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MEDICAID BULLETIN

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# Coverage During the 90-Day Enrollment Grace Period

The purpose of this Bulletin is to provide information about how the 90-day grace period during the *Return to Normal Enrollment* process relates to Medicaid and FAMIS (Family Access to Medical Insurance Security) health care coverage. As shared in prior Bulletins, Virginia has resumed normal Medicaid enrollment and renewal operations. Additional details about the *Return to Normal Enrollment* renewal processes, including toolkits and frequently asked questions, are available on the Cover Virginia website.

Medicaid eligibility rules have always allowed for retroactive coverage in certain circumstances. Similarly, as we move forward with our *Return to Normal Enrollment*, some members will be approved for retroactive coverage. This Memo provides information and resources on how providers can verify member coverage, including when a member is approved for coverage during a retroactive coverage period.

## Medicaid / FAMIS Eligibility and MCO Enrollment -

During the *Return to Normal Enrollment* transition, it is especially important for providers to verify Medicaid eligibility and enrollment at the time of service. Some members may transition to fee-for-service, including for retroactive coverage, before returning to managed care enrollment.

Individuals are initially enrolled in Medicaid/FAMIS fee-for-service (FFS) when approved for Medicaid/FAMIS eligibility, including for retroactive coverage, where applicable. Individuals who are determined eligible to participate in managed care are enrolled prospectively.[1] This prospective managed care enrollment process is not changing as a result of any retroactive enrollment allowed in the *Return to Normal* processes.

For example, if a managed care eligible individual is approved for Medicaid on or before the 18th of the month, MCO assignment would begin the first of the following month. If Medicaid eligibility coverage is entered after the 18th of the month, the MCO eligible member's managed care coverage dates will not start until the first day of the second month following the reinstatement.

[1] Except for newborns who are generally enrolled on the date of birth with the birth mother's MCO.

## Eligibility and MCO Enrollment Verification Resources -

DMAS provides two methods for providers to verify eligibility and managed care enrollment, including the on-line Automated Response System (ARS) and Medicall, (audio-system).

Contact information for ARS and Medicall is shown in the *Provider Contact Information and Resources* table at the end of this Medicaid Bulletin. Providers can check ARS and Medical on or around the 20th of the month to verify eligibility and enrollment for the following month.

## Billing for Services

Service authorization and claims processes are not changing as a result of the 90-day grace period. Providers should bill fee for service (FFS), or managed care based on the member's eligibility and enrollment information reflected in ARS and Medicall, including for any retroactive coverage approved for the member, as reflected in ARS or Medicall.

Hospitals should continue to bill for inpatient DRG admissions as they do today, i.e., claims should be submitted to the entity with whom the member is enrolled at admission, as reflected in the table below. The entity at admission is responsible for coverage from admission to discharge.

| Admit Plan | Enrollment Change | Responsible Plan/Entity* |
|---|---|---|
| FFS | FFS -> MCO | FFS |
| MCO | MCO -> FFS | MCO |
| MCO-1 | MCO-1 ->MCO-2 | MCO-1 |

** Responsible for the inpatient facility charges through the date of discharge. All other medically necessary services provided during the hospital stay, i.e., Physicians & other Professionals, are the responsibility of the enrolled plan based on the date of service by the professional. Reference the related DMAS/MCO provider manual for additional DRG and ancillary services billing guidelines.*

## Transitions Between Managed Care and Fee-For-Service

DMAS MCOs and the Department's fee-for-service service authorization contractor (Acentra Health), have processes in place, where applicable, to honor existing service authorizations.[2] This process minimizes the impact of disrupted services to the member as they transition. Upon verification of eligibility and enrollment, providers should contact the receiving entity (FFS or the MCO) to ensure that continuity of care authorizations are in place in a timely manner. Contact information for Acentra Health and each of the Department's MCOs is provided in the *Provider Contact Information and Resources* table below.

[2] For fee-for-service enrolled members, the provider must be a fee-for-service enrolled provider for Medicaid to pay the provider. Fee-for-service is not able to honor coverage of any MCO enhanced benefits. Members must be eligible on the date of service in order for fee-for-service or the MCO to pay the claim.

**PROVIDER CONTACT INFORMATION & RESOURCES**

| | |
|---|---|
| **Virginia Medicaid Web Portal Automated Response System (ARS)**<br>Member eligibility, claims status, payment status, service limits, service authorization status, and remittance advice. | https://vamedicaid.dmas.virginia.gov/ |
| **Medicall (Audio Response System)**<br>Member eligibility, claims status, payment status, service limits, service authorization status, and remittance advice. | 1-800-884-9730 or 1-800-772-9996 |
| **Acentra Health**<br>Service authorization information for fee-for-service members. | https://dmas.kepro.com/ |
| **Provider Appeals**<br>DMAS launched an appeals portal in 2021. You can use this portal to file appeals and track the status of your appeals. Visit the website listed for appeal resources and to register for the portal. | https://www.dmas.virginia.gov/appeals/ |
| **PACE** | http://www.dmas.virginia.gov/#/longtermprograms |
| **Magellan Behavioral Health**<br>Behavioral Health Services Administrator, check eligibility, claim status, service limits, and service authorizations for fee-for-service members. | www.MagellanHealth.com/Provider<br>www.magellanofvirginia.com, email: VAProviderQuestions@MagellanHealth.com,or<br>Call: 1-800-424-4046 |
| **Provider Enrollment** | In-State: 804-270-5105<br>Out of State Toll Free: 888-829-5373<br>Email: VAMedicaidProviderEnrollment@gainwelltechnologies.com |
| **Provider HELPLINE**<br>Monday–Friday 8:00 a.m.-5:00 p.m. For provider use only, have Medicaid Provider ID Number available. | 1-804-786-6273<br>1-800-552-8627 |
| **Aetna Better Health of Virginia** | www.aetnabetterhealth.com/Virginia<br>1-855-270-2365<br>1-866-386-7882 (CCC+) |
| **Anthem HealthKeepers Plus** | www.anthem.com/vamedicaid<br>1-833-207-3120<br>1-833-235-2027 (CCC+) |
| **Molina Complete Care** | 1-800-424-4524 (CCC+)<br>1-800-424-4518 (M4) |
| **Optima Family Care** | 1-800-643-2273<br>1-844-374-9159 (CCC+)<br>www.optimahealth.com/medicaid |
| **United Healthcare** | www.Uhccommunityplan.com/VA<br>www.myuhc.com/communityplan<br>1-844-284-0149<br>1-855-873-3493 (CCC+) |
| **Dental Providers**<br>DentaQuest | 1-888-912-3456<br>https://www.dentaquest.com/en/members/virginia-medicaid-dental-coverage/virginia-smiles-for-children |
| **Consumer Direct Care Network** (CDCN) - CCC Plus HCBS Consumer Directed Services Fiscal/Employer Agent (F/EA) | Toll Free Numbers:<br>DMAS: 1-888-444-8182<br>Aetna Better Health of Virginia: 1- 888-444-2418<br>Optima Health: 1- 888-444-2419<br>Email: infocdva@consumerdirectcare.com |
| **ACES$ Financial Management Services**<br>Consumer Directed Services Fiscal/Employer Agent (F/EA) | Toll Free Number: 833-955-4545<br>Email: supportva@mycil.org |
| **Public Partnerships, LLC (PPL)**<br>Consumer Directed Services Fiscal/Employer Agent (F/EA) | Toll Free Number: 1-833-549-5672<br>Email: pplva@pplfirst.com |

*** ***Important Alert*** ***

*The Federal 21st Century Cures Act requires all providers to enroll directly with DMAS through its Provider Services Solution (PRSS) provider portal. Providers should take action now to avoid payment delays. Virginia Medicaid MCOs have initiated provider terminations and/or payment suspensions for network providers until the provider is enrolled with DMAS through PRSS. At this time, the MCO will continue payments to network providers who have a pending application in PRSS. For additional information and resources,*
*visit https://vamedicaid.dmas.virginia.gov/provider/mco*