right away. You can get urgently needed care from out-of-network providers when network providers are unavailable or you cannot get to them.

MCC Member Services

CALL:	1-800-424-4524. This call is free. Our office hours are Monday through Friday from 8 a.m. to 8 p.m. Our nurses can be reached 24 hours a day, seven days a week. They can answer your health care questions. They can help with your long-term services and support needs. We have free interpreter services for people who do not speak English and 711 for people who have hearing or speaking problem 24 hours a day, seven days a week.
TTY:	711. This call is free and available 24 hours a day, 7 days a week. This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
WRITE:	Molina Complete Care 3829 Gaskins Rd Richmond, VA 23233-1437
EMAIL:	MCCVA@molinahealthcare.com
WEBSITE:	www.MCCofVA.com

Molina Complete Care

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