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https://dmas.virginia.gov

MEDICAID BULLETIN

Last Updated: 12/06/2023

Annual Service Plan Contractor for Fee-For-Service Individuals on the CCC Plus Waiver Effective 1/1/2024

This is to inform CCC Plus Waiver Fee-For-Service (FFS) providers of a change in the process for annual level of care reviews and service plan development effective January 1, 2024 and an important deadline FFS providers have to submit LOCERI reviews of CCC Plus Waiver FFS individuals.

The Centers for Medicare and Medicaid Services (CMS) requires that an individual receiving Home and Community-Based Services (HCBS) through a 1915(c) waiver have an annual person-centered service plan as well as an annual review of the individual's level of care. These requirements are to ensure that the individual still meets the necessary criteria for the waiver and that the service plan addresses the individual's person-centered needs, preferences, and goals and identifies all services and providers the individual is using to meet those identified needs. Previously, for FFS individuals on the CCC Plus Waiver, DMAS required FFS providers to conduct the annual level of care review (LOCERI) and to use the provider-developed plan of care, which identifies the tasks performed in a service, as the individual's annual service plan.

As part of the CCC Plus Waiver's five-year renewal, CMS determined that the development of the annual service plan by the provider constitutes a conflict of interest as DMAS must ensure that members have a choice when picking services and providers. CMS has identified this conflict of interest for the FFS population only. This conflict of interest does not apply to CCC Plus Waiver individuals under managed care because the care manager develops the overall service plan. DMAS is now required to change the service plan development process for CCC Plus Waiver FFS members.

Effective January 1, 2024, Acentra Health (formerly KePRO), the FFS service authorization contractor, will conduct annual level of care reviews and develop the annual service plan, using a modified version of the DMAS-99, for FFS members enrolled in the CCC Plus Waiver. Providers will no longer be responsible for conducting the LOCERI reviews due January 1, 2024 or later. Fee-for-service CCC Plus Waiver individuals who are due for LOCERI by December 31, 2023 must still have their provider conduct the review. Providers will still be required to complete the appropriate Plan of Care and submit it to Acentra Health for service authorization as they currently do. Acentra Health's service authorization unit will use the Individualized Service Plan developed by the LOCERI unit in collaboration with the provider's Plan of Care to determine service authorization approval.

Acentra Health will contact members by phone to schedule the face-to-face visit to conduct

the level of care review and develop the person-centered service approximately sixty days prior to the LOCERI due date. If the Acentra Health care manager is not able to reach the member, they may contact the waiver provider for assistance in scheduling the visit.

What Providers Can Do to Assist

Acentra Health will notify current FFS CCC Plus Waiver members of this change. Providers should inform affected members that this annual visit is required for all FFS CCC Plus Waiver individuals and encourage them to respond to Acentra Health's request to schedule a face-to-face visit in a timely fashion.

Providers should NOT schedule any LOCERI assessments for their FFS CCC Plus Waiver individuals who have a LOCERI due date of 1/1/2024 or after. Providers are responsible to complete all LOCERI reviews for waiver members who have a LOCERI due date prior to 1/1/2024. ***DMAS strongly encourages providers to complete and submit all LOCERIs, including those past due, by 12/25/2023***. Provider access to the LOCERI system will be removed 3/31/2024.

PROVIDER CONTACT INFORMATION & RESOURCES

Virginia Medicaid Web Portal **Automated Response System (ARS)** Member eligibility, claims status, payment status, service limits, service authorization status, and remittance advice.	https://vamedicaid.dmas.virginia.gov/
Medicall (Audio Response System) Member eligibility, claims status, payment status, service limits, service authorization status, and remittance advice.	1-800-884-9730 or 1-800-772-9996
Acentra Health Service authorization information for fee-for-service members.	https://dmas.kepro.com/
Provider Appeals DMAS launched an appeals portal in 2021. You can use this portal to file appeals and track the status of your appeals. Visit the website listed for appeal resources and to register for the portal.	https://www.dmas.virginia.gov/appeals/

Managed Care Programs

Cardinal Care Managed Care and Program of All-Inclusive Care for the Elderly (PACE). In order to be reimbursed for services provided to a managed care enrolled individual, providers must follow their respective contract with the managed care plan/PACE provider. The managed care plan may utilize different guidelines than those described for Medicaid fee-for-service individuals.

Cardinal Care Managed Care	https://www.dmas.virginia.gov/for-providers/managed-care/cardinal-care-managed-care/
PACE	http://www.dmas.virginia.gov/#/longtermprograms
Acentra Health Behavioral Health Services	https://dmas.kepro.com/
Provider Enrollment	In-State: 804-270-5105 Out of State Toll Free: 888-829-5373 Email: VAMedicaidProviderEnrollment@gainwelltechnologies.com
Provider HELPLINE Monday–Friday 8:00 a.m.-5:00 p.m. For provider use only, have Medicaid Provider ID Number available.	1-804-786-6273 1-800-552-8627
Aetna Better Health of Virginia	https://www.aetnabetterhealth.com/virginia/providers/index.html 1-800-279-1878
Anthem HealthKeepers Plus	http://www.anthem.com/ 1-800-901-0020
Molina Complete Care	1-800-424-4524 https://www.molinahealthcare.com/providers/va/medicaid/home.aspx
Sentara Family Care	1-800-643-2273
Optima Health United Healthcare	Optima Health 1-844-512-3172 www.uhcprovider.com/ 1-844-284-0149
Dental Provider DentaQuest	1-888-912-3456