MCO Resolution Panel Meeting Minutes

Date: 5/12/2022

Time: 10:00 – 11:30

Link:https://www.google.com/url?q=https://covaconf.webex.com/covaconf/j.php?MTID%3Dm8f7681a617768d7f098e455632776498&sa=D&source=calendar&ust=1652792397549425&usg=AOvVaw0z4wR3RH17661R8vWv_bBa

Meeting Minutes

Attendees:

Alyssa Ward	Beth Ludeman-Hopkins	
Laura Reed	Stefanie Pollay	
Emily Reynolds	Tammy Eames	
Jennifer Fidura	David Cassise	
Lakeisha Churchill-Noel	Izaak Funke	
Alice Nichols	Emily Bebber	
Lauren Howren	Jennifer Faison	
Mindy Carlin	Jessica Mackenzie	
Oketa Winn	Kim Moulden	
Rhonda Thissen	Scott Cannady	
Rita Hines		
Shamika Ward		
Sharita Outlaw		

Agenda Items:

- Review MCO Resolution Issues Log
- Project BRAVO updates
  - Mental Health Services Manual
  - Utilization/Dashboard Update
  - Summary of Issues DMAS is tracking
- Stakeholder Questions/Comments
- Conclusion and Next Steps

Welcome and Introduction –

Agenda Item 1

- BRAVO claims issue -sending claims for BRAVO services to commercial carriers
  - Providers have to submit claims to commercial plans who do not cover the BRAVO services to get an EOB to send to Medicaid MCOs. This causes delays and providers aren't getting paid in a timely manner
  - Main MCO that has this issue is United Healthcare
  - United Healthcare (Medicaid MCO) requires the EOB denial before they would pay which was never needed before
  - CCC+ Contract language: 12.4.12.3 Comprehensive Health Coverage
    - Prior to processing a claim for payment, the Contractor shall NOT require a provider and/or pharmacist to bill the primary carrier and include a denial for services that are known to be non-covered under Medicare or commercial insurance. The Contractor's request for an explanation of benefits (EOB) from the provider in there instances would delay timely payment

of these services. Examples of these services include, but are not limited to, LTSS waiver services such as personal care and respite care services. The Contractor can pay and pursue the Commercial insurance to assist with any potential delays of claim payments.

- Clarification request: Does this mean boards are not required to submit BRAVO services to the commercial carrier prior to payment?
    - Rhonda T: We did get a question similar to this from a provider regarding paying as secondary insurance. (The memo was shared with the panel via email).
- Jennifer F: Is there, at DMAS, a list of the services that MCOs cover and of those services which are not covered by commercial insurance?
    - Alyssa W.: That kind of list may be incredibly variable. Commercial plans usually pay for PHP and IOP, sometimes they pay for Adult Residential (which we don't except for ARTS), etc. We could theoretically generate a matrix of coverage, but most of our classic Medicaid specific services don't cover this, for instance mental health case management.
    - Jennifer F: Regarding the list, every so often an auditor gets an idea to hyper-focus on this topic, and we usually end up having taken a long time to explain that Medicaid is usually the only service that covers certain specific services.
- Oketa W: Do we know if Medallion 4 or CCC+ have any contract language to address specific issues whether the provider need to provide the EOB?
    - We don't know for sure. CCC+ does have a clause for specifically moving forward with coverage without the EOB, but Medallion may not (the example spoken of was specific to Med4 contract).
    - Kim M will research this and follow up with Oketa W

BRAVO Updates

- Progress has been good
- Implementation of crisis services has been fairly complex, as expected
- We are going to be turning pre-implementation workgroups into post-implementation learning collaboratives to act as support teams
    - Goal by July- have had one meeting with providers at least
- Parts of the Mental Health Manual went up for public comment (Chapter 4 and ACT Appendix), will be up for between 10-14 days, please add comments as needed/wanted.
- Crisis comments came down recently, they will be revised and re-published for public comment soon
- We are still working on creating a public dashboard, we want to make it as accurate as we possibly can but we have a lot of data points (the word "millions" was used) and we have had a lot of glitches that need to be resolved.
- To highlight some of the global issues we've been focused on:
    - MST/FFT Credentialing has been resolved
    - ABA Service Authorizations and Claims denials for Optima, VP, and Molina are still working towards resolution
    - GT Modifier Claim Denials health plans are working on updating their systems to reprocess claims
    - BRAVO services are not easily found on health plan provider/services search page and they are working on this. Optima and Aetna's search functions are live.
    - Claims data and incorrect modifiers are being checked, some health plans are allowing incorrect modifiers to be billed and paid, DMAS has met with MCOs individually to review this issue
    - Adding additional ABA Place of Service Codes is a continuing process, numeric codes are listed on the presentation
    - Questions/Comments
        - Christy E: I heard that Anthem was having issues as well

        - Also been hearing from some members that RBTs are being denied because there is no modifier
    - Stand by for further updates

Stakeholder Comments and Questions

- Mindy C: I've been hearing that a lot of providers are having issues with credentialing from MCOs. MCOs aren't aware that the UM people can't see if something is listed as "pending," which also means that people listed as pending are sometimes not getting services for months
    - We want to know what the MCOs are looking at that would make this process take so long, and if we can get an answer or some suggestions to help streamline this kind of issue?
- Oketa W: At one point credentialing was an issue, but we have not been hearing much through the mailbox
- Jennifer F: One of the reasons DMAS may not be hearing much is that this issue is generally just chaos and most of us have accepted it at this point. We've gotten used to it being a "not efficient" process. Could we not have a credentialing process that was universal across the MCOs? But DMAS may not be hearing much only because people are not talking about it.
- Mindy C: A lot of our members have talked about having to wait a minimum of an hour just to get someone on the phone from Molina to discuss credentialing.
- Alyssa W: This has been a historical long problem for commercial healthcare, and the process has always been a challenge. It took 6 months to get credentialed, the application was over 10 pages long, and generally just a terribly bureaucratic process, and then the credentialing committees also meet at scheduled times, so the wait to just get looked at could take a while.
- Mindy C: Is there any authority DMAS has over this process? Who dictates how evaluations are done, who needs to be evaluated? Is there any way we could unpack this a bit? Does it need to be handled by the legislature?
    - Laura R: We do have standards and timelines, stipulated by the NCQA (National Committee for Quality Assurance), and it's in our contract that providers have to adhere to these standards and timelines but I don't know what's supposed to happen if someone misses their timelines?
    - We also have issues with regards to lost papers, and the way this process gets handled if there's a dispute about whether an application is considered "clean," complete, and accurate. There's also an element of it being a workforce issue with difficulties in hiring.
- Rhonda T: The only timeframe requirement for credentialing according to NCQA is that providers must be notified within 60 days of the credentialing committee's decision, so we may want to get some examples of what the experience of this policy is. Overall, it just doesn't look to be that specific
- Suggestion: Even if we could create some kind of provider education to help recognize when/if someone is making mistakes so that we can try to prevent delays
- Alyssa W: DMAS can, at the very least, take this issue back and report out at the next resolution panel
- Jennifer F: One of the things commercial call centers do is collect metrics, which is something they are required to do, so if something like that isn't in the current contract (since we're developing for Cardinal Care) then this is something that they absolutely should report on.
    - Generally speaking the updated contract should have:
        - Credentialing timeframes
        - Required reporting
        - Call center standards/metrics
        - The authority to actually hold people accountable and maintain a basic standard of quality
- Note that DMAS does actually have some of these requirements in their contracts currently, but it may still be worth reiterating and focusing on.
- How can we make this something actionable? What should we be doing differently? Just writing it into the contract may not be enough if they just ignore it.

Conclusion/Next Steps –

- Are there any additional updates our stakeholders would like to report out on?
- Mindy C: The only other thing I can think to share is that my members have been raising issues about background checks. We're trying to figure out what our barriers/issues and obstacles are for this? I also wanted to let other groups know, from a workforce perspective, that I'd be happy to share info or collaborate in order to work on this together.
    - Alyssa W: This is actually a topic the governor's workforce is looking into as well with regards to the Safe & Sound taskforce.
- Action Items for DMAS: Respond to VACSB issue(Commercial Insurance and BRAVO services) and look into credentialing issue as it relates to contract language (CCC+ and Medallion 4)
- The next panel will be on **July 14th**.

Chat Log:

from bludeman-hopkins to everyone: 10:00 AM
Beth Ludeman-Hopkins, VACSB
from Rhonda Thissen to everyone: 10:00 AM
Rhonda Thissen, DMAS Integrated Care Division
from Tammy Eames to everyone: 10:00 AM
Tammy Eames- Piedmont CSB
from Jennifer Fidura to everyone: 10:00 AM
Jennifer Fidrua, VNPP
from mindy carlin to everyone: 10:00 AM
Mindy Carlin, VACBP
from Izaak Funke to everyone: 10:00 AM
Izaak Funke, DMAS
from Lauren Howren to everyone: 10:01 AM
Lauren Howren, DMAS Integrated Care
from Alyssa Ward to everyone: 10:03 AM
Thank you Tammy for that information.
from Alyssa Ward to everyone: 10:07 AM
I also want to clarify--if this is true for BRAVO services, this is true for all services in the contract?
from mindy carlin to everyone: 10:12 AM
Anything to reduce administrative burden only helps
from Rhonda Thissen to everyone: 10:13 AM
Laura, I just sent that claims processing memo to you
from Christy Evanko to everyone: 10:13 AM
Sorry to arrive late. Christy from Virginia Association for Behavior Analysis is here.
from mindy carlin to everyone: 10:14 AM
Thx for raising this issue Tami and Beth!
from mindy carlin to everyone: 10:15 AM
If I have another MCO issue should I raise now?
from Laura Reed to everyone: 10:22 AM
Beth, I have been sending emails out to all provider associations, you are on the list serv.
from Laura Reed to everyone: 10:22 AM
If you haven't received them, I can forward them to you
from Stefanie Pollay to everyone: 10:25 AM
https://www.aetnabetterhealth.com/virginia/find-provider
from Stefanie Pollay to everyone: 10:25 AM
https://www.optimahealth.com/providers/find-doctors-drugs-and-facilities
from mindy carlin to everyone: 10:27 AM
Can this slide be shared?
from Laura Reed to everyone: 10:28 AM
Yes, we will send it with the meeting minutes
from Jennifer Faison, VACSB to everyone: 10:36 AM
That's exactly right, Jennifer. It's ongoing for the CSBs.
from bludeman-hopkins to everyone: 10:36 AM
Yes - I agree - this is an ongoing issue for the Bds.

from Jennifer Faison, VACSB to everyone: 10:40 AM
I think there is a timeline required either in budget language or code that Senator Dunnavant sponsored.
from Christy Evanko to everyone: 10:43 AM
Isn't this the bill?
from Christy Evanko to everyone: 10:43 AM
2020 HB822 (Head)
from Christy Evanko to everyone: 10:44 AM
https://lis.virginia.gov/cgi-bin/legp604.exe?ses=201&typ=bil&val=HB822
from Christy Evanko to everyone: 10:45 AM
There seem to be too many loopholes, because the law says that the application must be complete, but it's easy to find ways to say the application isn't complete.
from Laura Reed to everyone: 10:46 AM
Individuals LMHPs can bill during their credentialing period, per a memo that I can send out, its agencies that cannot bill during credentialing period.
from mindy carlin to everyone: 10:48 AM
There's an association for every type of healthcare provider — seems a strong coalition could be formed.
from mindy carlin to everyone: 10:49 AM
We can gather data on the impact via a survey and share with other groups
from mindy carlin to everyone: 10:49 AM
Is this a CSB issue too?
from Christy Evanko to everyone: 10:50 AM
Please include VABA Mindy, as this is an issue for us as well
from bludeman-hopkins to everyone: 10:50 AM
Yes - it is absolutely a CSB issue. Thx for bringing this up.
from Laura Reed to everyone: 10:56 AM
Policies and Procedures
from Laura Reed to everyone: 10:57 AM
Medallion IV COntract: 4.6.A Credentialing Policies and Procedures
from Laura Reed to everyone: 10:57 AM
42 CFR § 438.214
from bludeman-hopkins to everyone: 10:57 AM
Contacts would be most helpful for this issue.
from Stefanie Pollay to everyone: 10:58 AM
there are standards for that, I remember when CCC Plus began there were dashboards they had to send to show their wait times, etc
from mindy carlin to everyone: 10:59 AM
Thx all!!
from mindy carlin to everyone: 10:59 AM
Happy to collaborate with others on this
from Alyssa Ward to everyone: 11:01 AM
https://www.anthem.com/provider/credentialing/?cnslocale=en_US_va
from Alyssa Ward to everyone: 11:01 AM
Click here to see ANthem's practitioner rights around credentialing
from Alyssa Ward to everyone: 11:01 AM
this includes timelines, etc
from Alyssa Ward to everyone: 11:01 AM
I would encourage everyone to review each MCO website for now to determine the scope of such "bill of rights" for each MCO process

from Alyssa Ward to everyone: 11:02 AM
Practitioners and HDOs have the right to review information submitted to support their credentialing applications. This right includes access to information obtained from any outside sources with the exception of references, recommendations or other peer review protected information. In the event that credentialing information cannot be verified, or if there is a discrepancy in the credentialing information obtained, the Credentialing staff will contact the practitioner or HDO within thirty (30) calendar days of the identification of the issue. This communication will specifically notify the practitioner or HDO of the right to correct erroneous information or provide additional details regarding the issue in question. This notification will also include the specific process for submission of this additional information, including where it should be sent. Depending on the nature of the issue in question, this communication may occur verbally or in writing. If the communication
from Alyssa Ward to everyone: 11:04 AM
https://www.virginiapremier.com/providers/join-our-network/
from Alyssa Ward to everyone: 11:05 AM
https://www.virginiapremier.com/providers/