

Frequently asked questions: update on Long-Term Services and Supports (LTSS) authorization and care coordination processes

Virginia | HealthKeepers, Inc. | Anthem HealthKeepers Plus Medicaid products

This document provides guidance for LTSS providers on the authorization and care coordination process, which has been updated to align with the Level of Care Eligibility Review Instrument (LOCERI) timeline. This enhancement establishes stronger coordination to help members experience smoother care transitions, fewer service gaps, and more timely support from their care teams.

Regional Rollout Schedule

Region		Go-live
1	Tidewater	February 1, 2026
2	Central	April 1, 2026
3	Northern/Winchester and Western Charlottesville	June 1, 2026
4	Roanoke/Alleghany and Southwest	August 1, 2026

1. What is changing in the LTSS authorization process?

Beginning on the "Go Live" date listed in the Regional Rollout Schedule above, all LTSS authorizations will align with the member's LOCERI schedule. Each authorization will end 30 days following the member's next LOCERI due date, ensuring synchronization across LOCERI assessments, HRAs, ICT meetings, and UM reviews.

This alignment improves care coordination and reduces administrative burden by eliminating off-cycle authorization requests, ensuring services remain active. At the same time, assessments and ICTs are completed, and timely, person-centered planning is promoted between Care Management (CM), Utilization Management (UM), and providers.

2. Who is affected by this change?

All LTSS providers providing community-based services must follow this new process. Both providers and care managers are expected to collaborate before any authorization submission.

3. What does 30 days after LOCERI due date mean?

Each member's authorization end date will now be automatically set 30 calendar days after their next LOCERI due date. This creates one aligned review cycle and eliminates unnecessary interim authorizations.

4. How should providers prepare for the new process?

- Review all health plan materials and resources regarding this change. This will equip you with the knowledge and information you need to succeed in the process.
- Attend scheduled webinars and office hours to learn more and ask clarifying questions as needed to prepare for this process. Engagement and collaboration will be important to ensure the success of this process, reduce administrative burden, and ensure a seamless transition.
- Collaborate early with the member's care manager before submitting an authorization request.
- Participate in the Interdisciplinary Care Team (ICT) meeting to confirm service levels.
- Avoid off-cycle submissions unless directed by the CM or UM.

We advise providers to:

- 5. How will the new workflow look?**

Initial with Continuity of Care (COC):

1. The health plan will honor the COC authorization for 90 days.
2. CM and provider complete the HRA.
3. ICT meeting is held and recommendations finalized.
4. CM will document hours discussed per ICT recommendations with the UM team.
5. Provider submits authorization documentation to the UM team.
6. UM reviews and issues authorization.
7. Authorization end date is 30 days after the next LOCERI due date.

Annual reassessment:

8. UM auto-extends authorization 30 days after the LOCERI due date.

9. CM and provider complete the HRA
10. ICT meeting is held and recommendations finalized.
11. CM documents hours discussed per ICT recommendations with the UM team.
12. Provider submits authorization documentation to the UM team.
13. UM reviews and issues authorization.

6. What if the provider cannot collaborate with CM?

We will issue a one-time 30-day authorization to give provider and CM time to collaborate on an ICT. ICTs are a requirement.

7. What if the member refuses or cannot be contacted (UTC)?

The provider will still need to collaborate with the CM. CM will document the refusal or make renewed contact attempts. Auth will be extended as a one-time courtesy to allow additional time to contact member. Assessments are required to continue on the waiver.

8. How will this impact provider workload?

Initially, providers may experience more frequent ICT participation and coordination with CMs. Over time, the alignment is expected to reduce duplicate submissions and short-term extensions, improving efficiency. However, providers are still required to submit their authorization documentation via the normal process after meeting with the CM and member for the ICT meetings.

9. How will HealthKeepers, Inc. communicate these changes?

Provider Relations will share updates through bulletins and newsletter articles and on <https://anthem.com/va/provider>, as well as in virtual training sessions, webinars, and LTSS Office Hours.

10. What is the implementation timeline?

See the schedule above.

11. Who can providers contact for help?

Providers are invited to attend our scheduled webinars to learn more and engage with us, so we can address any questions or concerns you may have. We will have our Provider Relations, UM, and CM personnel on the calls to answer any questions. Should providers have any additional general questions, their assigned provider network education representative or Provider Relations representative can assist, or they can reach us at valtsspr@anthem.com.

12. Can Interdisciplinary Care Team (ICT) meetings be held virtually for providers?

Yes, ICT meetings may be held virtually. Most ICT meetings will likely be conducted by phone.

13. Is a nurse required to attend the Interdisciplinary Care Team (ICT) meeting, or may a non-clinical staff member participate?

The ICT is to discuss the members' service plan needs, particularly related to personal care hours. Hours recommendations will be discussed, and the POC will be developed and reviewed. Attendance will need to be by whoever the agency decides should be part of that discussion and submission.

14. If a Tidewater member's authorization expires in January, must the provider conduct an ICT meeting and coordinate with the Care Coordinator before submitting the renewal, or can they proceed as usual since this is before the February 1, 2026 go-live date?

Providers should proceed as usual. If the authorization renewal occurs before the February 1 go-live date, no changes to the current process are required.

15. For an authorization being renewed in January, what will the authorization date span be? Will it be issued for a full year, or will it end 30 days past the LOCERI review date?

The authorization date span will be the full year. Once the ICT is scheduled, the provider and CM will collaborate to determine whether the current hours are appropriate or require a change. If a change is needed, the provider will submit a new POC to UM for review, which would modify the authorization currently on file. The new end date would be 30 days past the next LOCERI due date. This is how the authorization will eventually be aligned.

16. Who is responsible for payment while we are waiting for the Care Manager to see the client?

The Care Manager has up to 30 days to complete the visit. We bill weekly for services rendered; however, billing cannot occur until an authorization is received.

Providers may request authorization when new to HealthKeepers, Inc. before the CM assessment; however, the authorization will be for a short duration — 90 days — to allow time for the provider and CM to meet with the member for an ICT call and discuss needs and appropriate POC. The provider will then submit the new POC to UM for authorization, which will extend for 30 days past the next LOCERI date.

17. When can care begin for a new patient?

According to DMAS, the start of care is defined as the date the provider (agency or consumer-directed Services Facilitator) completes the DMAS-99 assessment.

18. If a provider sends a representative other than the nurse to the ICT meeting, is the nurse still required to attend to complete the DMAS-97 A/B, DMAS-99, and related forms, and to obtain the required member or family signatures?

Whoever is typically involved in your SF/agency company with the development of the plan of care needs to be at the ICT.

19. Providers have shared during Home Healthcare meetings that annual authorizations must be conducted in person. If HealthKeepers, Inc. allows virtual ICT meetings, does this conflict with or violate the requirement for providers to be in person for the annual reauthorization process?

Assessments must be completed in person. ICT participation can occur while the provider is in the home completing the assessment and obtaining signatures, or the provider can complete the DMAS-99 assessment on another date and then participate virtually in an ICT call, or vice versa. Member/PCG signatures are required on the DMAS-99 and DMAS-97 A/B forms. How you implement your process is up to your company.

20. Provide clarification on the Director of Nursing (DON)'s current role, since others with decision-making roles in the provider agency can represent the provider in the ICT meeting, and they pay their nurses for completing assessments.

Assessments must be completed in person. ICT participation can be completed while the provider is in the home completing the assessment and obtaining signatures, or providers can complete the DMAS-99 assessment on another date and then participate virtually on an ICT call or vice versa. Member/PCG signatures are required on the DMAS-99 and DMAS-97 A/B forms. How you decide to implement your process is up to your company.

21. Is the signature of the nurse needed on the assessment to request authorization if the nurse was not present at the ICT meeting?

Assessments must be completed in person. ICT participation can be completed while the provider is in the home completing the assessment and obtaining signatures, or providers can complete the DMAS-99 assessment on another date and then participate virtually on an ICT call or vice versa. Member/PCG signatures are required on the DMAS-99 and the DMAS-97

A/B form. How you decide to implement your process is up to your company. The DMAS-99 must be signed by the person in your company who completed the assessment.

22. How long are ICTs? Providers are worried they won't be able to do these, plus the face-to-face visits, due to heavy caseloads.

ICT length varies based on the needs of the member. ICT has always been a requirement and should already be part of the process.

23. Are providers paid for ICT calls? Providers were told it is part of their requirement to collaborate with CM.

Participation in Interdisciplinary Care Team (ICT) meetings is a care coordination requirement under the DMAS CCC Plus program and is outlined in the HealthKeepers, Inc. CCC Plus Provider Manual (see Care Coordination/ICT responsibilities section). ICT participation is part of the collaborative care model and supports person-centered planning and authorization decisions.

There is no separate reimbursement for ICT attendance alone. However, providers may align ICT participation with a scheduled routine visit or reassessment, when clinically appropriate, and bill for the covered service delivered during that encounter in accordance with DMAS and HealthKeepers, Inc. billing guidelines.

Authorization decisions are based on medical necessity and program requirements, which include provider engagement in the member's care coordination process. ICT participation supports that process, but is not a standalone billable activity.

24. Who can attend the ICT — can an office manager attend instead of an RN?

Whoever currently attends the ICT meetings and can speak to the members' needs.

25. By the time providers receive the ICT letter, the meeting has already occurred. Can they be emailed the letter instead?

The provider will always receive a letter; however, providers can communicate with their members' assigned CM to develop a flexible process to maximize participation.

26. How do providers escalate issues when CM is not responsive after multiple outreaches?

Outreach to Provider Relations and/or member services and request notification to the CM manager. When escalating to the PR Reps and CM managers, please document your attempts and prepare them for sharing.

27. Go live for NOVA, the new LTSS Authorization and Care Coordination processes on June 1, 2026.

Although our agency is NOVA-based, we serve members who reside in Tidewater. When must we begin using the new process for Tidewater members?

The rollout is based on where the member resides, not where the provider is located.

Tidewater members entered the new process on February 1, 2026.

NOVA members will begin the new process on June 1, 2026.

Therefore, providers should follow the rollout timeline for the member's region.

28. Where can I find the LOCERI due date?

- a. Log into the DMAS MES website.
- b. Select on the menu bar.
- c. Navigate to the LOCERI Module.
- d. Select the Create tab.
- e. Select on the + sign -LOCERI Renewals Due Member search.
- f. Enter Medicaid ID.
- g. Search (**do not select the length of time**).

LOCERI User Guide

Login and navigation training: [CRMS-202 — LOCERI Login and Navigation](#)

29. How do I locate the member's Care Manager?

You can locate the member's Care Manager via TMV in Availity Essentials.

How to access Total Member View (TMV)

1. Log in to **Availity Essentials**.
2. Select **Payer Spaces**.
3. Choose **Anthem HealthKeepers Plus**.
4. Select **TMV**.

Locating the member's Care Manager

1. Log in to TMV
Open TMV and go to the main Member Search screen.
 2. Search for the member
Use **the** following:
 - HealthKeepers, Inc. Member ID to include alpha prefix
 - Click **Search**, then select the correct member from the results.
 3. Open the Member Summary
Once the member's profile loads, you'll land on the **Member Summary** or **Eligibility** page (depending on your TMV version).
Select the dropdown box on the top left of the screen.
 4. Navigate to the Member's Care Coordination/Care Team Section
 - Look for **Care Management** at the top navigation.
 5. Locate Care Manager Assignment
Inside the Care Management or Care Team section, you should see:
 - **Care Manager Name**
 6. How far in advance does the CM notify the provider about the ICT meeting?
We ask that the CMs send notification no less than seven days prior to the ICT date.
 7. Can someone other than the current SF for the family attend the ICT call?
Yes. If the assigned SF is unable to attend the ICT call, a representative who is familiar with the member's case and can comfortably speak to their needs and conditions should participate.
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