AGENDA
IMC Workgroup

April 3rd 2019 | 1:30-3:00pm | Philanthropy Center, 1020 W. Riverside Ave.

By computer: https://zoom.us/j/911995757

By phone: +1 720 707 2699 • Access Code: 911 995 757

1:30 WELCOME & INTRODUCTIONS

1:45 DISCUSSION

- Early Warning System debrief - BHT
- Provider questions – see following pages
  - Contracting for 2020 - MCOs
  - Medicaid as secondary insurance/payor of last resort
    - WISe & other programs not covered by Medicare and/or commercial
  - Short term credentialing for locums – update from MCOs
  - Other questions (below)
- SERI Q&A – Gail Kreiger, HCA (2:15pm)
- Interpreter Services update – HCA (2:30pm)
- Other discussion

2:45 NEXT STEPS

- Outstanding topics/items for next time
  - Reconciliation process issues
- Meeting date/time

3:00 ADJOURN

NOTES

Early Warning System Update

- Sam – more reponses for survey this month than last, so continuing to get better info
- Things are generally looking good. Some issues that MCOs are working to address – reported FFS/capitated payment issues, Availity issues, CPT codes denied even though in SERI
- Single bed certs down from 2018
- Email HCAEWS@hca.wa.gov with questions or to get webinar invite

Provider Questions

1. *Contracting for 2020*
   a. Will the MCO's still have "capped" contracts with the BH providers after 2020? Currently some have contracts that mirror their BHO but does that go away in 2020?
      i. Still an option. Providers should talk one-on-one with MCOs about contract options.

2. *Medicaid as secondary*
    a. *Excelsior* - In relation submitting claims & encounters for clients who have commercial as primary. Usually bill the primary and then the secondary if get denial from primary. Since WISe isn't recognized by commercial, we don't actually get a denial to be able to proceed to bill Medicaid.

    b. *Spokane Public Schools* – Yesterday in the workgroup it was mentioned that people are needing clarification on how to bill Medicaid for WISe services when they have a primary insurance. We have had a similar situation as well but not specific to WISe services.

    An example we have is our student has Kaiser as primary according to information their mother gave our therapist and Molina IMC as secondary (Molina does not reflect this information yet however, but that could change). SPS does not hold a contract with any of the commercial carriers so we are not set up to bill them. I contacted our provider rep at Molina who said that we would still need to bill Kaiser, receive a denial, and then submit a claim to Molina attaching the denied EOB in order to receive payment.

    It was mentioned that it would need to be built into the contract we hold with the MCO's that we would bill them directly for services that will be denied by the primary insurance. Is that correct? In our case we cannot bill the primary for any services at all at this time. This will most definitely be something that comes up when we start billing FFS to the MCO's.

    An issue that we have is that, we won't know if these students have a primary insurance until we receive the denials or requests for refunds from the MCO's. The student doesn't always know if they have primary other than Medicaid and that commercial insurances are not reflected in ProviderOne. And our older students are not required to have the parents involved in their care so there would be no reaching out to them.

    Since there is little chance that we can verify primary eligibility prior to services being rendered, should we still report these as MCO responsibility in the cap numbers for utilization? How/will this impact us if the students end up having a commercial primary insurance after the fact?

        i. CHPW would normally deny those claims outright, unless we know for a fact that service isn't covered. And would need a way to find out if that service is covered with the particular carrier. If you had an EOB, that would be ideal.
        ii. Molina – similar for Molina
        iii. Amerigroup (answer via email) – understand that with certain specialty billing (i.e. Medicare/WISe) that providers are unable to submita denial with a claim to secondary payers. We will still process WISe claims without denial from primary
        iv. Laurie (Pioneer): how can we can submit for services not covered by Medicare? I've been submitting to Medicaid and getting denied
            - If you have the copy of the denial from Medicare, that would be good. Otherwise, if can't get denial bc that isn't a covered service, contact MCO individually offline, we can get a work around (Maureen.Correia@molinahealthcare.com)
        v. Corey Cerise – there's a set of codes where Medicare services not covered. HCA has put together a doc with those codes/taxonomies – can share that out to providers again. What cercumstances don't need to provide an EOB. Specific to Medicare. As far as other insurance, would still need some way to track that the service is not covered by that plan.
            - Alice Lind – HCA's been working to get the most recent advice up to date. Hard to keep up with Medicare changes. Can share what we have from most recent changes, although some things won't likely change over time.

3. *Additional payment questions*
    a. *YFA Connections* – we're in a capitated contract - outpatient services paid PMPM. We have a handful of members who also have private insurance for some reason. Under the BHO, we billed the private insurance company and they sent us the money and then we sent it to the BHO. We still go thru the process of billing the primary insurance. Feels like double billing, but we're required to bill the insurance. What should we do?
        i. MCOs will take that question back.
        ii. Would you put it in Third Party Revenue reporting?
        iii. Whitney from Molina – we have this on our radar. Every BHO handled those dollars differently. Will brainstorm with the other MCOs and HCA.

    b. *POCC* – Medicaid clients on P1 shows that they have a commercial insurance, but client says they haven't had that insurance for a couple of years. Getting denial from MCOs because of this.
        i. Follow up – Jodi to send specific question to Sarah to send to HCA

    c. *Children's Home Society* – when we bill the primary insurance (commercial) with H-codes, insurance company sends back request for more info – progress note, explanation of the code, etc. Then they come back and deny that. Then you can finally bill the MCO. It's time intensive. Commercial in general doesn't cover H-codes. Way to streamline?
        i. MCOs will take to their workgroup

4. *Credentialing for locums*
    a. *NEWACS* - A question was raised at last month's IMC meeting about credentialing for locums, which our rural providers often have to use to fill workforce gaps. These locums come and go on short-term, so asking how to expedite credentialing for locums. Think that's a very significant issue that some MCOs not credentialing for shorter than 60 or 90 days. Would encourage MCOs to reconsider that policy. MCOs said at the January meeting that they'd have to follow up, but we still didn't have answer at our February meeting. Any follow-up would be appreciated.
        i. Can practice up to 6 months w/o being credentialed
        ii. Megan at Molina – confirmed with credentialing team, locums would be covered under agency credentialed. Would not need to be individually credentialed. Add them to your provider roster.
        iii. Amerigroup - Locums need to be included in monthly roster submissions to AMG. No further action/credentialing is needed.

5. *Other questions*
    a. *SPS* - Do we have to send in a update to the MCO's every time our therapists renews their license?
        i. Send as part of your monthly provider roster update so you don't have any denial issues.

    b. *NEWACS* - When a person is being discharged from our Evaluation & Treatment Facility on a court-ordered "Less Restrictive Alternative," how are we supposed to arrange the SMS trip home if the client is required to be in "voluntary status" in order to obtain a non-ambulance trip? (Technically, LRAs are court-orders for involuntary outpatient treatment. In this situation, the person is truly ready to go home and doesn't need an ambulance ride. Seems like we have a technicality to work out with HCA).
        i. Follow-up – forward to Alice & Todd at HCA

c. *Children's Home Society* - Do we know how long we are to keep a provider on our roster after they have left our agency? I am putting in the term date and sending it to the MCOs, but am curious if I keep the providers on indefinitely?
    i. Submit term notice on following monthly maintence roster, then can take them off subsequent.

d. *Passages* - We have a client who's lost Medicaid and we're trying to figure out Medicaid rules. Does the person lose coverage the day a letter to them says it's effective, e.g. effective this date March 10th, you are no longer eligible for Medicaid, OR do they lose it the first of the month in which they no longer become eligible, OR do they lose it the first of the month after they're found ineligible?
    i. In the client letter, it will have an end date for eligibility. Not the day they get the letter.

e. *NEWACS* - We would like to include MAT (Suboxone, Naltrexone…but NOT methadone as we do NOT have that certification) as a service provided through our SUD program. We would do this through E&M codes. Is there anything we'd need to do with the MCOs to add this service and start reporting? Would there be any rate adjustment since this is a new service?
    i. Contact the MCOs individually to see if any amendments need to be put in place. Molina – would require an amendment in most cases.

f. *ABHS* – if we change our billing address, how do we do that with the MCOS?
    i. CHPW - we have a form on our website for any demographic changes. Ask for 30 days notice thru the form. Contact directly if shorter timeline than that.
    ii. Coordinated Care – reach out to your contract contact.
    iii. Molina - will send specific email box for that. Amerigroup – will follow-up
    iv. Sarah will post information on IMC website under MCO Resource Roundup as received

g. *NEWACS* - We still have not heard if/how any MCO will cover UAs for individuals enrolled in SUD services. We have been told that each MCO has "state-only" funds cover this service (and outreach-engagement for MH/SUD services), but we have no mechanism in place to bill for this—was never discussed during the contracting process. Will MCOs cover the UAs for SUD-enrolled clients when these are not ordered by a physician, and if so, how do we bill and at what rate? (Note—these SUD UAs are NOT ordered by a prescriber so they won't fall under the Medicaid UA rule).
    i. Alice - MCOs do have a very limited amount of money in their wrap around contract for clients who need wrap around services. Anticipate that they will spend most of those funds on room & Board for residencial E&T and other places where Medaid services are covered but room & board are not. Leaves very little money for other things like UA, therapeutic interventions for children, PACT services, sobering services. Every region need to determine how to allocate and how much, just like the BHO had to do. Just a couple of sources of funds for that. HCA putting out guidance, not yet finalized, around rules for Medicaid coverage. But for state only funds, that has to be done on a regional basis. May need to look for block grant or criminal justice funds for that. Right now is a state-wide issue.
    ii. No updates from the MCOs. Waiting for some updates on HCA UA guidance. More controversial than we expected, taking longer to release the guidance from HCA.

h. *Children's Home Society* - The MCO FAQ sheet on the BHT website states Evidence Based Practices for children's public mental health care are provided to children 18 and under in Washington State. On the HCA 2019 EBP Reporting Guide it states children under 18. Can we get clarification on whether we can report EBPs on 18 year olds?
    i. HCA contracts say up to age 21. Probably refers to up to 21. HCA working on a hard and fast answer and will get back to you.

SERI Q&A

Gail Kreiger (HCA) – bottom line, read the updated SERI. Summary sheet of changes in the back. Major components of the modality by modality that have been changed.

i. Engagement and Outreach H0023 - looks like this CANNOT be used for MCO Medicaid clients as it is State funded - is this true? Is there another code to use or do we stop providing this service to MCO Medicaid clients?
    i. Same code also used for Rehab Case management – state funded service. Engagement & Outreach has been available for both Medicaid & State funded services.
    ii. Kelli Miller – will look at old SERI to compare
    iii. Gail - in that modality section, says that this is state funded only. Not available for federal funds match.
    iv. Will look into further to clarify

j. Care Coordination - H2021 - can only be used for people 21 and under - is there a code for Adults for Care Coordination with medical providers or do we use H2015 Comp Comm. Support Services?
    i. Wonder if the limit is applicable only to the child & family team meetings, not to all H2021
    ii. Identical to old version of the SERI
    iii. Corey – will look to into
    iv. Is there flexibility to have expansion? Was created/used for WISe.
    v. Modifiers there are more than youth age

k. Page 94 - SUD Assessment - states "H0001 or 0124" - what is 0124 -it's not listed anywhere that we can find.
    i. Couple places where when we were working with the MCOs. 0124 is a revenue code used for facility based care. Offering the opportunity to use one or the other based on how the systems were programmed.
    ii. Will remove 0124 from SERI

l. HH Modifier - under the BHO we did not use this code for COD services - we used mental health services codes. Our COD groups are run by CDP's and it appears now that they will not "count" as COD services because the CDP's are not mental health certified? This will under report COD services significantly.

m. If we are able to re-configure our EMR earlier may we use units vs. minutes prior to July 1, 2019?
    i. Need to work out with MCOs. In Pierce, all of the plans have agreed to take both. Work directly with plans on that.
    ii. Amerigroup – by request, MCOs were be able to take either minutes or units. Configure by what the provider requested. The providers that requiested, we had to configure system for that provider. But can't switch back and forth. Let us know in advance if want to do it before July 1.

n. COD Treatment (pg 124) - It appears from the Notes section that if a CDP/CDPT is also an Agency Affiliated Counselor – they are able to bill for these services using the HH modifier – is that correct?

Follow-up – Sarah will send these questions to Gail again for clarification/answers.

Interpreter Services Update – Todd Slettvet, HCA

- We are aware of the concerns & issues in the very rural counties. Statewide issue, and know there is more we can do to improve that process
- We are required to offer all interpreter jobs first to in-state union interpreters bc of the collective bargaining agreement
- Work around- process to reimburse providers up to our collectively-bargained rate for interpreters. Recognize that there is a gap – costs more than we are allowed to reimburse. We are working to develop some recommendations to our leadership to explore other solutions. Current vendor does not have telephonic option, so loking at that. 2018 HCA attempted to procure a ventor for telephonic, but were unsuccessful. So only able to offer in-person
- Provider has to start a request using the Universal portal. Anytime after that request has been made & verified (verifies eligibility and covered service and attempts to offer to in-state interpreter), provider can cancel request and get their own person off-contract and follow the reimbursement process.
- HCA is exploring options for a telephonic interpreting – adding with our current vendor. Fall back option if that isn't possible, is to work w/ dept of interprise services to procure vendors who can offer telephonic & video remote interpreter. Won't be in place until Oct. 2020
- Asking BHAs to provide estimated uncovered interpreter costs per year. Get budget impacts of the uncovered.
- Timeline for recommendations? – hope in the next few weeks.
- If we have a telephonic interpreter available to us, are there restrictions to us getting reimbursed for that?
    - Because our current vendor doesn't have telephonic, we aren't currently reimbursing for that. But we are looking into options for to be able to reimburse.
- IFD – just to clarify, it's face-to-face only and not mileage?
    - Correct. Our rate includes mileage and travel time as part of the rate. But the rate we negotiated likely is not covering the provider costs when they have to go off our contract.