Bayou Health Provider Call – Summary
January 14, 2015

FOLLOW-UP ASSIGNMENTS	
1. Provider Directory Point of Contact for each health plan	See follow up in Q&A below
2. 2015 CPT/HPC code updates	
3. Spend-down Retro-Enrollment/180 filing timeframe	

Call Statistics:

- Number of Callers – 250 plus
- Number of Assignments – 3

Meeting Facilitator:
Mary TC Johnson, Deputy Medicaid Director

DHH Announcements
Managed Care Organization (*MCO) contracts:*

- *January marks the end of DHH's first 3 year contract for Medicaid Managed Care.*
- *The new Bayou Health Contracts will begin February 1, 2015. The five (5) health plans will consist of the following: Amerigroup, AmeriHealth Caritas, Aetna, Louisiana Healthcare Connections, United Healthcare.*
- *Key Contract Changes:*
    - *All health plans were integrated to 1 delivery model-all plans are full risk MCOs. There is no longer a Shared Savings (CCN-S) option; but we have adopted several of the key lessons learned from that model, such as provider incentives, payment for quality improvements/outcomes.*
    - *Value added for members: Some dental and vision for adults, Circumcisions, among others.*
    - *Value added for providers: Savings distribution*
    - *Hospice Services and Chisholm Members (3,000 and 5,000) will be added to Bayou Health*

Open Enrollment:

- *Open enrollment began 11/13/2014*
- *The Choice period will end on 1/20/2015*
- *The effective date for these member choices will be 2/1/2015*
- *Auto-assignment of members will take place 1/21/15-1/29/15.*
- *Members will have a 90 day window to change health plans. The last possible date to change will be 4/29/2015.*

Purpose of Weekly Provider:

- *Identification of systemic issues and to expedite remediation and correction of reported issues.*
- *Ensure timely follow up and follow through of reported system issues.*
- *Methods of Communication between Providers/DHH/Health Plans*

- *www.MakingMedicaidBetter.com*
- *Informational Bulletins*
- *Health Plan Advisories*
- *Bayouhealth@la.gov*
- *BayouHealth.com (primarily member related information)*
- *Directly with each Health Plan via IB 12-27 Provider Issues & Escalation*

Questions & Comments

Q: Can we have a provider directory point of contact for each plan?
A: Yes. We will need to get this from each health plan.

After Call Follow-up: All five prepaid plans have contracting contact information online at www.makingmedicaidbetter.com (On the left side navigation bar select "I am a health care provider. Then, select "Useful contacts". http://new.dhh.louisiana.gov/index.cfm/page/1065.

Q: Inquired about requirements for contracting with UHC
A: Providers will need to re-contract with the MCO UHC plan. Providers should reach out to the health plan for detailed information. *See link in previous question*

Q: Will the health plans use the updated 2015 CPT/HPC codes? The current Medicaid fee schedules are not up to date.
A. The health plans depend on Medicaid to update the fee schedules. DHH staff who could respond as to when the fee schedules would be updated were not on the call but DHH would look into and get back with providers.

After Call Follow-up: The Department is in the process of completing the 2015 HCPCS update. It is the Department's intent to have the new 2015 codes and updates on file as soon as possible. Providers should submit claims for the appropriate HCPCS code to preserve timely filing. The fee schedules will be updated once the 2015 HCPCS update is complete.

Q. How can providers verify that they have been linked to a health plan?
A. Providers such reach out to the health plans and verify they are linked as well as verify that the information on file (e.g. address, phone number) are correct. In addition, a search should be conducted at www.bayouhalth.com should be conducted. Providers also need to check to ensure that they are not linked to a health plan that they did not contract with.

Q. Inquired as to when the new timely filling requirements will start.
A. Dates of service on or after 2/1/15. The 180 day timely filing requirement is for initial claims and not voids or adjustments. The provider will be required to submit the initial claim within 180 days of the date of service (DOS). Providers should follow up with each health plan regarding their timeframes for adjustments to be processed as this is up to the health plan to determine.

Q: Will Molina follow the new 180 day timely filing requirement as well?
A: DHH is working on having this requirement across the board. We will provide follow-up after the call.

After Call Follow-up: It has been confirmed that Legacy/FFS Medicaid will implement the same 180 timely filing requirement effective for dates of services on or after 2/1/15. The only exception will be the claims billed directly to Magellan for the LBHP program.

Q: Network Adequacy and MCO responsibility/accountability for Registry errors
A: It is the MCOs' responsibility to ensure that the information they have on file is correct. If a provider is linked to a provider that they have not contracted with, the provider should notify DHH of this issue. Fines and other administrative actions may be imposed if this is confirmed to have occurred.

Q: Will the system have the health plan ID #? Will the MCOs accept the Medicaid ID# for billing?
A: The system will have the Medicaid ID# but not the Health Plan ID#? It is an individual plan decision as to whether or not the MCOs will accept the Medicaid ID# for billing. Providers should reach out to the plans regarding their policy.

Q: How will the 180 timely filing requirements affect the Medicaid Spend Down members?
A: Medicaid Spend Down is carved out of Bayou Health; therefore, there will be no effect on these members on the MCO side.

After Call Follow-up: Under DHH review and follow up with provider to work through process for Medicaid Spend Down recipients in Legacy/FFS.

Q: Do we need to contract with MCO for members previously served by CCN-S?
A: Yes. The MCOs will have continuation of care plans for the transition but the provider will have to contract with the MCO to continue providing services. Providers should reach out to the MCO regarding there continuation of care plan. It will be a good idea to verify or submit prior authorizations once it is determined that a member is linked to a particular MCO.

Q: How does auto-assignment work – is the criteria published?
A: It is published as Appendix F of the Bayou Health MCO – RFP.

Q: Are the provider manuals and policies available, as providers are signing contracts that refers to requirements specified in the Provider Manual.
A: The manuals have been under review by DHH and the External Quality Review Organization. DHH will check on the status of these reviews and postings and push out what we can as soon as we can and also check with the MCOs to at least get the latest draft posted.

Q: Will the MCOs pay for experimental services?
A: Experimental drugs are not covered but Mary asked that the provider submit their question via the Bayou Health.com so that she can obtain a response.

Q: Are there other changes that will occur that DHH can share that will be beneficial to providers? (e.g. LaHIPP, 39 Week Initiative etc.)
A: DHH will publish specific guidance to Health Plans and providers through informational bulletins, health plan advisories, etc. If anybody has a specific question or issue, please email it to bayouhealth@la.gov

Q: What referrals are required for these services?
A: Providers will need to check with the individual health plans regarding referral policies.