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# **The Virginia Medicaid (Medallion II) and CHIP (FAMIS) Programs**

**Administered by  
The Department of Medical Assistance Services  
Division of Health Care Services**

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# Why We Are Here

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- **To Promote Executive Branch and General Assembly Initiatives to Expand Managed Care Statewide**
- **To Clarify Misconceptions**
- **To Explain Managed Care**
- **To Answer Questions**
- **To Listen**

# Medallion II/FAMIS

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DMAS' mandatory managed care and FAMIS programs with contracted Managed Care Organizations (MCO) marked a 15-year anniversary on 1/1/11.

Enrollment - September 1, 2011:

Medicaid FFS	287,585
Medicaid (MEDALLION) PCCM	53,231
Medicaid MCO (Medallion II)	531,417
FAMIS FFS	8,298
FAMIS MCO	53,917

# Why Managed Care?

## Background

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The Department embraced managed care for 6 major reasons:

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

# Background

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3. **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.
4. **Member Service** – The Department was unable to develop a full service client member service unit. MCOs are able to offer 24/7 call centers, member information and programs, outreach.

# Background

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5. **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.
6. **Cost** – The MCO program is full risk, thus it provides the Department with a stable predictor of costs.

# Value Added Benefits of MCOs

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- 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

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- 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. 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

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- 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%.

# A Closer Look at Adult Patient with Diabetes

## Which Would you Prefer for your Patient?

- Patient is enrolled in Fee-for-Service Medicaid :
  - Primary care doctor and his/her practice are responsible for coaching the patient on how to manage their condition
- Patient is enrolled in a Medicaid MCO, the MCO will:
  - Provide phone-based case management and mailed prompts for eye exams, immunizations, monitoring and management of HbA1c levels, lipid profiles, blood pressure and weight control.
  - Strongly encourage the enrollee to work in partnership with their physician to manage their diabetes, prevent complications and prevent unnecessary visits to the ED.

Did you know? MCOs have sophisticated Information Systems with algorithms that promptly identify enrollees who are newly diagnosed and/or whose diabetes is unmanaged?





# Affected Localities for July 1, 2012 Expansion

Approximately 75% (45,000) of the Medicaid and CHIP enrollees in the following localities will be enrolled in a managed care organization:

- **Bland**
- **Bristol**
- **Buchanan**
- **Carroll**
- **Dickenson**
- **Galax**
- **Grayson**
- **Lee**
- **Norton**
- **Russell**
- **Scott**
- **Smyth**
- **Tazewell**
- **Washington**
- **Wise**

Those who are deemed as ineligible for managed care, will receive care through fee-for-service. Refer to 12 VAC 30-120-370 B for the complete list. Also, carved out services and prior to Managed Care enrollment are always FFS.

# Medallion II – Who is Included?

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

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

- Medicare and Other Primary Insurance
- Nursing Homes
- Hospice
- PACE
- Birth Injury Fund enrollees

Refer to 12 VAC 30-120-370 B for the complete list.

# Managed Care Health Plans

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Health plans working to be approved for the area to serve Managed Care eligibles are:

- **Amerigroup Community Care** 1-703-286-3972
- **Anthem HealthKeepers** 1-540-853-5077
- **MajestaCare, a Plan of Carilion Clinic** 1-855-606-4304
- **Southern Health/CareNet** 1-866-240-4345, Ext. 6739
- **Optima Family Care** 1-804-510-7434
- **Virginia Premier Health Plan** 1-800-727-7536, Option 6

# Carved-out Services

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- DMAS (FFS) continues to reimburse for:
  - Community rehabilitation mental health, mental retardation, and substance abuse treatment
  - Targeted Case Management (Medicaid only-not covered under FAMIS)
  - Lead Investigations
  - Abortions (only for life or health of mother)
- Dental Services will continue to be provided through our *Smiles for Children*<sub>SM</sub> program and reimbursed by DentaQuest (formerly Doral Dental)

# How Members Get Enrolled

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- New Medicaid eligibles and former MEDALLION enrollees will be 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

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- 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.
- Medallion II Open Enrollment (May and June). Changes become effective July 1<sup>st</sup>.
- FAMIS Open Enrollment occurs on the member's anniversary date.

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**HOW DOES THIS  
AFFECT YOU?**

# Complexity

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- **Yes, there will be greater complexity.**
- **Yes, there are benefits to providers and patients.**
- **Yes, DMAS will support providers through this transition.**

# MCOs Interested in SWVA

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- **Amerigroup Community Care**
- **Anthem HealthKeepers Plus**
- **CareNet – Southern Health**
- **MajestaCare – a Health Plan of Carilion Clinic**
- **Optima Family Care**
- **Virginia Premier Health Plan**

# MEDALLION

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Effective May 1, 2012, all MEDALLION clients in the expansion area return to fee-for-service Medicaid until July 1, 2012 to prepare for MCO enrollment.

If you are a MEDALLION provider, you will no longer receive the \$3 PMPM from Medicaid.

# Providers Must Contract

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- **In order to see managed care members, you must contract with MCOs or receive a prior authorization.**
- **Providers may steer patients to preferred MCOs and advise that they choose particular MCOs.**
- **Know the MCO network for specialty care.**

# Medical Homes

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- **The MCOs have expressed an interest in developing patient centered medical homes:**
  1. Behavioral Health
  2. Care Coordination
  3. Dental
  4. Telemedicine
  5. Transportation
- **Talk to them...this could provide you with opportunities!**

# MCO Contracting Requirements

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- **We encourage you to contract with multiple MCOs.**
- **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.**
- **A MCO contract allows you to see both 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.**
- **The MCOs must submit final networks to DMAS by December 30, 2011.**

# Credentialing – Consider Timing

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

# If You Do Not Contract

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- 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, your payment will be denied. Providers may not bill the member.

# Medical Transition

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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.

# Eligibility Verification

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- 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

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- 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

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## For Medicaid:

- Providers may appeal with the MCO and exhaust the MCO process. After completing MCO process, may appeal to DMAS.
- 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

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- FAMIS MCOs require small co-pays of \$2 or \$5 for most services.
- Non-emergency transportation is not covered.

# Managed Care Resource Guide

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

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[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 & FAMIS Central Processing Unit

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**Medicaid Clients can receive assistance by calling the  
Managed Care HelpLine at  
1-800-643-2273  
TDD: 1-800-817-6608  
8:30 am – 6:00 pm Monday through Friday**

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**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!

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**For a copy of this presentation, visit:**

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

**Click on Managed Care on left side of page**

**or go directly to:**

**[www.dmas.virginia.gov/content\\_pgs/mc-home.aspx](http://www.dmas.virginia.gov/content_pgs/mc-home.aspx)**