



# The Virginia Medicaid (Medallion II) and CHIP (FAMIS) Program Expansion

## Effective July 1, 2012

---

Administered by  
The Department of Medical Assistance  
Services



# Managed Care Enrollment

**DMAS' mandatory managed care program using contracted Managed Care Organizations (MCO) marked a 16 year anniversary on 1/1/12.**

## **Enrollment - April 2012:**

<b>Medicaid FFS</b>	<b>293,325</b>
<b>Medicaid (MEDALLION) PCCM</b>	<b>43,743</b>
<b>Medicaid MCO (Medallion II)</b>	<b>569,301</b>
<b>FAMIS FFS</b>	<b>7,553</b>
<b>FAMIS MCO</b>	<b>56,864</b>



# Why Managed Care?

- **Access**  
The Department does not have a network development team and therefore had access gaps. The MCOs are able to leverage their commercial and/or health system networks to increase access.
- **Quality**  
The Department's outcome measures are low (EPSDT, Immunization, Prenatal Care). MCO outcomes are higher. Requiring plans to have NCQA accreditation moved Virginia scores into higher percentiles.



# Background

- **Credentialing**

The Department experienced concerns with some of the providers in the FFS networks (unverified qualifications, no site visits, no reporting mechanism). MCOs using NCQA standards have achieved superior networks through credentialing.

- **Member Service**

The Department is unable to develop a comprehensive member service unit. MCOs are able to offer 24/7 call centers, member information and programs, outreach.



# Background

- **Case Management**  
The Department is unable to offer case management, chronic care management, enhanced prenatal care and disease management programs. The MCOs offer these programs plus predictive modeling and patient-centered care.
- **Cost**  
The MCO program is full risk, thus it provides the Department with a stable predictor of costs.



# Value Added Benefits of MCOs

- Virginia is one in a handful of states that require our contracted MCOs to obtain National Committee for Quality Assurance (NCQA) accreditation.
- NCQA is the gold standard in evaluating health plan quality by employers, consumers, regulators and health plans.
- All current MCOs not only meet this requirement, they have all been ranked nationally by NCQA in the top 50 for 2011.
- Provider Relations and dedicated provider staff.
- Patient Education Information - Member handbooks, provider directories, newsletters and health information (available in English and Spanish).



# Value Added Benefits of MCOs

- **Enhanced Services** - Most provide services above Medicaid covered services (e.g., vision services for adults).
- **Case Management** for special needs and identified populations.
- **Dedicated staff** (or contract with organizations like CHIP) to provide outreach, education, and to visit members. Some MCOS visit members to explain program.
- **24 Hour Advice and Triage Nurse Helpline** - A toll-free number to discuss information on a disease or illness (e.g. asthma, pregnancy) or receive advice on the treatment of a minor fever, accident or illness.
- **MCOs have unique programs** to help manage difficult patients including drug seekers, frequent ER users and chronic disease sufferers.

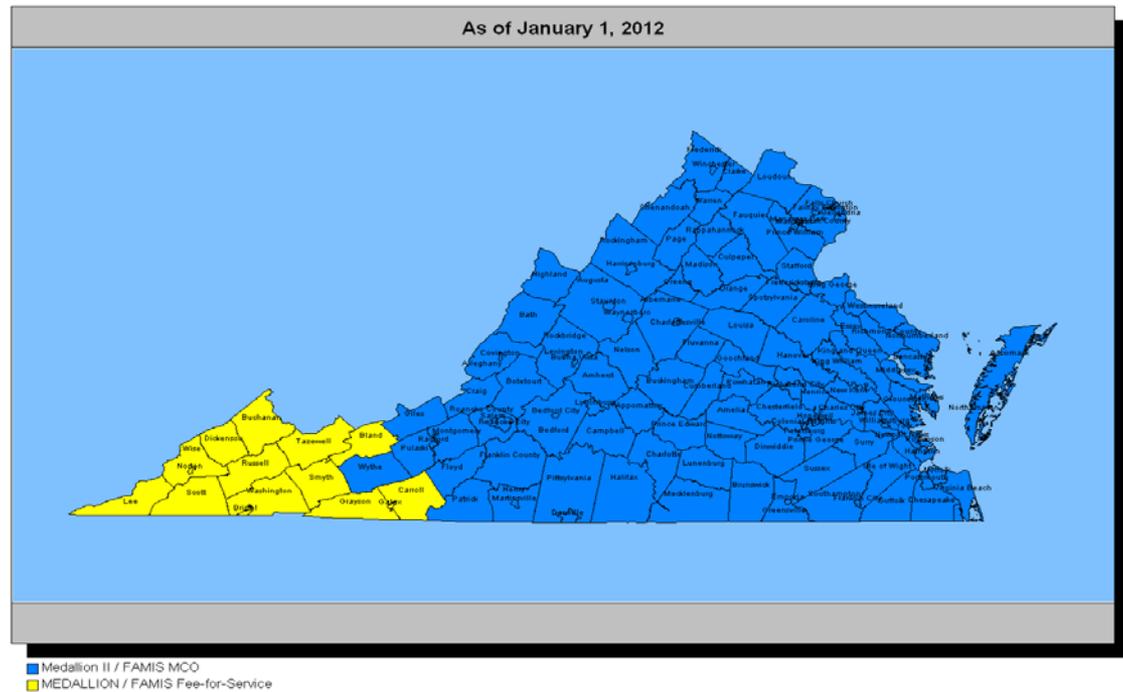


# Value Added Benefits of MCOs

- **Disease/Health Management Programs -** Provide disease management programs and provide patient/outreach information on how to manage asthma, diabetes, maternity, etc.
- **Immunization rate of 83% is substantially above the national average of 63%.**
- **Diabetes programs have demonstrated a decrease in hospital admission and emergency room visits.**
- **The HEDIS measure for 'use of appropriate asthma medications' (87% - 95%) is above the national rate of 86%.**

# Department of Medical Assistance Services

## Medallion II / FAMIS Managed Care





# Affected Localities for July 1, 2012 Expansion

- The counties of:  
Bland, Buchanan, Carroll, Dickenson,  
Grayson, Lee, Russell, Scott, Smyth,  
Tazewell, Washington, Wise
- The cities of:  
Bristol, Galax, Norton



# Medallion II – Who is Included?

**Mandatory Medicaid enrollment of managed care eligible individuals into an MCO - mostly children, families and disabled individuals.**

**Medicaid individuals who are excluded from MCO enrollment and will receive services through fee-for-service Medicaid, and include:**

- **Medicare/Other Primary Insurance**
- **Nursing Homes/State Institutions**
- **Hospice**
- **Technology Assisted Waiver**
- **Birth Injury Fund enrollees**
- **Individuals hospitalized under fee-for-service (remain fee-for-service until discharged – see instructions on the DMAS managed care web page)**
- **Individuals admitted to DMAS authorized Residential Treatment (Level C) Facilities (remain fee-for-service until discharged – see instructions on the DMAS managed care web page.**

Coverage for individuals excluded from managed care and services that are carved out of the MCO Contract are handled through fee-for-service, by DMAS or the DMAS contractor. For detailed instructions and information, refer to the DMAS Managed Care Web page at

[http://dmasva.dmas.virginia.gov/Content\\_pgs/mc-home.aspx](http://dmasva.dmas.virginia.gov/Content_pgs/mc-home.aspx)



# Managed Care Health Plans

**Six health plans are approved to serve  
Managed Care eligibles for the area :**

<b>Amerigroup Virginia, Inc.</b>	<b>1-800-231-8076</b>
<b>Anthem HealthKeepers Plus</b>	<b>1-540-853-5077</b>
<b>Southern Health CareNet</b>	<b>1-866-240-4345</b> <b>Ext. 2226739</b>
<b>MajestaCare-A Plan of Carilion Clinic</b>	<b>1-866-996-9140</b>
<b>Optima Family Care</b>	<b>1-804-510-7434</b>
<b>Virginia Premier Health Plan</b>	<b>1-866-285-8963</b>



# Carved-out Services

- DMAS (FFS) continues to reimburse for:
  - Community mental health rehabilitation, mental retardation, and substance abuse treatment services
  - Targeted Case Management (Medicaid only-not covered under FAMIS)
  - Lead Investigations
  - Abortions (only for life or health of mother)
  - Treatment Foster Care Case Management
  - School services (included in the child's individualized education plan – IEP)
- Dental Services will continue to be provided through *Smiles For Children*<sub>SM</sub> by DentaQuest



# How Members Get Enrolled

- New Medicaid managed care eligibles and former MEDALLION enrollees are pre-assigned to one of the MCOs and notified by mail in late May
- Recipients must call the Managed Care Helpline by June 18<sup>th</sup> to make choice or be automatically enrolled into the pre-assigned MCO
- MCO enrollment effective 7-1-12
- FAMIS members will be assigned in June for July 1<sup>st</sup>



# Medicaid - Changing MCOs

- Ninety (90) days after the effective date to change MCOs for any reason
- After 90 days changes are only allowed with approval from DMAS for good cause which is defined by regulation
- Annual Open Enrollment (May and June). Changes become effective July 1<sup>st</sup>
- FAMIS Open Enrollment occurs on the member's anniversary date



# HOW DOES THIS AFFECT YOU?



# MEDALLION Program Ends

- **The MEDALLION program ended April 30, 2012. If you were a MEDALLION provider, after April 2012 you will not receive \$3 PMPM from Medicaid for clients.**
- **Effective May 1, 2012, all former MEDALLION clients in the expansion area returned to fee-for-service Medicaid to prepare for MCO enrollment effective July 1, 2012**



# Providers Must Contract

- **In order to see managed care members, you must contract with MCOs or receive a prior authorization**
- **Providers may refer patients to preferred MCOs and advise that they choose MCOs with whom the provider is contracted**
- **Know the MCO network for specialty care. Avoid referrals to specialists outside the patient's MCO network**



# MCO Contracting Requirements

- We encourage you to contract with multiple MCOs (maintain DMAS contract for patients covered under FFS)
- Your business needs and the MCO's ability to meet those needs must be a consideration
- Each MCO is responsible for the development of its own provider network
- The MCO provider contract defines the scope of the relationship with the plan to include reimbursement, and expectations
- An MCO contract allows you to see the MCO's Medicaid and FAMIS enrollees
- Each MCO has dedicated provider relations staff to help you. Get to know who they are and how to reach them



# Credentialing – Consider Timing

- **Credentialing – As with commercial and private insurance, the plans will require that providers go through a credentialing process before becoming part of a plan's network**
- **This process may take up to 90 days before contracting is completed**



## If You Do Not Contract

- You will not be able to continue to treat managed care eligible members
- For services rendered to a MCO member without benefit of a contract with the MCO or an agreement for reimbursement/out-of-network authorization, your payment will be denied. Providers may not bill the member.



# Medical Transition

**DMAS will support providers in this transition.**

- **To assist in the transition process, DMAS will be providing the MCOs with Medical Transition Reports and Health Status Survey information from the Managed Care Helpline**
- **This information will assure that services with authorizations, etc., are transferred to the MCOs, without disruption**
- **If you have prior-authorized a service, the authorization must be honored by the new MCO until it can be transitioned, if applicable**



# Eligibility Verification

- **Always verify eligibility! At each visit, eligibility must be verified prior to services being rendered. Providers may use the MCO eligibility verification systems or use the DMAS systems:**
  - **Web-based**
  - **Telephone**
  - **Swipe card**
- **Presentation of ID card does not guarantee eligibility**
- **If eligibility is not verified the MCO is not responsible to cover service and the member cannot be billed**



# Billing

- **Claims for covered services provided to MCO recipients are submitted to the MCO for payment**
- **Providers must adhere to MCO contract terms including claim submission timelines, which may differ from Medicaid**
- **Many MCOs have electronic claim submission and payment capability**
- **Providers cannot bill a recipient for any services provided that are covered within the State Plan**
- **If a recipient agrees, in writing and in advance of receiving the service, to pay for a service that is not a State Plan covered service, then a provider can bill the recipient for that service**



# Appeals

## For Medicaid:

- Providers may appeal with the MCO and exhaust the MCO process. After completing MCO process, may appeal to DMAS
- Members (or providers on behalf of members) may appeal to MCO or DMAS or both concurrently

## For FAMIS:

- Providers may only appeal through the health plan.
- Enrollees must exhaust MCO appeal process.
- External review option available once MCO appeal process has been exhausted. Enrollee sends request to DMAS



# FAMIS Differences

- FAMIS MCOs require small co-pays of \$2 or \$5 for most services
- Non-emergency transportation is not covered (some MCOs offer a limited number of trips as an enhanced benefit)



# Managed Care Resource Guide



**Commonwealth of Virginia**  
**Department of Medical Assistance Services**

[http://dmasva.dmas.virginia.gov/Content\\_pgs/mc-home.aspx](http://dmasva.dmas.virginia.gov/Content_pgs/mc-home.aspx)



# Medicaid Managed Care Help Line

**Medicaid Clients can receive  
assistance by calling the  
Managed Care HelpLine at**

**1-800-643-2273**

**TDD: 1-800-817-6608**

**8:30am – 6:00pm Monday - Friday**



# FAMIS Central Processing Unit

**FAMIS Clients can receive assistance  
by calling the**

**Central Processing Unit at**

**1-866-87FAMIS  
(1-866-873-2647)**

**TDD:1-888-221-1590**

**8 a.m. to 7 p.m. Monday - Friday**

**9 a.m. to 12 noon Saturday**



# Thank You!

[www.dmas.virginia.gov](http://www.dmas.virginia.gov)

[www.virginiamanagedcare.com](http://www.virginiamanagedcare.com)

[ManagedCareHelp@dmas.virginia.gov](mailto:ManagedCareHelp@dmas.virginia.gov)

[www.famis.org](http://www.famis.org)