OPTIMA COMMUNITY COMPLETE PROVIDER MANUAL

SUPPLEMENTAL INFORMATION

This supplemental Provider manual (supplement) is available for Providers who participate with Optima Community Complete (OCC), the Optima Health Medicare Advantage Dual Special Needs Program (D-SNP). Information contained in this supplement details additional information and exceptions that are specific to D-SNP. Unless otherwise indicated in this supplement, information in the core Provider Manual, the Optima Health Medicare HMO Supplemental Manual, and the Optima Health Medicaid Program Provider Manual applies to D-SNP as appropriate. Providers should continue to refer to the core Provider Manual and Supplemental Manuals for policies and procedures not addressed in this supplement and contact Provider Relations or their Network Educator for additional questions regarding D-SNP.

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OPTIMA COMMUNITY COMPLETE AND D-SNP OVERVIEW

Optima Community Complete (OCC) is the Medicare Advantage Dual-Eligible Special Needs Plan (MA D-SNP) administered by Optima Health. OCC provides Medicare Part A, B, and D benefits for Members who are also eligible for full Medicaid benefits. Special Needs Plans allow a monthly enrollment. The Member must apply by the last day of the month for their coverage to begin the first of the next month.

Medicare Advantage D-SNP plans limit membership to people who qualify for Medicare A, B, and D and full Medicaid coverage. Approved populations for MA D-SNP include the following dual-eligible categories:

- Qualified Medicare Beneficiary Plus (QMB+)
- Special Low Income Medicare Beneficiary Plus (SLMB+)
- Other Full-Benefit Dual Eligible (FBDE)

Medicare beneficiaries with full Medicaid coverage may elect any MA D-SNP plan and Medicaid plan that is approved for their area. Eligible Members are encouraged to but are not required to choose the same managed care health plan for their Medicare and Medicaid benefits (unaligned).

When Medicare beneficiaries choose the same managed care health plan for D-SNP and Medicaid (aligned), there are numerous benefits. For these OCC/Medicaid program Members, Optima Health will coordinate coverage of the Member's Medicare benefits through OCC and Medicaid benefits through Optima Health Medicaid program, streamlining administrative processes for Providers and meeting the Member's need for coordinated, comprehensive care. OCC is available statewide in Virginia, except Accomack County.

In addition to standard Medicare coverage, OCC Members may also qualify for additional services typically covered under Medicaid Managed Long-Term Services and Supports such as:

- Care Management
- Transportation
- Home and Vehicle Modifications
- Assistive Technology
- Home Delivered Meals post hospitalization
- Mental Health and Addiction Services
- Nursing Home Care (both skilled and long term care)
- Personal Care
- Private Duty Nursing
- Personal Emergency Response Systems
- Respite

OCC integrates Medicare and Medicaid benefits through care coordination so Members receive a more seamless care experience matched to their specific needs. Providers serving OCC Members benefit from the increased coordination of care and benefits by Optima Health. OCC Care Coordinators perform a Health Risk Assessment (HRA) and develop individualized care plans (ICPs) in collaboration with Members, their families, and Providers. An interdisciplinary care team (ICT), designed to facilitate easy communication between Optima Health and all Providers touching a Member's care, oversees progress on ICPs.

Providers submit claims directly to OCC. Optima Health coordinates payment to the Provider from Medicare and Medicaid. OCC Members have Medicare cost sharing protection under their Medicaid benefits. Providers may not bill Members for the balance of any service rendered, nor bill them for services not reimbursed by OCC. Members may have copayment requirements for prescription drugs covered under Medicare Part D.

OCC Providers are responsible for adhering to requirements and regulations from this Supplemental Manual, the Optima Health Medicaid Program Provider Manual, the Optima Health Provider Manual, Optima Health Provider Agreement, and state and federal governments.

Provider Participation Requirements

Medicare Advantage and Medicaid program Providers contracted with Optima Health are included in the OCC network unless they have opted out of D-SNP. For further information on credentialing and participation requirements, please refer to the Optima Health Provider Manual or contact a Network Educator.

In addition to the requirements defined in the Optima Health Medicaid Program Provider Manual. OCC Providers must agree to the prohibition on billing Members for Medicare Part A and B deductibles, premiums, and copayments. OCC Members are protected from all cost-sharing for Medicare Part A/B and Medicaid services. Members who are not institutionalized or receiving care under a Home and Community-Based Services waiver may be responsible for Part D copayments for prescription drugs.

Providers are expected to participate on ICTs and assist Members and Optima Health Care Coordinators to develop and maintain ICPs.

Model of Care Training

Providers are required to maintain DSNP Model of Care training on an annual basis. Providers may access the Optima Health DSNP Model of Care training at:

www.optimahealth.com/providers/provider-support/education/.

This Provider Manual, provider newsletters, and our Network Educators are also resources for DSNP Model of Care training guidelines.

MEMBER IDENTIFICATION AND INFORMATION

D-SNP Members will have 2 Identification Cards, one for their Medicare D-SNP coverage and one for their Medicaid coverage. There will be a D-SNP Identification Card that indicates the D-SNP plan chosen by the Member and a Medicaid Identification Card that indicates the Medicaid Plan chosen by the Member. Providers should obtain both ID cards and verify benefits for both the Medicare and Medicaid plans for these dual eligible Members.

Providers may identify eligible Optima Health D-SNP Members through multiple means including:

- Optima Health D-SNP Member ID card – example provided below
- Optima Health Provider Portal –optimahealth.com
- Optima Health Call Center (Eligibility) – 1-800-229-8822
- Evidence of Benefits statements (EOBs)

Eligibility

In general, individuals are eligible for Virginia D-SNP if they are eligible for Medicare Part A, B, and D, and are also fully eligible for Medicaid. The three categories of Virginia residents who are eligible for OCC are listed below. However, individuals meeting these criteria who are already enrolled in certain waiver or assistance programs may be excluded from D-SNP.

- **Qualified Medicare Beneficiary Plus (QMB+):** an individual entitled to Medicare whose income is equal to or less than 100 percent of the Federal Poverty Level (FPL) and who is determined eligible for full Medicaid coverage.

- **Special Low-Income Medicare Beneficiary Plus (SLMB+):** an individual entitled to Medicare whose income falls between 100 percent and 120 percent of the FPL and who also meets the financial criteria for full Medicaid coverage.

- **Other Full-Benefit Dual Eligible (FBDE):** an individual entitled to Medicare, who does not meet the income or resource criteria for QMB+ or SLMB+, but who is eligible for full Medicaid coverage either categorically or through optional coverage groups based on Medically Needy status, special income levels for institutionalized individuals, or home and community-based waivers.

Medicare population categories for which DMAS only pays a limited amount each month toward their cost of care are not eligible for MA D-SNP plans. Those categories include, but are not limited to, Qualified Medicare Beneficiaries (QMBs), Special Low Income Medicare Beneficiaries (SLMBs), Qualified Disabled Working Individuals (QDWIs) and Qualifying Individuals (Qis).

Grace Period

DMAS requires an enrollment grace period for D-SNP Members that lose their Medicaid coverage. During this grace period, the Member may not be balanced billed. Optima Health Medicaid program provides a 3- month grace period for D-SNP Member enrollment. If at the end of the 3-month grace period, Medicaid coverage has not been reinstated, the Member will be disenrolled from the D-SNP plan as well.

Optima Community Complete Member Services

OCC Member Services (1-800-927-6048 and the free TTY phone line 1-800-828-1140 or 711) are available to OCC Members from 8:00 am to 8:00 pm ET 7 days a week from October 1 through February 14. Between February 15 and September 30, Member Services is available from 8:00 am to 8:00 pm ET, Monday through Friday. These numbers are published in the Member materials and assist the Members in contacting the Plan with questions regarding their health plan benefits, eligibility, claims, behavioral health services, or any other question/information related to their health plan benefit coverage. The OCC Member website is www.optimahealth.com/communitycomplete.

CARE MANAGEMENT

All OCC Members receive assistance coordinating their care from an Optima Health Care Coordinator. Care Coordinators conduct comprehensive Health Risk Assessments (HRAs) with 100% of OCC Members to stratify them into levels of care; identify areas for intervention and monitoring; and understand the Member's existing supports.

Optima Health Levels of Care

Health Risk Assessments are repeated periodically to ensure the Member receives the appropriate level of care coordination as their condition and circumstances evolve. However, the Care Coordinator may adjust the Member's level of care at any time on the advice of the ICT.

Individualized Care Plans/Health Risk Assessment

The Health Risk Assessment forms the basis for the Member's ICP. Care Coordinators develop ICPs with Members and Providers to reflect the Members health needs, barriers, treatment plans, and goals. ICPs include:

- Member's goals
- Treatment and education needs

- Type and frequency of services to be provided
- Potential barriers and mitigation plans
- Measurable objectives for meeting goals
- Estimated timetable for achieving the goals and objectives

ICPs are available to Providers involved in the Member's care on the Optima Health Provider Portal at Providers.optimahealth.com. Providers may access the ICP, add comments, and send notifications to the Care Coordinator directly through the Portal.

Interdisciplinary Care Team

The Member's Interdisciplinary Care Team may include the Member; the Member's authorized representative, the Care Coordinator, the Member's Primary Care Provider, specialists, and other Provider types supporting the Member. The goal of the ICT is to ensure clear communication channels between Providers, coordinate care, and overcome any barriers preventing the Member from achieving his or her health goals.

As care coordination, ICPs, and ICTs are an integral part of the OCC, OCC Providers are expected to participate on ICTs for their assigned Members. Providers may contact their Network Educator for further information on care management services for OCC Members.

PRIOR AUTHORIZATION

Prior Authorization is required for:

- Advanced diagnostic radiology services including, but not limited to MRI, MRA, CT, CTA and PET scans
- Cardiac rehabilitation services (Medicare covered)
- Chiropractic care (Medicare covered)
- Durable medical equipment/supplies/prosthetics – single items over $500
- Elective ambulance transport
- Electroconvulsive therapy
- Genetic testing
- Home health care
- Inpatient hospitalization (including mental health care)
- Intensive outpatient program
- Insulin pumps
- Medicare covered Part B injectable drugs
- Outpatient rehabilitation services
- Outpatient substance abuse
- Outpatient surgery
- Partial hospitalization
- Pulmonary rehabilitation services (Medicare covered)
- Skilled nursing facility
- Therapeutic radiology services
- X-rays

PHARMACY

The Optima Community Complete formulary is available at:
http://www.optimahealth.com/communitycomplete

Mail-order pharmacy services are available for a minimum of a 63-day supply and a maximum of 90-day supply. Order forms are available from the OCC website above. Prescriptions are generally received within 14 days.

BENEFITS

OCC Members receive all benefits covered by original Medicare plus additional supplemental benefits. General benefit information and the complete Evidence of Coverage (EOC) for OCC are available on the OCC website at http://www.optimahealth.com/communitycomplete under Plan Overview. Specific OCC benefit information is available to Providers by calling Provider Relations during OCC business hours.

Service Types Typically Covered by Medicare and Medicaid

MEDICARE TYPICALLY COVERS	MEDICAID TYPICALLY COVERS
• Inpatient Hospital Care (Medical & Psychiatric)	• Medicare Copayments
• Outpatient Care (Medical & Psychiatric)	• Hospital and SNF (when Medicare benefits are exhausted)
• Physician and Specialist Services	• Long Term Nursing Facility Care (custodial)

MEDICARE TYPICALLY COVERS	MEDICAID TYPICALLY COVERS
• X-Ray, Lab & Diagnostic Tests	• Home & Community Based Waiver Services like personal care & respite care, environmental modifications, & assistive technology services
• Skilled Nursing Facility (SNF) care	
• Home Health Care	
• Hospice Care (covered by FFS Medicare)	• Community Behavioral Health and Substance Use Disorder Services
• Prescription Drugs	• Medicare Non-Covered Services, like OTC drugs, some DME and supplies, etc.
• Durable Medical Equipment	

OCC Supplemental Benefits

OCC offers additional supplemental benefits that are not covered by Fee-For-Service Medicare:

Hearing
One routine hearing exam per year and one fitting/evaluation for a pair of hearing aids per year is covered. The benefit allows up to $2,000 a year for hearing aids.

Chiropractic
Routine Chiropractic care is offered with a limit of 12 annual visits. This covers therapeutic manipulation and adjustment,

Dental (Preventive and Comprehensive Dental)
Includes preventive services such as oral exams, prophylaxis and bitewing x-rays in addition to a $4,000 maximum for restoration, extractions and dentures under the comprehensive dental benefit.

Eye Exams and Eyewear
One routine eye exam a year and up to $300 for eyewear (combined total for contacts, lenses and frames).

Over the counter medications and medical supplies are covered up to $400 every 3 months.

Routine Podiatry Care
Up to 8 preventive treatments a year, i.e. cutting or removal of corns, warts, calluses and nail care.

Virtual Diabetes Management Program
Participation in a telemedicine Diabetes Management program with Continuous Glucose Monitoring.

Wellness Programs
OCC has a $400/year fitness benefit for gym or fitness classes; fitness programs designed for the elderly; nutritional and weight management education; and additional coaching for smoking cessation.

MDLIVE Program
Video and phone appointments for routine medical conditions with board certified internal medicine, family medicine or emergency medicine physicians 24 hours a day/7days a week/ 365 days a year are included.

Worldwide Emergency/Urgent Care
$50,000 max plan benefit coverage for Emergency or Urgent Care treatment worldwide.

Benefit Limitations

Diabetic test strips should be obtained from participating retail pharmacies. Monitors, cartridges for insulin pumps, etc.

CLAIMS

Providers submit claims directly to OCC. Optima Health coordinates payment to the Provider between OCC and the Member's Medicaid plan.

Optima Community Complete (Medicare) is primary on all Medicare covered services. Optima Health Medicaid program is secondary but primary on non-Medicare covered services.

D-SNP Members are protected from all balance billing. In Virginia D-SNPs are "zero cost Share" plans. Providers may not seek payments for cost sharing from OCC Members for health care services. Providers cannot bill D-SNP Members for services not reimbursed by Medicaid or OCC, during the enrollment Grace Period, or for the difference between what has been paid and the billed charges.

Skilled Nursing Facility claims must be submitted with the appropriate Resource Utilization Group (RUG) code and assessment identifier.

OCC PROVIDER APPEALS

A document with detailed information on how to make a complaint, request a coverage decision or file an appeal about covered Medicare medical care and service or covered prescription drugs is available on the Optima Community Complete website at: https://www.optimahealth.com/documents/forms/general/optima-community-complete-complaints-coverage-decision-appeals.pdf. This document includes specific timelines and contact information.

Members may make a compliant, request a coverage decision, or file an appeal for Part C medical care or services or Part D prescription drugs themselves or appoint an authorized representative. Physicians may act as an authorized representative if requested by the Member.

Members should call OCC Member Services for assistance or contact Medicare as indicated in the document above. Medicare requests should be made within 60 days of occurrence. A pre-service expedited (fast) decision process is available when required by the Member's condition.

If the complaint, coverage decision or appeal is about Medicaid program benefits, Members should follow the process for their Medicaid plan. Medicaid plans require complaints to be filed within 180 days of the concern or issue.