Entry of Managed Care Organizations (MCOs) for the Medicaid/FAMIS Programs in The Roanoke and Alleghany Regions

Frequently Asked Questions

	QUESTIONS	ANSWERS
	ADMINISTRATION	
1.	Which of the MCOs will actually be available for members residing in Allegheny County, Covington City, Franklin, Montgomery, Pulaski and Wythe Counties?	On January 1, 2012, Amerigroup Community Care, Anthem HealthKeepers Plus offered by HealthKeepers Inc., MajestaCare-A Health Plan of Carilion Clinic, Southern Health CareNet, Optima Family Care and Virginia Premier Health Plan will be administering health care services to Medicaid and FAMIS managed care eligibles in the following localities: Alleghany County, Bath County, Bedford, Bedford County, Botetourt County, Buena Vista, Covington, Craig County, Floyd County, Franklin County, Giles County, Henry County, Highland County, Lexington, Martinsville, Montgomery County, Patrick County, Pulaski County, Radford, Roanoke, Roanoke County, Rockbridge County, Salem, Wythe County
	PROVIDER NETWORK	
2.	What do I need to do in order to continue to serve the Medicaid population? Who should I call?	Providers are strongly encouraged to contract with at least two or more MCOs. This will allow you to continue serving some of the Medicaid and FAMIS managed care population. It will be helpful to your patients to advise them of the MCOs with which you are contracting so that they may continue to be seen by your practices. If you have not been contacted by one of the MCOs, DMAS encourages providers to begin the contracting and credentialing process. Please be aware that credentialing may take up to 90 days. If you wish to contract with the MCOs, please call: Amerigroup Community Care 1-703 286 3972 Anthem HealthKeepers Plus offered by HealthKeepers Inc. 1-540-853-5077 Southern Health CareNet 1-866-240-4345, Ext 6739 MajestaCare-A Health Plan of Carilion Clinic 1-855-606-4304 Optima Family Care 1-804-510-7434 Virginia Premier Health Plan 1-800-727-7536, Option 6 Also, there will continue to be a few individuals who will remain in FFS and providers need to maintain their provider enrollment with Medicaid to continue to serve FFS.

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3.	DME Provider-How will the expansion affect our business? Many of our patients do not want to change DME providers.	Although many members are currently utilizing a DME provider; the member will have to obtain services from a DME provider within their chosen MCO network. The members have a choice of 6 health plans. Members may call the health plan that he/she is enrolled to inquire if their DME provider participates. Also, the provider would need to contact each health plan to discuss becoming one of their network providers.
	ELIGIBILITY/MEMBERSHIP INTO AN MCO	
4.	Will individuals who go into the MCO continue to have Membership cards?	Yes, members who go into the MCO will continue to receive their Medicaid plastic ID card in addition to their MCO ID card. As always, providers should verify program eligibility at *each* visit because eligibility can change.
5.	Will the patients who are currently assigned to FFS Medicaid be initially asked to pick a MCO or will they simply be randomly assigned to one? In other words, if I sign up with only part of the MCOs will my patients be asked to pick an appropriate one prior to being assigned or must they do that in the 90 days after assignment? How will they indicate their desire to change - by phone, mail or email? During the period required for them to change must they deal with the MCO to which they were assigned?	Once members are enrolled in Medicaid, they will receive a letter indicating that they have been pre-assigned to a contracted MCO. The preassignment letter shall indicate a plan in which the member will be enrolled if he/she does not make a selection by the midmonth cutoff which is usually the 18th of the month (for December 2011 the cutoff will be the 16th). Members are encouraged to exercise their selection choice. They have about 3 weeks to change plans. For the initial ninety (90) calendar days following the effective date of enrollment, the member will be permitted to disenroll from one health plan and enroll in another health plan without cause. If the member does not disenroll during the ninety (90) day period, he/she may not disenroll without cause for the remainder of the enrollment period. In addition, there will be an annual open enrollment period. The Department will inform the member of the opportunity to remain with the current health plan or change to another health plan without cause. Those members who do not choose a new MCO within the open enrollment period shall remain in his or her current health care selection. To change MCO assignment, members should call the Managed Care HelpLine at 1-800-643-2273 from 8:30 am – 6:00 p.m. EST.
6.	Will we still be able to verify enrollment using the DMAS website?	Yes, you will still be able to verify MCO assignment. All providers of services should verify program eligibility at *each* visit because eligibility can change. Relying on the permanent plastic card or even a newly issued MCO card *does not* guarantee current eligibility or reimbursement. DMAS offers a web-based Internet option to access information regarding member eligibility. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov. The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider. Providers may also access service authorization information including status via KePRO's Provider Portal, at http://dmas.kepro.org/. <u>Eligibility Vendors</u> DMAS also has contracts with the following eligibility verification vendors offering internet real-time, batch and/or integrated platforms. Contact information for each of the vendors is listed below.

	QUESTIONS	ANSWERS
6.		Eligibility Vendors Passport Health Communications, Inc. www.passporthealth.com sales@passporthealth.com Telephone: 1 (888) 661-5657 SIEMENS Medical Solutions – Health Services Foundation Enterprise Systems/HDX www.hdx.com Telephone: 1 (610) 219-2322 Emdeon www.emdeon.com Telephone: 1 (877) 363-3666
7.	Will some members still have PCPs?	Yes, members will continue to be assigned to a primary care physician by the MCO; however, providers must verify program eligibility at *each* visit.
8.	The provider currently contracts with a commercial plan; do I have to contract with the Medicaid product?	Yes, please call: Amerigroup Community Care 1-703 286 3972 Anthem HealthKeepers Plus offered by HealthKeepers Inc. 1-540-853-5077 Southern Health CareNet 1-866-240-4345, Ext 6739 MajestaCare-A Health Plan of Carilion Clinic 1-855-606-4304 Optima Family Care 1-804-510-7434 Virginia Premier Health Plan 1-800-727-7536, Option 6
9.	Will the members currently assigned to Virginia Premier be left with Virginia Premier unless they express a desire to change?	Yes, Virginia Premier members will be left with Virginia Premier unless they express a desire to select another MCO during their open enrollment period.
10.	What Vision Plan do the MCOs participate with?	Anthem— Davis Vision Optima—EyeMed MajestaCare-March Vision Amerigroup--Block Vision, Inc. Virginia Premier--Vision Service Plan CareNet--Vision Service Plan
11.	We are podiatrists and see several Medallion patients. If Medallion ends on October 31st and the new MCO's do not begin until the first of the year, who do we bill for those patients seen in November and December?	The member will be in FFS during December; therefore, bill Medicaid (DMAS). Once the member enrolls into the MCO, providers should bill the MCO. Importantly, providers will also need to verify eligibility at the time of service because the individual can move between MCOs during the first 90 day (trial period) and between MCO and FFS on-going (as a result of eligibility/program changes).
12.	I am a pharmacy and would like some guidance on what we need to do in order to continue to serve the Medicaid population.	Please call the phone numbers below for assistance. Amerigroup Community Care 1-703 286 3972 Anthem HealthKeepers Plus offered by HealthKeepers Inc. 1-540-853-5077 Southern Health CareNet 1-866-240-4345, Ext 6739 MajestaCare-A Health Plan of Carilion Clinic 1-855-606-4304 Optima Family Care 1-804-510-7434 Virginia Premier Health Plan 1-800-727-7536, Option 6

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<tr><th></th><th>QUESTIONS</th><th>ANSWERS</th></tr>
<tr><td></td><td colspan="2">REIMBURSEMENT/TRANSITION OF SERVICES</td></tr>
<tr><td>13.</td><td>Will a Federally Qualified Healthcare Clinic (FQHC) or a community health center that is located in a school be able to provide the services at the school site and bill the MCO for services?</td><td>Yes, a Federally Qualified Healthcare Clinic (FQHC) or a community health center that is located in a school (and not providing school based services) will be able to provide the services at the school site and bill the MCO for services. However, if the services are included in the members Individualized Education Plan (IEP) then the services are not payable through the contracted health plans.</td></tr>
<tr><td>14.</td><td>If a newborn that I care for is assigned to his or her mother's MCO and I do not participate with that MCO, how do I get paid for care rendered until the child can be changed into a MCO with which I participate?</td><td>If the provider on-call at the time of birth treats the newborn in the hospital and any follow-up appointments for up to three calendar months (birth month plus 2 months) is not in the MCO network or until the health plan can transition the newborn to a network provider, the Contractor is required to reimburse, in the absence of an agreement otherwise, at the Medicaid rate in place at the time the services were rendered. The newborn's continued enrollment with the Contractor is not contingent upon the mother's enrollment.

Please visit our website at http://dmasva.dmas.virginia.gov/Content_pgs/mc-home.aspx for additional information</td></tr>
<tr><td>15.</td><td>Will all secondary Medicaid claims have to be submitted on line through Medicaid's website?</td><td>For MCO enrolled individuals, the MCO is administering Medicaid and FAMIS benefits instead of DMAS. Most individuals with TPL will not be enrolled in an MCO. However, there are some cases where the TPL is entered while the individual is enrolled with the MCO. In these cases, the MCO will coordinate benefits. Therefore, for MCO enrolled individuals, the only claims that would come through DMAS are claims for carved-out services, and these claims must be sent in accordance with DMAS guidelines, as described in the appropriate DMAS Provider Program Manual. These manuals are available on the DMAS website at: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual.</td></tr>
<tr><td>16.</td><td>Currently, I see children outside of my geographical area. Since I have been seeing these patients for a long time will I be able to continue to see these children under an MCO?</td><td>Contractually, DMAS requires the MCO to assure that members have access to care within specific time and distance standards (see chart below) and within specific appointment time standards. Exceptions may be negotiated between the provider and the MCO in special circumstances (for example, where the normal pattern of securing health care services within an area falls beyond the prescribed travel distance, or where the provider with a certain skill level is not available within the service area such as treatment of cancer, burns, or other conditions). Providers should contact the member's assigned MCO to negotiate out-of-network coverage.

MCO Provider Access Time and Distance Standards
<table>
<tr><th>Type of Provider</th><th>Rural or Urban</th><th>Time</th><th>Distance</th></tr>
<tr><td>PCP</td><td>Rural</td><td>60 minutes</td><td>30 miles</td></tr>
<tr><td>PCP</td><td>Urban</td><td>30 minutes</td><td>15 miles</td></tr>
<tr><td>OB</td><td>Rural</td><td>45 minutes</td><td>--</td></tr>
<tr><td>Specialist</td><td>Rural</td><td>--</td><td>60 miles</td></tr>
<tr><td>Specialist and OB</td><td>Urban</td><td>--</td><td>30 miles</td></tr>
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17.	Does the MCO require modifiers for vision and hearing?	DMAS does not have this information readily available. Please contact the MCOs directly to obtain this information. MCO Provider Contact Numbers: Amerigroup Community Care 1-703 286 3972 Anthem HealthKeepers Plus offered by HealthKeepers Inc. 1-540-853-5077 Southern Health CareNet 1-866-240-4345, Ext 6739 MajestaCare-A Health Plan of Carilion Clinic 1-855-606-4304 Optima Family Care 1-804-510-7434 Virginia Premier Health Plan 1-800-727-7536, Option 6
18.	What if an MCO does not accept claims from our processor for claims?	DMAS does not intervene in billing and claims payment processes. Instead, billing and claims related processes are handled between the provider and the MCO.
19.	Formulary--It is a problem with prescription drugs because every plan has a different formulary and it is problematic. Is there a way for all the plans to have the same formulary?	Currently, each MCO may establish their formulary. However, each MCO has a procedure to allow providers to access drugs outside of their established formulary, if medically necessary. Also, if a formulary is in place, the MCO is required to notify those members who are affected by any formulary change, as well as notify the provider who prescribed the product.
20.	As a Community Mental Health Rehabilitation Services provider, that provides Psycho-social day program for 18 years old and over what do I need to do to contract with the health plans?	Community Mental Health Rehabilitation Services are carved-out and shall be paid by the Department under fee-for service. However, the MCO must provide information and referrals as appropriate to assist members in accessing these services. The MCO is required to cover transportation to and from these services and prescription drugs prescribed by the outpatient mental health provider. See link below for more information. Note: Psychosocial Rehabilitation service is not a FAMIS covered benefit. Accessing Carved-Out Services http://dmasva.dmas.virginia.gov/Content_pgs/mc-home.aspx Behavioral Health Services http://dmasva.dmas.virginia.gov/Content_pgs/obh-home.aspx
21.	We are a community health provider that provides mental health support, outpatient psychiatric diagnostic and pharmacological management; do we need to be enrolled with the MCO?	Yes, you need to contact each MCO because the MCO is responsible for covering outpatient mental health services; including, outpatient psychiatric diagnostic exams and pharmacological management. For assistance please see the managed care website at: http://dmasva.dmas.virginia.gov/Content_pgs/mc-home.aspx
22.	How will expansion efforts affect Residential Treatment facilities?	Once a member is authorized to go into a residential treatment facility (Level C) the member will be disenrolled or excluded from Medallion II participation. The residential treatment facility provider must contact the DMAS prior-authorization agent for authorization (KePRO). Medicaid coverage for residential level C treatment is provided through the Department's fee-for-service program as described in the DMAS Psychiatric Services Provider Manual, available at: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal.