better health together

NOTES
IMC Workgroup

May 1st 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
- Interpreter Services update
- Reconciliation process issues – MCOs & HCA
  - Process & timeline for capitated contracts
  - Deficits / making whole
- Other provider questions – see following pages
- TBD - SERI Q&A follow-up
- Other discussion

2:45 NEXT STEPS

- Topics/items for next time

3:00 ADJOURN

Meeting Notes – begin page 2

Outstanding Questions – begin page 7

NOTES

Attendee organizations: BHT, HCA, BH-ASO, Molina, CHPW, Amerigroup, Coordinated Care, Spokane Public Schools, SPARC, Frontier, Institute for Family Development, Spokane County Jail, Partners with Families & Children, Pioneer, New Horizon Care Centers, YFA Connections, Spokane Counseling Services, Riverside Recovery, Children's Home Society, Daybreak Youth Services, Catholic Charities

EWS DEBRIEF

- MCOs continue to use this to follow-up on reported issues
- Most indicators are holding steady, looking good
- HCA hopes to have EDIE data ready to share next month

INTERPRETER SERVICES UPDATE

- Submitted recommendations to leadership
- Recognize over-the-phone interpreting (OPI) as an option is a statewide issue, trying to address
- Need to prepare a legislative decision package to get needed funding to add OPI to current vendor contract. Because of that, earliest might have OPI is later next year

RECONCILIATION PROCESS

- Molina – we're working thru one-on-one with providers. If not been in contact, contact Megan Gillis Megan.Gillis@MolinaHealthCare.Com
- Molina – to the extent that there are reconciliation pieces to contract, most important thing providers focus on is claims & encounter submissions are being reconciled and accepted and paid. If provider have questions about claims/encounter submissions or response files, reach out to Corey Cerise Corey.Cerise@molinahealthcare.com
- Amerigroup – doing individual meetings with providers, reach out to Kathleen Boyle Kathleen.Boyle2@amerigroup.com if you haven't had contact (may have gone to someone else in your org)
- CHPW – if having issues, reach out directly to contract admin for CHPW. Can also reach out to Cathy Neiman Cathy.Neiman@chpw.org
- Question (Bryan Stanfill, Excelsior) – bc it's set up as regional (vs. provider proportion) shares, increases chances of provider having more or less than their contracted amount.
    - MCOs – Because it's part of contracting, so can't talk about it together. MCOs can't talk together about contracts by law, would love to all sit down together, but can't.
    - If an MCO comes knocking and says we've overpaid by X amount?
        - MCO would work out with provider individually
    - If the math isn't being done the same by the MCOs, how can we get to 100% or make sure we're not overpaid?
    - Frustration that good faith conversations about maintaining status of providers, but challenges this year
    - Amerigroup – working with providers individually, sitting down to find if there are pieces that aren't working. Knew we would have to go live and see what's working and not.
- Other contracting question: when will MCOs start contracting process with providers for 2020 contracts?
    - Molina expects to initiate conversations in fall
    - Amerigroup – will check with contract team and get back

Contracts & Reconciliation Contacts

Molina – Megan Gillis Megan.Gillis@MolinaHealthCare.Com
Amerigroup – Kathleen Boyle Kathleen.Boyle2@amerigroup.com
CHPW – Cathy Neiman Cathy.Neiman@chpw.org

PROVIDER QUESTIONS

1. ***Outstanding questions from April meeting (MCO/HCA follow-up needed)***
    a. How to handle money received from primary commercial while in capitated MCO contract:
        i. 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?
    b. H-codes – not covered by primary commercial, way to streamline process so don't need denial?
        i. 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?

    Answer (a&b): On the agenda for the HCA/MCO call tomorrow and hope to set up some work sessions to address – COB in general

    c. 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?

    Answer: EBPs can be reported for children under the age of 18 (0-17 years old).

2. ***New questions***
    a. What requirements does HCA have for websites – what we're needing to know is what alternative language do we need to include on our website?

    Answer: HCA did a little digging on this, and the issue of language and provider websites is actually covered under federal law (specifically the Americans with Disabilities Act, but also potentially the Affordable Care Act). Based on our cursory analysis, we identified what we think are a couple of key requirements:

    - Ensuring the website can be accessed using a screen reader
    - Ensuring that the website has prominent and clear "taglines" in the prevalent non-English languages for the region, outlining alternative format options, translations, and other required accessibility options per the ADA laws.

    However this may not cover all of the requirements that a provider's website may need to meet in order to comply with federal law; we strongly advise providers to bring this question to their compliance officer/risk manager or legal counsel as they would probably be the subject matter experts and better consultants for this question.

    b. I combed through some of the information available (rapid response questions etc.) and did not see this addressed. We operate an outpatient SUD facility. We have 1 case manager and 2 peer support that provide services to MCO covered clients. These three employees are not CDPTs or CDPs. We are just not beginning to put in our claims due to issues with getting set up through the MCOs. Those 3 individuals have been coding their services to case management (T1016) on our trackers but the SERI calls out that SUD case management must be provided by a CDP or CDPT (see below). My question is this: What code can we use and submit to an MCO for services provided by these individuals? They are providing services such as assisting clients with housing, clothing, food, work, workforce redevelopment and peer support. I am sending this question to you in hopes that you can help me determine the correct code to use. See below.

SUBSTANCE USE MODALITY: OUTPATIENT TREATMENT SERVICES

CASE MANAGEMENT

T1016	Case management, each 15 minutes	UN (1 or more)	GT HD HF (R) HH HZ U5	01-RN/LPN 02-ARNP/PA 03-Psychiatrist/MD 04-MA/Ph.D. 05-Below Masters Degree 09-Bachelors Level w/Exception Waiver 10-Master Level w/Exception Waiver 12-Other (Clinical Staff) 20-Chemical Dependency Professional 21-Chemical Dependency Professional Trainee	10 Minutes minimum for first unit For Medicaid funded individuals, this service may only be provided by a CDP or CDPT.

Answer: Will be able to start billing for SUD peer this summer – HCA will look into when that begins Bryan Stanfill (Excelsior) – some of it depends on whether someone is a certified peer. What we've done is bill under H2015. Sometimes there isn't exact category service, so find something that accounts for that but maybe has a different - connect with Bryan after meeting.
BHT also has upcoming learning opportunities around this:

- Collaborative Care Billing on July 19 (more here)
- Reimbursement for Care Management, date TBD

Update from HCA 5/3/19: Answer: Providers will be able to begin billing for SUD peer services on July 1, 2019. SUD Peer Support will be added to the SUD modalities in SERI so there will be a code for this. However, as the provider notes above, SUD case management services under T1016 must be provided by a CDP or CDPT in order to be reimbursed under Medicaid.

c. I am hoping you can point me in the direction of who could answer the question about how BH agencies are able to bill for care coordination. Typically we would use H2015 (case management) for this service but care coordination doesn't really require a behavioral health degree so there doesn't appear to be a taxonomy to register a non-BH provider under in order to bill for the service. There is a lot of pressure coming from HCA/BHT to do this – and we're excited to get going – but we need to be able to bill for the time or we can't pay for the position. We want to be using uncredentialled to providing case mgmt – we don't need licensed people making those connections to services.

Answer: According to HCA, there is no fee schedule.
Look at billing under H0047. Amerigroup has created a fee schedule for Non-Medicaid covered service – can share with any contracted providers. Contact Courtney Ward courtney.ward2@anthem.com
Other MCOs to follow up.

d. When individuals are released from incarceration and their benefits are reactivated by the Healthcare Authority, only the medical/behavioral health benefits are being reactivated. Behind the scenes, the Managed Care Pharmacy benefits of these individuals is remaining inactive/coded as suspended. Because these benefits are not visible in the Provider One system, there is no way for us as providers to know these benefits are inactive until the pharmacy tries to fill a prescription and gets a denial. The denial is then kicked back to the facility. Staff from the facility then have to call MCO member services and specifically request to have the Pharmacy benefits reactivated.

   Best case scenario, this process takes an hour or two. Worst case, this process can take days. However long it takes, in the meantime, residents cannot have any medications filled until their Pharmacy benefits are reactivated. Which means residents are going without things like insulin, blood pressure medications, mental health medications, and opioid replacement substances. We

need to figure out a way for the reactivation process to trigger a message to the MCO to activate pharmacy benefits at the same time.

Answer/Discussion: Molina – pharmacy segment at MCO sometimes delayed as a result of waiting HCA. Our Members Services can send an escalated request to get those benefits reactivated
CHPW – similar process.
Nicole Thomas (NHCC) – Our concern is that when the benefits are reactivated by the HCA, that isn't being sent to the MCO/pharmacy not being reactivated along with medical/BH benefits. Hoping for a correction for the notification to be sent from HCA to MCO automatically, rather than provider/client to have to go thru the process and wait 24-48 hours.
Molina – that information should flow from HCA to MCO to MCO pharm system. We're looking to link in our member services team to expedite that process.
NHCC – in our experience, pharm isn't reactivating until we (provider or client) call the MCO. So far, this has been happening across MCOs, not with any one specifically.
CHPW – we get a file every day from HCA, then we submit to our Pharmacy benefit to update on their end. So it does take time on our side to process. Is there any way to notify HCA 24hrs before jail release so they can start the process early and get to MCOs?
Amy Hood (Spokane County Jail) – Problem is that you don't always have a 24hr notice that a client is being released. We are working already with HCA thru Community-Minded Enterprises if we do have advance notice of their release.
Molina – will look into this. Our process is similar, but will check to make sure the process is working smoothly. We'll see if there is opportunity to expedite, but that may require assistance from HCA
Nicole – would it be helpful to contact the individual MCO when this happens?

- Corey Cerise (Molina) – Yes. Contact at Molina Corey.Cerise@molinahealthcare.com
- Julie – CHPW contact julie.leibbrand@chpw.org
- Amerigroup contact Kathleen.Boyle2@amerigroup.com

HCA – as you run into these issues, HCA would be happy to figure out a process or guidance doc to try to resolve this

e. Spokane Public Schools - recently updating our roster, and we have interns on our roster. Got a reply back from one of our MCOs that we do not enroll students of any kind. So can students bill? Have had trouble getting response from MCO on this. We get new interns constantly, and they're a big part of service in this community. This is the new person we go thru at that particular MCO, so the answer has changed with the new person. When the changes happen, we're not aware of them. Want to do the steps right, but have different people telling us different things.

Answer: BHT will help connect you with specific MCO to resolve.
Other orgs having this issue? No. YFA – our interns have been going through fine on our roster since we're credentialed at the org level.

f. Our clinical team has had some questions specific to Critical Incident Reporting. Based on the information we have from the MCOs we have questions regarding the following categories. For some foundation, the information we are referencing comes from a PowerPoint that was presented on 10/5/2018.
    - "Abuse, neglect, or exploitation of an Enrollee", specifically "Including neonatal exposure to drugs/alcohol"
        1. We are confused about who the "Enrollee" is in this instance. The unborn child experiencing "neonatal exposure to drugs/alcohol" is not considered the "enrollee" of our agency, so how would this be a requirement under this category?

        Answer: In order to answer this question, I would like to know where the "neonatal exposure to drugs/alcohol" is identified. I did not see it in the contract. However, having said that, the "Enrollee" in this case would be the birth mother. If there are any actions

that would be considered “abuse” “neglect” or “exploitation” of any enrollee, then that would be used.

- "Violent acts allegedly committed by an Enrollee"
    1. We are hoping to get some more clarity on the "allegedly" piece. Is there a requirement around who is making the allegations and where the allegations need to go (i.e. law enforcement, DCYF, etc.) for it to meet the threshold required for "allegedly" within this context? For example, is there something that distinguishes if we get this information through an adult (non-vulnerable) or if it is coming directly from law enforcement/probation?

  Answer: The term allegedly is more or less a due process term that extends consideration to the enrollee who “allegedly” commits the act but has not been convicted by the courts. Basically, it is used to convey that something is claimed to have occurred, although there is no legal proof. If a staff member sees the act in the media and it is clearly a media event and the enrollee has “allegedly” committed the act, then that is sufficient for the act to be documented in the HCA Incident Reporting system.
- "Event that is likely to attract media attention"
    1. It can sometimes be difficult to know what will, or will not, attract media attention. If, for some reason, we later learn that something has made it to the media but were not anticipating is as something that would have been "likely to attract media attention" would immediate reporting after the fact meet this requirement? Do we know how media is being defined with the increase in social media platforms? Has this changed beyond TV news, papers, etc.?

  Answer: This is a professional judgement decision. If, based upon the nature of the act the result will likely be a media attention, then that would fit. For example, an enrollee commits an act of arson to a religious organization, but there is minimal damage. Given the recent news events regarding arsons on religious facilities, then there is a reasonable possibility that could end up in the news. Even though no one was injured. Another example might be a situation where an enrollee believes they have been treated unfairly and takes actions to contact the media. Even if the story is not published, there is a “likely” media attraction depending upon the severity of the allegation and how seriously the media wants to treat it.

  This is a bit more difficult to answer because it involves staff judgement. The reality is if it is classified as likely to attract media attention and it does not, then it just becomes an event that was reported based upon the professional judgement of the staff and it remains that. If a staff member is unsure, it’s always a good idea to staff the incident with a Supervisor or contact the HCA Incident Manager for guidance.

  The purpose of this incident classification is to provide a “heads-up” to HCA that the event may bring media attention.
- "Other incidents, as required by MCOs"
    1. Are there any recent guidelines that have come out from MCOs collectively or is this an individual MCO decision?

  Answer: These decisions are *individual* MCO decisions.

OTHER DISCUSSION

- Jessica Diaz (HCA) – for our outstanding questions for this group, can the MCOs make a commitment to respond within a certain amount of time, and BHT to then out to the group?
    - Yes, BHT will send out outstanding questions within 2-3 days of meeting
    - Yes, MCOs can respond in a 2-3 week timeline (even if in some cases the answer is “we’re still looking into/needs more work”
        - Quicker timeframe for issues impacting client/provider services vs. systemic issues

- BHT will collate and send out answers to the group as received
- Can send questions to HCA via the mailboxes:
  - HCAintegratedMCquestions@hca.wa.gov – client specific questions
  - HCAmcprograms@hca.wa.gov – contracting or similar

Outstanding questions

For MCOs to address

1. Update MCO contact list – most recent is from February (available here)
2. Billing for case management: We operate an outpatient SUD facility. We have 1 case manager and 2 peer support that provide services to MCO covered clients. These three employees are not CDPTs or CDPs. We are just not beginning to put in our claims due to issues with getting set up through the MCOs. Those 3 individuals have been coding their services to case management (T1016) on our trackers but the SERI calls out that SUD case management must be provided by a CDP or CDPT (see below). My question is this: What code can we use and submit to an MCO for services provided by these individuals? They are providing services such as assisting clients with housing, clothing, food, work, workforce redevelopment and peer support. I am sending this question to you in hopes that you can help me determine the correct code to use.
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4. H-codes are not covered by primary commercial: Is there a way to streamline process so don't need denial? 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?

For HCA to address

5. Update HCA contact list – most recent we have is here.
   a. BHT contact should be changed to Sarah Bollig Dorn Sarah@betterhealthtogether.org (remove Charisse Pope)
6. SUD Peer: When will providers be able to begin billing for SUD peers? See question 2 above.
7. Potential for process/guidance doc for reactivating pharmacy benefits: see notes above for details of conversation

SERI questions

8. *(new)* H2011: I would like to confirm that we can continue to use H2011 for crisis services that are NOT provided by the BHASO crisis line. We have used that code with the U8 modifier for WISe, for mental health professional crisis response to our families. It looks like we can still use it, as it has the U8 modifier as a possibility but the service itself is described under the 'BHASO only' section.
9. H2027: In the description, it states Provider Type 12- Other (Clinical Staff) but there is no definition as to who qualifies. Would a CDP or CDPT be able to use this code?
10. H0023: It mentions "targeted population". Are there some examples that we could get for the Engagement and Outreach H0023 on page 126 of SERI 2019? Would AI/AN be a "targeted population"?
11. As follow up to the IMC Workgroup meeting, H0023 is a state funded code, does that mean if for SUD, we would be able to use the SABG to pay for these?
12. 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 clients?

    a. Same code also used for Rehab Case management - state funded service. Engagement & Outreach has been available for both Medicaid & State funded services.
    b. Gail - in that modality section, says that this is state funded only. Not available for federal funds match. Need to look into further to clarify
13. 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?
    a. Need to look into further. Wonder if the limit is applicable only to the child & family team meetings, not to all H2021. Modifiers there are more than youth age.
    b. Follow-up question - if it is only for 21 and under, is there flexibility to have expansion?
14. Page 94 - SUD Assessment - states "H0001 or 0124" - what is 0124 -it's not listed anywhere that we can find.
    a. 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.
    b. Will remove 0124 from SERI
15. 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.
16. 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?