Frequently Asked Questions
For Home Health/Personal Care/ PDN/Respite/Hospice Providers of 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.
How is EPSDT going to be handled for carved out services?	For any services that are listed as carved out services, continue to contact the entity that handles the review of these services. For example, for DD Waiver Services, contact DBHDS. If the service is not carved out, the health plans will be covering these services (such as their medical care, private duty nursing, personal care).
Will the providers each have their own standards for prior approval of Durable Medical Equipment (DME) or will all health plans have the same requirements?	The health plans are required to cover DME within at least equal amount, duration, and scope as DMAS. They may use alternate criteria, and have different service authorization (SA) requirements; however, the health plan criteria cannot have more restrictive benefit limits than DMAS. For example, they can have an authorization limit than differs from the SA limit in the DMAS Appendix B of the DME Provider Manual, but they cannot set a maximum coverage limit that differs from the Medicaid benefit maximum.
If an authorization is received for one health plan but the member moves to another health plan, who covers the service? The health plan that approved the authorization or the health plan at the date of service?	When a member changes health plans, authorizations will be honored by the new health plan. The plan that the member is enrolled in on the date of service will pay for the service rendered. The exception is hospital services when there is a Diagnosis Related Group (DRG) payment. The plan that initiated the approval will pay the entire DRG from admission to discharge. One additional exception is for customized DME that must be specially ordered and is authorized by the plan; per the CCC Plus Contract, Attachment 5 – CCC Plus Coverage Chart; Part 1 - Medical Equipment and Supplies.

Question	Answer
How often can CCC Plus members change plans?	Members have up to 90 days from the effective date of their enrollment to change to another health plan for any reason. Members are also permitted to change at any time if good-cause exists, with approval by DMAS. (Health plan assignment changes do not happen mid-month.) Members can also change annually during open enrollment without cause. The first open enrollment period begins in 2018, from October – December with a January 1, 2019 effective date. This time period corresponds with the Medicare Open Enrollment period. CCC Plus enrollment is handled by the CCC Plus Helpline. Members who want to change health plans can do so by calling the CCC Plus Helpline at 1-844-374-9159 or online at: https://cccplusva.com/.
How long will a current authorization from Medicaid be valid after the rollout? Will it be honored for 90 days?	An authorization for an individual enrolled into a CCC Plus health plan is honored up to 90 days from the effective date of enrollment or until the end of the existing service authorization, whichever comes first.
When will our client be notified of what plan that they are enrolled in?	Letters with assignments will be mailed to the members around the 23rd of each month, following the health plan assignment run on the 18th of each month. Enrollment is effective the first of the next month following assignment, which is about 30-45 days from the day they receive the initial assignment letter.
Am I correct in that each person's letter will have them assigned to a health plan but the letter will also list other options?	Correct. The letter explains that the member has a choice of health plans and includes a comparison chart of the health plans available, including the extra benefits that each health plan offers. The letter explains that if the member does not select a plan, they will be assigned to the plan named in the letter. The letter also provides information on how to contact the CCC Plus Helpline by phone or on line to make a health plan change. Members can also look on the CCC Plus website to see in which health plans their providers participate. The CCC Plus Helpline website is https://cccplusva.com/
Will all members have their card information prior to the start date?	It is a requirement that the health plans mail ID cards to members in time for the members to receive their ID card prior to the first day of their enrollment with the plan. If a member does not receive their ID card, they should contact their health plan to report this in the event that the card is lost/stolen and also to obtain any assistance with access to needed care needs.

Question	Answer
If a member chooses to switch to a new health plan before the 18th of the month, when does the health plan they have selected receive the member's information from the state? We have many members switching plans. The system is already showing their newly selected plan, but the health plans say they have not received any information. Is there a number or email we can call to expedite the transfer of the members information to the newly selected plan?	If an individual switches health plans before the 18th of the month, then the change will be effective the 1st of the upcoming month. If the member calls after the 18th their selection will not be effective until the next month. This information is sent to the health plans four times a month. If the VA Medicaid Web Portal or the Medicall automated voice response systems are showing the CCC Plus enrollment with the health plan, the health plan will have already received the enrollment information from the State. The State also sends Medical Transition data to the health plans 4 times per month. You can send any specific questions that you have to cccplus@dmas.virginia.gov and a member of the DMAS team will research and respond to your question/concern.
We have at this time been unable to obtain authorizations for several of the new health plans that we have contracted with. What expectation does DMAS have for providers to deliver products and supplies to patients when the health plan does not provide authorization?	If the authorization is in place prior to the individual being enrolled into CCC Plus, the health plan is responsible for coverage for up to 90 days or the end of the authorization. If it is a new authorization, the member or provider should reach out to the assigned Care Coordinator with the health plan. If unable to resolve, contact DMAS through email at cccplus@dmas.virginia.gov .
Who is responsible to reimburse for hospice services when an individual is in CCC Plus?	If the member has Medicare, Medicare will reimburse as the primary payer and the CCC Plus health plan will reimburse as the secondary payer. Medicare services will not change. If the individual is receiving hospice through Medicare, then continue to bill Medicare the way you do today. For Medicaid members, the health plan will pay any deductibles and coinsurance up to the Medicaid allowable rate. The nursing facility room and board charges should be billed to the health plan to pay the Medicaid portion.

Frequently Asked Questions
For Home Health/Personal Care/ PDN/Respite/Hospice Providers of CCC Plus

Question	Answer
Do members with HIPP ever enroll into the CCC Plus program or they permanently excluded?	Currently, CCC Plus excludes individuals who are enrolled in HIPP.
Is it true that everyone on the CCC Plus Waiver is now able to receive Assistive Technology (AT) funding of $5,000?	There is currently a benefit of $5000 available for each service, (Assistive Technology and Environmental Modification services) per fiscal year for all individuals enrolled in the CCC Plus Waiver only. For children, any service needed past the $5000 limit should be requested through the health plan for EPSDT review.
When will the information for billing be provided to the home care agencies?	A list of charts specific to different provider types is listed here: https://www.dmas-devbo.dmas.virginia.gov/for-providers/managed-care/ccc-plus/provider-resources/
Will we get a list of Care Coordinators for our clients? How will we know where to send a completed UAI/EDCD waiver screening? Should we continue to send the UAI to the provider and the Care Coordinator?	The PC and respite chart provided on the DMAS website can be used as a resource to answers some of these types of questions. Copies of the UAI should be sent to the health plans. A health plan directory is also available on the DMAS website that has contact information to find out who the Care Coordinator is for a particular member. Medicaid Memo 8/17/17 provides instructions to screening teams for where to send UAI and other screening information for CCC Plus members.
How do you identify a member who has PACE?	The eligibility indicator for PACE in the Virginia Medicaid Web Portal is (PP)
If a patient elects hospice after enrolling into CCC Plus and resides in a nursing facility, who is responsible for billing the room and board to the CCC Plus plan?	This is the same process as fee-for-service. If the member has Medicare, continue to bill Medicare as you do now. Bill the health plan following the process outlined in the chart posted on the DMAS website at: https://www.dmas-devbo.dmas.virginia.gov/for-providers/managed-care/ccc-plus/provider-resources/ What you previously billed to Medicaid is now billed to the CCC Plus health plan.

Question	Answer
Are the CCC Plus plans required to reimburse hospice providers following the same guidelines as DMAS? Or will the signed contract determine reimbursement?	Health plans will reimburse providers in the same manner DMAS does. To some extent, providers may negotiate a reimbursement rate with the health plan.
For hospice agencies, you stated that we were excluded. If we bring someone on to hospice who has CCC Plus, do we have to be contracted with their respective health plan? If we are not, do we have to send them to another agency that is?	Individuals currently receiving hospice benefits and not enrolled in CCC Plus, are excluded from enrollment into CCC Plus. If the individual is already enrolled in CCC Plus and elects to use hospice services, they will remain in the program and receive the hospice services through the CCC Plus health plan. To continue serving an individual in CCC Plus, providers have to be contracted with the individual's health plan. The member's Care Coordinator can help them choose an in-network hospice provider.
If a hospice patient is an active patient when the transition takes place, they remain on traditional Medicaid. If the patient discharges from hospice and then later re-admits a few months later, will they be transitioned to CCC plus or stay again with traditional Medicaid?	It will depend on the timing of disenrollment from hospice and when they are re-enrolled. If an individual is enrolled or re-enrolled with hospice before becoming enrolled in CCC Plus, they will remain excluded from CCC Plus.
If an individual is in hospice, who would need to coordinate the patient's care with the Care Coordinator?	The Care Coordinator will coordinate the member's care, working in collaboration with the member and the member's treating health care providers, including the different hospice providers.
How will the CCC Plus health plans track the patient's liability for their room and board?	DMAS is sending the health plans the Patient Pay information.

Question	Answer
Please explain what the Preadmission Screening (PAS) team needs to do once a client has been approved for services and what CCC Plus will provide for the client?	The process for PAS will remain the same as it is today for CCC Plus, except the health plans will now give the members choices of in-network Providers. The Medicaid Memo dated 8/17/17 provides instructions to screening teams for where to send the UAI and other screening information for CCC Plus members.
For Community Personal Care Providers, what do we need to do when we are notified our clients have moved to a CCC Plus provider if we already have our authorization for services? Will the clients experience a break in services due to the transition?	The members will not experience a break in services. There is a continuity of care period of up to 90 days or until the current service authorization ends, whichever comes first. You should contact the health plan directly regarding the status of an authorization.
Do you have any details on obtaining authorizations for service from the 6 CCC Plus plans?	**https://www.dmas-devbo.dmas.virginia.gov/for-providers/managed-care/ccc-plus/provider-resources/**
Will the screenings in ePAS automatically be sent to the CCC Plus health plan? If not, where does the PAS team send the screening and which sections of the PAS packet do they need?	Until further notice, continue to use the ePAS system as you currently do.
Are there transportation services for members in CCC Plus?	Transportation is a Medicaid covered service and covered under CCC Plus. The Health Plans contract with different transportation brokers. Transportation contact information for each health plan is available on the back of the Member ID card.

Frequently Asked Questions
For Home Health/Personal Care/ PDN/Respite/Hospice Providers of CCC Plus

Question	Answer
What is the process for those who are approved for EDCD waiver and want consumer directed services? Will the CCC Plus health plan contact Service Facilitators for the client and coordinate this with the client?	The process for those approved for the EDCD waiver and who want consumer directed services remains the same. The member's Care Coordinator can provider a list of in-network Service Facilitators and can assist the member with this.
For EPSDT, school kids that do not have skilled nursing or Private Duty Nursing (PDN) listed on their IEP, who will the providers bill for school nursing services?	Providers should bill the CCC Plus health plan in which that child is enrolled. The Medicaid Memo dated 6/30/17 provides a chart for where to send requests for PDN services depending on whether in the IEP (school based) and if FFS, Medallion or CCC Plus..
Will Humana CCC demonstration members be allowed to keep Humana for Medicare and have a new health plan for CCC Plus?	Humana does not have a CCC Plus contract, so the individuals will have to choose one of the CCC Plus health plans for their Medicaid services. Medicare is not changing. If the individual has a Humana Medicare plan, they can keep it.