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MS Medicaid PROVIDER BULLETIN

MISSISSIPPI DIVISION OF MEDICAID

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Executive Director
MS Division of Medicaid

Focusing on Quality, Sustainability in 2020

By the time this issue of the Provider Bulletin publishes, we will be well into the first quarter of 2020. But as I write this article, it is still January and the legislative session is just getting underway.

It's been a month of transition, both in state government and at the Mississippi Division of Medicaid (DOM). To begin with, then-Governor-elect Tate Reeves announced on Jan. 6 that I was his choice to continue leading Mississippi's Medicaid program under his administration, which officially began with his inauguration on Jan. 14. It has been an honor to serve in this office, and I'm grateful for the opportunity to continue leading this vital agency and strengthening partnerships with the provider community.

Also in January, our new lieutenant governor, Delbert Hosemann, announced his Senate committee assignments, while Speaker of the House Philip Gunn, re-elected to his third term, made his assignments for House committees. Legislative sessions following an election year can last up to 125 days rather than 90 days, and the 2020 Legislature is set to run until May 10.

With the transition complete, it's now time to focus on the year ahead, working with the new administration and collaborating with lawmakers throughout the extended legislative session. In keeping with Gov. Reeves' theme of "raising expectations for Mississippi," my goal is to work toward raising expectations for Mississippi Medicaid. My expectation for this year is that "above and beyond" will be seen as the new norm in this agency.

Priorities in alignment

Seema Verma, the administrator for the Centers for Medicare and Medicaid Services (CMS), spoke at a national health conference late last year, and her remarks struck a chord. In the speech she spoke about the role of government in health care and finding a sustainable path forward, and her thoughts reflect the core concerns we currently face at DOM.

"We are focused on creating incentives for entities that innovate to deliver value, quality, and better outcomes," Verma said. "It is an important blueprint for any sustainable and effective health care system."

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Although CMS governs Medicare and state Medicaid programs, states have a good deal of flexibility in how they administer their Medicaid programs. Our attitudes don't necessarily have to conform to those of CMS on the federal level, but it's good to know what they are focused on and where our priorities are in alignment.

To summarize, Verma stressed that government cannot be the answer to every problem. Our form of government was conceived as the mechanism to provide a secure environment where states, communities and the individual can thrive. With regard to health care, Verma's vision consists of three points: providing a safety net for the most vulnerable; ensuring sustainability; and "setting fair ground rules for a flourishing and competitive health care market, while putting patients first."

"Few question the need for a safety net," she said, adding that what is controversial is the safety net's scope. In practical terms, scope is determined by what's sustainable. The finite resources we have to work with ought to dictate scope, but we can stretch those resources further by promoting value and quality-based incentives that produce better outcomes.

That concept is exactly what DOM began developing last year with initiatives we've already implemented, such as the Quality Incentive Payment Program, and others we are exploring, such as developing reimbursement rates to nursing facilities based on certain quality measures.

Verma's third point about fostering a competitive health care market ties in to our commitment to developing strong and fair partnerships with the provider community, as well as other stakeholder groups.

Common-sense approaches, like those expressed by Verma and those pursued by DOM, are the key to real sustainability and better overall health.

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.

PROVIDER COMPLIANCE

Civil Money Penalty Grant Training

The Division of Medicaid and Mississippi State Department of Health (MSDH) Division of Licensure and Certification are hosting a free, one-day educational seminar for nursing home providers and other individuals or organizations interested in applying for a Civil Money Penalty (CMP) Grant.

Several speakers experienced in the nursing home industry will share their expertise and perspectives on developing successful CMP grants. Attendees will be able to speak with industry representatives on products and services devoted to improve care and quality of life for nursing home residents.

If your organization is seeking funding from the Centers for Medicare and Medicaid Services for a project benefiting nursing home residents, you are urged to attend this educational seminar. Registration will be available March 2, 2020 on the MSDH website.

Continuing education hours for nursing home administrators are pending. For more information, please call 601-359-6141.

Seminar Details:
Date: April 30, 2020
Time: 9:30 a.m. - 4:30 p.m.
Location: Jackson Medical Mall
University of Mississippi Medical Center ~ Gilliam Room
350 West Woodrow Wilson Drive
Jackson, MS 39213

CMP Grant Solicitation Notice

The Division of Medicaid and the Mississippi State Department of Health, Health Facilities Licensure and Certification invite you to apply for Civil Money Penalty (CMP) grant funds for projects to improve Mississippi nursing home residents' quality of life and/or quality of care. Recommended projects currently include: quality of care and/or training related to adverse drug events including opioids, anticoagulants, and diabetic agents; reducing adverse drug events involving harm; and reducing healthcare-acquired infections. The balance in the Mississippi Division of Medicaid CMP Fund as of December 31, 2019 is $13,930,556.03, and the balance of the CMP Emergency Fund is $1,488,561.00. CMP grant resources are located at https://medicaid.ms.gov/programs/civil-money-penalty-cmp-grant-awards-program/. Please call the Mississippi Division of Medicaid at 601-359-6141 if you have any questions.

Balance Billing Medicaid Beneficiaries

Mississippi Medicaid participating providers are prohibited from balance billing Medicaid beneficiaries for Medicaid covered services. Medicaid providers agree to accept, as payment in full, the amount paid by the Medicaid program for all services covered under the Medicaid program within the beneficiary's service limits with the exception of authorized deductibles, co-insurance, and co-payments. Providers who balance bill Medicaid beneficiaries (bill a beneficiary for an outstanding balance) for covered services are in violation of this policy. Providers who continue to violate this policy risk termination from participation in the Medicaid program by the Office of Program Integrity. Termination from participation in the Medicaid program also results in termination with the managed care organizations (MCOs). Providers must ensure that billing activity is compliant with all federal and state regulations. Please refer to the Miss. Admin. Code Title 23, Part 200, Rule 4.2 for additional information regarding conditions of participation in the Mississippi Medicaid Program.

PROVIDER COMPLIANCE

Durable Medical Equipment Providers – Certificate of Medical Necessity

A Certificate of Medical Necessity (CMN) form is completed by the prescribing provider prior to services being rendered and must contain a written reason why the item is medically necessary. Requests for durable medical equipment (DME) require documentation of medical necessity.

Effective March 1, 2020, all fee-for-service (FFS) requests for incontinence items (diapers, pull-ups, blue pads and ointments) must be submitted on the Mississippi Division of Medicaid (DOM) CMN form. As a reminder, DOM covers incontinence items in accordance with Mississippi Administrative Code Title 23, Part 209: Chapter 2: Medical Supplies. DOM covers up to six (6) units of incontinence garments per day, for a maximum of thirty-one (31) days per month, for beneficiaries aged three (3) and above, only when certified as medically necessary and prior authorized by the Division of Medicaid or designee. One (1) unit is equal to one (1) diaper or one (1) pull-on or one (1) underpad. The six (6) units can consist of any combination of diapers, pull-ons and/or underpads. Failure to obtain prior authorization will result in denial of payment.

The DOM CMN form will be the only CMN form accepted for FFS beneficiaries requesting incontinence items beginning March 1, 2020; all other CMNs used for incontinence items will be rejected. The CMN form can be found on DOM's website at https://medicaid.ms.gov/wp-content/uploads/2019/11/CMN-Incontinence-Supplies.pdf.

If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Updates for Prescribed Pediatric Extended Care Providers

Effective January 1, 2020, State Plan Amendment (SPA) 19-0002 Prescribed Pediatric Extended Care (PPEC), was approved by the Centers for Medicare and Medicaid Services (CMS) to allow the Division of Medicaid (DOM) to add coverage and reimbursement of PPEC services for Early and Periodic Screening, Diagnosis and Treatment (EPSDT)-eligible beneficiaries to the State Plan. The approved SPA is located on DOM's public website https://medicaid.ms.gov/wp-content/uploads/2020/01/MS-19-0002-Approved-Pages.pdf.

DOM covers medically necessary PPEC services for EPSDT-eligible beneficiaries when prescribed by the beneficiary's attending physician and prior authorized by DOM's Utilization Management/Quality Improvement Organization (UM/QIO) or a contracted Coordinated Care Organization's (CCO's) UM/QIO.

PPEC fees are published on DOM's website at https://medicaid.ms.gov/providers/fee-schedules-and-rates/.

Nursing Home Providers

Effective October 1, 2020, the Optional State Assessment (OSA) will be required to complete all Minimum Data Set (MDS) resident assessment instruments. As the Division of Medicaid continues to move forward with fully implementing the Patient Driven Payment Model (PDPM), we will keep the provider community abreast of upcoming changes.

Authorization Reviews by Alliant Health Solutions

Effective August 1, 2019, the Mississippi Division of Medicaid (DOM) transitioned to a new Utilization Management/Quality Improvement Organization (UM/QIO) vendor, Alliant Health Solutions (Alliant) https://ms.allianthealth.org/. Alliant is responsible for determining medical necessity for all fee-for-service (FFS) authorization review requests including, but not limited to, prior authorization reviews, continued stay reviews, and retrospective reviews.

Prior Authorization Review Requests - reviews for medical necessity before services are initiated or rendered.

Continued Stay Review Requests - reviews performed to determine if continuation of services is medically necessary and appropriate.

Retrospective Review Requests - reviews for medical necessity after services are initiated or rendered when a beneficiary is determined retroactively eligible for Medicaid or switches to another payer. Retroactive Medicaid Eligibility is determined in accordance with the Mississippi Medicaid Administrative Code, Part 101, Chapter 8, Rule 8.4 and may include all three (3) or any of the three (3) months prior to the month of application.

Providers may have received denials for untimely submission from Alliant during the UM/QIO transition. DOM and Alliant are reviewing the process and timeframes associated with submitting retrospective review requests. Retrospective review requests are limited to three hundred sixty-five (365) calendar days from the date of service (DOS), where retroactive eligibility occurred and with supporting documentation. Requests that exceed three hundred sixty-five (365) calendar days from the DOS will be reviewed on a case-by-case basis. Providers will be notified in advance, if changes are made to the retrospective review request submission timeframe.

Alliant's authorization determination is not a guarantee of Medicaid payment. Medicaid services are subject to the terms, conditions, and limitations of the Medicaid program, including timely filing requirements for Medicaid claims, in accordance with the Mississippi Administrative Code Title 23, Part 200, Rule 1.6.

Attention: Hospital Providers Inpatient Authorization Process

Effective May 1, 2020, hospital providers will be required to adhere to the outlined timeframe for requesting authorizations from the Division of Medicaid (DOM) Utilization Management and Quality Improvement Organization (UM/QIO), Alliant Health Solutions. Nothing in this notification will supersede DOM authorization process for maternity related services or newborns.

Elective or Non-Emergency Inpatient Admission

- The provider shall request authorization for elective or non-emergency inpatient admission from Alliant. Prior authorization must be obtained at least one (1) to three (3) business days before admission.

Emergency Inpatient Admission

- The provider must request authorization for an emergency inpatient admission within one (1) business day of admission.

Continued Stay Review

- Provider must request a continued stay review within two (2) business days prior to the expiration of the authorization but no later than one (1) business day after the expiration of the authorization.

Retrospective Review

- Requests for post service reviews will be considered when prior authorization was not obtained due to extenuating circumstances. (i.e., beneficiary was unconscious upon arrival, acts of nature impairing the provider's ability to verify the beneficiary coverage/eligibility status, services authorized by another payer who subsequently determined member was not eligible at the time of service, etc.)

More information regarding DOM policy can be found at https://medicaid.ms.gov/.

For assistance with authorization requests, please visit Alliant Health Solutions website at https://ms.allianthealth.org/.

PHARMACY NEWS

Beneficiary Health Management Program

In an effort to reduce unnecessary or inappropriate utilization of pharmacy services, the Division of Medicaid (DOM) Office of Program Integrity (PI) has implemented pharmacy lock-in procedures known as the Beneficiary Health Management (BHM) Program. As a requirement of 42 CFR §431.54, if a Medicaid agency finds that a beneficiary has utilized Medicaid services at a frequency or amount that is not medically necessary, the agency may restrict, for a reasonable period of time, that beneficiary to obtain Medicaid services from designated providers only. The Office of Program Integrity manages the BHM Program by screening beneficiaries against criteria designed to identify drug seeking behavior and inappropriate use of prescription drugs. Effective November 1, 2019, the Office of Program Integrity began to lock-in qualifying beneficiaries into specific pharmacies. A registered nurse within PI with the assistance of a pharmacist in the Office of Pharmacy reviews claims and pharmacy point-of sale data to identify patterns of inappropriate, excessive or duplicative use of pharmacy services. Individuals identified for lock-in are restricted to a particular provider for pharmacy services. If a pharmacy which is not their assigned pharmacy submits a claim, that pharmacy will receive a claim denial message to contact the Office of Program Integrity at 1-800-880-5920 for questions.

The Division of Medicaid has also required the coordinated care organizations (CCOs) to implement a lock-in program. The CCOs are required to report to DOM all beneficiaries they have identified for lock-in. DOM has established procedures for reviewing beneficiary utilization of pharmacy services. Please refer to the Miss. Admin. Code, Title 23, Part 305, Chapter 2 for additional information regarding the Beneficiary Health Management Program.

HPV Vaccination Series Completion Findings and Key Recommendations For Improvement - YOU are the KEY to HPV cancer prevention.

In the United States, approximately 19,000 new Human papillomavirus (HPV) infections occur in teens and young adults every day. Every year, there are approximately 14 million new HPV infections nationwide. About 50% of them occur in 15 to 24-year-olds. For most people, HPV clears on its own. For others who don't clear the virus, it could cause certain cancers and other diseases. Mississippi's incidence rate of HPV-related cancers reported for the 2008-2012 timeframe was estimated at 14.3 per 100,000 persons, higher than the U.S. national average of 11.7 per 100,000 persons.

According to the Center for Disease Control and Prevention's (CDC) TeenVaxView, HPV vaccination rates are increasing as more children are up to date on HPV vaccination. Nationally, 51.1% of adolescents ages 13-17 years of age were up to date on HPV vaccination series, compared to only 32.6% of Mississippi adolescents.

Despite HPV vaccination completion rates rising across the nation, Mississippi continues to rank at the bottom of all states. A review of Medicaid's 2017 claims shared with the Drug Utilization Review (DUR) Board reported a completion rate of 28.8%, with 3,928 of 13,656 beneficiaries having completed the vaccination series in 2017, which was a rate similar for all Mississippians in 2017.

As a result, the DUR Board recommended a need to promote effective strategies to improve HPV vaccination rates to prevent this sexually transmitted pathogen from causing anogenital and oropharyngeal disease in males and females.

Gardasil 9, the only HPV vaccine available in the U.S. since 2016, is designed to protect against acquisition of HPV infection and development of subsequent HPV-associated disease. The CPT code for HPV 9 vaccine (Gardasil 9) is 90651.

Indications and age range: In accordance with the Advisory Committee on Immunization Practices (ACIP) in the U.S., HPV vaccination for all females and males is recommended in the following age ranges:

Age at initiation	Recommended number of HPV vaccine doses	Recommended interval between doses	Recommendation for interrupted schedule
9 - 14 Years *, except immunocompromised persons	2	0, 6–12 months§	If the vaccination schedule is interrupted, vaccine doses do not need to be repeated (no maximum interval).
15 - 26 Years and immunocompromised persons	3	0, 1–2, 6 months**	

**ACIP recommends routine HPV vaccination for adolescents at age 11 or 12 years; vaccination may be given starting at age 9 years.*
§ In a 2-dose schedule of HPV vaccine, the minimum interval between the first and second doses is 5 months.
*** In a 3-dose schedule of HPV vaccine, the minimum intervals are 4 weeks between the first and second doses, 12 weeks between the second and third doses, and 5 months between the first and third doses.*

ACIP recommends catch-up for persons through age 26 years who are not adequately vaccinated. ACIP recommends vaccination based on shared clinical decision making for individuals ages 27 through 45 years who are not adequately vaccinated.

Effective communication, parent education and avoiding missed opportunities are keys to improving HPV vaccination rates. A physician's recommendation is the single best predicator of vaccination success.

ADDITIONAL RESOURCES – Successful strategies and communication techniques for use with parents about HPV vaccination can be found at the following links.

Boosting Your HPV Vaccination Rates – Bundle all adolescent vaccinations and other suggestions. https://www.cdc.gov/hpv/hcp/boosting-vacc-rates.html

- For example: You can say, "Now that your son is 11, he is due for vaccinations today to help protect him from meningitis, HPV cancers, and whooping cough. Do you have any questions?"
- Remind parents of the follow-up shots their child will need and ask them to make appointments before they leave.

Answering Parents' Questions about HPV Vaccine – Most parents will accept HPV vaccination when you effectively recommend the vaccine and address their questions. https://www.cdc.gov/hpv/hcp/answering-questions.html

Top 10 Tips for HPV Vaccination Success – Attain and Maintain High HPV Vaccination Rates. https://www.cdc.gov/hpv/hcp/educational-materials.html

4 Key Phrases That Can Help to Shape a Clear Vaccination Recommendation

1. "I've seen people with this disease."
   - Ask your patient (or their parent) if they've ever known someone who's suffered from this disease. Sharing a personal or professional experience can help them understand the real impact the disease can have.
2. "The CDC recommends you get this vaccine."
   - Make sure your patients are aware of the CDC recommendation for each vaccine you are recommending they receive.
3. "This vaccine may help prevent this disease."
   - Help patients understand that the vaccine you are recommending may help protect them against a potentially serious disease (cancer).
4. "I believe you (or your child) should get this vaccine."
   - Your patients trust you as a health care provider. They want more than just the facts about vaccination; they want to know why you recommend it for them specifically.

About 80% of people will get an HPV infection in their lifetime. Recommending HPV vaccination for all 11–12-year-olds can protect them long before they are ever exposed. CDC recommends two doses of HPV vaccine for all adolescents at age 11 or 12 years.

Remember, YOU are the key to HPV cancer prevention.

At the time of this article, Gardasil is covered as a medical benefit for fee for service beneficiaries.

Ref: https://www.cdc.gov/

COORDINATED CARE NEWS

ANNOUNCEMENT REGARDING CO-PAYS FOR SOME MAGNOLIA HEALTH MEMBERS*

Magnolia Health has implemented co-pays for pharmacy benefits beginning January 1, 2020.

For some Magnolia Health members, a $1 co-pay for prescription medications may apply. Members who are under the age of 18 or who are pregnant will not be charged a co-pay.

Letters have been sent out to the members regarding this change as well as new Magnolia Health Member ID Cards with the co-pay information on them.

United Healthcare of MS – Access and Availability Standards

As a reminder, primary care providers (PCPs) and obstetricians must be available to members by phone 24 hours a day, 7 days a week, or have arrangements for telephone coverage by another UnitedHealthcare participating PCP or obstetrician. Any coverage arrangements that deviate from this requirement must be approved by a UnitedHealthcare medical director or physician reviewer.

Standards for Timely Appointment Scheduling:
Emergency Care Immediately upon the member's presentation at a service delivery site.

Primary Care

- Urgent, symptomatic office visits must be available from the member's PCP or another care provider within 24 hours. This would involve the presentation of medical symptoms that require immediate attention but are not life-threatening.
- Routine office visits or non-urgent, symptomatic visits must be available from the PCP or another care provider within 7 calendar days. A non-urgent, symptomatic office visit would involve medical symptoms that don't require immediate attention.
- Non-symptomatic office visits must be available from the member's PCP or another care provider within 30 calendar days. This type of visit could include wellness and preventive care such as physical examinations, annual gynecological examinations, child and adult immunizations or other services.

Specialty Care

- Specialists and specialty clinics should arrange appointments within 45 days.

Behavioral Health (Mental Health and Substance Abuse)
Behavioral health care providers should arrange appointments for:

- Emergency care (non-dangerous to self or others) immediately upon presentation
- Urgent problems within 24 hours of the member's request
- Post Discharge from an acute psychiatric hospital within 7 days
- Routine Non-urgent issues within 21 days of the member's request

United Healthcare of MS – After-Hour Care – Members need to be able to reach a provider by phone after normal business hours. Physicians (PCP, Specialists and Behavioral Health) are required to provide 24 hour a day, 7 days coverage to members.

Acceptable after-hours messages or responses are:

- Primary Care Provider's (PCP) answering service will verify that it will contact the physician on-call for a patient's emergency.
- PCP's triage nurse will verify that he or she will speak with the patient for an emergency call, evaluate the nature of the emergency and contact the physician on-call or direct the patient to a hospital emergency room.
- PCP can be reached when called directly.
- PCP's office phone message directs the patient to call a specific telephone number to reach the PCP's answering service, who will then contact the physician on-call for an emergency.
- PCP's office answering machine directs the patient to call a specific telephone number to reach a hospital switchboard and/or hospital emergency room that will reach the physician on-call for emergencies.

Unacceptable for after-hours coverage are:

- PCP's answering machine directs the patient to proceed to the nearest hospital emergency room.
- PCP's office telephone number rings without an answer.

United Healthcare of MS – Antidepressant Medication Management (AMM)

UnitedHealthcare wants 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.

United Healthcare of MS – Consumer Assessment of Health Providers and Systems (CAHPS) Survey

Annually, our members are asked to take a survey to learn more about their level of satisfaction with services received from our care providers and UnitedHealthcare. The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey results we obtain from our members are used to identify our strengths and weaknesses. These results offer an opportunity to identify the key drivers of success and areas for improvement to help increase member satisfaction. The areas that members are asked to rate are:

- Rating of Health Plan
- Rating of All Health Care
- Rating of Specialist
- Rating of Person Doctor

- Getting Care Needed
- Getting Care Quickly
- Customer Service
- How Well Doctors Communicate

The CAHPS survey will be mailed to a random sample of members beginning in February and ending in May.

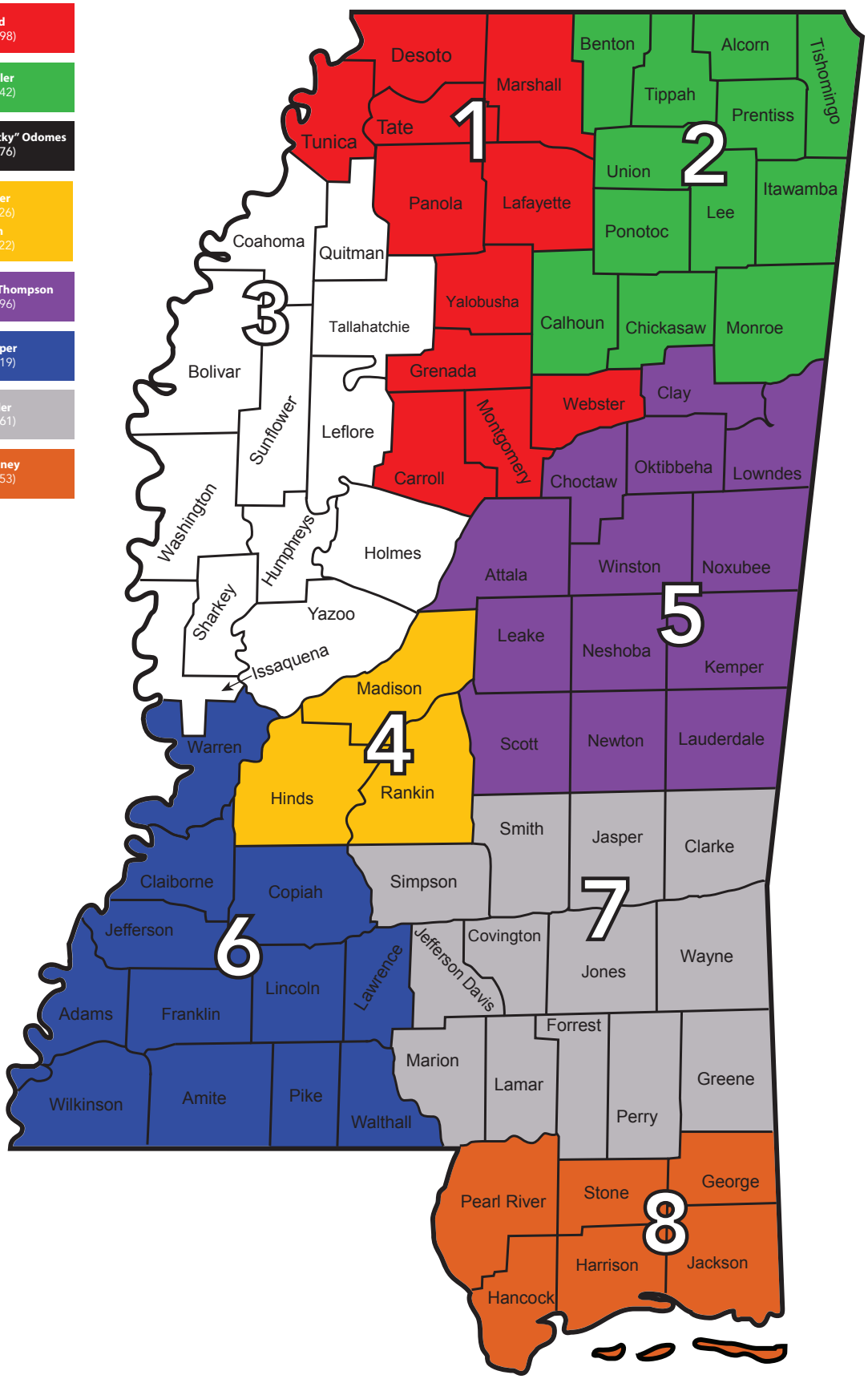
Molina Healthcare of MS – Important Notice to Providers Regarding Demographic Updates

If your practice or facility has moved, added a location, constructed a new facility, or made any other changes that impact demographics, you must notify our health plan of the changes. Please complete a Provider Information Update Form located on our provider website under frequently used form and return it via email to the address on the form. Delegated providers must ensure these changes are reported to your delegated contact. Please allow time for the demographic updates to be completed and reflected in our system. Failure to report demographic updates timely may impact future payments. If you have any questions, please contact Provider Services at 1-844-826-4335 or contact your local Provider Services Representative.

Provider Information Update Form
https://www.molinahealthcare.com/providers/ms/PDF/Medicaid/provider-information-update-form.pdf.

FIELD REPRESENTATIVE REGIONAL MAP

1	Latasha Ford (601.572.3298)
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 (601.206.2996)
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 **Latasha Ford (601.572.3298)** Latasha.Ford@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	
AREA 7 **Porscha Fuller (601.206.2961)** porscha.fuller@conduent.com		**AREA 8** **Connie Mooney (601.572.3253)** connie.mooney@conduent.com
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	**TBA Interim Contacts: Justin Griffin (601.206.2922)** justin.griffin@conduent.com **Randy Ponder (601.206.3026)** randy.ponder@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

MARCH 2020

MON, MAR 2	Checkwrite
THURS, MAR 5	EDI Cut Off - 5:00 p.m.
MON, MAR 9	Checkwrite
THURS, MAR 12	EDI Cut Off - 5:00 p.m.
MON, MAR 16	Checkwrite
THURS, MAR 19	EDI Cut Off - 5:00 p.m.
MON, MAR 23	Checkwrite
THURS, MAR 26	EDI Cut Off - 5:00 p.m.

APRIL 2020

THURS, APR 2	EDI Cut Off – 5:00 p.m.
MON, APR 6	Checkwrite
THURS, APR 9	EDI Cut Off – 5:00 p.m.
MON, APR 13	Checkwrite
THURS, APR 16	EDI Cut Off – 5:00 p.m.
MON, APR 20	Checkwrite
THURS, APR 23	EDI Cut Off – 5:00 p.m.
MON, APR 27	Confederate Memorial Holiday DOM Closed
THURS, APR	EDI Cut Off – 5:00 p.m.

MAY 2020

MON, MAY 4	Checkwrite
THURS, MAY 7	EDI Cut Off – 5:00 p.m.
MON, MAY 11	Checkwrite
THURS, MAY 14	EDI Cut Off – 5:00 p.m.
MON, MAY 18	Checkwrite
THURS, MAY 21	EDI Cut Off – 5:00 p.m.
MON, MAY 25	Memorial Day DOM Closed
THURS, MAY 28	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.