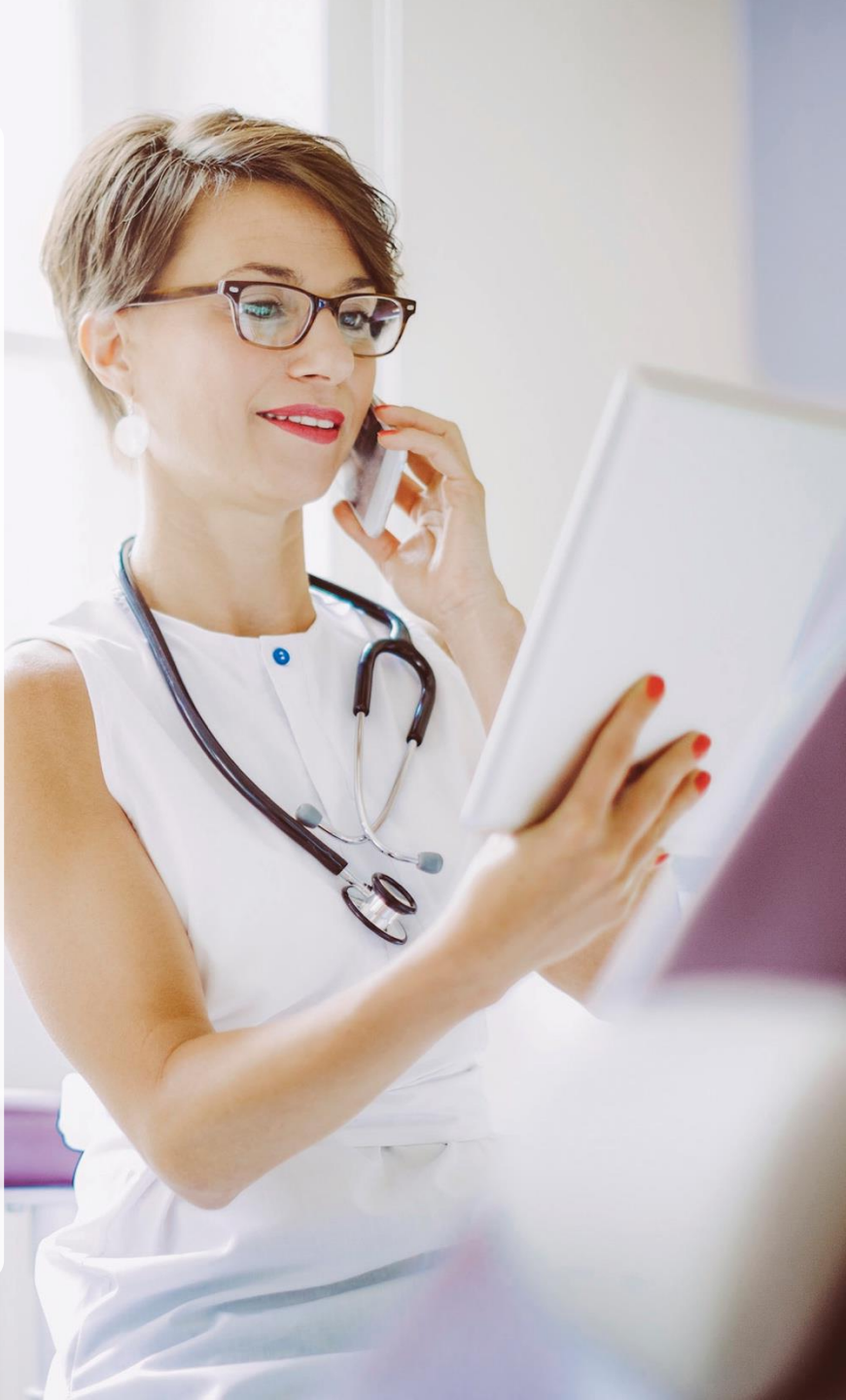
Anthem BlueCross

Medi-Cal Managed Care
L.A. Care
Medicare Advantage
Cal MediConnect Plan

Long-term services and supports provider orientation

Updated January 2021

This communication applies to the Medicaid, Medicare Advantage and Medicare-Medicaid Plan programs for Anthem Blue Cross (Anthem).



Today's agenda

- Introduction to Anthem Blue Cross (Anthem)
- Long-term services and supports (LTSS)
- Community-based adult services (CBAS)
- Coordination of Multipurpose Senior Services Program (MSSP)
- Nursing facilities
- Claims and grievances and appeals
- Provider responsibilities
- Care management and utilization management
- Provider resources
- Member benefits and services
- Additional resources

Who we are

- As a leader in managed healthcare services for the public sector, Anthem helps low-income families, children, pregnant women and people with disabilities get the care they need.
- We help coordinate physical and behavioral health care and offer disease management programs, education and access to care.
- We partner with local community organizations to help members make healthy decisions and connect them to the resources they need. To address community priorities and specific health concerns, our partnerships include:
  - Schools.
  - Advocacy groups.
  - Community- and faith-based organizations.
  - Local businesses.

Our experience

Together, Anthem Blue Cross and its Anthem, Inc. health plan affiliates serve more than 7 million people in state-sponsored health plans.

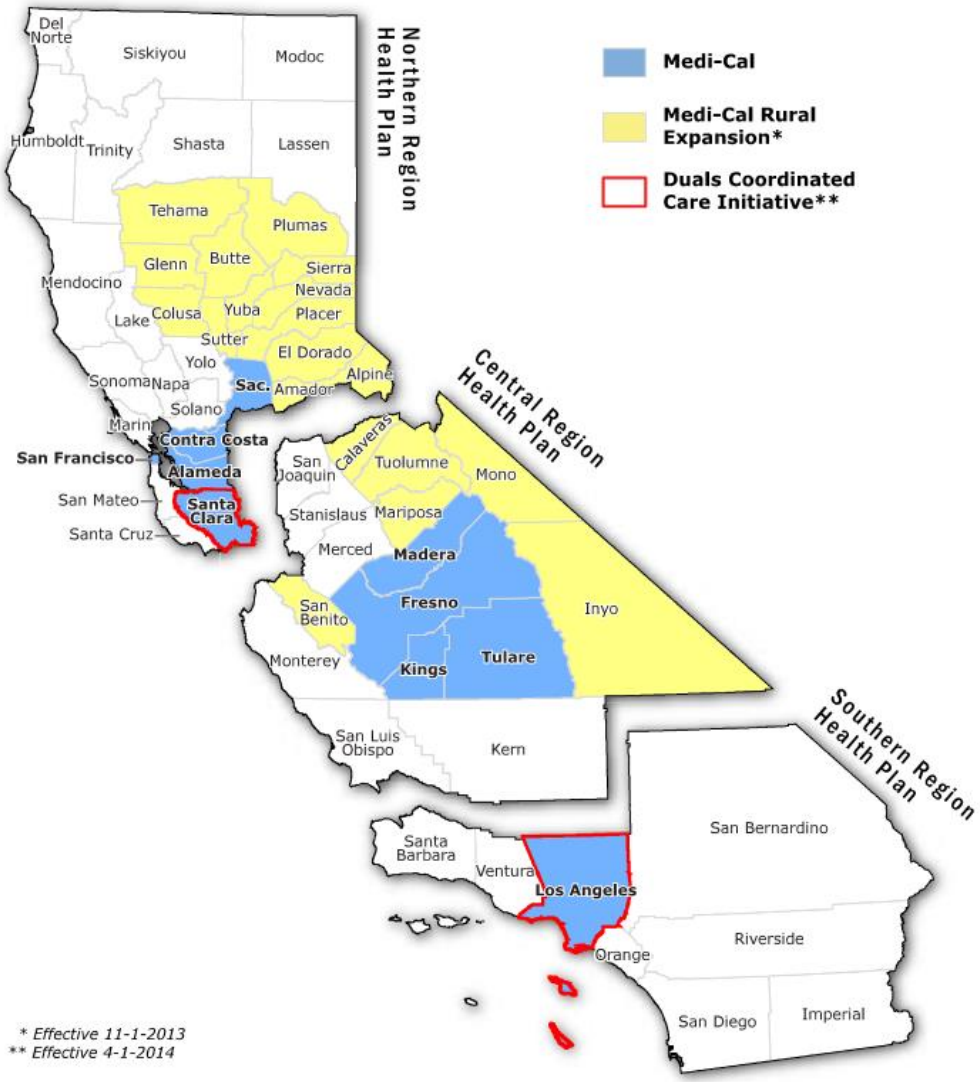
- **Operating in 22 states**
  - A leading provider of heath care solutions for public programs
- **Offering over 25 years in Medicaid experience**
  - Access to high-quality, coordinated care for low-income families, seniors and people with disabilities
  - A Medi-Cal Managed Care (Medi-Cal) plan administering LTSS benefits since 2014
- **Serving members with complex needs in nine states**
  - 350,000 members enrolled in LTSS programs
  - Over 1.1 million Medi-Cal members in California

Who we serve

Anthem serves several populations in California with benefits coordinated by various teams.

- Anthem Blue Cross Cal MediConnect Plan (Medicare-Medicaid Plan) is an LTSS program in Santa Clara and Los Angeles counties and covers:
  - LTC, excluding skilled nursing
  - CBAS
  - MSSP
- Statewide programs include:
  - CBAS
  - MSSP
  - In-home supportive services (IHSS)

Our service area



Long-term services and supports

LTSS service model

Anthem has developed an evidenced-based model of care that offers coordinated care delivered by a network of providers with expertise to meet the needs of the specialized population.

We have designed a care system to meet the intentions of the Medi-Cal and Anthem Blue Cross Cal MediConnect Plan with a coordinated, integrated person-centered system of care that ensures high quality and an excellent member experience with the goal and focus of allowing members to remain in the least restrictive setting.

LTSS service model (cont.)

Key features of our LTSS service model include:

- Supporting members who are aging and/or have a disability to live independently in their home- or community-based setting of their choice.
- Increased access to home- and community-based services.
- Support for family members and caregivers.
- Partnering for successful outcome resulting from:
  - Early identification and intervention.
  - Coordination and use of resources.
  - A cooperative and supportive relationship with providers.

Our approach to LTSS

Anthem's integrated approach to care incorporates the following key elements:

- **Person-centered care coordination:**
  - Anthem brings together the right combination of healthcare, services and supports while taking members' preferences and priorities into account. Anthem's full-spectrum care and service coordination approach emphasizes an individualized, member-centric focus that supports self-direction, personal preference and individual goal-setting.
- **Guiding members through complex systems:**
  - Services and supports for members with LTSS needs can be confusing, so Anthem's here to help guide members. Anthem's offerings go beyond healthcare to connect members with the resources that are right for them.

Our approach to LTSS (cont.)

Anthem's integrated approach to care incorporates the following key elements:

- **Helping members thrive in the community:**
  - We provide members and families with resources to build, maintain, or rebuild their lives with their families and friends. These supports include access to housing and transportation. By coordinating LTSS, we improve the quality of care and services, eliminate barriers, and support members to live independently at home and participate fully in their communities.

Our approach to LTSS (cont.)

Anthem's integrated approach to care incorporates the following key elements:

- **Community partnerships:**
  - Anthem has a long history of working effectively with members, advocates, families, stakeholders, service providers, and faith- and community-based organizations. Our grassroots community collaboration is the cornerstone of our innovative and individualized approach to healthcare and service delivery.

Anthem's team of professionals helps individuals in need of LTSS to live independently. We help coordinate services and supports, increase access to self-directed options and provide members with a single point of contact to navigate complex systems of care.

LTSS: overview

Managed long-term services and supports (MLTSS) consists of a variety of California state programs that provide services to help individuals remain living independently in the community or the most appropriate setting of their choice.

MLTSS is provided over an extended period, predominantly in the member's home or community, but also in facility-based settings such as nursing facilities. MLTSS consists of four distinct benefits:

- IHSS
- CBAS
- MSSP
- Long-term care (LTC)

Community-based adult services

CBAS: eligibility

CBAS services may be provided to Medi-Cal beneficiaries over 18 years of age who:

- Meet nursing facility A or B requirements.
- Have organic/acquired or traumatic brain injury and/or chronic mental health conditions.
- Have Alzheimer's disease or other dementia.
- Have mild cognitive impairment.
- Have a developmental disability.

Request for CBAS services

Providers who identify a potential need for CBAS services may submit a request for eligibility authorization to begin the CBAS assessment process.

- Complete a request for an H2000 (comprehensive multidisciplinary evaluation).
- Fax the *Request for CBAS Services Fax Coversheet*, signed order for CBAS and member's history and physical (H&P).
- Within 30 calendar days, Anthem will review the request for the H2000, which may include a face-to-face interview with the member at the CBAS center.
- Expedited requests will be reviewed within three calendar days of the request receipt.
- Anthem has developed internal policies and procedures that outline rules for waiving the face-to-face visit to determine eligibility.

CBAS-billed services

The following billing codes and rates are used for CBAS services:

HCPCS code	Description
H2000	Comprehensive multidisciplinary evaluation
S5102	Day care services, adult; per diem
T1023	Screening to determine the appropriateness of consideration of an individual for participation in a specific program, project or treatment protocol, per encounter. Prior authorization is not required. There is a limit of five days per participant's lifetime. A statement that the *Physician Authorization and Medical Information* form is on file at the center must be entered in the *Remarks* area of the claim.

- All codes are to be billed with revenue code 560 (medical social services-general classification).
- CareMore* Claims department: Claim filing requirements or status inquiries for Medicare Advantage members may be directed to **1-877-211-6553**.

Request for adult day services

Request for S5102 (adult day services):

- Fax the *Request for CBAS Services Fax Coversheet*, *Individual Care Plan (ICP)* and level of service.
- Requests for services should be submitted at least one day prior to start of services.
- Requests can be faxed to the following:
  - Anthem Blue Cross Cal MediConnect Plan members fax: **1-866-639-2281**
  - Medi-Cal members fax: **1-855-336-4041** or **1-855-336-4042**
  - CBAS department phone: **1-855-871-4899**

Coordination of Multipurpose Senior Services Program

MSSP: eligibility

In general, to be eligible for MSSP services, a member must:

- Be 65 years of age or older.
- Live within an MSSP service area.
- Be eligible for Medi-Cal.
- Be certified for nursing home placement.

Providers may begin the referral process for a member by contacting Anthem at **1-855-871-4899**.

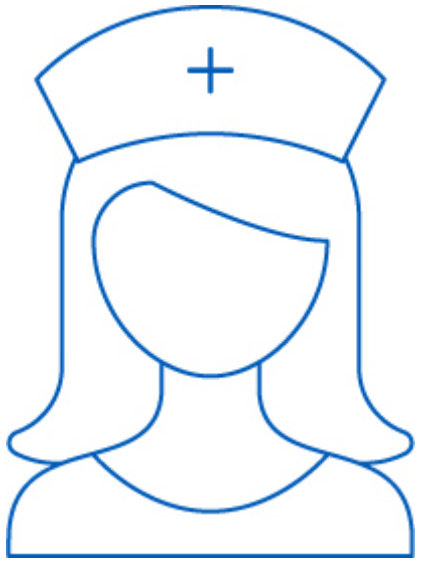
MSSP: billing

- MSSP providers are paid a flat per member per month (PMPM) rate that has been established by the California Department of Health Care Services.
- MSSP providers must submit a monthly invoice to Anthem no later than the 10th day of each month.
- The invoice shall include information on each Anthem member enrolled in the program as of the first day of the month for which the report is submitted.
- MSSP providers may not submit separate claims to different plans for the same MSSP recipient within the same invoice period.
- Any questions related to MSSP billing and payments should be directed to their MLTSS Provider Relations representative or to LTSSProviders@anthem.com.

Nursing facilities

Nursing facilities: eligibility

Eligibility extends to Medi-Cal beneficiaries who require 24-hour long- or short-term medical care as prescribed by a physician for custodial or long-term subacute (no skilled needs).



Nursing facilities: access to care

- Placement is made through a physician/licensed healthcare provider referral.
- Contact our Member Services or Care Management LTSS department at **1-855-871-4899** for assistance with or questions about getting your client into a facility.
- Request for authorizations are only received via fax requests and may be sent to:
  - MLTSS providers:
    1-877-279-2482 (Los Angeles) or **1-844-285-1167** (Santa Clara)
  - Anthem Blue Cross Cal MediConnect Plan providers:
    1-844-831-6608 (Los Angeles) or **1-866-639-2281** (Santa Clara)
- Authorizations are required, and should a member leave the facility, Anthem should be contacted to update the authorization.

Nursing facilities: billing

- Follow the standard billing from the *UB Billing Editor Book* for the appropriate bill type.
- Use revenue codes 0190 for room and board.
  - For coding bed hold days and leave days, please use 018X series:
    - 0180 — General
    - 0185 — Nursing Home (for Hospitalization)
- Per diem payments exclude items listed in *Title 22, CCR, 51511* and *51511.5*. These items are separately billable and payable as outlined in *Title 22, CCR 51511* and *51511.5*.
- Ancillary charges should not be included on the claim.

Billing accommodation codes

Description	Regular services	Leave days non-DD patient	Leave days DD patient	Bill value code 24 (box 39-41)	Bill as a cent (box 39-41)
NF-B regular	01	02	03	24	$0.01; $0.02; $0.03
NF-B rural swing bed program	04	05	N/A	24	$0.04; $0.05
NF-B special treatment program: mentally disordered	11	12	N/A	24	$0.11: $0.12
NF-A regular	21	22	23	24	$0.21; $0.22; $0.23
Rehabilitation program — mentally disordered	31	32	N/A	24	$0.31; $0.32
ICF developmental disability program	41	N/A	43	24	$0.41; $0.43
ICF/DD-H 4-6 beds	61	N/A	63	24	$0.61; $0.63
ICF/DD-H 7-15 beds	65	N/A	68	24	$0.65; $0.68
ICF/DD-N 4-6 beds	62	N/A	64	24	$0.62; $0.64
ICF/DD-N 7-15 beds	66	N/A	69	24	$0.66; $0.69

Billing accommodation codes (cont.)

Description	Regular services	Leave days non-DD patient	Leave days DD patient	Bill value code 24 (box 39-41)	Bill as a cent (Box 39-41)
NF-B adult subacute					
Hospital DP/NF-B — ventilator dependent	71	73	79	24	$0.71; $0.73; $0.79
Hospital DP/NF-B — non-ventilator dependent	72	74	80	24	$0.72; $0.74; $0.80
Free-standing NF-B — ventilator dependent	75	77	81	24	$0.75; $0.77; $0.81
Free-standing NF-B — non-ventilator dependent	76	78	82	24	$0.76; $0.78; $0.82
NF-B pediatric subacute					
Hospital DP/NF-B — supplemental rehabilitation therapy services	83	N/A	N/A	24	$0.83

Billing accommodation codes (cont.)

- Facilities must bill indicating the accommodation code that is applicable to the custodial claim, as this drives the appropriate payment rate for a facility based on the California Medi-Cal rate for the facility.
- Accommodation codes should be billed with a value code 24 and billed as a cent amount.

Member financial liability/share of cost

- For members who have a Medi-Cal share of cost (SOC), the LTC facility is responsible for collecting the SOC amount each month and must represent the liability in box 39 on each claim submitted.
- The SOC should be indicated by billing value code 23 with amount collected on the claim.
- The payment remitted by Anthem will be reduced by the member liability amount.
- Please note, if a member does not have an SOC, a minimum amount of $0.00 is required.

Claims and grievances and appeals

Submitting claims

We accept paper claims, but we encourage you to submit claims on our secure website or using electronic data interchange (EDI):

- Submit both *CMS-1500* and *UB-04* claims on our secured website.
- Submit 837 batch files and receive reports through the secured website at no charge. You must register for this service first.
- Use a clearinghouse via EDI. Using our electronic tool helps reduce claims and payment processing expenses and offers:
  - Faster processing than paper.
  - Enhanced claims tracking.
  - Real-time submissions directly to our payment system.
  - *HIPAA*-compliant submissions.
  - Reduced claim rejections and adjudication turnaround time.

EDI tips

- Availity* is the preferred EDI vendor for Anthem:
  - Visit **https://www.availity.com**.
  - Email support@availity.com.
  - Call **1-800-282-4548**, Monday through Friday, from 5 a.m. to 4 p.m. PT.

- For Medicare Advantage managed by CareMore Health:
  - Enroll with Office Ally* at **www.officeally.com** for electronic claims submission.
  - Enroll with Change Healthcare* (formerly Emdeon) at **www.changehealthcare.com** for electronic funds transfer (EFT) and electronic remittance advice (ERA).

EFT/ERA

EFT

- Anthem allows EFT for claims payment transactions; claims payments can be deposited directly into a previously selected bank account.
- Providers can enroll in this service by contacting the EDI Solutions Helpdesk at **1-800-470-9630**.

ERA

- Anthem offers secure electronic delivery of remittance advices, which explain claims in their final status.
- This service is offered through EDI. For more information, providers and vendors may call the EDI Solutions Helpdesk at **1-800-470-9630**.

Electronic claims

Electronic claims can be submitted using a clearinghouse via EDI. Below is a list of most commonly used electronic payer IDs:

- Availity: 47198
- SSI Group:* 47198
- Change Healthcare (formerly Emdeon): 47198
- ICS:* 47198
- CareMore: CARMO
- Office Ally: BC001

Paper claims

Anthem also accepts paper claims. Paper claims can be mailed to:

Anthem Blue Cross
Attn: Claims
P.O. Box 60007
Los Angeles, CA 90060-0007

Providers must bill with *HIPAA*-compliant codes.

Timely filing and balance billing

Timely filing

- Please refer to your contract to obtain your timely filing limit to ensure submission of claims within the appropriate time frames from the date of service.

Balance billing

- Balance billing is defined as a provider charging a Medi-Cal beneficiary for the difference between the Medi-Cal reimbursement rate and the customary charge for the service.
- You may not balance bill our members.
- You must complete the notification/authorization process before providing noncovered services.

Grievances and appeals

We encourage providers and members to seek resolution of issues through our grievance and appeals process. The issues may involve dissatisfaction or concern about another provider, the plan or a member.

- Provider grievances and appeals are classified into the following three categories:
  1. Grievances related to the operation of the plan, including: benefit interpretation, claim processing and reimbursement
  2. Provider appeals related to adverse determinations
  3. Provider appeals of nonmedical necessity claims determinations

Grievances and appeals (cont.)

- Member grievances and appeals can include but are not limited to the following:
  - Access to healthcare services
  - Care and treatment by a provider
  - Issues having to do with how we conduct business

Grievances and appeals (cont.)

- Grievances may be filed by calling the Customer Care Center or submitting in writing to the Grievances and Appeals department.
- Providers may file a written grievance by using the *Physician/Provider Grievance Form* located in the *Forms Library* of the *Provider Resources* page of the Anthem website at **https://providers.anthem.com/ca**.
- Providers may fax the form to: **1-866-387-2968**.
- Providers may mail the form to:
  Anthem Blue Cross
  Attn: Grievances and Appeals Department
  P.O. Box 60007
  Los Angeles, CA 90060-0007

Provider responsibilities

Provider responsibilities

As a participating provider, you have certain responsibilities related to working with Anthem and its members. You're responsible for:

- Treating all members with respect and dignity, providing appropriate privacy, and treating member disclosures and records confidentially, giving members the opportunity to approve or refuse their release.
- Participating in and cooperating with Anthem in any reasonable internal and external quality assurance, utilization review, continuing education and other similar programs established by Anthem.
- Complying with all applicable federal and state laws regarding the confidentiality of patient records.
- Collaborating with the member's care coordinator.
- Providing culturally competent care.

Please refer to your provider manual for a complete list.

Home- and community-based settings rule

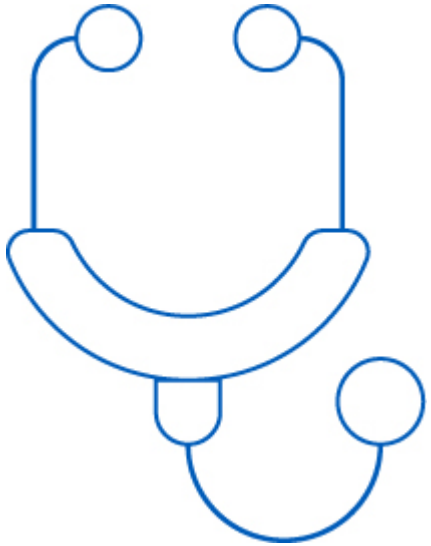
The purpose of the home- and community-based settings (HCBS) rule is to ensure that individuals receive services in settings that are integrated in and support full access to the greater community.

- The HCBS final rule applies to:
  - Residential and nonresidential settings, including certified and licensed homes.
  - Day programs and other day-type services.
  - Employment options and work programs.

HCBS rule (cont.)

Key provisions of the settings rule require:

- Services to be provided in HCBS in their entirety.
- Services to be integrated in and support full access to the greater community.
- Each individual to have a person-centered plan.



HCBS rule (cont.)

The goal of the HCBS final rule is to enhance the quality of services provided by:

- Maximizing opportunities and choices for individuals.
- Promoting community integration by making sure individuals have full access to the community.
- Making sure individuals have the opportunity to work and spend time with other people in their community who do not have disabilities.
- Ensuring individual preferences are supported and rights are protected.
- Establishing person-centered service planning requirements, which includes a process driven and directed by the individual to identify needed services and supports.

HCBS rule (cont.)

- For Anthem providers, this means you may need to make changes in how you operate in order to meet the new federal rules by:
  - Modifying policies and program designs.
  - Changing where and how your service is delivered.
  - Providing training to ensure that your staff members understand the expectations of the rules.
- Anthem will continue to provide information and resources to providers to support compliance.
- States must develop transition plans for existing waivers and state plan amendments; states must demonstrate compliance by March 22, 2022.

Person-centered thinking

- Assists people in having positive control over the lives they have chosen for themselves.
- Focuses efforts on people who have lost or may lose positive control because of society's response to the presence of their disability.
- Underlies and guides respectful listening, which leads to respectful action, building better lives, not better paper.
- Supports people in having positive control over the life they desire and find satisfying, where they:
  - Are recognized and valued for their contributions (current and potential) to their communities.
  - Are supported in a web of both business and personal relationships within their communities.

Person-centered thinking (cont.)

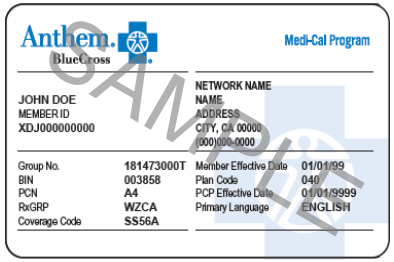
Why person-centered thinking?

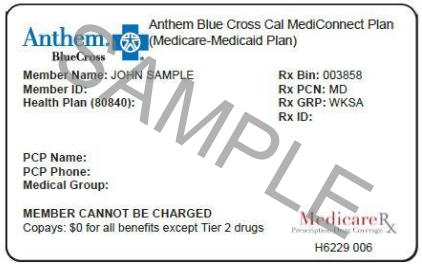
- It's the right thing to do!
- It is the foundation for meeting the Centers for Medicare & Medicaid Services (CMS) requirements for residential settings and service planning.
- It meets the CMS requirement that person-centered service plans must be developed through a person-centered planning process.

Member eligibility

Medi-Cal members under Anthem will receive two identification cards:

- Medi-Cal members will receive a state beneficiary identification card (BIC) from DHCS. The BIC contains eligibility information that is accessible when providers swipe the card in their point-of-service device before each visit.





- In addition to the state-issued BIC card, Anthem supplies each member with an identification card.
  - Anthem will issue ID cards within seven days from receiving the enrollment file from the state.

Member eligibility (cont.)

To verify Medi-Cal member managed care eligibility, choose one of the following four options:

1. Swipe the BIC at a point-of-service device.
2. Call the automatic eligibility verification system (AEVS) at: **1-800-456-2387**.
3. Visit the Medi-Cal website at **www.medi-cal.ca.gov/eligibility/login.asp**.
4. Visit the secure Availity website at **https://www.availity.com**.

To verify Medicare Advantage member managed care eligibility, choose one of the following two options:

1. Visit the provider access website at **www.caremore.com**.
2. Call **1-888-291-1358**.

Program integrity: fraud, waste and abuse

We are committed to protecting the integrity of our healthcare program and the efficiency of our operations by preventing, detecting and investigating fraud, waste and abuse. Combating fraud, waste and abuse begins with knowledge and awareness:

- Always confirm the recipient's identity.
- Ensure the services you render are necessary, completely documented in the medical records and billed appropriately.
- Tell us immediately: Call the Fraud and Abuse Hotline at **1-888-231-5044** (Monday through Friday, 8 a.m. to 6 p.m. ET) if you suspect or witness fraud, waste or abuse.
- Read more about reporting fraud, waste and abuse in your provider contract or provider manual.

Provider updates

- For voluntary updates separate from the SB137 outreach, use the new online *Provider Maintenance Form (PMF)* to notify Anthem of changes.
- The form is available in the Forms Library > General Forms on the *Provider Resources* page of our website at: **https://providers.anthem.com/california-provider/resources/forms**.

Care management and utilization management

Care management: member support programs

- **Population management**
  - Quality driven wellness and prevention campaigns and member targeting
  - MyHealth Advantage gaps in care analytics
    - Pipeline campaigns
    - Member targeting (EPSDT, ADHD, depression, behavioral health)
- **Disease management**
  - Condition management for high risk (for example, CHF, CAD, diabetes, asthma, COPD)
  - Maternity management for all risks
  - MyHealth Advantage gaps in care/medication compliance for all risks
- **Case management**
  - Predictive, complex and event-driven

Care management: team

- **The Care Management team includes:**
  - Credentialed, experienced registered nurses or social workers.
  - Teams with oversight of the member's physical, psychological, functional, social and referral issues.
- **Cases appropriate for care management include:**
  - Medically complex members with special healthcare needs.
  - Members with chronic long-term conditions.
  - Members with frequent emergency room visits or hospital admissions.
- **Cases appropriate for LTSS service coordination include:**
  - Members needing LTSS (for example, assistance with activities of daily living or instrumental activities of daily living).
  - Members needing nursing facility level of care.

Care management: referrals

- Providers, nurses, social workers and members or their representatives may refer members to care management by:
  - **Phone:** Call Care Management 24/7 through the Customer Care Center at **1-855-817-5786**.
  - **Fax:** Submit a completed *Care Management Referral Form* to **1-866-333-4827**.

Utilization management

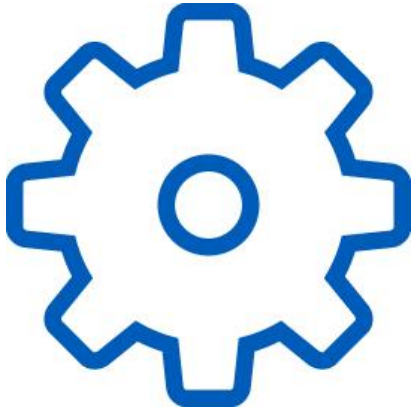
Our utilization management (UM) program is a collaboration with providers to promote, provide and document the appropriate use of healthcare resources, which reflect the most current UM standards from the National Committee for Quality Assurance (NCQA).

- In conjunction with providers, UM assists in providing access to the right care to the right members at the right time and in an appropriate setting.
- The UM department provides pre-service, concurrent and post-service reviews using clinical criteria on sound clinical evidence. These criteria are available upon request by contacting the UM department via:
  - Phone: **1-888-831-2246, option 3**.
  - Fax for CSR: **1-866-333-4826**.
  - Fax for prior authorization: **1-800-754-4708**.

UM (cont.)

For Anthem Blue Cross Cal MediConnect Plan authorizations for LTC, fax:

- **1-866-639-2281** (Santa Clara).
- **1-844-831-6608** (Los Angeles).



For MLTSS authorizations:

- Fax **1-844-285-1167** (Santa Clara).
- Fax **1-877-279-2482** (Los Angeles).
- Call **1-855-871-4899**.
- Call **1-562-622-2950** (Medicare Advantage providers).

UM: pre-service review

A pre-service review is required before rendering some services. Requests are reviewed for:

- Member eligibility.
- Appropriate level of care.
- Benefit coverage.
- Medical necessity/functional necessity.

UM: pre-service review (cont.)

Examples of services requiring pre-service review include but are not limited to:

- Inpatient hospital care.
- Selected surgical procedures (performed in an outpatient or ambulatory surgical center).
- Selected durable medical equipment (DME), home healthcare, skilled nursing facilities, hospice and all infusion therapies.
- Selected MRIs, CT scans, experimental and investigational services, transplants, and cardiac and pulmonary rehabilitation.
- Out-of-network services.

Continuity of care

Members keep their current providers and service authorizations at the time they enroll for up to six months for Medicare services and up to 12 months for Medi-Cal services if all the following criteria is met:

- The provider, member or his/her representative can make a direct request to Anthem to continue seeing his/her current provider.
- Anthem is required to approve this request if the member can show an existing relationship with a primary or specialty care provider, with some exceptions.
- Anthem will determine if there is a pre-existing relationship by reviewing the member's health information available to us. The provider or member may also give Anthem information to show this pre-existing relationship with a provider.

Continuity of care (cont.)

- An existing relationship means that the member saw an out-of-network primary care provider at least once or specialty care provider at least twice for a nonemergency visit during the 12 months prior to the date of the member's enrollment in Anthem Blue Cross Cal MediConnect Plan.
- When the member makes a request to continue with a current provider, the member or his/her provider must provide documentation of an existing relationship and agree to certain terms.
- As the continuity of care period ends, the member will need to see doctors and other providers in the Anthem network.

Quality management

Anthem's quality assessment and performance improvement includes:

- Analyzing relevant utilization data using NCQA standards to detect potential under- and over-utilization.
- Providing best practice methods, which are up-to-date with effective strategies for quality healthcare delivery.
- Offering educational toolkits with member care guidelines and resources for improving compliance.

Provider resources

Customer Care Centers

- We are committed to providing excellent service to both members and providers.
- Our Customer Care Center team is available for both members and providers Monday through Friday, from 7 a.m. to 7 p.m. PT:
  - **1-800-407-4627** (outside of Los Angeles County)
  - **1-888-285-7801** (inside of Los Angeles County)
  - **1-888-291-1358** (Medicare Advantage providers)

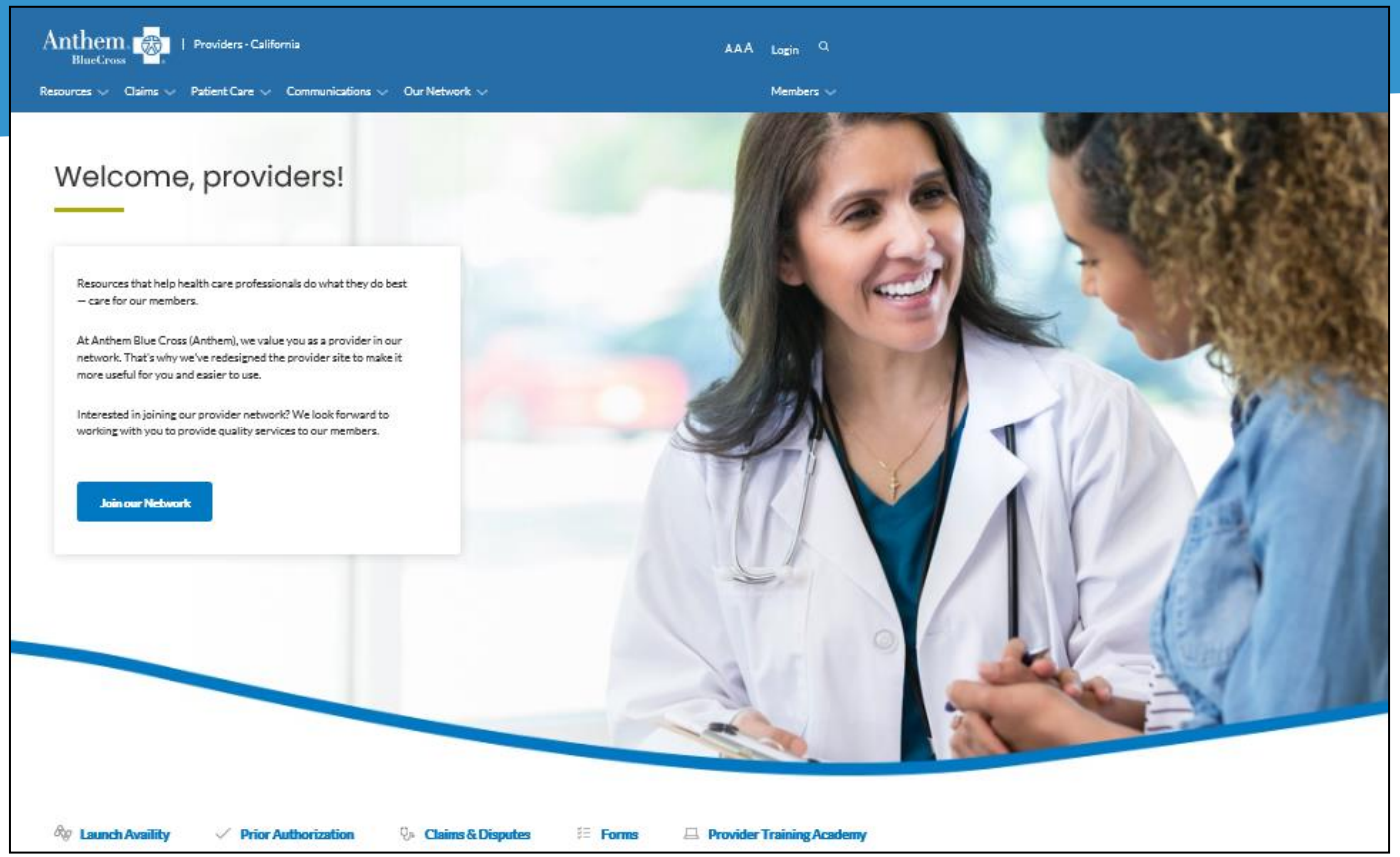
Provider Relations

Our regionalized Provider Relations staff:

- Conducts provider education and training.
- Engages providers in quality initiatives.
- Builds and maintains the provider network.
- Offers support for claims and billing questions and issues.

Inquiries	Website	Customer Care Center
Eligibility verification	√	√
Claims inquiries	√	√
Benefit verification	√	√
Primary care physician assistance	√	√
Interpreter/hearing impaired services	√	√

Provider website



Our provider website is available 24/7 to all providers, regardless of participation status at:

https://providers.anthem.com/ca

Provider website (cont.)

The following are available on our public website, meaning registration and login are **not required** to access:

- News and announcements
- The provider manual and resource guides
- Reimbursement policies
- Claims forms
- The provider directory
- Education and training resources
- The formulary

Availity: secure website

The following are available on our secure website through Availity, meaning registration and login **are required** to access:

- Prior authorization status lookup.
- Pharmacy prior authorization.
- PCP panel listings.
- Member eligibility verification.
- Claim status and payment disputes.

Availity: functions

In Availity, providers can perform many common claims and provider practice functions including:

- Submitting claims and claim payment disputes and checking their status.
- Checking member eligibility.
- Updating provider practice information.
- Managing provider accounts.
- Accessing our reimbursement policies.
- Accessing provider forms.

Availity: the advantage

Multiple payers	Availity offers a single sign-on with access to multiple payers.
No charge	Transactions are available at no charge to providers.
Accessible	Functions are available 24/7 from any computer with internet access.
Simple	The standard screen format makes it easy to find the necessary information needed and increases staff productivity.
Compliant	Availity is compliant with *HIPAA* regulations.
Training	Live, web-based and prerecorded training webinars are available to users at no cost. FAQ and comprehensive help topics are available online as well.
Support	Availity Client Services is available at **1-800-AVAILITY** (**1-800-282-4548**), Monday through Friday from 5 a.m. to 4 p.m. PT
Reporting	User reporting allows the primary access administrator to track associate work.

LiveHealth Online*

- LiveHealth Online allows members to visit with a doctor, therapist, psychologist or psychiatrist through live video via a smart device or computer.
- Members may use the application when urgent health conditions arise and they are unable to see their own doctor (for example, in the case of the flu, fevers, diabetes and conjunctivitis).
- Doctors have the ability to send prescriptions directly to a pharmacy.
- For access, members need to create a LiveHealth Online account either through the website at **www.livehealthonline.com** or by downloading the free LiveHealth Online mobile app.

Member interpreter services

- Providers must notify members of the availability of interpreter services and strongly discourage the use of friends and family, particularly minors, to act as interpreters.
- To obtain free interpreting services, please call our Customer Care Centers:
  - **1-800-407-4627** (outside of Los Angeles County)
  - **1-888-285-7801** (inside of Los Angeles County)
- For after-hours telephone interpreter services, call the 24/7 NurseLine at **1-800-224-0336**.
- Interpreter services require 72 hours advance notice and 24 hours cancellation notice.

Cultural competency

- Anthem recognizes that providing healthcare services to a diverse population can present challenges.
- Our cultural diversity and linguistic services toolkit, called *Caring for Diverse Populations,* was developed to give you specific tools for breaking through cultural and language barriers in an effort to better communicate with your patients. The toolkit can be downloaded on our provider website at **https://providers.anthem.com/ca**.

24/7 NurseLine

Members

- Telephone access to registered nurses for:
  - Answers to general health questions
  - Guidance with health concerns

Providers

- Available after regular business hours to:
  - Verify member eligibility
  - Schedule after-hours interpreter services for medical visits or telephone conversations

Available 24/7 by calling **1-800-224-0336**.

Provider communications

- The provider manual is a key support resource for:
  - Prior authorization requirements.
  - An overview of covered services.
  - The member eligibility verification process.
  - Member benefits.
  - Access and availability standards.
  - The grievances and appeals process.
- We'll tell you about any business changes and important updates through a variety of communications. Expect to see bulletins, network updates, letters and fliers via fax and/or posted on our provider website, found at **https://providers.anthem.com/ca**.

Member benefits and services

Enrollee rights

- Anthem members should be clearly informed about their rights and responsibilities in order to make the best healthcare decisions. This includes:
  - Being treated with dignity and respect.
  - Being afforded privacy and confidentiality in all aspects of care and for all healthcare information, unless otherwise required by law.
  - Being provided a copy of their medical records upon request and to request corrections or amendments to these records.
  - Having advanced directives established and explained to them if the participant so desires.
- Please refer to the *Anthem Blue Cross Provider Manual* for more information.

Medi-Cal benefits and services

- Some of the benefits/services members receive are:
  - Coordination of managed care plan.
  - Initial health assessments (IHAs).
  - Physician office visits — inpatient and outpatient services.
  - DME and supplies.
  - Emergency services.
  - Care management and utilization management.
  - Pharmacy benefits by IngenioRx.*
  - Preventive and restorative dental services covered by Denti-Cal.
- Detailed benefits/services information is available in the provider manual located on the Anthem provider website.

Member service guide and provider directory

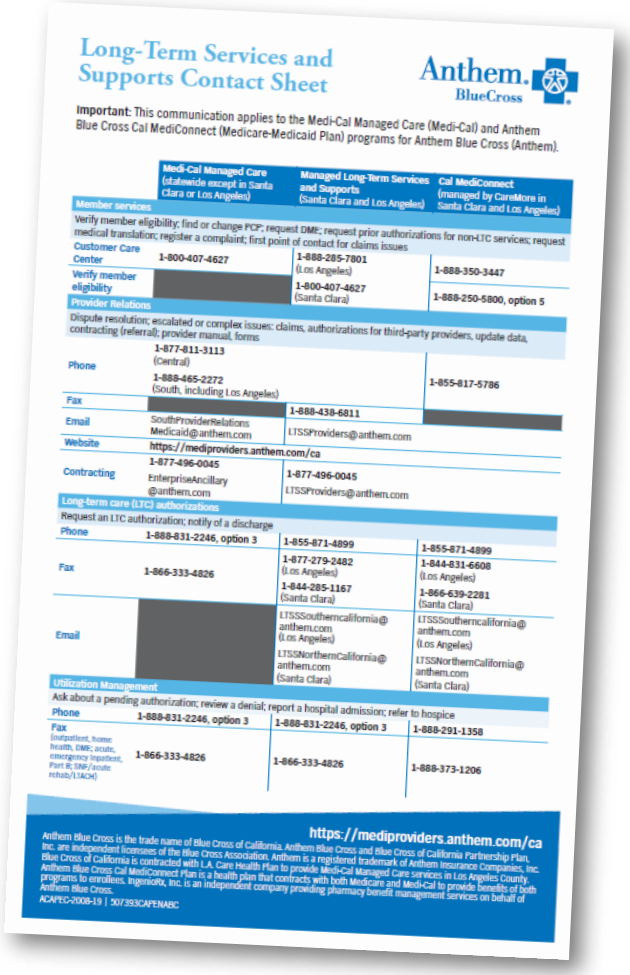
Medi-Cal members receive an *Anthem Blue Cross Member Service Guide/Evidence of Coverage (EOC)* and provider directory.

- The member service guide includes information on:
  - Benefits and exclusions
  - Prior authorization process and requirements
  - Member rights
  - Contact information
- The provider directory lists providers that work with Anthem:
  - Primary care physicians and specialists
  - Pharmacies, hospitals, skilled nursing facilities and urgent care centers
  - Ancillary and LTSS providers

Key contacts

The *Long-Term Services and Supports Contact Sheet* is available on the provider website for download.

https://providers.anthem.com/ca> Provider Support > Manuals, Training & More > Resources



Long-Term Services and Supports Contact Sheet

Anthem. BlueCross

Important: This communication applies to the Medi-Cal Managed Care (Medi-Cal) and Anthem Blue Cross Cal MediConnect (Medicare-Medicaid Plan) programs for Anthem Blue Cross (Anthem).

	Medi-Cal Managed Care (statewide except in Santa Clara or Los Angeles)	Managed Long-Term Services and Supports (Santa Clara and Los Angeles)	Cal MediConnect (managed by CareMore in Santa Clara and Los Angeles)
Member services			
Verify member eligibility; find or change PCP; request DME; request prior authorizations for non-LTC services; request medical translation; register a complaint; first point of contact for claims issues			
Customer Care Center	1-800-407-4627	1-888-285-7801 (Los Angeles) 1-800-407-4627 (Santa Clara)	1-888-350-3447
Verify member eligibility	[redacted]		1-888-250-5800, option 5
Provider Relations			
Dispute resolution; escalated or complex issues; claims, authorizations for third-party providers, update data, contracting (referral); provider manual, forms			
Phone	1-877-811-3113 (Central) 1-888-465-2272 (South, including Los Angeles)		1-855-817-5786
Fax	[redacted]	1-888-438-6811	[redacted]
Email	SouthProviderRelations Medicaid@anthem.com	LTSSProviders@anthem.com	
Website	https://mediproviders.anthem.com/ca		
Contracting	1-877-496-0045 EnterpriseAncillary @anthem.com	1-877-496-0045 LTSSProviders@anthem.com	
Long-term care (LTC) authorizations			
Request an LTC authorization; notify of a discharge			
Phone	1-888-831-2246, option 3	1-855-871-4899	1-855-871-4899
Fax	1-866-333-4826	1-877-279-2482 (Los Angeles) 1-844-285-1167 (Santa Clara)	1-844-831-6608 (Los Angeles) 1-866-639-2281 (Santa Clara)
Email	[redacted]	LTSSSoutherncalifornia@anthem.com (Los Angeles) LTSSNorthernCalifornia@anthem.com (Santa Clara)	LTSSSoutherncalifornia@anthem.com (Los Angeles) LTSSNorthernCalifornia@anthem.com (Santa Clara)
Utilization Management			
Ask about a pending authorization; review a denial; report a hospital admission; refer to hospice			
Phone	1-888-831-2246, option 3	1-888-831-2246, option 3	1-888-291-1358
Fax (outpatient, home health, DME; acute, emergency inpatient, Part B; SNF/acute rehab/LTACH)	1-866-333-4826	1-866-333-4826	1-888-373-1206

https://mediproviders.anthem.com/ca

Additional resources

Medi-Cal Managed Care overview

- Each Medi-Cal member is required to select a PCP that will oversee medical care.
  - A PCP is a network physician who provides both the first contact for a person with an undiagnosed health concern as well as continuing care of varied medical conditions, not limited by cause, organ system or diagnosis.
  - The PCP has responsibility for the complete care of his or her patient, including referring or obtaining precertification for covered services for members to the appropriate provider of care within the network.
- Each member has a care manager and an Interdisciplinary Care Team (ICT) assigned to assist with developing care plans, collaborating with other team members and providing recommendations for the management of the member's care.

Who we serve

LTC

- Excludes skilled nursing
- Includes a wide range of services provided to elderly individuals and people with disabilities who need ongoing care due to a chronic condition

IHSS

- Provides needed services for members to stay safely in their own home as an alternative to out-of-home placement

CBAS

- Offers services to eligible older adults and/or adults with disabilities to restore or maintain their optimal capacity for self-care and delay or prevent inappropriate or personally undesirable institutionalization

MSSP

- Designed to help seniors who are at risk of nursing facility placement and who can and wish to remain living in their homes or in the community

In-home support services (IHSS)

IHSS provides in-home assistance to eligible aged, blind and disabled individuals as an alternative to out-of-home care and enables recipients to remain safely in their own homes. Members receive support with:

- Household chores such as cleaning, cooking, grocery shopping and laundry.
- Personal care and paramedical services.
- Protective supervision for people living with mental health conditions.
- Transportation to and from medical appointments.

Community-based adult services (CBAS)

CBAS is a facility-based program that provides skilled nursing, social services, physical and occupational therapies, personal care, family/caregiver training and support, meals, and transportation.

- The primary objectives of the program are to:
  - Restore or maintain optimal capacity for self-care to frail elderly persons and other adults with physical or mental disabilities.
  - Delay or prevent inappropriate or personally undesirable institutionalization in long-term care facilities.

Multipurpose Senior Services Program (MSSP)

The **MSSP** program provides additional HCBS to individuals eligible for Medi-Cal who are 65 years or older and disabled as an alternative to nursing facility placement. MSSP allows the individuals to remain safely in their homes. Members get support with:

- Medical care coordination.
- An emergency response system.
- Respite care.
- Transportation.
- Home safety changes or minor repairs.
- Legal help.
- Home-delivered meals.
- Money management.
- Housing help.

Long-term care (LTC)

The **LTC** program is for individuals who need financial support to pay for nursing home stays. The program is designed for individuals and seniors with chronic conditions and debilitating health problems that require 24-hour care. Members get support with:

- 24-hour medical care and supervision by licensed staff.
- Assistance with medical appointments.
- Pulmonary and respiratory care.
- Medicine management.
- Social and recreational activities.

LTC through Medi-Cal does **not** cover rates at senior residences, board and care facilities, nor assisted living facilities.

*CareMore is an independent company providing Medicare services on behalf of Anthem Blue Cross. Availity is an independent company providing secure provider services on behalf of Anthem Blue Cross. Office Ally is an independent company providing claims submission services on behalf of Anthem Blue Cross. Change Healthcare is an independent company providing claims submission services on behalf of Anthem Blue Cross. The SSI Group, LLC is an independent company providing claims submission services on behalf of Anthem Blue Cross. ICS is an independent company providing claims submission services on behalf of Anthem Blue Cross. LiveHealth Online is an independent company providing telehealth services on behalf of Anthem Blue Cross. IngenioRx, Inc. is an independent company providing pharmacy benefit management services on behalf of Anthem Blue Cross.

https://providers.anthem.com/ca

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