LOUISIANA
DEPARTMENT OF
HEALTH

Louisiana Medicaid
Administrative Simplification Committee

February 20, 2024

Agenda

- Introductions
- Helpful E-mails
- Previous ASC follow-up items closed
- Provider Enrollment Portal
- Professional services updates
- Newborn Enrollment
- Contract Reminder
- Recoupment Discussion
- Re-assignment Policy
- Provider Directories
- Provider Question/Suggestions
- Screenings
- Q&A

Undersecretary Michael Harrington

Michael Harrington, LDH's new undersecretary, is a former chief executive officer/chief operating officer of adult/pediatric tertiary and community health services including post-acute services.

With more than 25 years of service in for-profit and nonprofit health systems, his passion is developing reliable processes that engages people, process, technology and culture to improve patient and staff safety while balancing efficiency and effectiveness.

Helpful Emails

Provider/MCE issues:	**ProviderRelations@la.gov**
Transportation issues:	**MedicaidTransportation@la.gov**
TPL issues:	**TPL.inquiries@la.gov**
MES inquiries:	**MESInquiries@la.gov**
Member Linkage:	**MemberLinkage@la.gov**

Previous ASC Meeting follow up

- MCOs were polled and all responded they were current with roster and credentialing contract timeframes.
- Pediatric Developmental, Autism, Perinatal Depression Screening - Informational Bulletin 21-3. No other issues reported.

Provider Enrollment Portal Help Desk

The Provider Enrollment Portal Help Desk is ready to help.

Invitation letters to enroll new providers through the Portal will start in 2024. A notice will be provided when this process starts.

Email:
LouisianaProvEnroll@gainwelltechnologies.com

Phone: 833-641-2140

Professional Services Updates

- 2024/Annual HCPCS updates
- Fee Schedule Change Indicator
- Assistant at Surgery
- COVID-19 Vaccines
- EPSDT Fee Schedule
- Smoking Cessation

Brandon Bueche/Dawn Tate

LDH Rate Review Process

- The State Fiscal Year 2022 Business Plan Established an annual rate review process that compares current provider rates across Medicaid, the southern average, the national average, Medicare rates, and commercial rates (if available) for all provider types on a staggered three-year cycle to allow for resourcing.

Newborn Enrollment Process (Maximus)

Were the incorrect assignments stopped?

Were all identified that were incorrectly assigned?

Have all incorrectly assigned been reassigned?

Why are the MCEs recouping from providers?

Newborn IB regarding contract language requiring MCEs to subrogate instead of recouping from the provider.

* 2.3.12.4.6 For newborns disenrolled, the MCO in which the newborn was incorrectly enrolled shall not recover Claim payments from the provider. The MCO in which the newborn is incorrectly enrolled shall seek such Claim payments from the MCO in which the newborn should have been enrolled on the dates of service.

Contract Reminder

An MCE shall not prohibit, discourage, intimidate, or in any other way take retaliatory action against a provider that reports any complaint to LDH.

Recoupment Discussion

Recoupment Timeframes:

- Before a recoupment is executed by an MCE, the provider shall have **sixty (60) calendar days** from **receipt** of written notification of recoupment to refute the recoupment.
- The MCE has **thirty (30) calendar days** to review the provider's response.
- Retroactive disenrollment requires MCEs to initiate provider recoupment in writing within **sixty (60) calendar days** of the date LDH notifies the MCE of the change.
- Post-Payment recoveries from providers and liable third parties are required to seek recovery from the provider **within sixty (60) calendar days after the end of the month** it learns of the existence of the liable third party.
- Post-Payment recoveries should be recovered by the MCE where date of service is **ten (10) months or less** from the date stamp on the provider recovery letter.
- Post-Payment recoveries should not sought from the provider where date of service is **greater than ten (10) months** but shall be sought directly from liable third parties.

Recoupment Discussion – Continued

Independent Review:

- Independent Review (Act 349/2017 Regular Session) allows the IRR process to be used for recoupments if the IRR is submitted to the MCO within 180 days of the date on which the MCO recoups monies remitted for a previous claim payment.

Subrogation:

- For enrollees retroactively disenrolled due to the invalidation of a duplicate Medicaid ID the and the valid ID is linked to another MCE, in accordance with the contract, the MCE shall subrogate the amount of the paid claims to the MCE that paid the claims for the dates of service.
- For newborns disenrolled, the MCO in which the newborn was incorrectly enrolled shall not recover Claim payments from the provider. The MCO in which the newborn is incorrectly enrolled shall seek such Claim payments from the MCO in which the newborn should have been enrolled on the dates of service.

Notification:

- MCEs only have 60 days from the date LDH notifies the MCE of the change to recoup from the provider.

PCP Enrollee Reassignment Policy

The following **core elements** shall apply to all in-network PCPs, all enrollees who have been assigned to the current PCP for at least 90 days, and enrollees who have not seen the assigned PCP within the prior 12 months.

- **Analysis** – the MCO shall perform claims analysis on a quarterly basis and based on the previous 12 months (at a minimum) of claims history, including wellness visits and sick visits.
- **Reassignment** – an enrollee will be eligible for reassignment if they have visited an unassigned PCP at least once within the previous 12 months. (criteria in MCO Manual)
- **Provider Notification** – MCO publishes the results of their claims analysis to their provider portals on the 15th calendar day of the second month of each quarter.
- **Enrollee Notification** – MCOs must notify the affected enrollees.
- **LDH Notification** - Report 364.

PCP Enrollee Reassignment Policy - Continued

Provider Notification – MCO publishes the results of their claims analysis to their provider portals on the 15th calendar day of the second month of each quarter.

- The results shall identify all enrollees eligible for reassignment from the PCP along with enrollees eligible for reassignment to the PCP. Enrollees identified as eligible for reassignment to the PCP shall be shared as informational only considering this data is subject to change via the dispute protocol below.

The results of the analysis shall be published in a format that is able to be downloaded/exported into Excel. The

- PCP is allowed 15 business days to review before any enrollees are reassigned.
- MCOs must also include a protocol for provider disputes with the results from the claim analysis. To dispute the reassignment of the enrollee(s) from the PCP, the provider must provide documentation (e.g., medical record, proof of billed claim, etc. for at least one date of service) that they have seen the enrollee(s) during the previous 12 months.
- MCOs must incorporate a flag for providers to identify new enrollees on their rosters/panels easily and a flag to indicate if the enrollee was auto-assigned or not. This flag is for all enrollees, not just reassigned enrollees.

Provider Directories

- Quarterly Provider Directory audits continue.
- Providers should continue to review their data and email the MCO with corrections.
- Providers can email the below addresses if they find incorrect information in the provider directory:
  - ABH- LAProvider@aetna.com
  - ACLA- network@amerihealthcaritasla.com
  - HBL- lainterpr@healthybluela.com
  - HHH- lamedicaidproviderrelations@humana.com
  - LHCC- lhc_provider_credent@centene.com
  - UHC- hpdemo@uhc.com

Provider Directories (cont.)

- Providers have the ability to initiate directory corrections from the directory itself. This is a preferred, very efficient method. Screen shot below:

- Providers must ensure that information communicated to the patient should match the information in the provider directory.

Screenings Discussion

Provider Suggestions/Questions

- Add a column to the fee schedules where an indicator would be utilized to view only updates/changes/deletions to the fee schedule.
- MEVS is not updating timely and/or is not accurate.
- Clarity regarding a grace period vs being locked in.
- LDH/Medicaid call center & information provided to patients – "letter from physician", "for cause"
- Continued challenges with TPL – adds to massive administrative complexity and inefficiencies, including:
  - MCO & State TPL files do not match and are often incorrect.
  - MCO & State continue to add ineffective coverage to TPL files

Provider Suggestions/Questions

- **STERILIZATION CONSENTS**
- LDH should revamp their handling of sterilization consents.
- Currently, MCOs should pay Anesthesia claims without the need attach a redundant sterilization consent forms if surgeon submitted consent and claim paid; however this doesn't consistently occur.
- Anesthesia providers are still having to procure sterilization consent forms from surgeon's office; having to send multiple requests/phone calls before surgeon's office sends consent (very time consuming).
- Consider making the consent form a prior authorization of sorts, have it provided to hospital by OBGYN prior to surgery!

Provider Suggestions/Questions

- **LACK OF UNDERSTANDING IN PROCESSING ANESTHESIA MEDICALLY DIRECTED CLAIMS**
- MCOs will often pay one leg of anesthesia charges, when billed under medical direction, i.e. with MD charge on line and CRNA charge on a separate line, denying the other (MD or CRNA) charge.

Provider Suggestions/Questions

- **ELIGIBILITY** - deferred most to TPL committee
- Clarity on TRADITIONAL MCR primary what type Medicaid can be secondary- FFS/-- (MCO only if Behavioral Health)
- How are behavioral health Services determined?
- Clarity on Medicare Advantage primary what type Medicaid can be secondary
- Clarity on Market place insurance vs Medicaid

Provider Suggestions/Questions

- Per IB 21-15: Effective 07/01/2021, MCOs are not paying additional reimbursement ($20.00 per time unit) for the dental services for ASA 00170 when modifier 23 appended.

- MCOs denying second claim processed as duplicate when 2 claims sent with different place of service (POS), i.e. school and office.
- Anesthesia electronic claims denied for sterilization consent form. Claims should not have denied if the surgeons claim was submitted with sterilization consent and paid.
- Denials for ordering/rendering providers not enrolled in LDH portal – MCOs all using different CARC/RARC. Suggest having MCOs use a standard response (CARC/RARC).

TPL Subcommittee Meeting

When – Today at 1 p.m.

Questions & Answers

Next Meetings

- May 14, 2024
- August 13, 2024
- November 12, 2024

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THANK YOU