MS Medicaid
PROVIDER BULLETIN

MISSISSIPPI DIVISION OF
MEDICAID

2019 Year-End Roundup

DREW L. SNYDER
Executive Director
MS Division of Medicaid

As the year quickly draws to a close, I wanted to take an opportunity to look back and highlight some of the key developments that took place at the Mississippi Division of Medicaid (DOM) during the last 12 months. It's been another transformative year as the agency adapts to meet the evolving challenges of today and increase value for all of our stakeholders going forward.

Phase 2 of the EASE Initiative Implemented

In April, we announced that DOM would begin covering more prescription drugs per month and more home health visits per year for Medicaid beneficiaries, marking the second phase of the Medicaid EASE Initiative.

First announced in December of last year, the Medicaid EASE Initiative – Enhancing Access to Services and Engagement – is a series of programmatic changes aimed at increasing Medicaid beneficiaries' access to needed services in the most appropriate setting.

In the second phase of the EASE Initiative, DOM increased the monthly prescription drug limit from five to six prescriptions and increased the number of home health visits per state fiscal year from 25 to 36.

Both changes took effect July 1, 2019.

This followed the first phase of the EASE Initiative, which lifted the physician visit limit for beneficiaries from 12 to 16 visits per year beginning Jan. 1, 2019.

These changes were possible thanks to a productive partnership with Mississippi lawmakers, who granted DOM additional flexibilities in how the program is administered during the 2018 legislative session.

Cost Drivers Impact DOM's 2021 Budget Request

In September, DOM had the chance to present its initial budget request for fiscal year (FY) 2021 to the Joint Legislative Budget Committee. For the current fiscal year, FY2020 (which began on July 1, 2019), we initially requested $954.5 million in state funding for the agency, which we subsequently revised downward to $939 million during the legislative session in early 2019. In the end lawmakers appropriated $931 million.

Unfortunately, our budget request for FY2021 will be higher due to several key cost drivers. The first is the reduced federal match for the Children's Health Insurance Program (CHIP). For Mississippi, the federal medical assistance percentage (FMAP) will decrease from 95.39% to 84.10%, contributing to a $15.9 million impact for DOM.

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Another significant factor is the reinstatement of the Affordable Care Act's Health Insurer Fee, which we did not have to pay thanks to a moratorium this year. That accounts for an additional $14.8 million in spending.

There are other variables, as well, that can be difficult to budget for, such as new high cost drugs coming into the market, and a recently approved treatment for Spinal Muscular Atrophy that is priced in the $2 million-range.

Despite those impacts to the bottom line, I'm hopeful DOM will be able to revise the FY2021 request downward later in the fiscal year, while at the same time introducing new quality initiatives, which are highlighted below.

Quality Incentive Programs Introduced

In the September issue of the Provider Bulletin, DOM's Quality Incentive Payment Program (QIPP) was detailed, which was implemented at the beginning of FY 2020 as a new component of the Mississippi Hospital Access Program (MHAP). DOM is also developing two additional quality initiatives beginning in the current fiscal year. These initiatives involve the Coordinated Care Organizations (CCOs) and the state's academic medical center. All three include quality measures, targeted improvement levels and accountability.

The Mississippi Medicaid Access to Physician Services (MAPS) is a new directed payment program developed in conjunction with the University of Mississippi Medical Center (UMMC). The program will work similarly to MHAP, whereas, the CCO will receive additional funds to pass through to certain provider groups based on utilization of services.

The program is intended to increase access and quality of care to primary and specialty care services for Medicaid beneficiaries by increasing payments made to qualified practitioners employed by or affiliated with UMMC.

The third program is the Managed Care Incentive/Quality Withhold program that will be applied to the MississippiCAN capitation rate payments. This quality withhold will be based on established quality metrics, such as Healthcare Effectiveness Data and Information Set (HEDIS) scores, which are already being reported by the CCOs and the organization's performance relative to HEDIS measures.

WEB PORTAL REMINDER

For easy access to up-to-date information, providers are encouraged to use the **Mississippi Envision Web Portal.** The Web Portal is the electronic approach to rapid, efficient information exchange with providers including eligibility verification, claim submission, electronic report retrieval, and the latest updates to provider information. The **Mississippi Envision Web Portal** is available 24 hours a day, 7 days a week, 365 days a year via the Internet at www.ms-medicaid.com.

DOM has set a 1% withhold of capitation rates for FY2020 and expects to increase the withhold to 2% of capitation rates in FY2021. DOM is requesting approval for this program as a part of the capitation rate certification performed yearly by the Centers for Medicare and Medicaid Services (CMS).

Supporting Graduate Medical Education

In August, DOM submitted a State Plan Amendment to CMS to enhance residency training opportunities for primary care physicians around the state.

This effort began after Dr. John Mitchell, director of the Office of Mississippi Physician Workforce (OMPW), reached out to DOM to discuss a better way to support graduate medical education in this state.

In 2012, the Mississippi Legislature established the OMPW because Gov. Bryant and lawmakers recognized the need to increase the number of physicians – especially primary care physicians – in underserved areas of the state. Part of that strategy included supporting graduate medical education, more commonly known as residency training, for primary care physicians.

Since 2012, DOM has been supporting hospitals and their residency programs in the form of supplemental payments to accredited programs based on inpatient discharges. Research shows that physicians tend to stay where they train, which is to say, if we want more practitioners in rural areas of the state, we need robust residency training programs located in those areas.

As it turns out, supplementing hospitals based on inpatient discharges proved unpredictable as more and more services are now provided on an outpatient basis. After discussions with Dr. Mitchell and House Public Health Chairman Rep. Sam Mims, who helped draft the original OMPW legislation, we revised our policy to supplement hospitals based on a more equitable per-resident rate and to include additional residency training programs. DOM submitted a State Plan Amendment with the policy change to the Centers for Medicare and Medicaid Services in August with an effective date of Oct. 1, 2019.

Dr. Mitchell described this enhanced support as critical and thanked DOM for helping to provide more training opportunities for the next generation of Mississippi providers. This is just one example of the impact we can make through good customer service.

Medicaid Leaders Tour Tyson Drugs

The South Reporter, https://www.southreporter.com/news/medicaid-leaders-tour-tyson-drugs

Mississippi Division of Medicaid leadership visited Tyson Drug Co. recently to learn more about how owner Bob Lomenick has designed and implemented a system to assist patients in getting their medications in a timely and efficient manner.

Executive Director Drew Snyder, Deputy Executive Director Tara Clark, and Pharmacy Director Terri Kirby came to Holly Springs to observe the innovative way community pharmacies are providing care to their patients.

Lomenick said he has organized the pharmacy to cut out the hectic environment and to improve efficiency for staff and convenience for patients. That includes monthly adherence phone calls to clients. When patients are called to remind them of their medications, they are also asked if they have any over-the-counter needs. Those are tucked in the package, ready to pick up in one easy transaction. Patients are also reminded during the routine phone call if they need to get a flu shot. Immunizations for shingles, pneumonia, and hepatitis, to name a few, are also available.

"Constant communication is the key," Lomenick said.

The goal is to get patients to pick up their medications by leaving them a reminder on their phone. The pharmacy also offers delivery. Those who fail to respond after four days get a follow-up call.

Lomenick said very few clients complain about the reminders. Patients get used to getting the calls and appreciate the reminders.

The system keeps track of whether patients are picking up their meds by a sign-for prescription device at the checkout counter. Some patients pick up their meds on the quick pick-up side, located one door down from the front door on the west side of the building.

Lomenick has gained a reputation as an industry innovator. Part of Tyson's mission is to help patients manage multiple medications and follow their dosage schedule. He created Right Way Meds to synchronize patient refills by combining strip-packaging technology with medication therapy management.

Patients taking multiple medications can have their prescriptions filled in compliance packaging to cut down on complex dosing regimens. An easy glance lets the patient know if he or she has taken or missed a medication using the strip-packaging dispensing system. The system boosts patients' adherence. It makes Tyson's workflow smoother but more importantly, also leads to healthier patients.

Inside the building is a maze of small office spaces where patients pick up medications or get immunization shots. The pharmacy also has a compounding lab where dermatological products (topical delivery of medicines) are made as well as stomach medicines, veterinary medicines, and some pills.

On completion of the pharmacy tour, Snyder was asked if he had taken his flu shot. He had not. So, Lomenick asked, "Why not do it now?"

Snyder agreed to a short interview after receiving his flu vaccine from Amanda Honeycutt, student pharmacist at Ole Miss.

"I'm really impressed to see what Tyson's is doing to promote medication adherence and to go above and beyond," Snyder said. "It's not just the medications that can improve a pharmacy. They (pharmacists) play a big role."

Snyder said his visit was a good opportunity to see the innovative tools healthcare providers are using to improve outcomes and to reduce the total cost of care. Medicaid's pharmacy director suggested he visit Tyson's to see cutting-edge pharmacy practice.

State and federal dollars in Mississippi spent on Medicaid comes to $5.9 billion annually, Snyder said. The state pays $1.4 billion or close to 24 percent. Mississippi's enrollment, though on the decrease in recent years, has stabilized at 720,000. The highest spent on one beneficiary is for a hemophiliac whose treatment costs have come to $4.8 million, Snyder said. The lowest average cost for a healthy child is about $200 a month for all care. A non-disabled, non-pregnant adult costs between $400 to $500 a month for their medical care, he said. Mississippi has about 40,000 to 50,000 patients in that category.

Snyder said Medicaid expansion is up to the Mississippi Legislature. Enrollment is on the decline in Mississippi and there is no significant growth in enrollment, he said.

Tyson Drugs has four locations: on the square in Holly Springs, Right Way Meds, Potts Camp Pharmacy and G&M Pharmacy in Oxford. The company has about 60 employees.

PROVIDER COMPLIANCE

Attention ALL Providers – NEW Prior Authorization Requirement for Certain Physician Administered Drugs (PADs)

Effective October 1, 2019, the Mississippi Division of Medicaid (DOM) requires prior authorization (PA) of certain Physician Administered Drugs (PADs) billed through the Medical Benefit. DOM covers PADs in accordance with Mississippi Administrative Code Title 23, Part 203, Chapter 2, found on DOM's public website at https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-203.pdf.

HCPCS Code	Physician Administered Drug
J1428	Exondys 51 (eteplirsen)
Q2042	Kymriah (tisagenlecleucel)
J3398	Luxturna (voretigene neparvovec-rzyl)
J2326	Spinraza (nusinersen)
Q2041	Yescarta (axicabtagene ciloleucel)
J3590*	Zolgensma (onasemnogene abeparvovec-xioi) *Zolgensma does not have an established HCPCS code

Failure to obtain authorization will result in denial of payment. The National Drug Code (NDC) number of the drug being administered should be submitted along with its corresponding Healthcare Common Procedure Coding System (HCPCS) Code.

Providers must obtain authorization for fee-for-service (FFS) beneficiaries from DOM's Utilization Management and Quality Improvement Organization (UM/QIO), Alliant Health Solutions. Please refer to Alliant Health Solutions' provider portal at https://ms.allianthealth.org/ or call Alliant directly at 1-888-224-3067.

For beneficiaries enrolled in the Mississippi Coordinated Access Network (MississippiCAN), providers should contact Magnolia Health, Molina Healthcare, or United Healthcare Community Plan for specific authorization and documentation requirements.

ATTENTION: Durable Medical Equipment (DME) Providers – Reminder regarding coverage of gloves and disposable wipes

Gloves

The Mississippi Division of Medicaid (DOM) does not cover gloves provided solely for the convenience of the beneficiary, the beneficiary's family, or any health care provider. DOM reimburses for gloves in accordance with Mississippi Administrative Code Title 23: Medicaid Part 209 Durable Medical Equipment and Medical Supplies, when they are medically necessary and considered standard care for the treatment of a beneficiary's medical condition and dispensed in quantities that meet a beneficiary's medical needs without excessive utilization.

Providers should refer to the following DME Administrative Code sections, regarding inclusion of gloves:

Title 23: Medicaid Part 209 Durable Medical Equipment and Medical Supplies
D.   Dressing (Bandaging) Supplies (page 76)
F.   Enteral Feeding (page 76)
J.   Insulin Pump Supplies (page 78)
L.   IV Supplies (page 78)
S.   Suction Pump Supplies -Respiratory and Gastric (page 80)
T.   Drug Infusion Catheter (page 81)
U.   External Drug Infusion Pump (page 82)
X.   Tracheostomy Supplies (page 82)
Y.   Urinary Catheters (page 83)

Disposable Wipes and Washcloths

Incontinence wipes/washcloths do not meet the definition of a medically necessary medical supply and therefore are not reimbursable by the Division of Medicaid.

For any questions, please contact the Mississippi Division of Medicaid at 601-359-6150.

Updates for Private Duty Nursing Providers

Private Duty Nursing (PDN) services are defined as skilled nursing care services for beneficiaries who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or skilled nursing facility.

The Division of Medicaid covers medically necessary PDN services for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) eligible beneficiaries when ordered by the beneficiary's primary physician or appropriate specialist and prior authorized by the Division of Medicaid's Utilization Management/Quality Improvement Organization (UM/QIO) or a contracted Coordinated Care Organization's (CCO's) UM/QIO.

Fees are published on the Division of Medicaid's website at https://medicaid.ms.gov/providers/fee-schedules-and-rates/.

- TG Modifier – The TG modifier is reserved specifically for ventilator dependent patients. Use of the TG modifier is restricted to procedure code S9123-Nursing Care by a Registered Nurse (RN) and does not apply to PDN services provided by a Licensed Practical Nurse (LPN).

- Incorrect billing may result in claim denials.

- PDN services require prior authorization and are reviewed for medical necessity. Alliant Health Solutions (Alliant) is the UM/QIO for fee-for-service (FFS) beneficiaries. Contact Alliant for prior authorization submission at 1-888-224-3067 or visit the Alliant web portal at https://ms.allianthealth.org/.

- For beneficiaries enrolled in the Mississippi Coordinated Access Network (MississippiCAN), providers should contact Magnolia Health, Molina Healthcare, or United Healthcare Community Plan, for beneficiaries enrolled in Mississippi Coordinated Access Network (MSCAN), for specific authorization and documentation requirements.

ATTENTION: Early, Periodic Screening, Diagnosis, and Treatment (EPSDT) and Vaccines for Children (VFC) Providers

Medicaid providers are responsible for updating and reporting any changes to their provider files within thirty (30) days of the effective date of the change.

To prevent non-receipt of important letters, notices, and non-payment of claims, providers should check and update their servicing location and provider affiliations with the most accurate information.

Providers may verify information on their provider file via the Mississippi Medicaid Envision web portal. Please log into the provider secure portal, select Inquiry Options, then select Provider Record Inquiry to view information.

Recovery Audit Contractor

The Division of Medicaid (DOM) contracted with LaunchPoint Ventures dba Discovery Health Partners to administer the MS Medicaid Recovery Audit Contractor (RAC) program. Discovery Health Partners utilizes a provider portal as a self-service tool for providers to retrieve claim and audit information specific to each audit. Providers can also review all documentation related to Discovery's findings. All providers or providers' staff can register to use the Discovery Portal using the registration code provided by Discovery in your correspondence letter.   For specific instructions on how to register and navigate the Portal, please visit https://provider. discoveryhealthpartners.com/.

The Office of Program Integrity provides oversight of the RAC Program to ensure compliance with contract requirements and federal and state guidelines. Providers must follow processes as outlined in the RAC notification letters. Upon receipt of the final demand letter from the RAC, providers must respond by submitting full payment or requesting a formal Administrative Hearing complying with all requirements of Miss. Admin. Code 23-300. **Please do not void and/or adjust claims.** Providers who do not

respond to final demand letters from the RAC within the required thirty (30) calendar days will have overpayments identified withheld from future payments.

Providers are encouraged to monitor the DOM website for updates and announcements regarding the Mississippi Recovery Audit Contractor program. Current approved audit concepts are located on the DOM website at https://medicaid.ms.gov/providers/recovery-auditor-contractors/. Providers can submit inquiries, complaints, and other communications as it relates to the MS Medicaid RAC program to MSRAC@medicaid.ms.gov.

What Happened to My Claims?

Have you ever wondered what happened to your unreimbursed/unpaid claims? Many times a provider may ask this question. "What happened to my payment for claims related to dates of service, XX/XX/XXXX? We did not receive any payment." This scenario may be related to issues with the provider's National Provider Identifier (NPI) number.

The NPI is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique 10-digit identification number for covered health care providers. If you are a health care provider who bills for services, you must have an NPI number. NPI numbers submitted to Medicaid should be the same number as submitted to other payers, such as Coordinated Care Organizations (CCOs), Medicare, and other payers, as this is your unique identifier. **Your Medicaid claims will deny if your NPI is not on file with Mississippi Medicaid. Additionally, claims may deny if a provider has one NPI number linked to multiple Medicaid numbers. If you know the NPI is on record with Mississippi Medicaid, providers should submit the appropriate taxonomy code in conjunction with the NPI number. These taxonomy codes must also be on file with Mississippi Medicaid.**

The NPI is meant to be a lasting identifier and is expected to remain unchanged even if a health care provider changes their name, address, provider taxonomy, or other information that was furnished as part of the original NPI application process. Providers may verify information on

their provider file via the Mississippi Medicaid Envision web portal. Please log into the provider secure portal, select **Inquiry Options**, then select Provider Record Inquiry to view information. Only personnel authorized by the provider may see this information.

Medicaid providers are responsible for reporting any changes to their provider files in writing within 30 days of the effective date of the change. Ensuring that your Medicaid provider file is updated with accurate information will prevent the non-receipt of important letters, notices, and payments to the incorrect bank account. Changes that should be reported include but are not limited to:

• Addresses
• Phone Number(s)
• Fax number(s)
• Contact name
• E-mail address
• Banking information
• Provider affiliations
• Change of ownership- Requires completion of a Provider Enrollment application
• Managing/Directing employee information
• Change of tax identification
• Individual and group name changes
• NPI numbers

Several forms are available for use in submitting changes. The Change of Address form is located on our website at www.ms-medicaid.com by clicking on Provider/Forms. The EFT (Direct Deposit Authorization Form) is located on our website at www.ms-medicaid.com by clicking on Provider/Provider Enrollment. Additional forms may be found in both of these locations.

The completed forms may be submitted by fax or mail to Conduent Provider Enrollment.
Fax number: 888-495-8169
Address: Conduent Provider Enrollment
                          P. O. Box 23078
                          Jackson, MS. 39225

If you have any questions about unreimbursed/unpaid claims, please contact a Conduent Customer Service Representative at 800-884-3222. If you have questions regarding your provider records, please contact Conduent Provider Enrollment at 800-884-3222.

Attention Providers: Reminder - Effective July 1, 2019, MS Medicaid Began Accepting Medicare Advantage Part C Secondary Claims Electronically

Effective July 1, 2019, MS Medicaid providers were able to submit electronic claims for dual eligible beneficiaries with Medicare Advantage Part C coverage. The Division of Medicaid and Conduent anticipated this change to be very beneficial for the Medicaid provider community. It eliminates the need to drop claims to paper and attach the Medicare Advantage Explanation of Benefits (EOB), thus, reducing time and cost.   Some of the feedback received from the provider community credits the implementation of the ability to submit secondary claims electronically with resulting in increased efficiency and a savings on several hours per week with the reduction of manual effort.

The Medicare Advantage claims should be submitted in separate files and not combined with the Medicaid primary files. The Submitter Name in Loop 1000A, Segment NM103 "**ADVANTAGE/MEDICARE-PART-C**" should be used for 837P and 837I claims.

Use of an incorrect file Submitter Name will cause your file to process incorrectly.

When reporting the Medicare Advantage Crossover 837 claims, Loop 2320 – Segment SBR09 should be submitted with 'MB' for Part B claims and 'MA' for Part A claims.

Refer to the segment examples included in the 837I and 837P Companion Guides Appendices.

Claims for beneficiaries with both Medicare Advantage Part C coverage and third party coverage may also be billed electronically. It is very important to identify both the Medicare Advantage and the Other Commercial insurance using the correct payer ID.

Providers should review the following resources for data specifications and information. These can be found on the Mississippi Medicaid EDI Solutions site:
http://edisolutionsmmis.portal.conduent.com/gcro/ms-guides
'ANSI ASC X12N 5010 837I Companion Guide Version 9.0.PDF''ANSI ASC X12N 5010 837P Companion Guide Version 4.0.PDF'

Important notes:
- This change **ONLY** applies to billing claims electronically for dual eligible beneficiaries with Medicare Advantage Part C coverage, **NOT** traditional Medicare coverage.
- Use CARC 253 (Sequestration – reduction in federal payment) for reporting Sequestration amount.

Providers who choose to continue to submit Medicare Advantage Part C claims as paper claims should continue to follow the procedures in place.

Provider Testing:
Providers/Clearinghouses are required to submit test files and verify responses before submitting the production files.

Please follow the instructions below for test files submission:
- Providers can submit 837 test files for Medicare Advantage Part C crossover Part A and Part B claims.
- Test files can be submitted at any time; our system will accept and process the test files weekly on Thursdays.
- Submit 837 X12 test files with the same approved Submitter ID and submission method currently used for production data.
- Use "T" in the Interchange Control Header (ISA15 Usage Indicator) to indicate that the file is a TEST file. Restrict test file to have 100 claims or less.
- Please refer to changes mentioned in the provider communication manual for specific segment information.
- Responses for test claims will be available weekly on Thursday night.
- See results by processing the returned TA1, 999, 277CA and 835 X12 files with the "T" flag.

Please refer to below instructions to submit Medicare Advantage Part C secondary claims using WINASAP5010 software:
- WINASAP needs to be installed on your computer (PC).
- The Trading Partner setup screen needs to be updated with all required values with the Trading Partner ID, Trading Partner name [organization name should be entered as "ADVANTAGE/MEDICARE-PART-C"] and contact information.
- If you are using the same PC for submitting traditional crossover claims and Medicare

Advantage crossover claims, the organization name should be changed every time to "ADVANTAGE/MEDICARE-PART-C" when submitting and extracting the Medicare Advantage crossover claims.
- It is recommended that you use two different computers for traditional claims and Medicare crossover claims for WINASAP. This will allow these two different methods to be utilized simultaneously with no need to repeat the setup process when changing from one type to the other.

COORDINATED CARE NEWS

Molina Healthcare: Important Notice to Non-Participating Providers

All Out-of-Network Providers (Physicians, Nurse Practitioners, Facilities, and Ancillary Providers) must obtain a Prior Authorization (PA) prior to rendering services. All Non-Participating Providers require authorization regardless of services or codes.

To join our network, please complete the Contract Request Form found on our website at https://www.molinahealthcare.com/providers/ms/medicaid/forms/Pages/fuf.aspx and follow the instructions given.

After completing, a representative from our Provider Contracting Department will reach out to you regarding the enrollment and credentialing process.

For additional information, email
MHMSProviderContracting@Molinahealthcare.com

The Prior Authorization Guide and forms are located on our website at:
https://www.molinahealthcare.com/providers/ms/medicaid/forms/Pages/fuf.aspx

Reimbursement of Non-Participating Providers

Non-Participating Providers are reimbursed at 50% of the current Mississippi Medicaid Fee-For-Service Fee Schedule for covered Non-Emergent services, if accompanied by a valid prior authorization number.

Non-Participating Providers are reimbursed at 100% of the current Mississippi Medicaid Fee-For-Service Fee Schedule for covered Emergency Services. Prior authorization is not required for covered Emergency Services.

Reimbursement will be limited to a period for the treatment of an Emergency Medical Condition, including Medically Necessary services rendered to the Member until such time as he or she may be safely transported to a network Provider service location. From that time forward, the applicable non-participating provider rate will apply.

Members experiencing an Emergency Medical Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or to stabilize the patient.

Molina is now collaborating with DirectAssure

We are now collaborating with DirectAssure to help maintain a more accurate and timelier provider directory. Working in concert with CAQH ProView®, which is accessed by 1.4 million providers to self-report and regularly attest to their professional and practice information, DirectAssure enables providers to update their directory information once and share it with all participating health plans they authorized to receive that data.

We encourage all providers to sign up for CAQH ProView® in order to utilize DirectAssure as a tool to easily update and distribute provider directory data to Molina Healthcare. DirectAssure reduces the burden on healthcare providers and health plans alike, eliminating redundant outreach and increasing directory accuracy.

How DirectAssure Works

- DirectAssure emails reminders, on at least a quarterly basis, to select providers on behalf of par-

ticipating health plans to review their directory information.

- Providers log in to CAQH ProView®, review a specific dataset in a Provider Directory Snapshot, make any necessary updates and then confirm that the directory information can be published.

- The confirmation is time stamped, and a snapshot of information is taken for audit purposes.

- This directory data includes provider location, contact information, specialty, medical group, institutional affiliation, and whether they are accepting new patients.

To register, please visit https://www.caqh.org/. For more information about DirectAssure, visit https://www.caqh.org/solutions/directassure.

If you have any questions, please contact your Molina Healthcare Provider Services Representative.

Antidepressant Medication Management (AMM)

We want to spread the word and increase awareness of this measure. The following information will be distributed to providers this quarter.

Understanding HEDIS® Measures: Antidepressant Medication Management (AMM)

Healthcare Effectiveness Data and Information Set (HEDIS) measures can help enhance quality of care by identifying ways to support preventive care. By working with UnitedHealthcare on HEDIS medical record collection, your efforts can have a direct impact on better patient outcomes – from improved medication adherence to closing clinical care gaps to deeper member engagement in their own well-being.

We realize some of you have questions on specific measures. To help you improve performance for the

Antidepressant Medication Management (AMM) measure, we've shared tips and recommendations.

The HEDIS AMM Measure

AMM: The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and remained on an antidepressant medication treatment. This measure is strictly related to medication compliance.
Two rates are reported:

- Effective Acute Phase Treatment: The percentage of members who remained on an antidepressant medication for at least 84 days or 12 weeks.

- Effective Continuation Phase Treatment: The percentage of members who remained on an antidepressant medication for at least 180 days or six months. The clock starts at the earliest prescription dispensing date for an AMM medication during the intake period.

Recommendations for Stronger Performance

To improve diagnosis and treatment for this measure, please keep these recommendations in mind:

- Use screening tools such as the PHQ-9 to support identification of mild, moderate, or severe depression.

- Use objective assessments to identify who would benefit from medication.

- Remember that not all dysphoria is major depression.

- Explore alternative non-pharmaceutical treatments.

- Offer supportive therapy instead of or in addition to medication.

- Educate patients about their medications:
  - Help them understand it may take up to 12 weeks for full medication effectiveness.
  - Emphasize the importance of taking medications for at least six months even if they feel better.
 - Discuss side effects and the importance of medication adherence.

SECURE PORTAL – DOCUMENTATION ALERT

Magnolia Health continues to improve the stability and functionality of the Secure Provider Web Portal for prior authorization submissions, we are excited to announce the release of a new documentation alert. A pop-up window appears if clinical documentation has not been attached. At that point, the provider can add helpful documentation for an efficient clinical review.

Prior Authorization Request: Documentation Alert
This new digital initiative is one of many more enhancements to come.
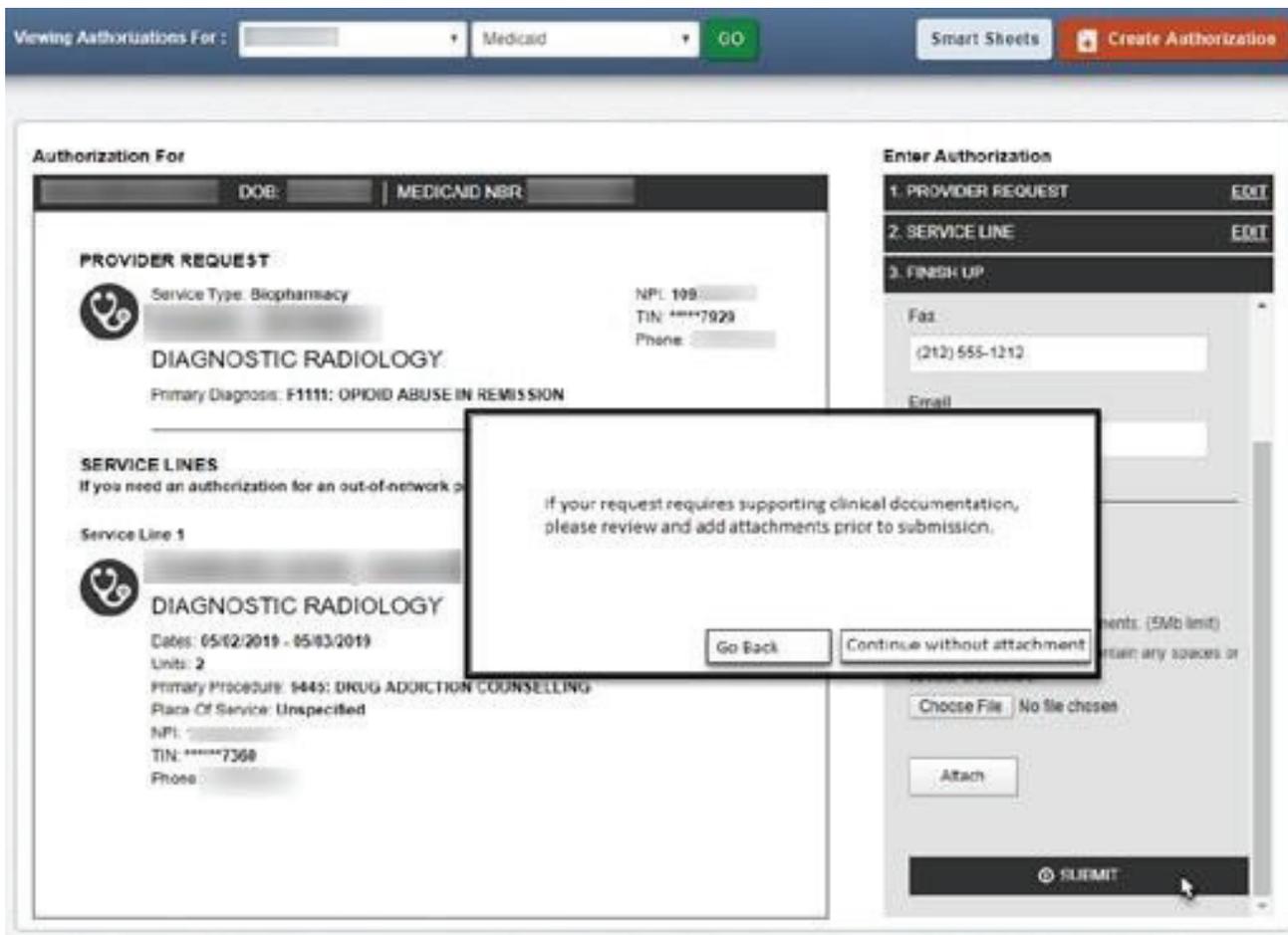
FIELD REPRESENTATIVE REGIONAL MAP

1 Jonathan Dixon
(601.206.3022)

2 Prentiss Butler
(601.206.3042)

3 Claudia "Nicky" Odomes
(601.572.3276)

4 Randy Ponder
(601.206.3026)
Justin Griffin
(601.206.2922)

5 LaShundra Thompson
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6 Erica G. Cooper
(601.206.3019)

7 Porscha Fuller
(601.206.2961)

8 Connie Mooney
(601.572.3253)
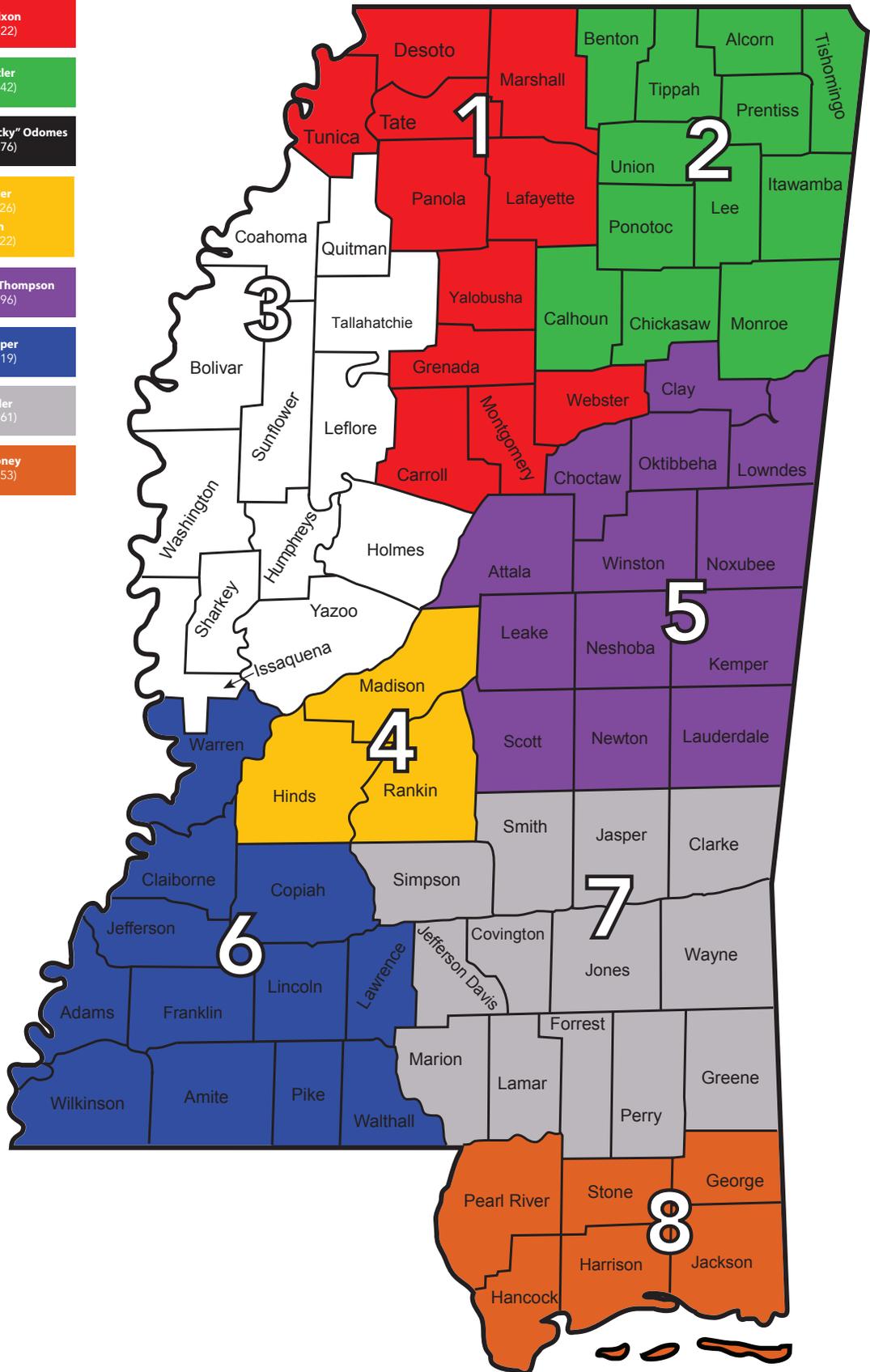
PROVIDER FIELD REPRESENTATIVES

PROVIDER FIELD REPRESENTATIVE AREAS BY COUNTY		
AREA 1 **Jonathan Dixon (601.206.3022)** jonathan.dixon@conduent.com	**AREA 2** **Prentiss Butler (601.206.3042)** prentiss.butler@conduent.com	**AREA 3** **Claudia "Nicky" Odomes (601.572.3276)** claudia.odomes@conduent.com
County	**County**	**County**
Desoto	Benton	Coahoma
Tunica	Tippah	Quitman
Tate	Alcorn	Bolivar
Panola	Tishomingo	Sunflower
Marshall	Prentiss	Leflore
Lafayette	Union	Tallahatchie
Yalobusha	Lee	Washington
Grenada	Pontotoc	Sharkey
Carroll	Itawamba	Humphreys
Montgomery	Calhoun	Yazoo
Webster	Chickasaw	Holmes
	Monroe	Issaquena
***Memphis**		
AREA 4 **Justin Griffin (601.206.2922)** justin.griffin@conduent.com **Randy Ponder (601.206.3026)** randy.ponder@conduent.com	**AREA 5** **LaShundra Thompson (601.206.2996)** lashundra.othello@conduent.com	**AREA 6** **Erica G. Cooper (601.206.3019)** ERICA.Cooper@conduent.com
County	**County**	**County**
Hinds	Clay	Warren
Rankin	Oktibbeha	Claiborne
Madison	Choctaw	Jefferson
	Attala	Adams
	Leake	Franklin
	Scott	Wilkinson
	Lowndes	Amite
	Winston	Copiah
	Noxubee	Lincoln
	Neshoba	Pike
	Kemper	Lawrence
	Newton	Walthall
	Lauderdale	
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County		**County**
Simpson		Pearl River
Jefferson Davis		Stone
Marion		George
Lamar		Hancock
Covington		Harrison
Smith		Jackson
Jasper		
Jones		**Slidell, LA**
Forrest		**Mobile, AL**
Perry		
Greene		
Wayne		
Clarke		
OUT OF STATE PROVIDERS	Latasha Ford (601) 572-3298 Latasha.Ford@conduent.com	

CONDUENT
P.O. BOX 23078
JACKSON, MS 39225

If you have any questions related to the topics in this bulletin, please contact Conduent at 800 - 884 -3222

Mississippi Medicaid Administrative Code and Billing Handbook are on the Web
www.medicaid.ms.gov

Medicaid Provider Bulletins are located on the Web Portal
www.ms-medicaid.com

DECEMBER 2019

MON, DEC 2	Checkwrite
THURS, DEC 5	EDI Cut Off - 5:00 p.m.
MON, DEC 9	Checkwrite
THURS, DEC 12	EDI Cut Off - 5:00 p.m.
MON, DEC 16	Checkwrite
THURS, DEC 19	EDI Cut Off - 5:00 p.m.
TUES, DEC 24-WED, DEC 25	DOM Closed
THURS, DEC 26	EDI Cut Off - 5:00 p.m.
WED, JAN 1	DOM Closed

JANUARY 2020

THURS, JAN 2	EDI Cut Off – 5:00 p.m.
MON, JAN 6	Checkwrite
THURS, JAN 9	EDI Cut Off – 5:00 p.m.
MON, JAN 13	Checkwrite
THURS, JAN 16	EDI Cut Off – 5:00 p.m.
MON, JAN 20	Martin Luther King, Jr. Day DOM Closed
THURS, JAN 23	EDI Cut Off – 5:00 p.m.
MON, JAN 27	Checkwrite
THURS, JAN 30	EDI Cut Off – 5:00 p.m.

FEBRUARY 2020

MON, FEB 3	Checkwrite
THURS, FEB 6	EDI Cut Off – 5:00 p.m.
MON, FEB 10	Checkwrite
THURS, FEB 13	EDI Cut Off – 5:00 p.m.
MON, FEB 17	President's Day DOM Closed
THURS, FEB 20	EDI Cut Off – 5:00 p.m.
MON, FEB 24	Checkwrite
THURS, FEB 27	EDI Cut Off – 5:00 p.m.

Checkwrites and Remittance Advices are dated every Monday. Provider Remittance Advice is available for download each Monday morning at www.ms-medicaid.com. Funds are not transferred until the following Thursday.