

Medicaid Physician& Managed Care Liaison Committee Meeting

August 22, 2013, from 10:00 AM - Noon in Conference Room 7A/B
600 East Broad St. Richmond, VA 23219

Meeting 1 AGENDA

I. Welcome and Introductions	Cindi B. Jones, Director Department of Medical Assistance Services (DMAS)	10:00 am
II. Goals and Objectives of the Meetings	Cindi B. Jones / Committee Members	10:10 pm
III. Overview of Medicaid Reform in Virginia	Cindi B. Jones	10:25 pm
IV. Managed Care and Quality Initiative Overview	Cheryl Roberts, Deputy Director for Programs, DMAS	10:45 pm
V. Primary Care Rate Increase/Vaccination Rate	Scott Crawford, Deputy Director for Finance, DMAS	11:10 am
VI. Physician Screening	Tom Edicola, Division Director, Program Operations	11:25 am
VII. Discussion of Agenda Topics for Future Meetings	Cindi B. Jones / Committee Members	11:40 am
VI. Wrap Up and Next Steps	Cindi B. Jones	11:55 am



Overview of Medicaid Reform in Virginia

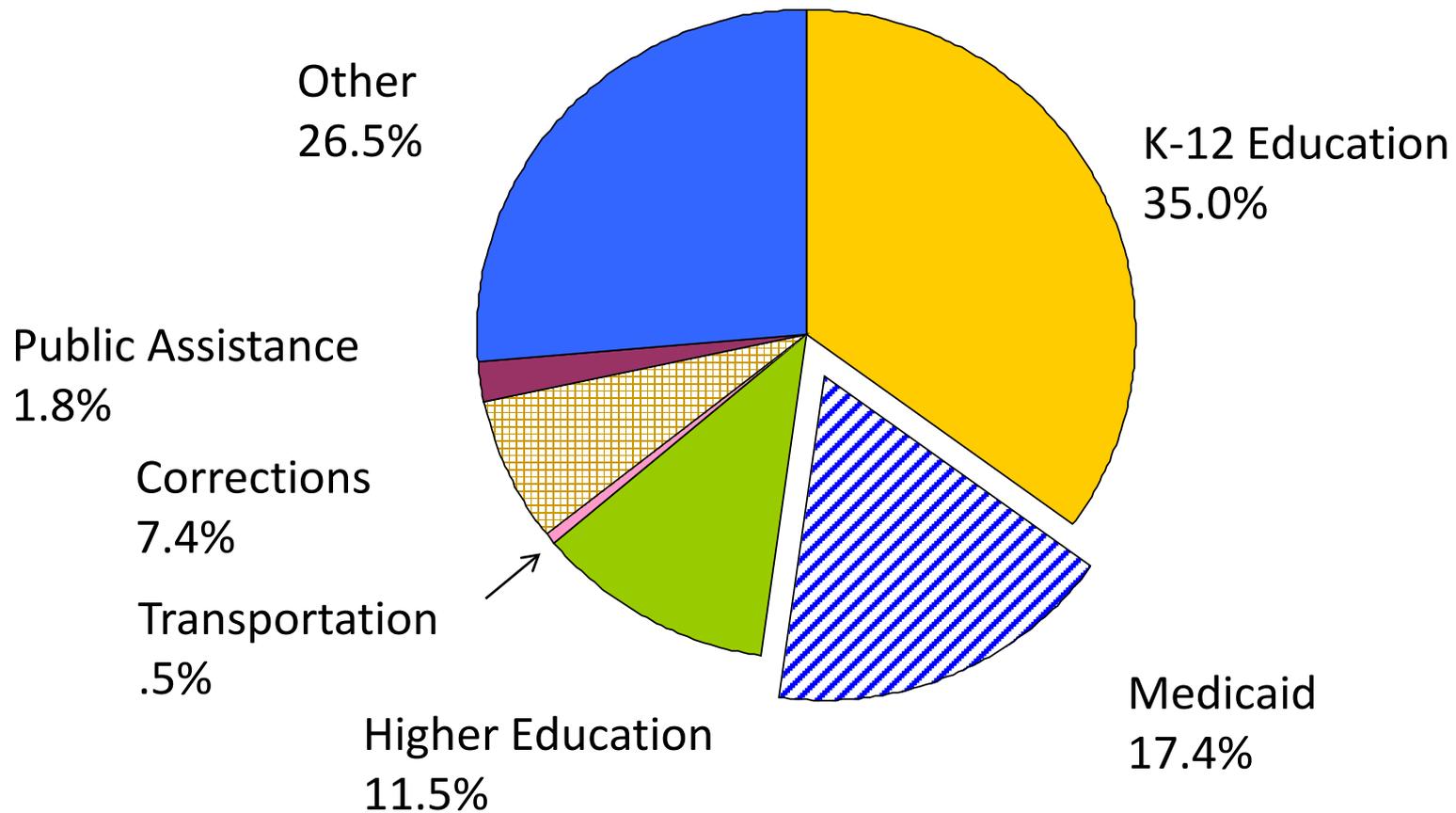
Cindi B. Jones, Director

Virginia Department of Medical Assistance Services

Medicaid Physician and Managed Care Liaison Committee Meeting

August 22, 2013

State General Fund Spending FY 2011



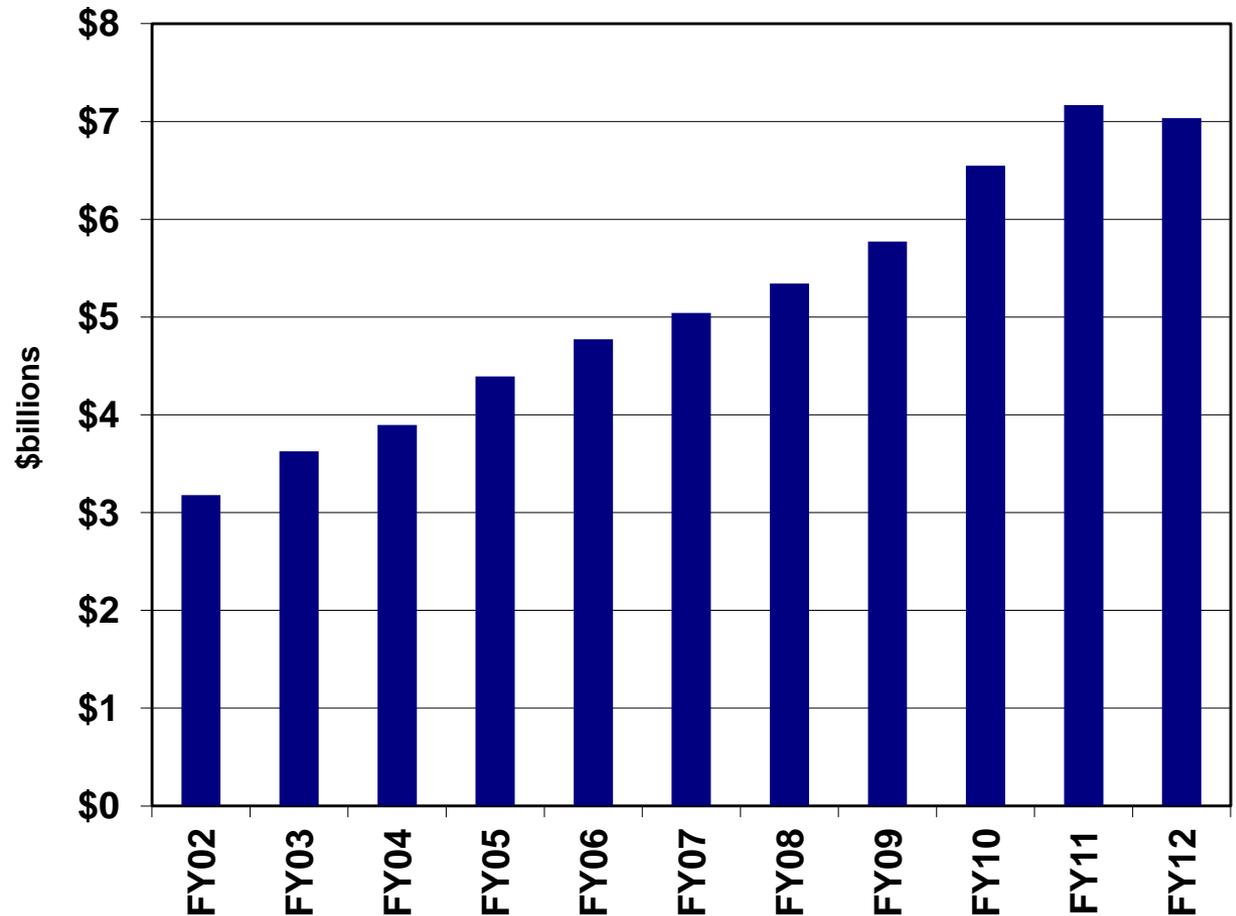
Source: National Association of State Budget Officers, Fiscal Survey of States; Spring, 2012

Virginia Medicaid Expenditures

Top Expenditure

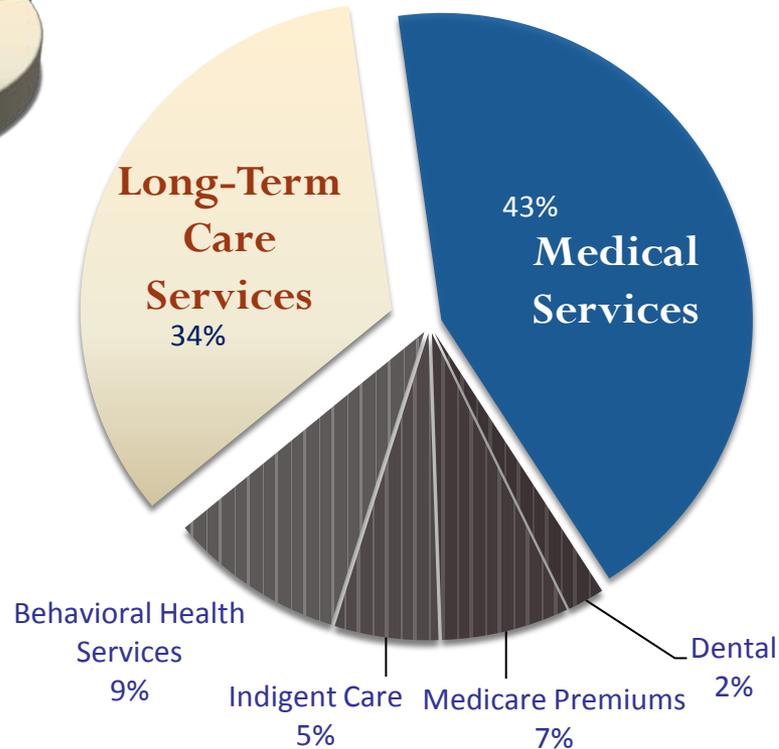
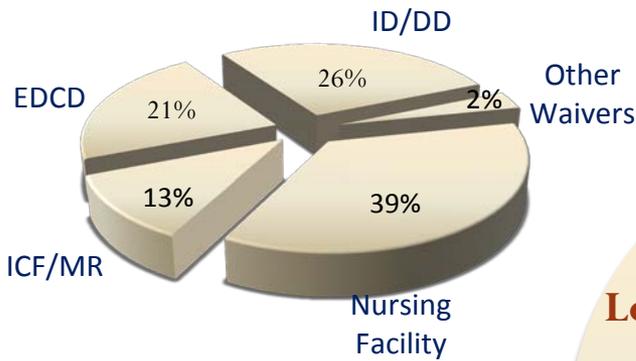
Drivers:

- **Enrollment Growth:** Now provide coverage to over 400,000 more members than 10 years ago (80% increase)
- **Growth in the U.S. cost of health care**
- **Growth in Specific Services:** Significant growth in expenditures for Home & Community Based LTC services and Community Behavioral Health services

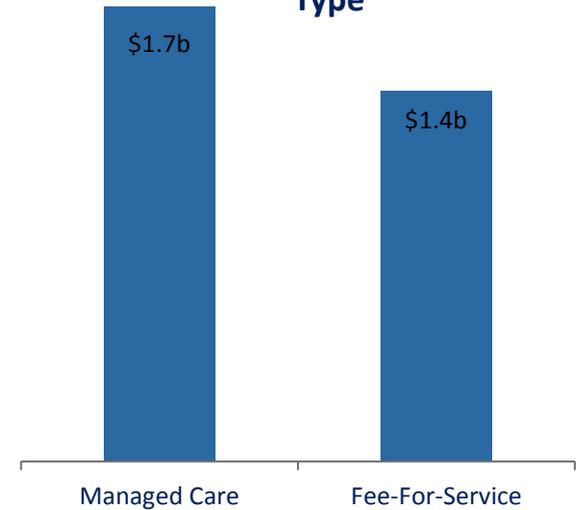


Composition of Virginia Medicaid Expenditures – SFY 2012

Long-Term Care Expenditures

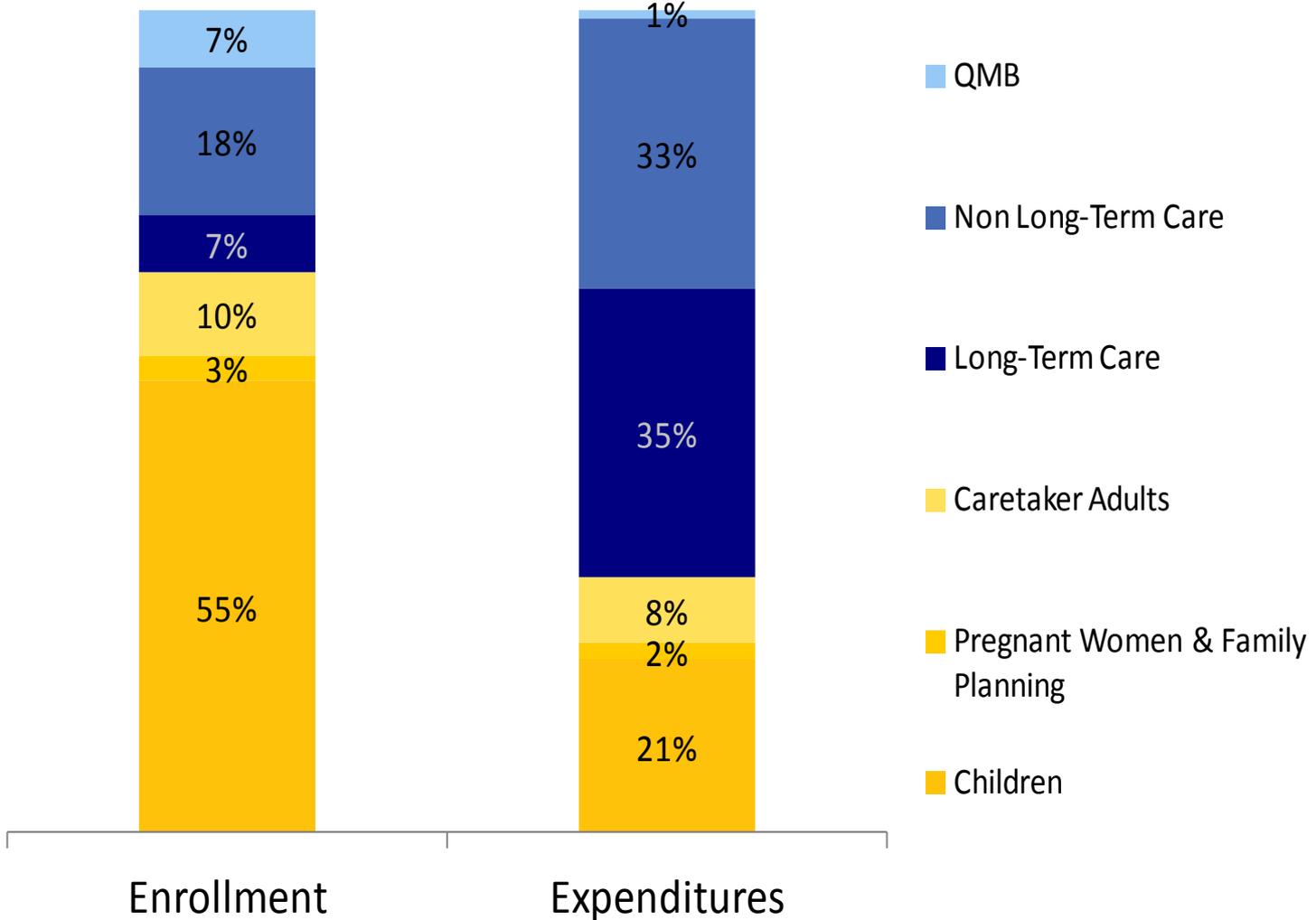


Medical Services by Delivery Type



Notes:

Virginia Medicaid: Enrollment v. Spending



Goals of Medicaid Reform

Effective Service Delivery

Service delivery should be efficient, cost effective, and provide quality services.

Efficient Administration

DMAS should be accountable, streamlined, and transparent.

Significant Beneficiary Engagement

Individuals should be engaged in, responsible for, and active participants in their health care.



Virginia Must Implement Medicaid Reform in Three Phases

- **Phase 1: Advancing Current Reforms**
 - Dual Eligible Demonstration
 - Enhanced Program Integrity
 - Foster Care
 - New Eligibility and Enrollment System
 - Veterans
 - Behavioral Health

Virginia Must Implement Medicaid Reform in Three Phases

● Phase 2: Improvements in Current Managed Care and FFS programs

- Commercial like benefit packages and service limits
- Cost sharing and wellness
- Coordinate Behavioral Health Services
- Limited Provider Networks and Medical Homes
- Quality Payment Incentives
- Managed Care Data Improvements
- Standardization of Administrative Processes
- Health Information Exchange
- Agency Administration Simplification
- Parameters to Test Pilots

Virginia Must Implement Medicaid Reform in Three Phases

- **Phase 3: Coordinated Long Term Care**
 - Move remaining populations and waivers into cost effective and coordinated delivery models
 - Report due to 2014 General Assembly on design and implementation plans

Working with CMS to Implement Reforms in Virginia

Key CMS Approvals/Support

- ☑ Medicare-Medicaid Enrollee (dual eligible) Financial Alignment
- ☑ Significant Reforms to the Managed Care Organization Contracts
- ☑ Fast Tracking Reviews of Eligibility and Enrollment Changes
- Additional Required Medicaid Reforms

Two Key Questions:

1. What Reforms Can be Implemented with the Existing Medicaid Population under Current Authority?
2. What Reforms Can be Implemented with the Existing Medicaid Population that Require Additional CMS Authority or Waivers?

Working with CMS to Implement Reforms In Virginia

- On August 15, 2013, DMAS submitted a concept paper to CMS, entitled “*Implementing Medicaid Reform in Virginia: A summary of planned reforms for review by the Centers for Medicare and Medicaid Services and interested stakeholders*”
- Contents
 - Purpose
 - Overview of the Medicaid Program
 - Existing Federal Authority for the Virginia Medicaid Program
 - Reforming Virginia’s Medicaid Program
 - Next Steps for Virginia

Status of Phase 1 Reforms

Title	Progress	Timeline/Target Date
Dual Eligible Demonstration Pilot	6 th State in the Nation to have signed MOU with CMS	<ul style="list-style-type: none"> • July 2013 - Negotiations started with selected health plans • August 2013 - Readiness Reviews • September 2013 - Contracting, Rates • January 2014 – Regional phased-in enrollment begins
Enhanced Program Integrity		Ongoing
Foster Care Enrollment into MCOs		<ul style="list-style-type: none"> • September 2013 – Begin expansion to Central, Tidewater, and Northern Virginia • Spring 2014 – Rest of the state

Status of Phase 1 Reforms

Title	Progress	Timeline/Target Date
Eligibility and Enrollment System		<ul style="list-style-type: none"> •October 2013 – New VaCMS eligibility system goes live for new Medicaid/FAMIS; Begin taking Medicaid/FAMIS applications based on new financial requirements MAGI •January 1, 2014 - Eligibility based on MAGI rules required to begin
Access to Veterans Benefits for Medicaid Recipients		<ul style="list-style-type: none"> •Ongoing
Integrity and Quality of Medicaid Funded Behavioral Health Services		<ul style="list-style-type: none"> •December 2013 – Implementation of strengthened regulations and a new Behavioral Health Services Administrator (Magellan)

Status of Phase 2 Reforms

Title	Progress	Timeline/Target Date
Commercial Like Benefit Package		<ul style="list-style-type: none"> • July 2014 for MCOs and FFS
Cost Sharing and Wellness		<ul style="list-style-type: none"> • July 2014 for MCOs and FFS
Limited Provider Networks and Medical Homes	July 2014 for FFS	<ul style="list-style-type: none"> • July 2013 for MCOs
Quality Payment and Incentives		<ul style="list-style-type: none"> • July 2013 (for MCOs) – Program implemented to establish the baseline target • SFY 2015 quality withholds begin
Parameters to Test Innovative Pilots		<ul style="list-style-type: none"> • July 2014 for MCOs and FFS

Status of Phase 3 Reforms

Title	Progress	Timeline/Target Date
Medicare-Medicaid (Duals) Enrollees Demonstration		<ul style="list-style-type: none"> • January 2014
ID/DD Waiver Redesign		<ul style="list-style-type: none"> • October 2013 - First Phase of DBHDs Study completed • July 2014 –ID/DD Waiver Renewal Due/Redesign
All HCBC Waiver Enrollees in Managed Care for Medical Needs (waiver services remain out)		<ul style="list-style-type: none"> • October 2014
PACE Program for ID/DD or other Pilot Coordinated Care Programs		<ul style="list-style-type: none"> • July 2015

Status of Phase 3 Reforms

Title	Progress	Timeline/Target Date
All Inclusive Coordinated Care for HCBC Waiver Clients, now including all HCBC waiver services		•July 2016
Complete Medicare- Medicaid (Duals) Coordinated Care across the State, including children		•July 2018



Department of Medical Assistance Services

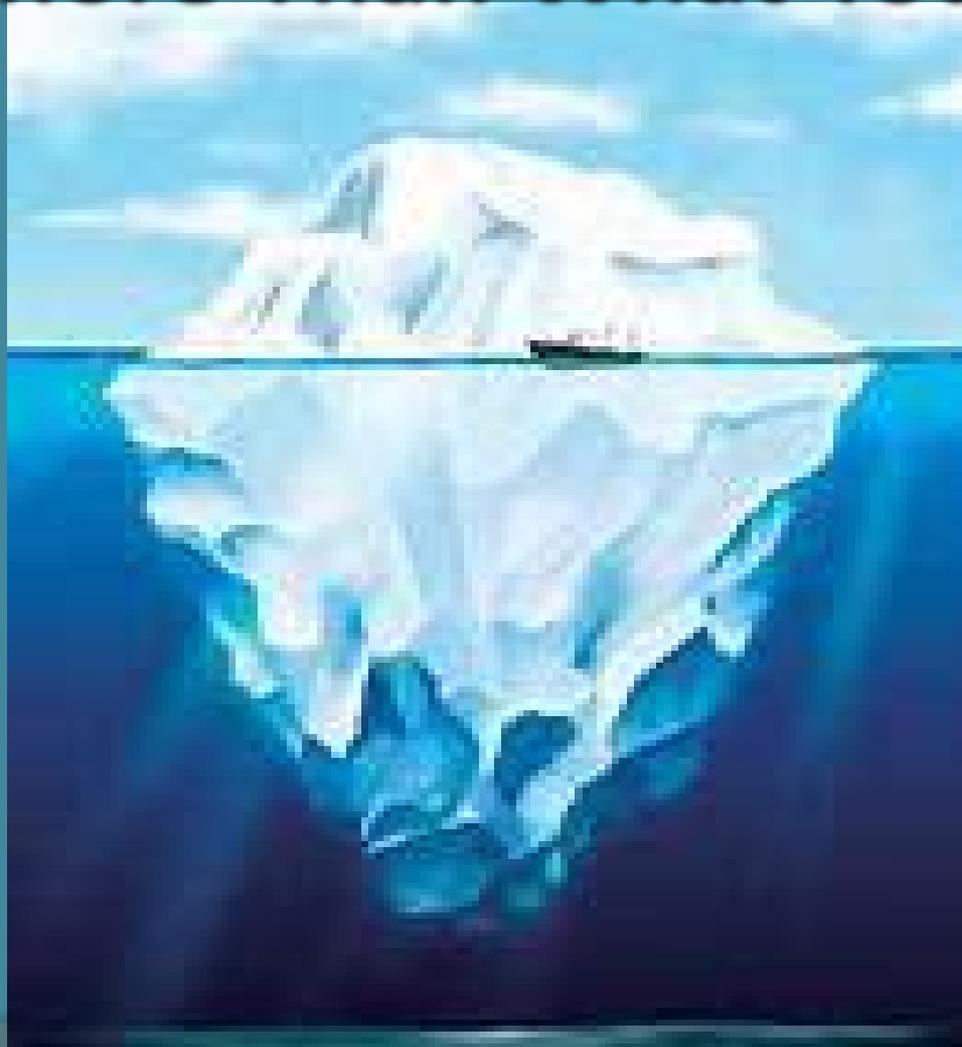


VIRGINIA MEDICAID MANAGED CARE PROGRAM DELIVERY AND QUALITY

Cheryl J. Roberts
Deputy Director, Health Management Programs
Virginia Department of Medical Assistance Services

Medicaid Physician and Managed Care Liaison Committee Meeting
August 22, 2013

Virginia Medicaid Managed Care It's More Than What You See





What is Medallion II ?

Medallion II

One view is that it is a Medicaid delivery system that provides the Commonwealth with:

- 7 contracted MCOs to provide Medicaid covered services
- Enrollee services
- Provider access
- Basic care coordination and management
- Some quality measurements
- Budget sustainability

But It's More:



700,000 Enrollees in Managed Care



National Medicaid Health Plans

DMAS now contracts with 3 of the largest health plans in the country

➤ **WellPoint #1**

{acquired Amerigroup Corporation - November 2012}

➤ **Kaiser #3**

{effective Fall 2013}

➤ **Aetna #4**

{acquired CoventryCares - May 2013}

4 Integrated Health Plans are Health Systems

				
Health System	Carilion	Inova	Sentara	VCU
Health Plan	MajestaCare	INTotal	Optima Family Care	Virginia Premier
# Enrollees	11,332	57,102	167,002	172,271
# Localities	39	58	113	106



12,800 + MCO Providers



Over 12,800+ credentialed provider sites

- Primary Care Physician 8,345
- Pediatrician 2,689
- OB/GYN 1,844

- Does not include specialist and other provider types
- Represents unduplicated count of MCO providers as of 1st quarter 2013



Does it Work? **Yes**

Commonwealth gets a large ROI for the dollar:

- Plans are compliant with federal and state regulations and State contract
- Increase in board certified providers and specialty networks
- Focus on preventive and wellness care
- Flexibility to provide enhanced services and rate structure
- Increase in care management
- Provide predictive modeling and chronic care management
- Collaboratively work with Department on quality, program integrity, and programmatic issues as ER diversion

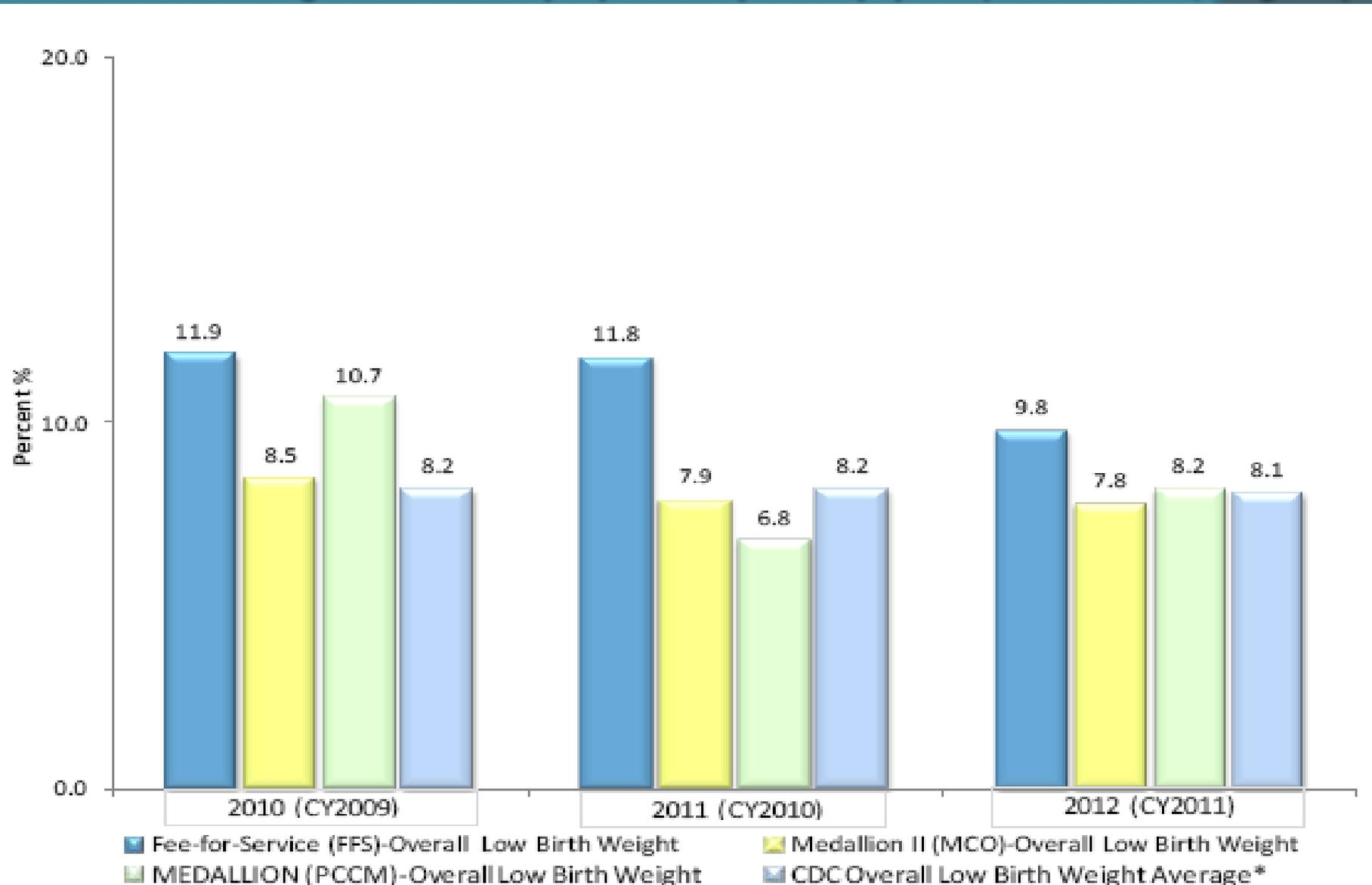
Does it Work? **Yes**

Commonwealth gets a large ROI for the dollar:

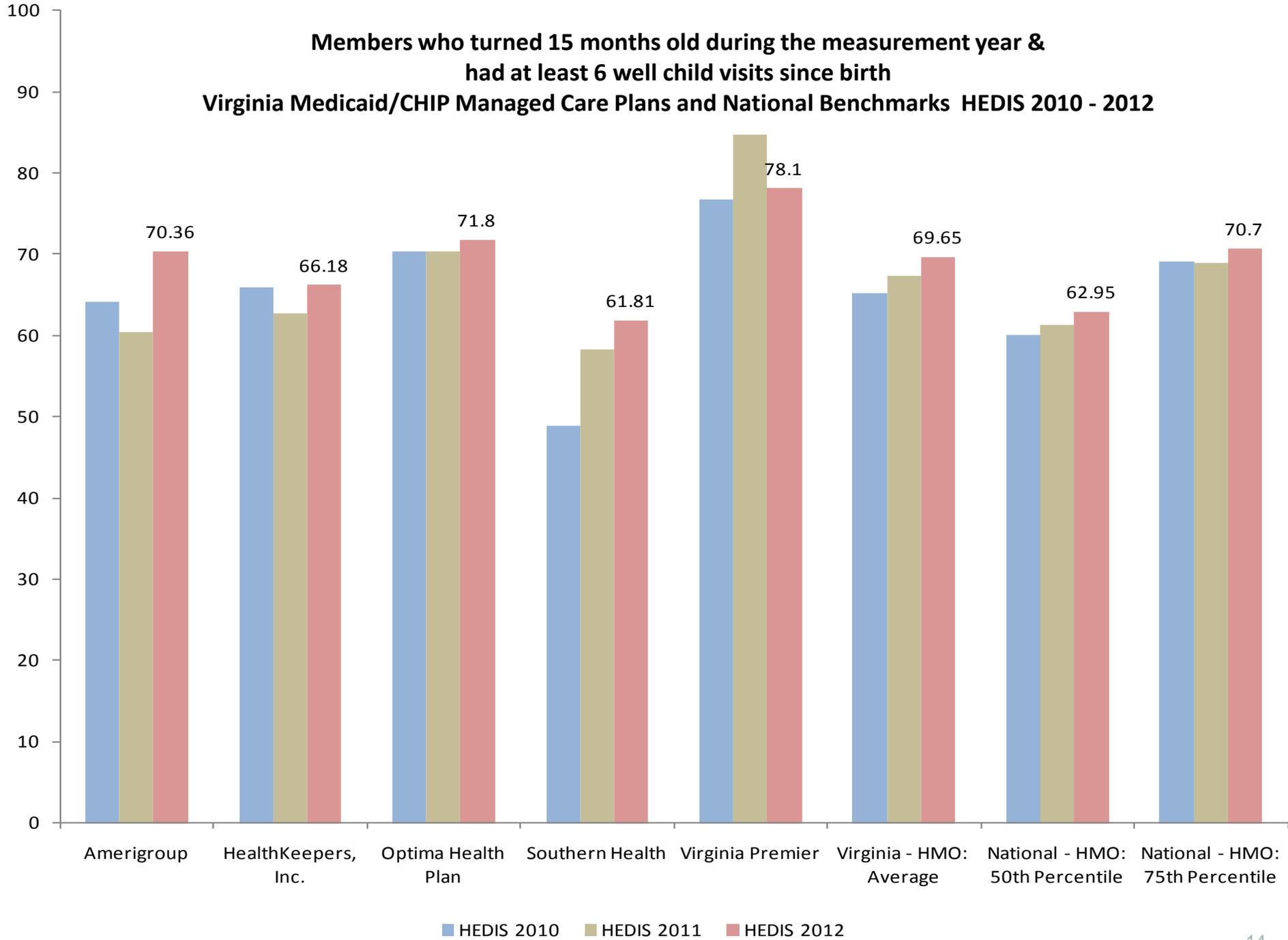
- Member materials and education
- Local presence (provider relations and outreach staff in the regions)
- 24/7 call access
- New models and innovation
- Budget certainty
- Created new jobs in the Commonwealth
- Plans solvent but no excess profits
- Positive quality and health outcomes

Low Birth Weight Rates by Delivery System

Overall Low Birth Weight Rates for Study Population by Delivery System (Overall LBW <2,500 grams)



**Members who turned 15 months old during the measurement year &
had at least 6 well child visits since birth
Virginia Medicaid/CHIP Managed Care Plans and National Benchmarks HEDIS 2010 - 2012**



Medicaid Managed Care



Today and Tomorrow

MEDALLION 3.0

Program Reforms

July 1, 2013:

- New Contract / New Program
- Total revamping after researching best practices of 13 states and 2 state site visits
- Collaboratives with CHCS, NASHP, and NAMD
- Created 3 oversight business units
 - Operations
 - Reporting and Systems
 - Business Analysis and Development

MEDALLION 3.0

Program Reforms

Includes more commercial plan benefit features, enhanced services and reporting, increased innovation:

- Chronic Care and Assessments
- Wellness Programs
- Maternity Program Changes
- Enhanced Data and Reporting
- New Populations (foster care and acute care for HCBS)
- New Rates and Data Analysis
- Enhanced Program Integrity Requirements

MEDALLION 3.0

Program Reforms

Medallion Care System Partnership (MCSP) – new payment/delivery model

- Each MCO to implement at least two MCSPs to improve health outcomes for Medicaid members through a system designed to integrate primary, acute, and complex health services
- Gain and/or risk sharing, performance-based incentives, or other incentive reforms tied to Commonwealth-approved quality metrics and financial performance, and partnerships with providers and/or health care systems
- Integrated provider health care delivery systems participation, improvement of member health outcomes as measured through risk adjusted quality metrics, and alignment of administrative systems to improve efficiency and member experience



What is Medallion II Quality Program ?

Federal Regulations

Quality Improvement in Medicaid Managed Care

- Code of Federal Regulations:
 - Section 438.202 State responsibilities
 - Section 438.204 Elements of State quality strategies
 - Section(s) 438.206 – 210 Access standards
 - Section(s) 438.214 – 230 Structure and operations standards
 - Section(s) 438.236 – 242 Measurement and improvement standards
- 42CFR Subpart E (External Quality Review) sets forth requirements of States to provide for an external quality review of each MCO annually
 - States with Medicaid managed care are required to provide for three mandated EQR activities as follows:
 - 1) Validate a sample of each MCO's performance measures annually;
 - 2) Validate two or more performance improvement projects (PIPs) for each MCO annually; and,
 - 3) Provide comprehensive review of MCO compliance with Federal and State operational standards – once every three years

**REGULATORY COMPLIANCE BY
MEDICAID (MCOs)
IS
IMPERATIVE,
BUT
COMPLIANCE *IS NOT*
SYNONYMOUS WITH QUALITY CARE**

Virginia Medicaid Managed Care Quality Framework



Quality Framework

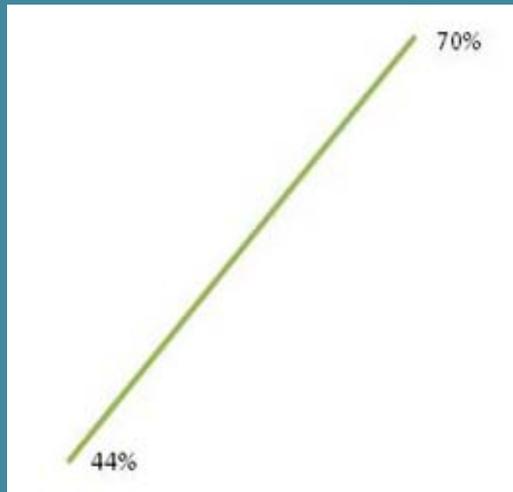
Current Medallion II contract includes these quality activities:

- ◎ **Performance improvement project validation** by the EQRO – topics are adolescent well child visits and follow-up to inpatient stay for behavioral health
- ◎ **Performance measure validation** by the EQRO – the EQRO validates the accuracy of the scores from the PIPs
- ◎ **Quality improvement plans** are required for HEDIS measures that do not meet national benchmarks
- ◎ **A priority set of HEDIS measures** are required by DMAS and the MCOs are required to conduct the CAHPS surveys for adults and children

HealthCare Effectiveness Data and Information Set (HEDIS) Measures Required by DMAS for Reporting

- Childhood Immunizations (Combo 2 and Combo 3) & each vaccine is reported separately
- Lead Screening in Children
- Breast Cancer Screening
- Timeliness of Prenatal Care
- Postpartum Care
- Well-Child Visits in the First 15 Months of Life each number of visits listed separately
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life
- Adolescent Well-Care Visit
- Asthma – Appropriate Use of Medication (all age categories)
- Cholesterol Management for Patients with Cardiovascular Conditions
- Control of High Blood Pressure (<140/90) among members diagnosed with hypertension
- Antidepressant Medical Management (Acute and Continuation)
- Follow Up After Hospitalization for Mental Illness 7 day and 30 day
- Comprehensive Diabetes Care (all age categories):
 - HbA1c Testing HbA1c Control
 - Eye Exams LDL Screen
 - LDL Control BP Control <140/90

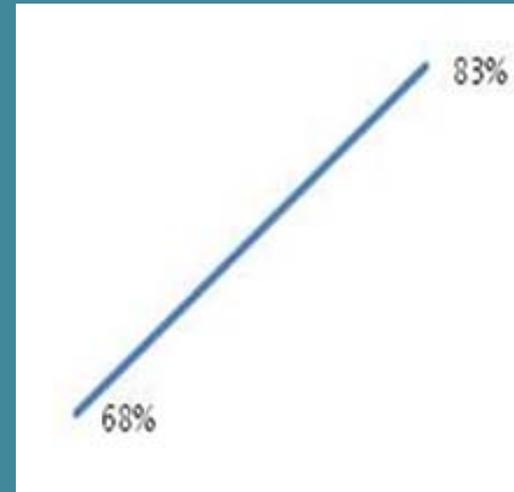
Results of Aiming for Higher Quality



Six or More Well-Child
Visits by 15 months of age

**

Up from 44% in HEDIS 2003
to 70% in 2012



Condition Management for
People with Diabetes (those
who had at least one A1-C
test during the year)

**

Up from 68% in HEDIS 2003
to 83% in 2012

Performance Improvement Project Validation

Adolescent Well Child Visits

- HEDIS 2010 national average Medicaid was 47.72
- Virginia average was 44.45

Follow-up Behavioral Health for Members with Inpatient Mental Health Stay

- Virginia's average for 7 day and 30 day follow-up after discharge is well below the national average

Both measures are challenging for managed care nationwide



HEDIS

3 Year Trend-VA FUH HEDIS Rates

	2010	2011	2012	%Change	Percentile
7 Day	36.21	43.78	55.43	19.22	50th
30 Day	62.51	74.9	87.3	24.79	90th



Collaboration Among Competitors

Virginia's Medicaid Managed Care Quality Collaborative

Featured as a best practice at the CMS
Medicaid Managed Care Quality Conference
2012

- ◎ Strategies
 - Leadership
 - Knowledge Management: experiences, insights, guidelines
- ◎ Common goals
 - Defined as improved performance
 - Sharing of lessons learned (best practices)
 - Impact both individual MCOs and overall population
- ◎ Objective information
 - Useful for the group to use problem solving as team activity
 - Trending data over time compares history and changes
 - Shared success AND failures promotes system changes to impact future results

MEDALLION 3.0

Quality Reform

Quality Incentive Program

- Withhold an approved percentage of the monthly capitation payment from the MCO
- Funds will be used for the MCOs' performance incentive awards
- Criteria to include assessment of performance in quality of care and member experience; composite scores on CAHPS adult and child measures; performance in EQRO-conducted activities; and other measures determined by the Department
- Awards proportionate to MCO benchmarks achievements for each performance measure
- Implemented in a three-year phased-in schedule

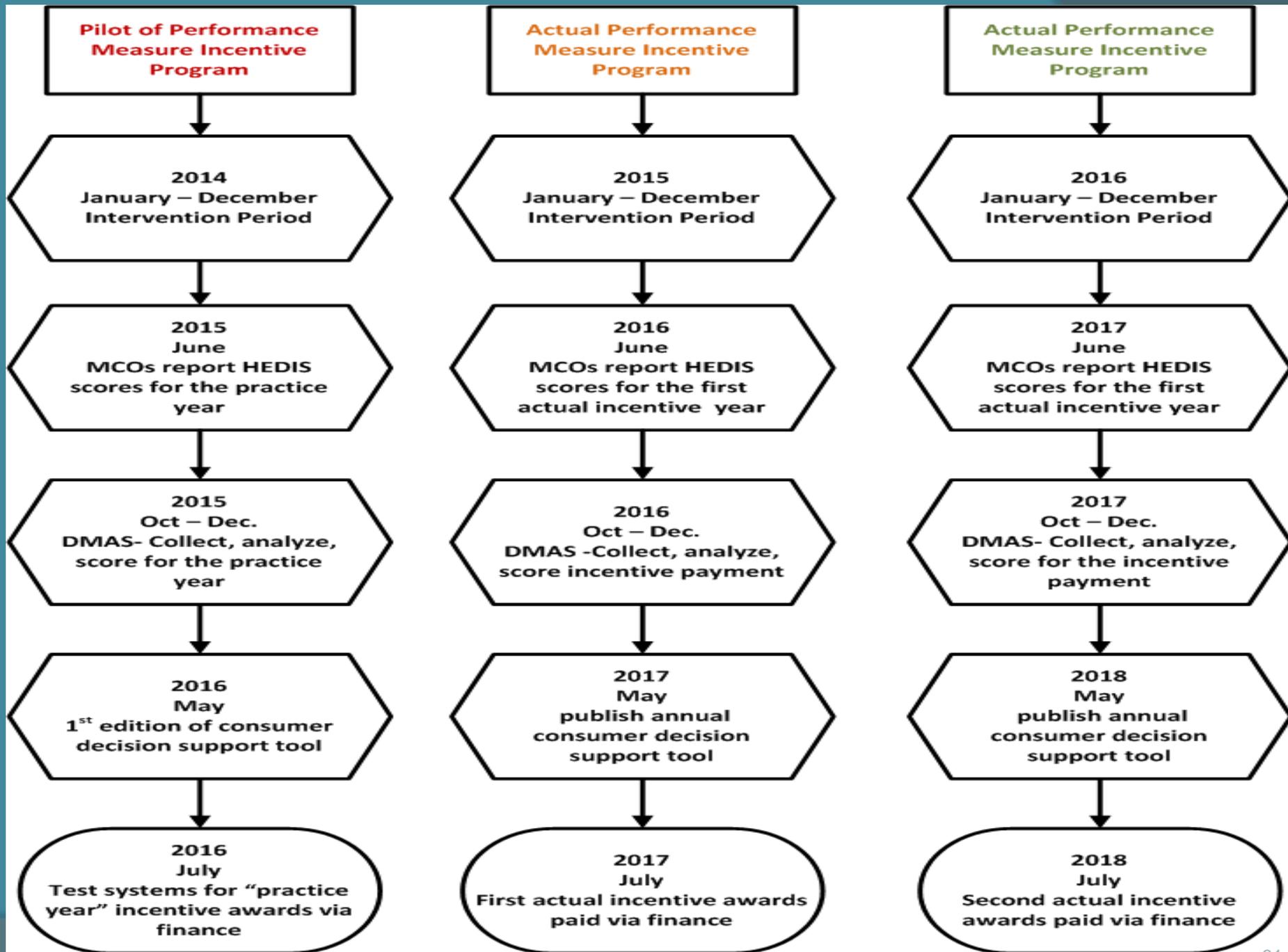
Proposed Measures for Performance Measure Incentive Program

HEDIS Measures

- Combo 3 Immunization Measure: Percent of 2 year olds who are fully immunized
- Percent of Members with Cardiovascular Condition and with Blood Pressure Controlled
- Percent of Members who are Pregnant and Receive Timely Prenatal Care

Process Measures

- Adjudication (pay or deny) of ninety percent (90%) of all clean Virginia Medicaid claims within thirty (30) calendar days of the date of receipt
- Timeliness & Accuracy of Reporting Deliverables
- Assessments – Children with Special Health Care Needs (CSHCN)- within 60 calendar days of enrollment. EQRO will establish a baseline through a focused study in 2014



**Program is Great
But we want it
Better,
Faster, and
Stronger**



Providers Can Help Improve Quality Care

- ⦿ Increase collaboration with health plans on complex care cases
- ⦿ Understand what the plans offer
- ⦿ Recognize the importance of access – new members have unique challenges (transportation, time off from hourly wage)
- ⦿ Utilize the opportunity for health education – especially new members
- ⦿ Have staff who understand the unique needs of the Medicaid population compared to commercial and Medicare populations
- ⦿ Offer after hours appointments/walk-in schedules to increase access and prevent unnecessary ED visits
- ⦿ Track your own performance on quality measures

MEDALLION 3.0

More Information

- Contract and Quality Reports on DMAS web site
http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx
- Read Managed Care Value Purchase document
http://www.dmas.virginia.gov/Content_atchs/atchs/wnew_f1.pdf
- Attend upcoming provider regional meetings
 - Northern Virginia – September 17, 2013
 - Hampton Roads/Tidewater – November 12, 2013
- Contact the MCOs representatives after the meeting



Medicaid Physician Primary Care Rate Increase

Scott Crawford, Deputy Director for Finance
Virginia Department of Medical Assistance Services

Medicaid Physician and Managed Care Liaison Committee Meeting
August 22, 2013



Affordable Care Act (ACA) Sec 1202

- Required that Medicaid fees increase to 100% of Medicare fees for primary care services provided by primary care physicians
- Authorized 100% federal funding for the increase
- Applied the increase to both FFS and managed care
- Effective for services in CY2013 and CY2014
- CMS published final rule November 6, 2012



Eligible Providers

- Physicians (and practitioners supervised by a qualifying physician)
- With Specialties or Subspecialties in Family Medicine, General Internal Medicine or Pediatrics
- Based on self attestation subject to audit
 - Board Certification
 - At least 60 percent of Medicaid FFS and MCO claims billed in most recently completed calendar year are for eligible primary care services
- About 6,000 have attested, mostly based on board certification



Eligible Services

- Primary Care Services
 - Evaluation and Management Procedures (99201 through 99499)
 - Vaccine and Toxoid Administration Procedures
- Only Medicaid services (not FAMIS)
- FFS and Managed Care services



Medicare Primary Care Rates

- Medicare Rates
 - Choice of Medicare region-specific rate or statewide average (6 Northern Virginia localities have higher Medicare rates than rest of state)
 - Choice of Medicare site of service rates or Medicare office rates (higher than facility rates)
- Medicare Rates as of January 1 or Updated Rates
 - Will use January 1 rates throughout the year
- But no lower than rates based on RVUs in 2013 times Medicare conversion factor in 2009
 - This is higher than current Medicare rates January 1



Implementation

- Worked closely with MSV and others to develop implementation plan and communicate with providers
- Filed federally required implementation plans for both FFS and managed care
- Received federal approval in late May 2013
- FFS payments (retroactive to January) began in July
- Payments to MCOs began in July
- Payments by MCOs have begun on multiple schedules



Payment Process

- FFS-DMAS pays claims initially at Medicaid rates and make quarterly supplemental payments
- Some MCOs use the same process
- Some MCOs pay the higher rate when they process the claim
- Increased payments for first 6 months:
 - FFS - \$9.9 mil.
 - Managed care - \$27.8 mil.

Provider Screening Regulations

1

Tom Edicola
Division Director, Program Operations
Virginia Department Of Medical Assistance Services

Medicaid Physician And Managed Care Liaison Committee Meeting
August 22, 2013

Agenda

2

- **Background**
- **Regulation Overview**
- **Implementation Plan**
- **What's Changing**
- **Impacts to Providers**
- **Communications**
- **Next Steps**
- **Q&A**

Background

3

- **The Centers for Medicare & Medicaid Services (CMS) published a final rule with comment period, entitled, *“Medicare, Medicaid, and Children’s Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers” (CMS-6028-FC)***
- **This rule was published in the February 2, 2011, edition of the “Federal Register”**
- **Regulations effective March 25, 2011**
- **States are still at various stages of compliance**

Background

4

- **Why the New Rules?**
 - Reduce likelihood of Fraud, Waste and Abuse
- **How?**
 - Expanded disclosure information
 - Increased screening and credentialing criteria
 - Shared data from Federal and State databases
- **When?**
 - At time of enrollment
 - On-going monthly
 - Revalidation

Regulation Overview

5

Federal Register /Vol. 76, No. 22 /Wednesday, February 2, 2011 /Rules and Regulations 5968

- **§ 455.405 State plan requirements.**
 - ✦ § 455.410 Enrollment and screening of providers
 - ✦ § 455.412 Verification of provider licenses
 - ✦ § 455.414 Revalidation of enrollment
 - ✦ § 455.416 Termination or denial of enrollment
 - ✦ § 455.420 Reactivation of provider enrollment
 - ✦ § 455.422 Appeal rights
 - ✦ § 455.432 Site visits
 - ✦ § 455.434 Criminal background checks
 - ✦ § 455.436 Federal database checks
 - ✦ § 455.440 National Provider Identifier
 - ✦ § 455.450 Screening levels for Medicaid providers
 - ✦ § 455.452 Other State screening methods
 - ✦ § 455.460 Application fee
 - ✦ § 455.470 Temporary moratoria

Implementation Plan

6

- **Impact Assessments completed for 3 areas**
 - Business/Operations
 - Technical
 - Provider
- **Defined initial requirements**
- **Created a project plan for implementation**
- **Currently in execution phase of project**
- **Status of Project is Green**

What's Changing

7

● Enrollment

- ✦ Providers will now enroll through our Web Portal
- ✦ Providers must be found eligible to participate and will be assigned a risk score

● Data Collection

- ✦ Additional information must be disclosed and captured on provider applications and in the MMIS
- ✦ Information is checked monthly against all required databases
- ✦ Exception reports worked and appropriate actions taken

● Credentialing

- ✦ Screening requirements are based on Federally classified risk categories (Limited, Moderate, High)
- ✦ All disclosed information must be screened against various databases at time of enrollment, monthly and at time of revalidation
 - Excluded Parties List System (EPLS)
 - Social Security Administrations Death Master File (SSA-DMF)
 - Medicaid and Children's Health Insurance Program (CHIP) State Information Sharing database (MCSIS)
 - List of Excluded Individuals and Entities (LEIE)
 - National Plan and Provider Enumeration System (NPPES)
 - Provider Enrollment, Chain and Ownership System (PECOS)

● Revalidations

- ✦ Occur no less than every 5 years and
- ✦ Can leverage Medicare and other SMA's enrollment and screening efforts

What's Changing? (cont)

Type of screening required	Limited	Moderate	High
Verification of any provider/supplier-specific requirements established by Medicare	X	X	X
Conduct license verifications, (may include licensure checks across States)	X	X	X
Database Checks (to verify Social Security Number (SSN), the National Provider Identifier (NPI), the National Practitioner Data Bank (NPDB) licensure, an OIG exclusion; taxpayer identification number; tax delinquency; death of individual practitioner, owner, authorized official, delegated official, or supervising physician)	X	X	X
Unscheduled or Unannounced Site Visits	X	X
Criminal Background Check	X
Fingerprinting	X

Risk Categories

9

- **Limited**

- Physicians or non-physician practitioners and medical groups, ambulatory surgical centers, renal facilities, FQHCs, hospitals, rural health clinics, skilled nursing facilities, residential psychiatric treatment facilities, adult day health care, private duty nursing, personal care, respite care, pharmacy, developmental disability waiver, and consumer directed service coordination

- **Moderate**

- Community mental health centers; CORFs; hospice; labs; ambulances

- **High**

- Home Health Agencies and DME

Impacts to Providers

10

- **Screening**

- Providers will now be identified as belonging to one of three risk categories: Limited, Moderate, and High
- Each risk category has different screening criteria
- Database checks will now be required for all providers
- For providers in the Moderate and High risk categories, an application fee will be required, as well as an onsite visit
- For High risk providers, a background check and fingerprinting check ***will eventually be required**

- **Application Fee Collection**

- Institutional providers will be required to pay an application fee
- SMA's will be required to collect and process this fee. Note: Providers already screened by Medicare or another State Medicaid Agency do not have to pay another application fee
- Application fee records and screening costs must be retained and reported to CMS
 - Reimbursement of excess goes to CMS
- Providers may request consideration of a hardship exception. Approval is by CMS

Application Fee Required

11

Application Fee set by CMS annually is currently \$532

- Hospitals
- Hospice
- Nursing Facilities
- Home Health Agencies
- Rural Health Clinics
- Outpatient Rehabilitation Facilities
- Federally Qualified Health Centers
- DME
- Independent Labs
- Renal Dialysis
- Clinics
- Emergency Ambulances
- Residential Psychiatric Treatment Facilities
- Prosthetic/Orthotic Providers

We project less than 5% of providers will require a fee paid to VA

Impacts to Providers (cont)

12

- **Ordering, Referring, and Prescribing Provider Enrollment**
 - All ordering, referring, and prescribing providers must be enrolled with VA Medicaid when included on claims for payment.
 - A new online enrollment will be available through the web portal.
 - The Virginia Medicaid ORP application will be based on the Medicare Enrollment Application (CMS-855O).
 - A streamlined application 1-pager and process will be implemented for enrolling ORP providers (e.g. demographic, license, adverse legal history)
 - Some new claim edits for editing ordering, referring, and prescribing provider (NPI) on claims;
- **Revalidation**
 - A provider is now required to revalidate every five years.
 - A process to revalidate providers has been created through our web portal.
 - Ability to leverage CMS or other SMA's screening will be automated into our process.

Impacts to Providers (cont)

13

Systems Changes by Functional Areas

- **Web Portal**
 - Online Enrollment
 - Direct Data Entry (DDE)
 - Automated Response System (ARS)
 - Provider Search, Provider Form Search, Provider Profile Maintenance
- **Executive Support System/Statistical Analysis System (ESS/SAS)**
- **MediCall**
- **Medicaid Management Information System (MMIS)**
- **Enterprise Content Management (ECM)**

Communications

14

- Medicaid Memo Published August 7, 2013
 - ✦ New Online Enrollment Procedures
 - ✦ Screening and Risk Scoring
 - ✦ Ordering Referring and Prescribing (ORP) Requirements
 - ✦ Application Fee Collection
 - ✦ Revalidation Process
 - ✦ Disclosure Information
- Follow Up Memo in September 2013
- Remittance Advice, Web Portal, On-hold message, Blast Email
- Associations and Contractors informed

Next Steps

15

- **Execution and Control Phase Completed by October 9, 2013**
 - Coding and Unit Testing
 - System Integration Testing
 - User Acceptance Testing
 - Operational Readiness Testing
 - Training
- **Implementation Phase**
 - Fourth Quarter of 2013
- **Project Closeout Phase**
 - ✦ End of the Fourth Quarter

Provider Screening Regulations

16

For more information contact:

Darryl.hellams@dmas.virginia.gov

(804) 786-9506

Questions?