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LTSS authorization and care management transformation

Introduction to the training

Training purpose:

Educate providers of long-term services and supports (LTSS) on the updated authorization and care coordination processes to improve compliance and service delivery.

Target audience:

LTSS provider organizations and their clinical teams are responsible for authorizations and service planning.

Key objectives:

Clarify process changes, expectations for collaboration, workflow impacts, and real-life authorization scenarios.

Purpose of these updates

Support the Virginia Department of Medical Assistance Services (DMAS) goals:

Aligns with DMAS's vision for improved person-centered care, compliance, and streamlined LTSS.

Reduce administrative burden:

Minimizes repetitive off-cycle submissions, short-duration authorizations, and unnecessary UM reviews.

Enhance member experience:

Improves continuity by synchronizing services with the Level of Care Eligibility Review Instrument (LOCERI) and ensuring timely, appropriate care.

Key changes overview

Authorization alignment:

Agency providers and service facilitators who provide consumer-directed attendant care (S5126) and agency-directed personal care (T1019) service authorizations will now extend by 30 days beyond the next LOCERI due date to streamline renewals and reduce gaps.

HRA and ICT timing:

Health risk assessments and interdisciplinary care teams (ICT) must occur prior to authorization requests, ensuring service plans are current and collaboratively determined.

Standardized submission flow:

Provider → Care Management ICT → UM → final authorization. This sequence eliminates redundant or noncompliant submissions.

Provider expectations

Collaborate with care managers (CMs):

Engage proactively with CM teams before submitting service requests to ensure alignment with member assessments and plans.

Follow the authorization timeline:

Align documentation and service requests with LOCERI-based timelines to prevent delays and reduce the number of claims deemed ineligible for reimbursement.

Participate in ICT meetings:

Attend and contribute meaningfully to ICT meetings to shape personalized service planning.

Educate members:

Explain the collaborative care planning process to members to support their engagement and understanding of the service.

Impacts on authorization processes

Synchronized timelines:

All assessments and ICTs now align with LOCERI dates, reducing out-of-cycle variability and promoting consistency.

Follow the authorization timeline:

The initial extension to align the existing authorization to end 30 days after the LOCERI due date will get everything aligned. Upon renewal, the auth will always end 30 days after the LOCERI due date.

Fewer claims are deemed ineligible for reimbursement, and fewer resubmissions:
Proper documentation and collaboration reduce incomplete or misaligned requests, cutting down on back-and-forth corrections and reducing authorization delays.

It will provide consistency between the health plan and the provider, putting the member at the center and ensuring the member understands the authorization plan and goals, as they collectively participate in the ICT.

Initial authorization with COC

Process flow overview

Step 1

COC authorization extension:

UM issues 90-day COC authorization at member enrollment to prevent service disruption while assessment occurs.

Step 2

HRA + ICT by day 30:

CMs and provider review their assessments and participate with the member in the ICT meeting to establish the service plan.

Step 3

Provider submits request:

If a change in hours is needed, the provider submits the clinical authorization request to UM using the current authorization submission process.

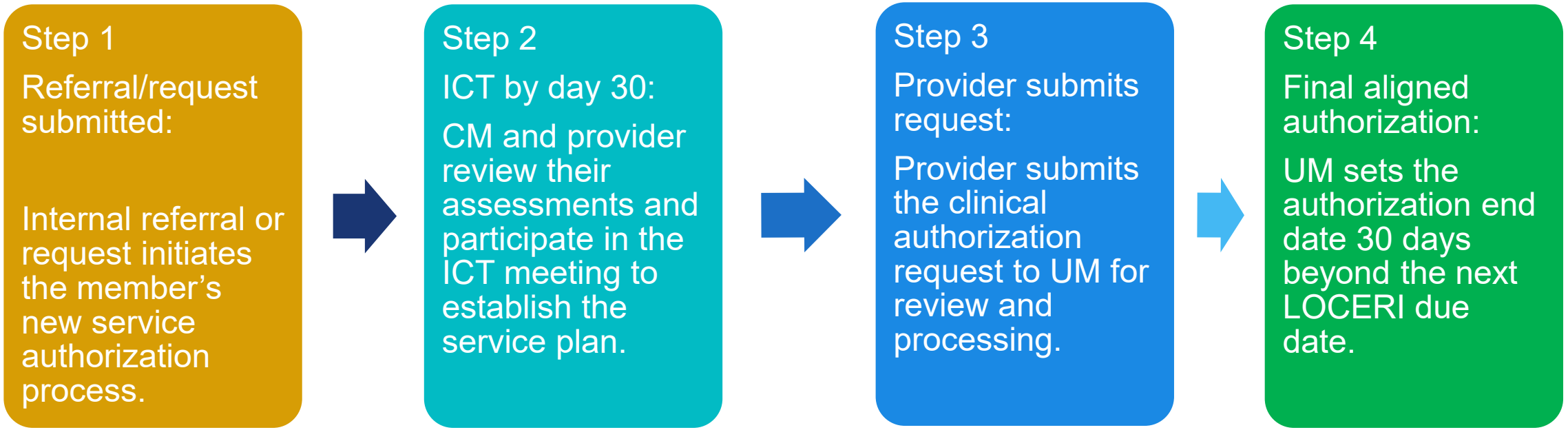
Step 4

Final aligned authorization:

UM reviews and sets the authorization end date 30 days beyond the next LOCERI due date.

Initial authorization without COC — internal referral

Process flow overview



Annual authorization alignment

Process flow overview

Step 1

Auto-extension:

UM extended all active authorizations on March 14, 2026, to end 30 days after the next LOCERI due date using system reports.

Step 2

HRA and ICT:

CM and provider review their annual assessments and ICT before the auto-extension expires.

Step 3

Documentation submission:

Provider submits the clinical authorization request to UM for the renewed authorization period.

Step 4

Final authorization:

UM reviews and issues aligned authorization with end date 30 days beyond LOCERI to prevent service disruption.

Potential deviations in the authorization process

- All scenarios will follow this same process for any deviations, which should rarely occur. For UTCs, refusals, or lack of provider involvement in ICTs, UM may issue a denial of an authorization request.

- If there is an Anthem-related issue (for example, case management not responsive or did not attend ICT), please indicate the issue on your fax cover sheet so we may follow up internally. These scenarios would not penalize the provider.

- Off-cycle requests: The UM team will not require an ICT for off-cycle requests. They will process and end the authorization 30 days after the LOCERI due date.

Training and resources

Mandatory webinars: Scheduled sessions for all LTSS providers to walk through new workflows, answer questions, and confirm readiness

Reference materials: FAQ documents, process maps, and decision trees available via our provider website (https://anthem.com/va/provider) and newsletters

Provider office hours: Recurring virtual Q&A sessions for one-on-one guidance, use-case troubleshooting, and feedback collection

Reach out to Provider Relations for help implementing changes or addressing specific authorization challenges.

Summary of key changes and newly implemented process updates

Standardized authorization period

- All LTSS authorizations end 30 days after the next LOCERI due date, ensuring service continuity and assessment time.

ICT meeting notice extension

- ICT meeting invitations now require a minimum 10-day advance notice to enhance provider participation and care planning.

Improved communication flexibility

- ICT notices can be sent via fax or email based on provider preferences, ensuring reliable communication.

CM contact transparency

- Authorization faxes include CM contact information, providing timely access without extra reach.

Questions and discussion

Let’s clarify and collaborate.

Open Q&A: Please share any questions about workflows, timelines, or expectations — we’re here to support your success.

Next steps: Review training materials, attend upcoming sessions, and connect with Provider Relations for tailored guidance.

Thank you and contact information

Network education rep contact

valtssnetworkeducation@anthem.com

Reach out with process, training, or system questions.

CM/UM contact

Providers can connect with the member's assigned CM by calling **800-901-0020**. There is an option to be transferred to CM.

Questions regarding authorizations would be directed to LTSS UM.

Contact Provider Services at **800-901-0020 (TTY 711)** and request the Virginia LTSS MMS intake team. Leave a message, and they will return the call within 48 hours. To obtain a member's assigned CM name and contact information, use TMV in Availity Essentials:

- Go to the Care Management tab. The LTSS CM is listed under programs.
  - This will not be in the banner at the top for members who are co-managed with other CMs (for example, FIDE members or members receiving a specialized targeted CM and LTSS CM).
- If you do not see the CM name listed in Availity Essentials (TMV), email: AnthemVALTSS@anthem.com for the CM name and contact information. Include the member's name, ID number, and date of birth.

Thank you and contact information (cont.)

Provider website:

https://anthem.com/va/provider

Access resources, updates, training materials, and bulletins.

Follow-up actions:

Attend office hours, share feedback, and collaborate with CM teams moving forward.

Contact information:

Provider Services: Monday to Friday, 8 a.m. to 8 p.m. ET

- Phone: **800-901-0020** (Medicaid-only members)
- Phone: **800-676-2583** (FIDE members)
- LTSS standard fax: **844-864-7853**
- LTSS expedited fax: **888-235-839**

VA-BCBS-CD-015867-26-S4322 | August 2026