GCACH Provider Readiness Workgroup
July 26, 2018
2:00 PM to 3:00 PM
Meeting Minutes

1. Attendees: Martin Sanchez, Jennifer Flores, Jesse Flores, Patrick Flores, Carol Willingford, Denise Clapp, Dana Oatis, Marianne Oliver, Yolonda Madirigal, Gordon Cable, Carol Moser, Kristy Needham, Claudia Torres, Steve Ghiglione, Shari Rowley, Sara Clark, Chris De Villeneuve, Penny Bell, Samantha Zimmerman, Frank Becker, Sela Barker, Donna Arcieri, Alicia Egan, Meagan Barth, Liz Rich, Ellen Christian, Megan Gillis, Scott Parker, Isabel Jones, Corey Cerise, Courtney Ward, Janice, Angelina Thomas, Dave Wilson, Tory Gildred, Jaime Carson, Cathy Pipes, Mathew Kuempel, Ed Thornbrugh, Mark Loes, Diane Halo, Shereen Hunt, Luke Hoisington, Christine Mickelson, Elyn Blandon, David Escame, Whitney Howard, Cicily Zornes, Angie Balli, Mike Berney, Julian Thompson, Teresa Aussem Lopez, Jennifer Vincenti

2. Review the Brief Overview-Non-Encounter Data Reporting Requirements in IMC Regions – Isabel went over the document below.

Brief Overview: Non-encounter Data Reporting Requirements in Integrated Managed Care Regions

The integration of behavioral health and physical health services through the Integrated Managed Care model affects the business operations of Managed Care Organizations (MCOs), Behavioral Health-Administrative Services Organizations (BH-ASOs), and behavioral health providers. One operational area impacted by this transition is the collection and reporting of non-encounter data (i.e. "native transactions"). This document serves as a brief overview of HCA's approach for native transaction data submission.

The majority of native transaction data is required to fulfill the federal Substance Abuse and Mental Health Services Administration's (SAMHSA's) Treatment Episode Data Set and National Outcome Measures reporting requirements. Native transactions are demographic and social determinate data elements that are currently defined in the DSHS Behavioral Health Data System Data Guide. However, the current infrastructure to collect and submit native transactions was not developed for the integrated managed care landscape.

Washington is in the process of developing a long-term solution to support the submission of native transactions. In February 2018, HCA submitted a two-year Corrective Action Plan (CAP) to SAMHSA that details HCA's 3-part strategy for developing this long-term solution.

HCA has identified two main priorities for this work:

1. Meet or exceed SAMHSA block grant reporting requirements plus data or reporting needs of state agencies, stakeholders and MCOs and BH -ASOs.
2. Standardize the native data collection process to minimize the burden on behavioral health providers at the point of care.

In March 2018, SAMHSA approved of HCA's CAP. Below are the highlights of the CAP and the timeline for completing this work:

	Activity	Estimated Timeline
Task 1	HCA will work with the BHOs, MCOs, BH-ASOs, and key community providers to confirm a set of data that includes the SAMHSA minimum data set as well as any additional data elements identified by the BHOs/MCOs/BH-ASOs as required to conduct their business. Once that data set is defined, the State will establish and define the minimum data set, including standard data definitions and transaction formats.	July 2018 - April 2019.
Task 2	Washington will convert SAMHSA reporting to the Mental Health (MH)-Treatment Episode Data Set (TEDS) format. This conversion effort will result in closer alignment with service encounter data already collected in ProviderOne, and will reduce the number of data elements that need to be collected in the supplemental native transaction submissions.	July 2018 - April 2019. This task is concurrent with Task #1.
Task 3	Examine two system options for submission of the newly defined data set: – Continued collection of non-encounter data from payers (ASOs and MCOs) into the Behavioral Health Data Store (BHDS) with modifications to accept any new data elements, or – Enhance ProviderOne to accept a new transaction that aligns with the data elements defined in Task #1, eliminating the need for a second system to support SAMHSA data reporting.	April 2019 – April 2020 We estimate 3 months for analysis of options, and 9 months for implementation.

Next Steps:

During this two-year CAP interim period, providers will continue to report service encounter data to the MCOs and BH-ASO. The MCOs and BH-ASO will continue to submit this data to HCA through ProviderOne. BH-ASO's will also still be required to report transaction 160.04 (DCR Investigation) and transaction 162.04 (ITA Hearing) during the interim period.

During this interim period, we encourage providers to continue collecting native transaction data, and to report the data if your region has a system and mechanism that enables you to do so. HCA will collaborate extensively with the MCOs, BH-ASO's and the behavioral health provider community throughout this two-year process, and we will soon be reaching out to engage stakeholders in Task 1 of our CAP.

HCA looks forward to working with our stakeholders on the development this long-term data solution and we will continue to communicate regularly on our progress on the CAP. For questions about HCA's CAP or this data gap issue, please contact Cathie Ott at cathie.ott@hca.wa.gov or Samantha Zimmerman at samantha.zimmerman@hca.wa.gov.

Question: Who are the 837s continued to be submitted to?
Answer: To the managed care plans primarily but not starting until 1/1/19.

3. Go over questions on the Question Tracker – MCOs

Questions: When will CPT codes for billing be available?
Answer: MCOs generally accept CPT codes listed as covered in SERI and on the HCA fee schedules. Any codes outside of that would need to be separately contracted/negotiated.
Based on experience in other regions, we are working with the BHO to obtain a list of codes currently utilized by providers to compare against SERI and identify outliers or "homegrown" codes that may have been utilized in the region.
We understand the importance of consistency across MCOs and getting this information to providers as quickly as possible.
MCOs encourage the use and submission of EBP codes on claims/encounters. Submitting EBP codes to MCOs will be different than submitting to the BHO- we will cover this in our IMC Symposiums.
HCA is working to draft a document to address any non-HIPAA compliant components of the SERI Guide. More communication will be shared on that soon.

Question: Will there be a sliding fee?
Answer: There are no sliding scale fees for Medicaid. A Medicaid member may have a spenddown to meet, but once on Medicaid, the member does not pay for services.
HCA - The plans will have a small percentage of state funds and the rest will be with the BHO-ASO. These funds could be used for housing for inpatient, outreach, other items that are allowable. The BHO-ASO will continue to contract out block grant dollars and other non-Medicaid funding sources. The 30% of the over all state funds are contracted to the Managed care plans. That 30% is divided equally between the MCO proportionate to their enrollment to support their % of the membership within the region. If you are a provider that has a contract for block grant dollars now with BHO that should stay the same into January 2019.

Question: What are MCO requirements and process for payment on dually eligible.
Answer: Medicaid is always the payer of last resort. For claims, the primary insurance should be billed first. Then the MCO may be billed. For Medicare, there are some provider levels and services that are not covered- in those instances, you do not need a primary EOB to bill Molina.
While you do not have to wait for primary EOB to submit encounters, you should still bill primary insurance.
Amerigroup does not serve duals in Greater Columbia.

Question: Who are all of our points of contacts? Will I be coordinating with a different person for contracts, billing/claims, IT, care coordination, etc.
Answer: Please see the completed MCO Contact Sheet. There are different contacts for different functional areas. If you are ever unsure who to reach out to, the Provider Services representative can guide you to the correct contact. For Amerigroup, your main point of contact for Implementation Activities is Courtney Ward.

Question: What clearinghouse will your plan be using? We intend to continue using Office Ally, will this be compatible?

Answer: Molina: Molina's clearinghouse is Change Healthcare. Providers can use other clearinghouses as long as those clearinghouses have an agreement to submit to Change Healthcare. Office Ally is a clearinghouse that already has connectivity with Change Healthcare.
CCW: Office Ally is one of the clearinghouses we use. For a full list of clearinghouses, please reference our Website (https://www.coordinatedcarehealth.com/providers/resources/electronic-transactions.html)
Amerigroup: Yes, we work with Office Ally. Our current vendors are Change Healthcare, Availity and Capario.
CHPW: Yes, Office Ally is supported. CHPW uses Availity.

Question: Will we be continuing to submit Native Data information from the Data Dictionary (demographics, client address, etc.) with your plan?
Answer: HCA is not requiring MCOs to collect the data at this time, so MCOs are not collecting the data from providers. It has not been determined what data will continue to be collected down the road and it is not expected to be determined and implemented until 2020. HCA will be organizing stakeholder groups to determine how and what data will be collected in the future. Per HCA, providers will be part of those stakeholder groups.

Question: What is your plan's process for pre-authorization for residential? What is the approved amount of time for getting the patient to the scheduled bed date? What is the approved amount of time for residential? Will your plan have its own authorization form or will it be standardized among the four chosen plans?
Answer: Molina requires prior authorization for all residential treatment services since they are not emergent and that would be considered a routine turnaround time, which is 5 calendar days. Ideally, the request would come as close to the bed availability date as possible or if the bed date is known whether the request is coming from a referent such as an OP provider/assessing agency or the providing agency themselves. However, we understand that this is not always possible. When the bed date is not available at the time of request, we open a 7 day authorization "window" to allow time for securing a bed date based on the clinical information provided. If the member fails to admit by midnight of that 7th day, we ask to be notified so that this window may be extended for a reasonable amount of time, like a few days. Depending on how much time has elapsed from the request date, we may request a very brief clinical update. If the bed is not going to be available for a significantly longer period of time or an unknown period, we will close the request and notify the requestor that a new request should be submitted at a future date. We authorize residential treatment in 14 day blocks of time. The provider will be given the last covered day date along with a written request for a continued stay review if more time is being requested. Molina has their own simple one page BH authorization request form which is available on our website or which can be e-mailed to the provider by request. MCO's are looking to regroup on UM, with prioritization on SUD to ensure alignment. Currently, MCOs each have their own authorization forms.

Question: In one region, the outpatient provider has 5 days once the authorization is in place to get the patient into residential, with a pre-scheduled bed date secured. What is your plan's policy going to be for residential agencies that do not give scheduled bed dates? For example, several residential agencies expect the patient and outpatient provider to call everyday to see about openings instead of giving an actual bed date. In these cases, a 5 day turn-around is not going to be feasible.
Answer: Same answer as above..
What about having the patient and outpatient provider to call everyday? The MCO would like to have a discussion on this offline.

Question: How often does your plan want claims and encounters submitted? Weekly? Bi-monthly? Monthly?
Answer: Molina: Once a clean claim is received, average turnaround time is 7.5 days. 95% of claims are paid within 30 days. For encounters, provider contracts request that encounters be submitted at least monthly. We understand that it may take some time to get up and running initially, but stress importance of submitting all encounters to ensure there is no negative impact to premiums, which would directly impact providers based on their payment methodology. Missing encounters could also impact the allocation of OP funds in a multi-provider county.
CCW: Agreed with the importance of submitting timely. For claims, we allow up to 365 days to file, but encourage submission early. For encounters, the provider contract should be referenced for specific requirements, but are normally required to be submitted within 30 days.
Amerigroup: Providers are encouraged to submit on a regular basis to ensure reporting of services are current, but cadence of submissions are not specifically called out in contract. We allow up to 365 days to file.
CHPW: Daily, weekly, or no less than monthly.

Question: Will your plan accept 837p files for claims and encounters? Will your plan be using electronic remittances? Our EMR is AvailHealth's product KeyNotes. As of now, KeyNotes can accept 835s and is testing 270/1 eligibility request/responses
Answer: Yes, all MCOs accept 837P (for Professional claims) and 837I (for Institutional). Providers can also receive electronic remittance advices (835s).

Question: What is the expected turn-around time for payment? If there are issues with the claims submission or receiving, will we still be paid?
Answer: For providers in GC that are paid on a capitated basis, payments will be made by the 15th of each month. Any invoiced programs (WISe, etc.) will be paid within 10 days of receipt of invoice. Clean claims generally process in our system in 30 days.
Amerigroup is working on invoice process and timelines will be communicated to providers well in advance of implementation.

Question: Is there any additional forms or paperwork we need to be creating or that you will be providing for claims submission, authorizations, or any other services provided?
Answer: MCOs will have forms we will be sharing with providers throughout the implementation period- invoice templates, PA forms, IMC Companion Billing Guide, etc.
Is there a timeframe for these forms? Please look at the timeline that was shared. Most will be available in October.

Question: Will there be state-only funds from your plan to reimburse for non-Medicaid services, such as outreach and interim services, for your Medicaid-covered patients?
Answer: Molina: For Molina, any providers that receive non-Medicaid funding today under the BHO, will continue to receive non-Medicaid funding under Molina's contract.
There will be a shift in the allocation of non-Medicaid dollars between the MCOs and BH-ASOs going forward. The funding is not being cut, the allocations are just shifting. Going forward the MCOs will receive

30% of the GFS funds, which will be allocated based on each MCOs enrollment in the region. MCOs would like for HCA to cover this topic at a future meeting.
Amerigroup will assess them on a case to case basis.

Question: Will your plan be able to reimburse for Community Outreach (in the SERI)? This is an approved service that is not connected to a particular person so at this time there is difficulty being reimbursed for it, as there is no demographic or individual encounter to submit.
Answer: MCOs and HCA to discuss- parking lot for a future meeting.

Question: All of the plans at the panel discussion mentioned "special projects" funding that is available to help with integration, innovation and whole-person care. Will there be language in the contract to help guide ideas for special projects and reimbursement?
Answer: The special project funding is between the providers and the ACH. MCO contracts do not reference this funding. MCOs would be happy to collaborate with providers on ways that the funding can be utilized to advance integrated care.
In other regions, MCOs have developed Capacity Building Committees to create a regional forum to assess requests to add or expand programs/services collectively.
Amerigroup: AGP does have Foundation dollars available for special projects across the state of WA. Any qualified 501c3 charitable organization can apply for funding through our online application. The organization may complete an Anthem Foundation Grant application or a Community Relations (CR) application and information can be found at www.anthem.foundation. Courtney Ward can also talk specifically about this process and projects with providers. Additionally, AGP has developed a Health Equity and Community Investment Committee and information is forthcoming about that committee, participation and distribution of funds. These dollars would not be a part of your Amerigroup contract, however.

Question: Will member eligibility need to be checked prior to every visit? Once a month? Twice a month?
Answer: Member eligibility must be checked at every visit. Members can switch MCOs as frequently as once a month and in addition to that, HCA sometimes has retro eligibility changes. In order to ensure you are billing the correct MCO and your claims are not denied, you should check eligibility before every visit.

Question: How will data submission occur?
Answer: For claims, MCOs can accept electronic submission through clearinghouses, paper, or manual entry through our provider portal. For encounters, MCOs accept electronic submission through a clearinghouse, paper, or electronic submission in 837 format direct to MCO. More specific information around claim submissions will be discussed during the provider symposiums.

Question: What Access to Care standards will be in place? (FFS vs Capitated)
Answer: Please clarify the question.

Question: Do you need separate NPI numbers for separate licensures?
Answer: If a provider holds multiple certifications (eg. CDP and LICSW certification), they do not need two different NPI numbers. Only one NPI is needed per provider.

Question: WISE Program – legal program; how will that be reimbursed? Fee for service could possibly limit open services and possibly not work.

Answer: WISe payment is reimbursed on a case rate payment.
TR lawsuit will have oversight in ensuring MCOs are meeting the same benchmarks, doing a lot of the same work the BHO has been doing.

Question: Currently billing Amerigroup via hard copy paper; will this change or will this continue with other MCO's?
Answer: For claims, MCOs can accept electronic submission through clearinghouses, paper, or manual entry through our provider portal. For encounters, MCOs accept electronic submission through a clearinghouse, paper, or electronic submission in 837 format direct to MCO. We encourage electronic submission via our Provider Portal or with an 837 through a clearinghouse.

Question: MCO's processes for outpatient services? Authorization required?
Answer: MCOs do not require authorization for outpatient services. A Prior Authorization grid is being developed by all MCOs to show which services require Prior Authorization, notification or concurrent review. CHPW: Currently requires PA for high intensity OP (eg. PACT and WISe).

Question: What is the process for the HCA to transition and communicate changes for UHC clients?
Answer: HCA will send out a letter in late September/early October that notifies clients that changes are coming in January. It informs them the MCOs will be responsible for BH coverage and tells them to expect a letter with their plan later in the year (and that they will be able to switch if they want to). In late November, early December, clients will receive an enrollment letter that identifies the MCO they will have.
Behind the scenes, in November, HCA will look at who is enrolled in United and have the P1 system assign them to a different plan. For clients enrolled with CHPW, Coordinated Care, Molina or Amerigroup, they will remain in the same plan on January 1 and will not experience a change of MCO.
The Communications Workgroup will develop other materials to share with clients and providers to help spread the word, as well, such as fact sheets and talking points.

Question: What is the process for reimbursement or will there be reimbursement available for refugee services?
Answer: We need some additional information on this. What funding supports that program today? Lutheran will circle back internally for clarification.

Question: Currently reimbursed via check will EFT be available?
Answer: Yes, all MCOs support EFT payments.

Question: What will be the process to submit Native Claims?
Answer: Please refer to HCA handout re: non-encounter data ("native transactions").

Question: Are they required to Credential each provider or just the facility?
Answer: Molina: We credential at the facility level. We will need a roster of all providers and staff that provide direct care to members.

4. Go over IMC Behavioral Health Provider Status Tracker – GCACH is wanting to meet with each provider to go over the MeHAF and Billing Toolkit. We will reach out to each provider and to set up appointments. GCACH wants to work one on one with the providers to develop the Transition Plan.

Integrated Managed Care
Behavioral Health Provider Status Tracker

GREATER COLUMBIA
ACCOUNTABLE COMMUNITY OF HEALTH

Provider	Registration in Portal	CSA Complete	Billing Toolkit	MeHAF	MeHAF Sent to MCOs	Billing Toolkit Sent to MCOs	Scheduled Appointment to meet	Met to go over Assessments	Follow up Appointments	Transformation/ Transition Plan	Contract Sent	Contract Complete	Funds Released to Provider
Barth Clinic	Sent Invite												
Blue Mountain Counseling	X	X											
Catholic Family & Child Services	X	X	7/26/18	7/9/18	7/20/18	8/3/18	X	X		X			
Comprehensive Healthcare	X	X	7/9/18	5/16/18	7/20/18	7/20/18							
First Steps	Sent Invite						8/8/18						
Ideal Balance	X		7/27/18	7/19/18	7/20/18	7/30/18	7/27/18	7/27/18	8/3/18	X			
Lourdes Counseling Center/Crisis	Need Contract	X	7/13/18	5/16/18	7/20/18	7/27/18	X	X		X			
Lutheran Community Services	X		7/3/18	7/3/18	7/20/18	7/20/18	7/6/18	7/6/18	7/31/18 8/14/18	X			
Merit Resources	X	X	7/13/18	7/13/18	7/20/18	7/20/18	7/27/18	7/27/18	8/13/18	X			
Palouse River Counseling	X	X		3/23/17	7/20/18								
Quality Behavioral Health	X	X	7/26/18	7/31/18	8/3/18	7/26/18							
Serenity Point Counseling	X		7/13/18	7/18/18	7/24/18	7/26/18	8/2/18	8/2/18					
Somerset Counseling	X	X	7/10/18	7/10/18	7/20/18	7/20/18	7/10/18	7/10/18	7/19/18 7/23/18 8/7/18	X			
Sundown M Ranch	X	X	7/26/18	7/11/18	7/20/18	7/26/18							
Tri-Cities Community Health	X	X	7/30/18	5/29/18	7/24/18	7/30/18	X	X		X			
Triumph Treatment Services	X	X	7/12/18	7/13/18	7/24/18	7/26/18							
Yakima Valley Farmworkers	X	X		7/30/18	7/30/18		X						

5. Next Meeting is August 8th 2-3pm

   MCOs would like to have a meet and greet after one of the Provider Readiness meeting.

6. Future Provider Readiness Workgroup Meetings
   August 23rd 2-3pm
   September 6th 2-3pm
   September 20th 3:30-4:30pm
   October 4th 2-3pm
   October 18th 3:30 – 4:30 pm
   November 1st 2-3pm
   November 15th 3:30 – 4:30pm
   November 29th 2-3pm
   December 13th 2-3pm
   December 27th 2-3pm