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Updates on LTSS authorization and care coordination processes

Date: [Enter]
Presenter: [Enter]
Organization: [Enter]

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 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 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.

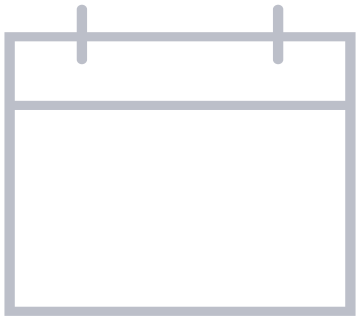
Enhance member experience

Improves continuity by synchronizing services with LOCERI and ensuring timely, appropriate care.

Key changes overview

Authorization alignment

All LTSS authorizations will now extend 30 days beyond the next Level of Care Evaluation Request Instrument (LOCERI) due date to streamline renewals and reduce gaps.



HRA and ICT timing

Health risk assessments (HRA) and Interdisciplinary Care Team (ICT) meetings must occur prior to authorization requests, ensuring service plans are current and collaboratively determined.

Standardized submission flow

Provider → Care Management ICT → UM → final auth. 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 Interdisciplinary Care Team 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 auth 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 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 amongst the health plan and provider, putting the member at the center and ensuring the member understands the authorization plan and goals, as they all collectively participate in the ICT.

Authorization scenarios

Initial with COC, annual alignment, and deviations:

- **Initial with Continuity of Care (COC):** 90-day extension from enrollment; CM and provider conduct HRA and ICT before UM issues aligned authorization.
- **Annual authorization alignment:** UM auto-extends auth 30 days past LOCERI; CM and provider complete assessments and ICT before request submission.
- **Potential deviations:** For UTCs, refusals, or lack of provider involvement in ICTs, UM may issue a denial of an authorization request.

Initial authorization with COC

Process flow overview

Step 1

COC auth extension

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

Step 2

HRA and ICT coordination

CM and provider complete HRA and hold ICT meeting by day 30 to establish a service plan.

Step 3

Submission and review

CM enters service plan in EMR system, provider submits clinical authorization request to UM, UM proceeds with auth processing.

Step 4

Final authorization

UM sets end date to 30 days past next LOCERI; ensures continuity and reduces administrative burden.

Initial authorization without COC — internal referral

Step 1

Referral or request is submitted, initiating the process for the member's new service authorization request.

Step 2

CM and provider complete HRA and hold ICT meeting by day 30 to establish a service plan.

Step 3

CM enters service plan in EMR system, provider submits clinical authorization request to UM, UM proceeds with auth processing.

Step 4

Final authorization. UM sets end date to 30 days past next LOCERI: ensures continuity and reduces administrative burden.

Annual authorization alignment

Process flow overview

Step 1

Auto-extension

UM uses system reports to extend authorizations 30 days past next LOCERI due date, maintaining service continuity.

Step 2

HRA and ICT

CM and provider must complete the Annual Health Risk Assessment and conduct ICT before expiration of the auto-extension.

Step 3

Documentation submission

CM enters service plan in EMR system, provider submits clinical authorization request to UM, UM proceeds with auth processing.

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.

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.

Conclusion

Reinforce collaboration

Effective care coordination depends on timely provider-CM engagement, particularly during assessments and ICTs.

Align with new standards

Follow LOCERI-driven timelines, documentation rules, and authorization flows to ensure compliance and continuity.

Stay engaged

Attend training, participate in office hours, and leverage provider support channels to maintain alignment and readiness.

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.

Case-specific clarification: Discuss any challenging member scenarios or deviation cases you’ve experienced under the prior process.

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.

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.

CM/UM line

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

Questions regarding authorizations would be directed to the LTSS Utilization Management Direct Line, which is **804-997-3100**. Follow the prompts and leave a message if there's no answer. Calls are returned within one business day by the LTSS Medical Management Specialist team.

Provider Services phone line

Providers can call the general Provider Services line of HealthKeepers, Inc. for assistance or to be routed to the appropriate care manager:

- Phone: **800-901-0020 (TTY 711)**
- Fax: **866-408-7087**

This line supports inquiries related to authorizations, benefits, eligibility, and care coordination

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