Frequently Asked Questions
For Service Facilitators participating in CCC Plus

Question	Answer
What is CCC Plus?	CCC Plus is a new Medicaid program that provides medical, behavioral, substance use disorder, and long term services and supports all under one program. CCC Plus is a statewide program that is being phased in by region. It began in the Tidewater region on August 1, 2017. If an individual is also enrolled in Medicare, their enrollment into CCC Plus does not impact their Medicare coverage.
Will CCC demonstration participants transition to CCC Plus with their current CCC demonstration health plan?	Participants in the CCC demonstration who are enrolled in Virginia Premier or Anthem will automatically be assigned to those same health plans for CCC Plus effective January 1, 2018.
How is the transition of authorizations going to happen between Kepro and the CCC Plus provider? Do we make a new request when the 90 days is up?	Prior to the effective date of CCC Plus enrollment, each health plan will receive a file with all service authorizations for the members assigned to them and they will generate authorizations for the Care Coordinators. The authorizations can last up to 90 days or until the end date, whichever comes first. Care Coordinators can work with the members to extend authorizations when appropriate.
When and how will the Service Facilitator be given notice as to which health plan their client(s) has chosen?	Monthly eligibility checks will clearly identify individuals enrolled and which health plan they are with. This will be available for provider viewing within the DMAS Medicaid portal after the 20th of each month.
Will public partnerships (PPL) continue to be the fiscal agent for consumer directed waiver services?	PPL will continue to be the fiscal agent. Nothing will change with PPL.
How can I find out who my client's Care Coordinator is?	To find out who your client's Care Coordinator is, call the CCC Plus health plan your client is enrolled in. The phone number is on the back of your client's health plan ID card. You may also ask your client as they will have received contact information in the mail identifying their Care Coordinator.
Now that the EDCD and Tech waivers are combined into the CCC Plus waiver, how much respite care services will be allowed since EDCD has 480 hours and Tech has 360 hours?	Starting July 1, 2017, those individuals in the Tech waiver will have service authorizations increased to 480 allowable hours for existing authorizations. Hours are set for per SFY (State Fiscal Year) from July 1 to June 30. Health plans may set different time frames.

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We will be submitting our authorization request for Consumer Direction (CD), Personal Care Attendant (PCA) and Respite Care hours to each of the health plans. When they authorize the hours, are they sending that authorization to PPL? Or do we have to also do a Kepro authorization request?	The health plan will automatically send service authorizations (SAs) to PPL. Once the member is in CCC Plus, you will not send any SAs to Kepro.
Under the CCC Plus waiver, will individuals be eligible for more than the Medicaid level of nursing hours (currently it is 16 hours/day max)?	Existing rules and regulations will still apply.
For individuals on the CCC Plus waiver, will they be able to access Assistive Technology (AT) and Environmental Modifications (EM)?	Yes, Assistive Technology and Environmental Modifications are included in the new CCC Plus waiver. The service authorizations will be issued by the CCC Plus health plan.
How do we find providers of Environmental Modifications (EM) and Assistive Technology (AT) for individuals on the CCC Plus waiver?	You should work with the individual's Care Coordinator. The Coordinator will have a list of all currently enrolled AT and EM providers.
Regarding Environmental Modifications and Assistive Technology services, how will providers submit quotes?	For CCC Plus members, EM and AT requests will be submitted to the individual's CCC Plus health plan. Check with each health plan for information on their process. For the CCC Plus Waiver fee-for-service individuals, SFs will use the Technology Assisted Waiver Provider Manual for guidance on EM and AT requests.
Who do we call if prescription drugs are not covered?	All of the health plans are using a common formulary. If the individual has Medicare they need to call their part D coverage. If they have CCC Plus, they can contact their health plan or Care Coordinator.
Magellan has been the provider for behavioral health services. Will they continue in this role? Will the other plans manage and cover these services like Applied Behavioral Analysis (ABA)?	The Magellan health plan participating in CCC Plus is different than the Behavioral Health Services administrator. Services under the administrator will continue until December 31, 2017. Starting January 1, 2018, the health plan will be responsible for Community Health Rehabilitation Services (CHRS).
How is this CCC Plus program change going to affect the audit process for Service Facilitators?	Audits for all providers are going to be performed through the health plan.

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Do you foresee a point at which the Care Coordinator will replace the Service Facilitator?	No, they have different roles and job responsibilities.
Plans and revisions have been the role of Service Facilitators. Would you clarify the roles of Care Coordinators versus Service Facilitators?	Service facilitators should work collaboratively with the Member's Care Coordinator to mitigate any duplication of services offered and to ensure that the member receives the care and services that they need in a timely manner.
As a Services Facilitator for the EDCD waiver, what do I need to know in order to facilitate services for these individuals who will now be in the CCC Plus Waiver?	There will be a health plan Care Coordinator assigned for each individual. Service Facilitators (SFs) should work with the Care Coordinators within the first 90 days of the enrollment. It is important that all SFs enroll with each of the six health plans in order to continue providing services to their Medicaid clients.
I am a SF. How do I enroll as a provider with the health plans? How do I bill the health plans?	To enroll as a SF provider, contact each health plan to find out the process for enrollment and credentialing and how to bill.
What happens to individuals currently enrolled in the CCC demonstration program with Humana?	They will remain with Humana until January 1, 2018. The CCC Demonstration participants will transition at that time and be assigned a new CCC Plus health plan.
For individuals who are dually enrolled in Medicaid and Medicare, can they have two different health plans (one for Medicare and one for Medicaid)?	Yes, "dually eligible" (which means the member is eligible for both Medicare and Medicaid) are allowed to work with two different health plans if they choose, or they can choose the same health plan for both. There is no requirement to have the same health plan for both. It is up to the member to make the decision that best meets their needs.
As a Services Facilitator, will I need to "re-enroll" the individuals I provide services to in consumer-directed waiver services under CCC Plus within the 90 day continuity of care period or somehow assign myself as their Services Facilitator once they are under CCC Plus?	No, you will not need to do anything if you remain the member's SF. Your information will be retained in the system.
If an individual is undergoing dialysis, will he/she be enrolled into CCC Plus? I have heard that those with End Stage Renal Disease (ESRD) are excluded.	When the CCC Plus program began on August 1, 2017, those individuals with ESRD were excluded from participation. However, that policy is now changed. If an individual with ESRD wishes to enroll in a CCC Plus

Question	Answer
	health plan, he/she may do so. It is not required but they now have the option of enrolling.
What is a D-SNP and where can I get more information?	A Dual Eligible Special Needs Plan, also known as a D-SNP, is an option for individuals who are qualified for both Medicare and Medicaid. An individual who has both Medicare and Medicaid has the opportunity to choose the same health plan, a D-SNP plan, to be both their Medicare plan and their Medicaid plan. Being in the same plan is beneficial for coordination of care. Individuals who are interested in enrolling in a D-SNP can call Medicare directly at 1-800-633-4227.
If an individual is in hospice and his/her hospice services are paid for by a non-Medicaid source such as Tricare or private health insurance, how should he/she choose a CCC Plus health plan?	Hospice is a Medicare and Medicaid benefit, therefore, any portion not covered by Medicare or primary insurance, will be forwarded to Medicaid for remaining reimbursement. Individuals currently enrolled in hospice are excluded from the CCC Plus program. For those who enroll in CCC Plus, and then it is later determined they need hospice, then the CCC Plus health plan will provide for the service. Regardless of payer source, the Medicaid member may choose the CCC Plus health plan that best meets their needs.
Care Coordinators are beginning to do their required assessments. In some situations, the Care Coordinators are determining that the personal care hours needed for an individual are being reduced from what that individual has used for years. The Care Coordinator's assessment may be different from the services facilitator's or personal care agency's assessment. What happens to the DMAS-97AB plan of care and services that are needed?	During the 90 day continuity of care period, the health plans cannot reduce current member services. The care planning team will meet to discuss changes in the member's condition or situation and will include the member, SF or agency staff in this meeting. At that time, services and hours may be adjusted. Members who disagree with action taken always have the right to an appeal with the health plan to address their concerns. The DMAS-97 AB plan of care form will remain the same until future revisions take place.
When the health care plan intends to reduce service hours, how much notice will the individual and facilitator be given so that necessary life adjustments can be made? This has a very significant impact on the PPL payroll process.	Providers must allow at least a 10 day notice to members, at a minimum, when reducing services. If the member disagrees with the reduction of services, the member may request a client appeal with the health plan. Upon the member's appeal request, their services may remain as is until the appeal hearing takes place. The provider cannot make changes until the health care assessment is completed.

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I will not be a CCC Plus provider. Do the CCC Plus health plans have a list of Service Facilitators who are ready, willing and able to pick up the clients I will be losing? If so, how will those providers be communicated to the client?	During the continuity of care period of 90 days, the Care Coordinators will be working with the members to help them locate their providers, including a new SF provider, within their health plan network.
When an individual is on a waiver and also enrolled in CCC Plus, will all respite care authorizations end on June 30th of each year? Will respite care be authorized for members for more than 1 year?	Each CCC Plus health plan has different authorization periods for respite care. Please contact the health plan for further information. Respite authorizations will have different end dates.
Once a member is enrolled into a CCC Plus health plan and we complete the level of care assessment (LOC) for the first month, do we submit that to the health plan or to DMAS or both?	The FFS provider will complete the Annual LOC for the initial roll-out month of the member's participation in the health plan. This action will include the submission into the LOC portal. For the second month of enrollment and thereafter, the Health Plan must do the Annual LOC and handle submission into the portal.
Once the individual is placed in the CCC Plus Program, when do the DMAS-97 and the DMAS-99 forms need to be faxed in to the CCC Plus health plan?	Fax both forms with the new service authorization request for the time period after the continuity of care period. The SF may also inquire further with the member's health plan Care Coordinator.
Are all 6 health plans going to do Quality Management Review (QMR) each year and will it be shared with DMAS to avoid duplication of audits?	All six health plans will conduct their own QMR audits of provider services. There will be coordination with DMAS so as not to duplicate other audits being conducted.
For health plans that use *Availity*, who do we contact if we have questions about the submission of claims?	*Availity*, a clearinghouse for the submission of claims, is utilized by some health plans. If you have questions, contact each health plan that uses *Availity* for information
If someone is enrolled in the CCC Plus program and then they enroll in HIPP or HIPP for Kids, will they be removed from the CCC Plus program? If they have HIPP or HIPP for Kids now and then decide to end the program, will they be enrolled in CCC Plus at that time?	HIPP is an excluded population so if an individual enrolls in HIPP or HIPP for Kids, then he or she would no longer be eligible for the CCC Plus program. Once an individual is no longer in HIPP or HIPP for Kids, then he/she would be enrolled, if eligible, into CCC Plus.

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How often will DMAS's Medicaid web portal be updated for Medicaid eligibility?	Updates for member eligibility can be checked on the 1st and on the 18th of each month.
If a child has a nurse through EPSDT for school and it's not currently on their IEP (Individualized Education Plan) will they still have access to that nurse at the beginning of the school year?	If a child needs the services of a nurse during school hours and already receives this service, it will be continued. If the child is already enrolled in CCC Plus, then a request needs to be sent to the CCC Plus health plan to be reviewed for medical necessity.
There is a lot in the news about funding being reduced by the federal government and some insurance companies withdrawing from the Insurance Exchanges. Will this impact CCC Plus?	DMAS is aware and are monitoring what is happening at the federal level. When an insurance company decides to withdraw from the State Insurance Exchange, it has no impact on CCC Plus. CCC Plus health plans are contracted through a separate process.