MississippiCAN Inpatient Hospital Transition

Frequently Asked Questions (FAQ)

Version Date: January 12, 2016

Please note responses from the Division of Medicaid (DOM) in black font. Other font colors are used for responses from UnitedHealthcare (blue) and Magnolia (orange).

1. What is the format that should be used when submitting time of birth?

Time of birth should be submitted using 24 hour (or military) time in the following format:

HOUR:MINUTE:SECOND

For example, a child born at 2:19 p.m. would be submitted as 14:19:00. A child born at 8:50 a.m. would be submitted as 08:50:00.

2. Who sets the authorization parameters for prior authorizations, Medicaid or the CCOs? Can Providers request to follow the Medicaid guidelines for prior authorizations?

Both CCOs have adopted DOM approved utilization review criteria. However, requirements are specific to the CCO and may not be the same as those under fee-for-service Medicaid. Providers should follow the utilization review criteria established by the CCO. Please refer to the information provided during the webinar presented by DOM on October 26, 2015 for additional information on each CCO's specific utilization review criteria. That information may be accessed at www.medicaid.ms.gov.

3. Are providers required to accept less than Medicaid rates for inpatient services from the CCOs? What about inpatient behavioral health services? If not, what recourse do Providers have to obtain no less than Medicaid rates for these services?

Providers are not required to accept less than the normal Medicaid reimbursement rate for any MississippiCAN covered service. Providers may choose to participate in DOM approved alternative payment models. Network participation cannot be conditioned upon participation in an alternative payment model.

4. Are Providers required to contract with multiple third-party vendors and affiliates in addition to UHC and Magnolia for services in order to obtain payments for Medicaid covered services?

Both CCOs accept CAQH credentialing, which shortens the enrollment and credentialing process for providers, multiple provider types.

Enrollment is required with both CCO's subcontractors for Behavioral Health, Dental, and Vision.

CAQH
Caqh.updhelp@acsgs.com
888-599-1771

Magnolia Health
http://www.magnoliahealthplan.com/files/2011/11/Magnolia-Credentialing-Application-Packet-Final-111108.pdf.

UnitedHealthcare
https://www.unitedhealthcareonline.com/ccmcontent/ProviderII/UHC/en-US/Assets/ProviderStaticFiles/ProviderStaticFilesPdf/Tools%20and%20Resources/Protocols/Credentialing_Recredentialing_Plan_2015_2016.pdf.

5. Please provide answers to the questions below regarding billing MississippiCAN CCOs as secondary:

When billing MississippiCAN as secondary will the CCOs follow Medicaid's rule as well?

Magnolia: Yes.

UnitedHealthcare: Yes, with the exception of submission of the taxonomy number in box 3B. Please see below.

If the patient has Blue Cross Blue Shield, currently DOM/Xerox does not accept electronic secondary claims. Instead providers must submit paper claims with EOBs or submit the claim via web portal. Wll the plans allow providers to bill secondary claims electronically?

Magnolia: If the provider uses our web portal to submit claims they can upload the EOP's; if not using Magnolia's web portal, the provider will have to file paper claims.

UnitedHealthcare: UHC will accept and does encourage providers to submit their secondary claims electronically.

When billing secondary with Medicaid, providers are required to submit taxonomy numbers in box 3B. Will the CCOs require the same information?

Magnolia: Yes.

UnitedHealthcare: UHC does not require the taxonomy code in box 3B but will capture and store the information if submitted.

Are there currently any written documentation from the CCOs on billing secondary claims?

Magnolia: Yes, http://www.magnoliahealthplan.com/files/2010/11/Provider-Manual-PDF3.pdf.

UnitedHealthcare: There is a Coordination of Benefits section in the provider manual with information on how to bill secondary claims.

6. **If the beneficiary is enrolled with MississippiCAN-Magnolia Health and the stay is related to Behavioral Health, should the coverage be listed as Cenpatico Behavioral Health or should we list the coverage and bill Magnolia Health Plan and Magnolia will forward the claim to Cenpatico?**

Magnolia: Behavioral Health Claims for Magnolia Beneficiaries should be submitted to Cenpatico at:

Claims Customer Service: (866) 324-3632

Ways to submit Claims:

Online	**www.cenpatico.com** (Will need logon information)
Emdeon	Payor ID 68068
Paper Claims	Cenpatico PO Box 7600 Farmington MO 63640-3809

Claims must be submitted within **180** days of the date of service.

Appeals must be submitted within **90** days of the denial.

Appeals (mail):	Cenpatico Appeals PO Box 7600 Farmington MO 63640-3809

7. **Is there a notification process for the mother at delivery or are the days automatic with no notification?**

The hospital must notify DOM within five (5) calendar days of the delivery using the Newborn Enrollment Form. The Newborn Enrollment Form will provide eQHealth Solutions with the initial information necessary to generate the Treatment Authorization Number (TAN) for the mother's stay when the stay is for five (5) days or less. The enrollment form is available on the Envision web portal for electronic

submission to the respective CCO, eQHealth and DOM. For mothers covered under fee for service Medicaid, no other reporting of the delivery is required.

Magnolia: Magnolia Health Plan requires maternal information to acknowledge maternity admission. The Division of Medicaid Newborn Enrollment Form includes all of the necessary information for routine deliveries and well-baby care (standard 3 day stay for vaginal deliveries, 5 day stay for C sections). The Newborn Enrollment Form must be fully completed and submitted to the Division of Medicaid within 5 days of delivery. If the Newborn Enrollment Form is completed and submitted timely, Magnolia Health Plan does not require any additional information for mother or newborn, unless complications develop during the stay. If complications develop with mother or baby that may necessitate additional hospital days or a non well-baby or NICU admission, a prior authorization should be submitted along with clinical information to support the stay within one business day of the decision that the higher level of care is needed.

UnitedHealthcare: Per Federal Mandate, UHC allows two (2) days for a vaginal delivery and four (4) days for a C-section. Notification is required within one (1) business day of mother's admission for delivery at 866-604-3267. A concurrent review will be required for any additional days beyond the federally mandated days. UHC policies are located at UHCcommunityplan.com.

8. To Magnolia: Regarding maternity delivery pre-certs, is pre-cert required?

Magnolia: Magnolia Health Plan requires maternal information to acknowledge maternity admission. The Division of Medicaid Newborn Enrollment Form includes all of the necessary information for routine deliveries and well-baby care (standard three (3) day stay for vaginal deliveries, five (5) day stay for C-sections). The Newborn Enrollment Form must be fully completed and submitted to the Division of Medicaid within five (5) days of delivery. If the Newborn Enrollment Form is completed and submitted timely, Magnolia Health Plan does not require any additional information for mother or newborn, unless complications develop during the stay. If complications develop with mother or baby that may necessitate additional hospital days or a non well-baby or NICU admission, a prior authorization should be submitted along with clinical information to support the stay within one business day of the decision that the higher level of care is needed.

9. Could representatives from Magnolia and United Behavioral Health speak to any behavioral health changes with this new process?

DOM conducted a webinar on November 17, 2015 for behavioral health. Please visit www.medicaid.ms.gov to access materials presented during the webinar.

Magnolia: Further detailed information including documentation requirements and examples will be made available on both the Magnolia Health Plan PIRC website http://www.magnoliahealthplan.com/for-providers/provider-resources/ and www.cenpatico.com.

UnitedHealthcare: There are not any changes to the current process of requesting authorizations for outpatient services. Admissions to an inpatient setting require pre-service notification. Notification of a scheduled admission must occur at least five (5) business days before admission. Notification of an unscheduled admission (including Emergency

admissions) should occur within one (1) business day after admission. Benefits may be reduced if Optum is not notified of an admission to these levels of care. Inpatient authorizations may be requested via portal (www.uhccommunityplan.com), phone (866-604-3267), or fax (888-310-6858). Clinical guidelines may be reviewed at www.providerexpress.com.

10. The six month timely filing requirement begins for admissions of December 1 for MississippiCAN members. Claims prior to December 1, do we still have a year to file?

Yes. Medicaid fee-for-service timely filing of initial claims is 365 days from date of service. However, please note that the CCO timely filing period is 180 days from the date of service. Inpatient Hospital claims for MississippiCAN members must be filed within 180 days beginning December 1, 2015.

11. What is the concurrent review process for the CCOs mental health and retrospective reviews?

Magnolia: The Provider must contact Cenpatico within 24 hours of an emergent inpatient admission. The Provider should contact Cenpatico via telephone (preferred), fax, mail, secure email or through our website with the appropriate clinical information to request an authorization. After-hours calls will be taken by Nursewise and authorized the next business day when a live review is done. All inpatient reviews are conducted via live telephonic review. InterQual medical necessity criteria are applied to all mental health cases, and ASAM criteria are applied to all chemical dependency cases. Cenpatico will make the determination for urgent concurrent, expedited continued stay, and/or post-stabilization review within twenty-four (24) hours of receipt of the request for services. Cenpatico's clinical team will concurrently review the treatment and status of all members who are inpatient through contact with the hospital's Utilization and Discharge Planning departments and, when necessary, the member's attending physician. The individual identified on the Initial Review will be considered the appropriate point-of-contact for all discharge planning. An inpatient stay will be reviewed as indicated by the member's diagnosis and response to treatment. The review will include evaluation of the member's current status, proposed plan of care, discharge plans, and any subsequent diagnostic testing or procedures.

UnitedHealthcare: Concurrent reviews should be submitted for medical necessity review prior to the last approved inpatient day. Retrospective reviews may be performed in cases of retroactive eligibility determinations. However, all urgent/emergent hospital admissions require notification within 1 business day.

12. Will regular Medicaid still require TAN numbers on OB after 3-5 days or newborns after 5 days?

The hospital must notify DOM within five (5) calendar days of the delivery using the Newborn Enrollment Form. The Newborn Enrollment Form will provide eQHealth Solutions with the initial information necessary to generate the Treatment Authorization Number (TAN) for the mother's stay when the stay is for five (5) days or less. The Newborn Enrollment Form is available on the Envision web portal for electronic submission to the respective CCO, eQHealth and DOM. For mothers covered under fee for service Medicaid, no other reporting

of the delivery is required. Otherwise, the Medicaid fee for service prior authorization process will not change.

13. Will United Behavioral Health utilize concurrent reviews?

UBH/Optum will not be completing true concurrent reviews; however, clinical care advocates will be discussing with the hospitals on a regular basis to begin discharge planning, talk about barriers that may be occurring, medication issues, etc.

14. Will court-committed patients be reviewed differently by Magnolia or UnitedHealthcare?

Magnolia and UnitedHealthcare will review and make clinical decisions based on medical necessity and not court commitment.

15. Magnolia said advanced imaging during observation or an emergency room visit does not require prior authorization. Does UHC?

No observation or emergency services require prior authorization, but providers must notify CCOs one (1) business day after emergency service.

UnitedHealthcare: In general, advanced imaging services associated with inpatient stays, emergency encounters, or observation admits resulting from an emergent medical condition do NOT require prior authorization. Outpatient imaging services DO require prior authorization. For details about Radiology and Cardiology authorizations see Radiology tab and Cardiology tab at www.uhccommunityplan.com.

16. Medicaid gives 3 and 5 days for OB deliveries and requires a TAN # to bill. What process will Magnolia and United use for OB deliveries? Medicaid also gives 5 days for newborns before we have to get TAN #. What process will Magnolia and United use?

Magnolia: Magnolia Health Plan requires maternal information to acknowledge maternity admission. The Division of Medicaid Notification of Delivery form includes all of the necessary information for routine deliveries and well-baby care. It must be submitted within 5 days of delivery. If complications develop with mother or baby that may necessitate additional hospital days, a prior authorization should be submitted along with clinical information to support the stay. Magnolia will allow 3 days total for vaginal delivery and 5 days total for C sections. Upon receipt of the Notification of Delivery form from the Division, Magnolia Health Plan will assign a Prior Authorization number for payment of services.

UnitedHealthcare: Notification is required within 1 business day of mother's admission for all deliveries. All emergency admissions require notification within 1 business day. All elective admissions require prior authorization.
Per Federal Mandate, UHC allows, 2 days for a vaginal delivery and 4 days for a C- section. This policy will also apply to all newborns. Newborn notification forms will serve as documentation related to initial inpatient admission and NICU services for newborns.

Concurrent review is required for any moms and newborns for requested days beyond the Federal Mandate or notification of newborn eligibility.

17. Do you now require going through your individual website and no longer use eQhealth for all 3 entities?

Providers will continue to submit prior authorization to eQHealth for beneficiaries enrolled in Fee-For-Service (FFS) Medicaid. However, providers must verify eligibility provided on the Envision web portal or AVRS, and contact the appropriate entity by program (Medicaid FFS, MississippiCAN, or CHIP).

Magnolia: Prior Authorization Requests for members assigned to Magnolia Health Plan should be obtained by either Magnolia Health Plan Provider Web Portal on our website http://magnoliahealthplan.com , secure email magnoliaauths@centene.com , secure fax 1-877-291-8059 (Hospital Inpatient) or 1-877-650-6943 (Outpatient) or by phone by calling 1-866-912-6285.

UnitedHealthcare: Authorizations must be requested through UHC via, fax, telephone or through online provider portal at uhconline.com, 866-604-3267 (phone) or 888-310-6858 (fax).

18. Discuss the continued stay notification requirements for NICU babies (for both plans).

Magnolia: Magnolia Health Plan will require clinical information every 5 days. This may vary on a case by case basis.

UnitedHealthcare: Concurrent reviews are done based on acuity of infant, impending discharge and/or other coordination needs every 1 to 7 days. Facilities may call via phone @ 1-866-604-3267 or fax 1-888-310-6858.

19. What is the limit for observation now for Medicaid and MCO's? Is it 23 hours a day, up to 72 hours?

DOM's observation policy will not change. Please refer to the Mississippi Division of Medicaid Administrative Code regarding observation, which is available at http://www.medicaid.ms.gov/wp-content/uploads/2015/09/AdminstrativeCode.pdf.

Magnolia: The APC payment system enacted by the Division of Medicaid effective December 2012 allows payment for medically necessary observation stays between 8 and 23 hours.

UnitedHealthcare: Observation limits are established through Medicaid policy. Only hours 8 through 23 are considered for reimbursement.

20. Please clarify whether the IRO/URO process applies to Medicaid managed care organizations.

An IRO is an Independent Review Organization. Under the PPACA, health plans must have an established method for external reviews for appeals which must comply either with an approved State external review or the Federal external review processes. https://www.cms.gov/CCIIO/Resources/Files/external_appeals.html. This is not applicable to Medicaid.

21. How will Medicaid address claims for overlapping dates? Will the providers be required to have 2 separate prior authorizations for the stay? *Ex*: If the patient comes in on 11-8-15 but doesn't discharge until 12-15-15, how will Medicaid and the CCO's handle the claims?

No. Providers will not be required to have two (2) separate prior authorizations for stays when the date of service overlaps in the example given. The date of admission determines the responsible payer. Regular Medicaid will be responsible for beneficiaries' admissions prior to December 1, 2015. Admissions, on or after December 1, 2015, will be the responsibility of the appropriate CCO. In the example above, Medicaid Fee-For-Service would pay for the inpatient stay based on the November 8th admission date. Both CCOs will accept prior authorizations issued by eQHealthSolutions prior to December 1, 2015 for dates of service December 1, 2015 or after.

22. What are the CCO requirements for inpatient retrospective coverage? Will the 180 day filing requirement start from DOS or date eligibility was granted?

Magnolia: Hospitalizations for newborns that are born to mothers who are granted Medicaid eligibility retroactively and assigned to Magnolia Health Plan will be covered. The 180 day filing requirement will start from the Date of Service (date of admission).

UnitedHealthcare: 180 day timely filing window is calculated from DOS (discharge date).

23. Will Medicaid managed care companies require pre-cert for admission if Medicare is primary and they are secondary? Medicaid currently does not require this.

Dual Eligibles (individuals with both Medicare and Medicaid) are excluded from MississippiCAN and will remain with Medicaid Fee-For-Service.

24. Will the webinar slides be made available? How can we ensure we are notified of future webinars?

Yes. The presentation is available on the DOM website at http://www.medicaid.ms.gov/inpatient-transition-information/. Notices are also available on the website. Please continue to visit www.medicaid.ms.gov for future trainings and information.

25. Will managed Medicaid offer LTAC and rehab in its covered benefits?

No. Long term care services are not covered by MississippiCAN.

26. Retro pre-certs: Since Medicaid always allowed for that but Magnolia and UHC do not, how will you handle?

Magnolia: Magnolia Health Plan requires Prior Authorization for scheduled inpatient stays. Prior Authorization for Emergency/Urgent and Post-Stabilization services is not required. Following stabilization, Magnolia must be notified of admission within 1 business day, via a Request for Authorization. Failure to abide by these steps may result in denied claims.

UnitedHealthcare: All emergency admissions require notification within 1 business day. All elective admissions require prior authorization. For highly unusual circumstances such as maternity or NICU, retrospective review may be performed.

27. What about pre-authorization when Medicaid is secondary? Will it be required for inpatient stays, i.e., Geri Psych dual eligibles?

Dual Eligibles are not enrolled in MississippiCAN. However, for Medicaid beneficiaries with other primary insurance, pre-authorization is required for all inpatient stays.

28. The span dates of services: if the patient comes in for observation 11-30 and is traditional Medicaid and the doctor deems an inpatient admit is necessary but the patient is CCO eligible on 12-1, who will cover the stay which does include the observation on 11-30?

There is no member/beneficiary eligibility change related to 12/1/15. Currently under Mississippi Medicaid, a stay that begins in Observation or the Emergency Room for which the beneficiary is admitted within 72 hours is paid as an inpatient stay for the entire stay from and through date of the claim. The TAN will be issued based on the date the physician writes the orders for admission. Therefore, the inpatient claim will include the charges for the outpatient part of the stay in the entire inpatient stay. The provider would bill days on the claim only from the date of admission (using value code 80 for covered days and value code 81 for non-covered days) and not include the outpatient days in the count. In the example given, the CCO should issue the TAN beginning 12/1/15, and allow the claim to be billed with first date of service from 11/30/15 through date of discharge.

29. Will United require notification on deliveries?

UnitedHealthcare: Notification is required within 1 business day of mother's admission for delivery. All emergency admissions require notification within 1 business day. All elective admissions require prior authorization. Per Federal Mandate, UHC allows, 2 days for a vaginal delivery and 4 days for a C-section. This policy will also apply to all newborns. Newborn notification forms will serve as documentation related to initial inpatient NICU services for newborns. Concurrent review is required for any moms and newborns for requested days beyond the Federal Mandate.

30. Regarding this issue: A patient with regular Medicaid needs a radiology exam, Evicore issues an authorization on 10/28. Then, on 11/1, the patient arrives for the study and has been changed to MCO. How to handle?

Providers must verify eligibility on the date of service to determine the appropriate payer. This information should also be displayed several days prior to the first of the month.

31. Is there any resolution for observation patients that get MRI, CTs etc. not requiring pre-certification?

In accordance with Mississippi Administrative Code Title 23: Part 220, Rule 1.2. B., 3. Prior Authorization for the advanced imaging procedures listed in Rule 1.2.A. is required in all settings except in an: 1. Inpatient hospital, 2. Emergency room, or 3. Outpatient hospital twenty-three (23) hour observation period.

Magnolia: Prior Authorization for Advanced Imaging is NOT required for Magnolia Health Plan members who are an inpatient, Observation, or Emergency Department admit.

UnitedHealthcare: In General Advanced imaging services associated with inpatient stay, emergency encounter, or observation admits resulting from emergency medical conditions do NOT require prior authorization. Outpatient imaging services DO require prior authorization. For details about Radiology and Cardiology authorizations see *Radiology tab* and *Cardiology tab* at www.uhccommunityplan.com.

32. Medicaid- Will all Medicaid recipients be enrolled with Magnolia or United Healthcare?

No. Not all Medicaid recipients will be enrolled in MississippiCAN. Beneficiaries on waivers, residing in institutions (other than Psychiatric Residential Treatment Facilities), enrolled in Medicare, over age 65, and hemophiliacs are not eligible for MississippiCAN and will continue to be covered through FFS Medicaid. Additional information is available at http://www.medicaid.ms.gov/wp-content/uploads/2015/08/2015-MississippiCANProvider-Workshop-Presentation.pdf.

33. Can webinar info be posted earlier? I didn't receive info until the day of the webinar.

Information about DOM webinars is distributed as soon as possible. The information that is presented during the webinars may be accessed at http://www.medicaid.ms.gov/inpatient-transition-information/. Please continue to check DOM's website for more information as it becomes available.

34. Will you count from delivery date for pre-cert or the pre-cert requirement or from when admitted?

Magnolia: Authorizations will be given from the date of admission.

UnitedHealthcare: Notification is required within 1 business day of mother's admission for delivery. All emergency admissions require notification within 1 business day. All elective admissions require prior authorization. Per Federal Mandate, UHC allows, 2 days for a vaginal delivery and 4 days for a C-section. This policy will also apply to all newborns. Newborn notification forms will serve as documentation related to initial inpatient NICU services for newborns. Concurrent review is required for any moms and newborns for requested days beyond the Federal Mandate or notification of newborn eligibility.

35. How will this change affect residential treatment for mental health? Will we still do 317?

The DOM-317 form must continue to be submitted to the DOM Regional Office by institutional/residential providers at the time of admission and at the time of discharge. Although residential treatment is not a covered benefit through the MCOs, Psychiatric Residential Treatment Facilities (PRTFs) will need to work with the MCOs to ensure care coordination is provided prior to admission, during the stay, and upon discharge. A MCOs care coordinator will assist the PRTFs with ancillary services to ensure the selected ancillary service provider is in the CCOs network.

36. Will the Medicaid application process be the same? Going to regional Medicaid office/ ex. if a patient is admitted to acute MH with no coverage and they need to apply, what do they need to do? Will Medicaid retro back?

The Medicaid application and enrollment process is the same.

37. Do inpatient psych admissions require pre-authorization? Does the hospital go thru the regular inpatient pre-authorization protocol or is this handled by sub-contractor (Cenpatico?)

Magnolia: Cenpatico Behavioral Health (CBH) serves the members of Magnolia Health. Our staff is available 24 hours a day, 365 days a week by calling (866) 912-6285. Providers must call CBH within 24 hours of an emergent admission. After hours calls will be taken by Nursewise and authorized the next business day when a live review is done.

UnitedHealthcare: All emergency admissions require notification within 1 business day at 866-604-3267. All elective admissions require prior authorization before admission. The hospital would follow the regular inpatient pre-authorization protocol. It is not handled by a sub-contractor.

38. If patient is a MisssissippiCAN member that is properly admitted to the hospital prior to 12-1 but discharges after 12-1, do we submit to Medicaid or to MCO?

The date of admission determines the responsible payer. Regular Medicaid is responsible for admissions prior to December 1, 2015; and the appropriate CCO is responsible for admissions after December 1, 2015.

39. Will UHC and Magnolia call the hospital if pre-cert needed after notification has been sent in on newborns or how will we know if pre-cert is required?

Magnolia: Providers should refer to the precertification in the Magnolia Health Plan Provider Manual located on the Magnolia Health Plan PIRC website http://www.magnoliahealthplan.com/for-providers/provider-resources/.

UnitedHealthcare: Notification is required within 1 business day of mother's admission for delivery. All emergency admissions require notification within 1 business day. All elective admissions require prior authorization. Per Federal Mandate, UHC allows, 2 days for a vaginal delivery and 4 days for a C-section. This policy will also apply to all newborns. Newborn notification forms will serve as documentation related to initial inpatient birth and initial NICU admission for newborns. Concurrent review is required for any moms and newborns for requested days beyond the Federal Mandate or notification of newborn eligibility. For NICU, concurrent reviews are done based on acuity of infant, impending discharge and/or other coordination needs every 1 to 7 days.

40. For maternity patients – when deciding on pre-cert requirements when Medicaid is secondary to a private payor, please comment/consider the patient may not have maternity benefits with the primary private payor.

Provider should submit proof of non-covered services from the private payor to CCO. CCO should pay claim.

Magnolia: Magnolia Health Plan does not require pre-certification for deliveries.

UnitedHealthcare: Both payor sources will be investigated for eligibility and enrollment. In the event that the primary insurance does not cover this benefit then CCO would be the payor of last resort.

41. Auto-certs--We currently get automatic authorization on certain diagnoses with eQHealth. Will that be the case with the managed care companies?

Magnolia: Magnolia Health Plan will not issue automatic authorizations.

UnitedHealthcare: No. This will be a case by case determination made by medical review in accordance with medical policies, DOM administrative code and Milliman Care Guidelines. All emergency admissions require notification within 1 business day. All elective admissions require prior authorization.

42. How will we handle retrospective reviews? (Example, patient gets Medicaid retrospectively after discharge.)

Magnolia: Hospitalizations for newborns that are born to mothers who are granted Medicaid eligibility retroactively and assigned to Magnolia Health Plan will be covered. The 180 day filing requirement will start from the Date of Service (date of admission).

UnitedHealthcare: Retrospective reviews will be performed in case of retro-eligibility. Please contact prior authorization at www.uhccommunityplan.com, 866-604-3267 or 888-310-6858 fax.

43. How will we handle retrospective authorizations? (Example, patient obtains Medicaid retrospectively after discharge.)

Magnolia: Hospitalizations for newborns that are born to mothers who are granted Medicaid eligibility retroactively and assigned to Magnolia Health Plan will be covered. The 180 day filing requirement will start from the Date of Service (date of admission).

UnitedHealthcare: Retrospective authorizations will be performed in case of retro-eligibility. Please contact prior authorization at www.uhccommunityplan.com, 866-604-3267 or 888-310-6858 fax.

44. Will additional information regarding MississippiCAN inpatient claims payments be available?

Yes. The FAQ document will be updated periodically. Inpatient transition information is available at http://www.medicaid.ms.gov/inpatient-transition-information/. Additionally, information will be available on each coordinated care organization's (CCO) website at www.magnoliahealthplan.com and http://www.uhccommunityplan.com/.

45. What authorizes the Division of Medicaid (DOM) to implement the hospital inpatient managed care program?

Senate Bill 2588 was passed in the 2015 Legislative Regular session. This bill authorizes DOM to include hospital inpatient services in the Mississippi Coordinated Access Network (MississippiCAN) managed care program effective December 1, 2015 and to transition the hospital inpatient Upper Payment Limit (UPL) program to the Mississippi Hospital Access Program (MHAP).

46. Which MississippiCAN CCOs will provide hospital inpatient managed care services coverage?

DOM contracts with two CCOs: UnitedHealthcare Community Plan (UHC) and Magnolia Health. Both will cover inpatient hospital services.

47. What Medicaid population will receive hospital inpatient services coverage through MississippiCAN?

All beneficiary members enrolled in MississippiCAN will receive inpatient benefit coverage through the coordinated care program.

48. What changes will be made to disproportionate share hospital (DSH) payments?

The DSH program will not change. DSH payments will be made in December 2015, March 2016 and June 2016. DSH surveys will be submitted annually. Provider Statistical and

Reimbursement (PS&R) reports will be issued to all Mississippi hospitals by DOM and both CCOs.

49. What changes will be made to upper payment limit (UPL) payments?

Federal rules do not allow UPL supplemental payments in Medicaid managed care. Therefore, pending CMS approval, the current UPL program will fully transition to the MHAP on December 1, 2015. A proposed State Plan Amendment (SPA) 2015-012 was submitted to the Centers for Medicare and Medicaid Services (CMS) on September 30, 2015 which removes all UPL language. Upon implementation of the MHAP, DOM will provide increased capitation payments per member per month to its MississippiCAN contracted coordinated care organizations (CCOs) in an amount equal to the Centers for Medicare and Medicaid Services (CMS)- approved FY 2015 UPL calculation. This increased capitation payment is referred to as MHAP. The CCOs are expected to contract with a third party to distribute 100% of MHAP payments to hospitals.

50. What is "MHAP"?

The Mississippi Hospital Access Program, or MHAP, is a program authorized by state legislation. The MHAP will apply to in-state hospitals and the out-of-state hospital that is authorized by federal law to submit intergovernmental transfers (IGTs) to the State of Mississippi and is classified as a Level I trauma center located in a county contiguous to the state line. It is DOM's intent that the MHAP will function to ensure patient access to hospital inpatient services for Mississippi Medicaid beneficiaries as provided in Mississippi Code Sections 43-13-117 and 43-13-145. Under MHAP, effective with hospital inpatient admit dates of service on or after December 1, 2015, a per-member-per-month (PMPM) add-on payment will be paid by DOM to the CCOs participating in MississippiCAN. This increased capitation payment is referred to as MHAP. The CCOs will be responsible for ensuring the distribution of 100% of MHAP payments to hospitals. CCOs are expected to contract with a third party entity to handle the distributions beginning in December 2015.

51. What will be the effective date of this transition?

This change will be effective December 1, 2015. The hospital inpatient UPL program began transitioning to the MHAP July 1, 2015 and will be completed by December 1, 2015, pending CMS approval.

52. With MississippiCAN covering inpatient status now, does that eliminate the Medicaid coverage altogether and mean that patients should only have one card?

The MississippiCAN CCOs will begin covering inpatient hospital services beginning December 1, 2015 for MississippiCAN eligible Medicaid beneficiaries only. Medicaid beneficiaries not enrolled in MississippiCAN will continue to receive inpatient hospital services through Fee-For-Service Medicaid as it is currently provided. Providers should verify eligibility at the date of service to determine the appropriate payor, since a Medicaid or CCO card is not a guarantee of eligibility.

53. Will there still be UPL payments made and prorated up through the effective date of the transition?

No. Pending CMS approval, the entire fiscal year 2016 MHAP payments will be distributed during the period December 1, 2015 – June 30, 2016.

54. Will the total assessments collected by DOM change?

No. The total assessments collected by DOM from hospitals are not changing. DOM will assess three types of taxes throughout the year: $104 Million Assessment; DSH State Match Assessment; and MHAP State Match Assessment. This year's amounts due from each hospital were e-mailed to hospitals on November 3, 2015.

55. When will assessments be due to DOM?

Assessments will be due monthly. This year, assessments will be collected beginning in December. Hospitals will be invoiced monthly for the amounts due. Payments can be made via check or electronic funds transfer. If remitting payment via electronic funds transfer, hospitals must contact the Office of Financial Reporting for instructions. *Note: Please refer to the New Assessment Invoice for further details.*

56. What is the new reporting requirement for newborns?

The hospital must notify DOM within five (5) calendar days of the infant's birth using the Newborn Enrollment Form. The enrollment form is available on the Envision web portal for electronic submission. Forms will be accepted beginning December 1, 2015.

The DOM Office of Eligibility will process newborn eligibility and notify the provider within five (5) business days of the newborn's permanent Medicaid identification (ID) number.

57. Is the Newborn Enrollment Form already on Envision? If so, where is it located (which tab)?

The Newborn Enrollment Form will be effective on December 1, 2015 and available on Envision website at that time. A draft is included in the training materials presented October 26, 2015. Inpatient transition information may be accessed at http://www.medicaid.ms.gov/inpatient-transition-information/.

58. Will the CCO require that the newborn have his or her own ID number prior to filing the claim, or can the newborn claim be filed using the mother's id number?

Yes. Newborns must have their own Medicaid ID number prior to filing a claim with the CCO. The mother's Medicaid ID may not be used.

59. What happens if DOM is not notified within five calendar days of the infant's birth?

DOM's Administrative Code requires that hospitals submit the Newborn Notification Form within five (5) calendar days of the infant's birth. Failure to notify DOM within five (5) calendar days of the infant's birth may result in delay in the assignment of the infant's Medicaid ID number by Medicaid and, by extension, may delay hospitals in obtaining the infant's Medicaid ID number. Delays in obtaining the infant's Medicaid ID number by the hospital may result in PA denials, claims denials (for claims billed without the infant's Medicaid ID number or with the mothers Medicaid ID number), denials for claims that exceed timely filing requirements, and other administrative challenges.

60. Is an application necessary for newborns?

If the mother has Medicaid coverage at the time of the birth or subsequently becomes eligible for Medicaid retroactively for the birth month, the infant is deemed eligible for the first year of life. The Newborn Enrollment Form will serve as the application when the mother has Medicaid coverage at the time of birth.

If the mother is not Medicaid-eligible at the time of birth, an application should be submitted to the appropriate Medicaid regional office for the mother and newborn

61. What happens if the infant born to a Medicaid-eligible mother has not been named at the time the hospital submits the Newborn Enrollment Form?

If the newborn has not been named by the time the hospital submits the Newborn Enrollment Form to DOM, the form will be submitted indicating the infant is unnamed. All other information on the enrollment form must be provided. Eligibility staff will attempt to determine the infant's name within DOM's newborn processing period. If obtained, the infant's name and Medicaid ID number will be sent in the eligibility response to the hospital. If the name cannot be determined within DOM's processing period, the infant will be assigned a Medicaid ID using the following information until the name can be updated on enrollment records:

- FIRST NAME: Newborn
- MIDDLE INITIAL: "F" or "M" based on gender
- LAST NAME: Mother's surname (unless a different surname is provided)

This information and the Medicaid ID assigned to the newborn will be included in the eligibility response to the hospital. The mother can be referred to the Office of Eligibility toll-free at 800-421-2408 to report the infant's name.

62. To whom should claims for newborns be billed?

Upon enrollment in Medicaid, newborns of a MississippiCAN mother on or after December 1, 2015 will be automatically assigned to the same CCO of the mother. Therefore, the provider should bill the CCO to which the mother has been assigned.

63. If I complete electronic newborn form, how does the mother sign the form or is it no longer required?

The mother's signature is not required on the Newborn Enrollment Form revised for use on and after December 1, 2015.

64. If mother does not have Medicaid at time of delivery and I complete Medicaid app, who then gets the newborn form?

If the hospital completes an application on a mother who is not Medicaid-eligible at time of birth, the Newborn Enrollment Form should be submitted through the provider web portal.

65. Magnolia stated that they would give 2 days for a vaginal delivery and 4 days for a C-section. If they go over these days we will have to get certification. UHC told us they give 4 days before certification is required. Both will require notification. Is this information correct and where can we find this documented?

Please refer to the information presented in the October 26, 2015 webinar for CCO specific prior authorization information. Inpatient transition information is available at http://www.medicaid.ms.gov/inpatient-transition-information/.

66. Will we be able to submit notification for UHC managed care on the UHC website?

UnitedHealthcare: Yes, www.uhconline.com.

67. Will a reference number be provided in order to track your notifications?

Magnolia: Only those Prior Authorizations that are submitted through the Magnolia Secure Web Portal can be tracked for status. We encourage providers to utilize the Secure Web Portal to submit PAs and supporting clinical documentation.

UnitedHealthcare: Yes, www.uhconline.com

68. Will inpatient stays automatically approve up to 19 days then concurrent review there after?

Both CCOs have adopted DOM approved utilization review criteria. However, length of stay determinations are specific to the CCO and may not be the same as those under Fee-For-Service.

Magnolia: Magnolia Health Plan will approve no more than 5 days at a time before requesting updated clinical information (pending DOM approval).

UnitedHealthcare: No, days approved will be determined on case by case basis. Concurrent review should be submitted prior to the last approved inpatient day.

69. NICU admissions-- These can be very lengthy stays. How often will we have to give clinical on NICU babies?

Magnolia: Concurrent review will occur no less than every 5 days, and may be subject to variations on a case by case basis.

UnitedHealthcare: This will be a case by case determination made by medical review in accordance with medical policies, DOM administrative code and Milliman Care Guidelines.

70. What will be the specific requirements for notification of admission, clinical, etc? Then what expected turn-around time can we expect from the managed care companies with approvals?

Magnolia: Magnolia Health Plan requires Prior Authorization for scheduled inpatient stays. Prior Authorization for Emergency/Urgent and Post-Stabilization services is not required. Following stabilization, Magnolia must be notified of admission within 1 business day, via a Request for Authorization. Failure to abide by these steps may result in denied claims. Decisions will be rendered within 1 business day after receipt of all necessary clinical information. Notification of the decision to provider will be within 24 hours of the decision.

UnitedHealthcare: All emergency admissions require notification within 1 business day. All elective admissions require prior authorization. Most notification/authorization decisions are rendered/communicated within 24 hours, but no later than two business days.

71. Who do Providers bill and how will hospital inpatient claims be paid for admit dates of service on or after December 1, 2015?

Fee-For-Service

Services for beneficiaries, who are not enrolled in MississippiCAN, received through the Fee-For-Service delivery system should be billed to DOM through its fiscal agent, Xerox. DOM will issue payment for stays with dates of admission prior to December 1, 2015. Providers will continue to receive a Prior Authorization Number (PA) from eQ-Health, submit the claim to Xerox and be paid under the All Patient Refined-Diagnostic Related Group (APR-DRG) methodology. No changes will be made to the current fee-for-service prior authorization process.

Managed Care Services

For dates of admission on or after December 1, 2015, services for beneficiaries (members) received through the MississippiCAN managed care delivery system will be paid by the appropriate CCO. Providers must obtain a Prior Authorization Number (PA) from the CCO in which the member is enrolled. The member's claim will be submitted to the appropriate CCO and be paid under the APR-DRG methodology.

72. Who will providers bill when a stay spans an enrollment change?

When the admission begins before a member's enrollment date in MississippiCAN, the providers must submit claims to Xerox. If the beneficiary becomes enrolled in MississippiCAN during the stay and is a MississippiCAN enrollee upon discharge, the providers must bill Xerox.

73. Magnolia /UHC – How do I refund money due to overpayment back to you? I've looked on website and have not been able to locate.

Magnolia: To submit payment to Magnolia Health Plan "overnight", Rush, or if tracking information is needed send to:

SunTrust Bank
Attn: Magnolia Health Plan, Inc./5164
2842 Business Park Drive, Bldg. G
Memphis, TN 38118-1555

If provider wants to use standard mail (no tracking available) send to:

Lock Box
Magnolia Health Plan, Inc.
P. O. Box 5164
Memphis, TN 38101

UnitedHealthcare: If a provider wishes to refund an overpayment on any UHC Community Plan account, they may do so by submitting a check to the following address:

UnitedHealthcare Community Plan
P.O. Box 740804
Atlanta, GA 30374-0800

Check should be accompanied by the following information. This will help to ensure the refund is accurately credited to the system and in a timely manner.

- Patient Name
- Patient Medicaid ID #
- Date of Service
- Amount originally paid by UHC
- Amount overpaid
- Reason account is considered overpaid
- Claim number (if available)
- UID from recovery letter (if available)
- Copy of UHC remit (if available)
- Name and phone number of person submitting refund in case questions arise

74. How will the treatment authorization (Prior Authorization) requirements change for admit dates of service on or after December 1, 2015?

The need for a prior authorization on the admission will not change. For managed care members, the prior authorization will be issued by the CCO based on the average length of stay for the admitting DRG. The automatic allowance of nineteen (19) days for the initial prior authorization is only applicable for Fee-For-Service Medicaid.

75. Outline the ability of insurance carriers to deny payment for a claim which has been previously pre-authorized. Comment on their legal ability to deny payment after they have already approved the stay through the prior authorization process.

Prior authorization is not a guarantee of payment for Medicaid. Payment is contingent upon appropriate documentation, and appropriate billing.

Magnolia: Prior Authorization is NOT a guarantee of payment. Please see the Provider Manual and other relevant documents for instructions regarding claims submission.

UnitedHealthcare: Prior approval review determines benefit and coverage authorization from a clinical perspective. Claim adjudication outcomes can be further impacted by member eligibility, provider participation status, and various claim edits based on CMS NCCI and other industry standards.

76. How do we find the Magnolia and United Healthcare manuals?

CCO provider manuals are located on their respective websites.

Magnolia: The Magnolia Provider manual can be accessed at http://www.magnoliahealthplan.com/files/2010/11/Provider-Manual-PDF1.pdf

UnitedHealthcare: www.uhccommunityplan.com (Provider Administrative Manual)

77. Behavioral Health issue: What will be the process for prior authorization for acute psych? Will they be conducted online or with a live care manager (Magnolia and UBH)? Will we receive authorized days at that time? If not, what will be the turn-around time for notification of authorization/ denials? Please explain concurrent review process. Will there be a specific date for review based on the admit date?

Magnolia: Cenpatico Behavioral Health (CBH) services the members of Magnolia Health. Our staff is available 24 hours a day, 365 days a week by calling (866) 912-6285. Providers must call CBH within 24 hours of an emergent admission. After hours calls will be taken by Nursewise and authorized. The local clinical team will follow up the next business day when a live review is done. Requests can be submitted by email, fax or online, but the preferred means of obtaining authorization is by phone. Cenpatico is required to comply with the standard pre-service authorization decisions and provide notice within three (3) calendar days and/or two (2) business days following the receipt of the request for services. Cenpatico will make determination for urgent concurrent, expedited continued stay, and/or post-stabilization review within twenty-four (24) hours of receipt of the request for services. Concurrent reviews will be conducted based on the member's admitting diagnosis, plan of care and discharge planning as determined from the initial review. Detailed information was presented at the Division of Medicaid Behavioral Health Webinar conducted on November 17th . Further detailed information including documentation requirements and examples will be made available on both the Magnolia Health Plan PIRC website http://www.magnoliahealthplan.com/for-providers/provider-resources/ and www.cenpatico.com

UnitedHealthcare: Authorizations may be requested via telephone or through online provider portal at uhccommunityplan.com, 866-604-3267 (phone) or 888-310-6858 (fax).

Will we receive authorized days at that time?

Yes, if the case meets medical necessity.

If not, what will be the turn-around time for notification of authorization/ denials?

For inpatient cases, turn around times for authorization and denials are determined via the State contract with MS-DOM. Turnaround time is currently one (1) business day for verbal notification from date of determination and one (1) business day for written notification from date of determination. For outpatient Prior Authorizations, prior authorizations decisions are made two (2) business days upon receipt of all clinical information.

Please explain concurrent review process.

Once a case is authorized, a specific number of days will be approved. Concurrent review should be submitted prior to last approved day.

Will there be a specific date for review based on the admit date?

Notification within 1 business day post admission for emergent/urgent cases. Prior authorization will be required prior to any routine admissions. Concurrent review should be submitted prior to last approved day.

78. How will the MississippiCAN payments compare to current FFS payments from DOM?

Both MississippiCAN and DOM pay for hospital inpatient services based on the APR-DRG payment methodology using the approved State Plan parameters.

79. What APR-DRG algorithm and version will the CCOs use?

The CCOs will mirror APR-DRG payment under the Fee-For-Service delivery payment methodology. Version 32 of the 3M™ grouper and the Version 33 mapper will be used under license from 3M Health Information Systems. Version 32 of the Health-Care Acquired Condition (HCAC) Utility and DOM APR-DRG payment parameters will also be used by the CCOs, and DOM APR-DRG payment parameters will be used by the CCOs.

80. How often are the APR-DRG payments updated by DOM and MississippiCAN CCOs?

The FFS APR-DRG rates are updated at least once annually by DOM and Xerox. The CCO will be notified by DOM of the updated APR-DRG payments and parameters and are required to implement these updates on the effective date.

81. What is the timely filing requirement for MississippiCAN claims?

Providers must file an initial claim within one hundred eighty (180) calendar days of the date of service. Claims filed within the appropriate time frame but denied may be resubmitted to the Contractor within ninety (90) calendar days from the date of denial.

82. What are the claims payment and denial parameters allowed by DOM for the CCOs?

The CCOs must pay at least ninety percent (90%) of all clean claims (as defined by Miss. Code Ann. § 83-9-5) for covered services, within thirty (30) calendar days of receipt and pay at least ninety-nine percent (99%) of all clean claims within ninety (90) calendar days of receipt, except to the extent an alternative payment schedule has been agreed to in the provider agreement. For other claims, the CCOs shall notify the Provider of the status (e.g., pend, deny, or other reason) of the claim and if applicable, the reason the claim cannot be paid within thirty (30) calendar days of the adjudication of the claim. CCOs must pay all other claims, except those from Providers under investigation for fraud, waste and abuse, within twelve (12) months of the date of receipt.

Claims pending or suspended for additional information must be processed (paid or denied) by the thirtieth (30th) calendar day following the receipt of information requested, otherwise the CCOs must close (pay or deny) any other suspended claim if all requested information is not received prior to the expiration of the thirty (30) calendar day period. The CCOs shall send Providers written notice for each claim that is denied, including the reason(s) for the denial.

83. If we have an inpatient denial, what is the appeal process for each company?

Providers must exhaust all levels of reconsideration and appeal prior to submission to DOM.

Magnolia: Appeal Process for Prior Authorization Denials: Magnolia has adopted utilization review criteria developed by McKesson InterQual® products to determine DOM approved medical necessity for healthcare services. Magnolia's Medical Director reviews all potential medical necessity denials and will make a decision in accordance with currently accepted medical or healthcare practices, taking into account special circumstances of each case that may require deviation from the norm in screening criteria. Denial notification will include the reason(s) for denial per section 17.A. of the contract. Providers may obtain the criteria used to make specific determinations by contacting the Medical Management department at 1-866-912-6285. Members, authorized representatives or healthcare professionals with the member's consent, may request an appeal with Magnolia related to a medical necessity decision made during the authorization or concurrent review process orally or in writing to:

Magnolia Health Clinical Appeals Coordinator
111 East Capitol Street, Suite 500
Jackson, MS 39201
1-866-912-6285
Fax: 1-877-851-3995

Appeal Process for Claims Denials: ALL requests for correction, reconsideration, retroactive eligibility, or adjustment must be received within ninety (90) days from the date of notification of denial. Details on submission of requests for claims disputes are located in the Provider Manual.

UnitedHealthcare: The appeal process is outlined in the Provider Administrative Guide (Provider Manual) found at www.uhccommunityplan.com. Appeals must be filed within 30 days of notice of action.

84. How will DOM monitor claims denial by the MississippiCAN providers?

DOM will monitor denials through required monthly reporting from the CCOs.

An explanation will be required for any percentage of denial in excess of two percent (2.0%) of total claims. Any denials for prior-authorization in excess of one percent (1%) of total claims processed with prior-authorization will be specifically explained.

Additionally, eQHealth Solutions (eQHS) will remain the Quality Improvement Organization responsible for oversight and all utilization management and reimbursement reviews, including for MississippiCAN members. This includes (a) clinical quality review, (b) utilization management determination review, (c) APR-DRG coding validation, and (d) claims adjudication logic validation.

85. How will Clinical Oversight be performed?

DOM contractors with specific knowledge will be used to complete the reviews of (a) medical necessity issues, (b) researching new technology, (c) developing medical policies, and (d) addressing quality issues. Each review will be performed by a contractor, of equal or greater specialty licensure in the specialty being reviewed, than the healthcare practitioners participating in the Medicaid program.

86. Will the same Utilization Review rules apply to the MississippiCAN inpatient population effective December 1, 2015 as they do for the current DOM standard Mississippi Medicaid patient today? For example, will we get the first nineteen (19) days approved without having to provide concurrent review during that timeframe?

Both CCOs have adopted DOM approved utilization review criteria. However, length of stay determinations are specific to the CCO and may not be the same as those under Fee-For-Service Medicaid. Please refer to the information provided during the webinar presented by DOM on October 26, 2015 for additional information on each CCOs specific utilization review criteria. Inpatient transition information is available at http://www.medicaid.ms.gov/inpatient-transition-information/.

87. If I am credentialed with DOM, must I also be credentialed with the CCO?

Yes. The CCOs perform their own separate credentialing process of all providers within their network.

88. If I am contracted with one or more of the CCOs, must I also be enrolled in the Mississippi Medicaid program?

Yes. All Providers who are contracted with one or more of the CCOs must also be enrolled in the Mississippi Medicaid program using the same National Provider Identifier (NPI) numbers.

89. How long do the CCOs have to process my credentialing application once it is fully completed?

The CCOs have ninety (90) days from receipt of a **fully completed application** to complete the credentialing process.

90. How long do the CCOs have to load the approved application into their claims payment processing system once it is completed?

The CCOs have thirty (30) days once the application is fully approved and completed, including other contractual provisions, to load it into their claims payment processing system.

91. What credentialing standards are nurse practitioners held to?

Contracted nurse practitioners acting as primary care providers (PCPs) shall be held to the same requirements and standards as physicians acting as PCPs.

92. How often does re-credentialing occur?

Re-credentialing occurs every three years. The CCOs will contact the Provider approximately six months ahead of the anniversary of the Providers original credentialing or last credentialing date to begin the re-credentialing process. The re-credentialing process essentially mirrors the process of the initial credentialing process including the verification of primary sources.

93. What are the credentialing requirements for laboratory testing sites?

In contracting with laboratory Providers and/or any Provider who bills for laboratory services, the CCO must ensure that all laboratory testing sites providing services have either a Clinical Laboratory Improvement Amendments (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number. Provider attestation of CLIA certificate is not acceptable.

94. What persons and/or entities are excluded from participating in MississippiCAN?

Any Provider that is excluded from participation by Medicare, Medicaid, including any other states' Medicaid program, or Children's Health Insurance Program (CHIP), including any other states' CHIP program, except for Emergency Services, cannot participate in MississippiCAN.

95. Does Third Party Liability apply under managed care?

Yes. Third Party Liability (TPL) refers to the legal obligation of third parties (e.g., certain individuals, entities, insurers, or programs) to pay part or all of the expenditures for medical assistance furnished under a Medicaid state plan including Medicaid CCOs.

96. Who is considered the primary payer when a beneficiary has other third party coverage?

DOM and its contracted CCOs, by law, are the "payer of last resort"; all other available third party sources must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid.

97. Does the beneficiary's third party insurance information effect the payment of inpatient hospital claims?

Yes. A method of avoiding payment of Medicaid claims when other insurance resources are available to the Medicaid beneficiary is called **Cost Avoidance**. If a Member has resources available for payment of expenses associated with the provision of covered services, other than those which are exempt under Title XIX of the Social Security Act, such resources are primary to the coverage provided by DOM and must be exhausted prior to payment. In accordance with DOM's billing manual, the CCO should reimburse for EPSDT, Title IV-D, and pregnancy-related services prior to billing of the third party source, and then pursue recovery of Medicaid payment, for practitioner services. Claims submitted for inpatient and outpatient hospital charges for labor and delivery and postpartum must be cost avoided. By law, all other hospital claims are excluded from the above exceptions. Hospital claims must be filed with the third party prior to billing the CCOs. .

98. Will DOM conduct a Third Party Liability audit?

Yes. An annual audit will be conducted by the DOM Office of Recovery. The purpose of the review is to ensure CCOs are accurately cost avoiding expenditures and recovering monies from any third party sources responsible for paying claims of Medicaid beneficiaries. DOM will review claims activity of randomly selected beneficiaries with dates of service within the specific fiscal year.

99. Can we get documentation from each CCO of what their requirements as of December 1, 2015?

Magnolia: The Magnolia Health Plan Provider Manual Inpatient section will explain our requirements and processes. It can be accessed on the Magnolia Health Plan PIRC website http://www.magnoliahealthplan.com/for-providers/provider-resources/.

UnitedHealthcare: All UHC policies can be found at uhccommunityplan.com.

100. For sterilizations, such as hysterectomy or tubal ligation, will the CCO require that a consent for treatment be on file prior to processing the claim?

A consent form is required for sterilizations per 42 CFR Part 441, Subpart F. The CCOs will use DOM's sterilization consent form, which should be submitted with the claim.

101. Presumptive Medicaid obtained while patient is in-house. Once the Medicaid number is assigned, how do we know which payor to authorize stay/services with?

Hospital Presumptive Eligibility (HPE) is covered by Medicaid Fee-For-Service.

102. Starting on Dec 1, 2015, if UHC and Magnolia Health are responsible to review of inpatient admissions instead of eQHS, are we going to be able to submit online and via fax as we do now to UHC and Magnolia Health on observation cases?

Magnolia: Requests for members assigned to Magnolia Health Plan should be obtained by either Magnolia Health Plan Provider Web Portal on our website http://magnoliahealthplan.com , secure email magnoliaauths@centene.com , secure fax 1-877-291-8059 (Hospital Inpatient) or 1-877-650-6943 (Outpatient) or by phone by calling 1-866-912-6285

UnitedHealthcare: Yes. Online submission is available through www.uhccommunityplan.com, 866-604-3267 or 888-310-6858 fax.

103. Also eQHS-will they still be the review company if a patient has traditional Medicaid and not a managed care plan or are all Medicaids from that date forward being transitioned to managed care?

Medicaid Fee-For-Service prior authorization process will not change, and will continue to be managed by eQHealth Solutions.

104. Will the changes discussed today affect critical access hospitals?

Yes. There is no distinction among provider classifications under MS Medicaid APR-DRG. Critical access hospitals are paid under the APR-DRG methodology.

105. Will the CCOs remittances utilize the MS Medicaid reason codes and remarks codes?

Magnolia: Magnolia Health Plan utilizes its own reason codes and remarks codes. These can be referenced in the Claims section of the Provider Manual.

UnitedHealthcare: No.

106. Do any of the Mississippi Department of Insurance administrative regulations apply to Medicaid Managed Care (MSCAN)?

Yes. The CCOs must adhere to federal and state regulations, including the Mississippi Department of Insurance regulations.

107. If the Behavioral Health webinar is conducted the week of 11/16/15, that leaves approximately 1 week to educate staff, including outreach staff across the state. The last week of November is Thanksgiving week which limits us further in preparing for the transition.

The Behavioral Health webinar was conducted on Tuesday, November 17, 2015. It is understood that continuous education and outreach is needed for assistance to providers by DOM and CCOs.

108. When is MississippiCAN open enrollment?

MississippiCAN and CHIP Open Enrollment is from October 1 to December 15 of each year.

109. When a new recipient obtains Medicaid and is going to be converted to managed care, how far in advance will this show in Envision? Will it show up prior to the 1st day of the month?

MississippiCAN eligibility will be displayed in Envision after the 20th
20th of each month for the following month.

Upon initial Medicaid eligibility, beneficiaries assigned to specified MississippiCAN categories of eligibility are enrolled into MississippiCAN 30 days after a notification letter has been mailed to members. However, newborns born to Medicaid mothers are enrolled into the same CCO as mother, as of their date of birth, after Medicaid ID number is obtained. Also, CHIP newborns are enrolled into the same CCO as mother as of their date of birth.

110. When is Medicaid going to start back paying for a patient having more than 1 type of therapy? If the patient has PT/OT/ST service, we get 3 different pre authorization numbers but Medicaid is paying/ denying the others for bundling (0110 edit).

This question is unrelated to the Inpatient transition. DOM is currently working to resolve this issue within the system. Until the requirements are finalized for the system update, mass adjustments are being done to pay certain PT/OT/ST claims that denied for bundling (0110 edit). Questions regarding this issue should be directed to DOM's Office of Hospital Programs and Services.

111. How can Medicare bundle pre- and post-care if that care is outside the hospital?

Medicaid cannot address a Medicare question.

112. Is there plan for dual eligible to have SNP plan like in Tennessee? (Special Needs Plan: an all-inclusive plan Medicare & Medicaid clients can get (like Humana provides). The Tennessee UHC offers these.

There are presently 3 SNPs in Mississippi (HealthSpring, Humana, and Windsor-Wellcare). These programs are Medicare Advantage Plans authorized by CMS. In Tennessee, the Part B premiums are applied to the MA Plan through the state, however, presently in Mississippi we simply verify Medicaid eligibility for MA Plans.

UnitedHealthcare: UHC operates Dual – SNP plans in many markets throughout the nation and is continuously looking for opportunities to expand in Mississippi.

113. Are MS BC/BS and UHC and Humana MA insurers abiding by the ACA appeals rules with hospital claims?

The Division of Medicaid can only address Mississippi Medicaid and MississippiCAN appeals. MississippiCAN appeals regulations are established through state contract with DOM.

114. Where can we find the presentations that are being referenced?

Presentations and notices are available on the DOM website. Please continue to check website for future trainings and information. Inpatient transition information is available at http://www.medicaid.ms.gov/inpatient-transition-information/.

115. Where should additional questions be submitted?

Please submit additional questions to inpatient@medicaid.ms.gov.

The FAQ document will be updated periodically. Inpatient transition information is available at http://www.medicaid.ms.gov/inpatient-transition-information/. Additionally this and other information will be available on each CCOs website at www.magnoliahealthplan.com and http://www.uhccommunityplan.com/.