Volume 31, Issue 4 October 2023

MS Medicaid PROVIDER BULLETIN

MISSISSIPPI DIVISION OF MEDICAID

Medicaid hospital payment initiatives announced which could net up to $689 million for hospitals

In September, Gov. Reeves announced two Medicaid hospital payment initiatives which could generate up to $689 million annually in additional Medicaid funds for Mississippi hospitals.

The Centers for Medicare and Medicaid Services (CMS) must approve both proposals, which were submitted earlier this month. If approved, both would be effective July 1, 2023.

Division of Medicaid Executive Director Drew Snyder (above) speaks at a press conference held by Gov. Reeves (right) announcing two Medicaid hospital payment initiatives on Sept. 21, 2023, in Jackson.

Photos by Rogelio V. Solis, AP

IN THIS ISSUE

WEB PORTAL REMINDER

VISIT DOM'S WEBSITE FOR LATEST UPDATES

Find the latest updates and important information on the DOM website under the Provider Portal at: **https://medicaid.ms.gov/mesa-portal-for-providers/**. The Provider Portal hosts many resources for providers such as webinars, FAQs, training videos, and Late Breaking News.

Click the links below to access portal resources.

PROVIDER COMPLIANCE

Mississippi's Certified Community Behavioral Health Clinic (CCBHC) Steering Committee Convenes

The Division of Medicaid (DOM) is working in partnership with the Mississippi Department of Mental Health (DMH) on a one-year Certified Community Behavioral Health Clinic (CCBHC) Planning Grant awarded to DMH from the Substance Abuse and Mental Health Services Administration (SAMHSA). To date, there have already been two steering committee meetings.

The Mississippi CCBHC Planning Grant aims to transform mental health and substance use treatment by providing sustainable funding for robust community treatment services. A Certified Community Behavioral Health Clinic is a specially designated clinic that offers a comprehensive range of mental health and substance use services.

The Mississippi Department of Mental Health and DOM will design Mississippi's approach to develop the CCBHC model.

CCBHCs will help Mississippi:

- Improve access to and delivery of community-based behavioral health services.
- Address gaps or barriers to care in Mississippi.
- Establish sustainable funding for additional investment in quality, evidence-based mental health and substance use services.
- Hold certified providers accountable for quality outcomes.
- Engage stakeholders and consumers of mental health services — including youth, family members, and community leaders — to provide input on a customizable approach to care that increases responsiveness to the needs of Mississippians.

To learn more and get involved in Mississippi's CCBHC efforts, please visit https://www.dmh.ms.gov/service-options/certified-community-behavioral-health-clinics/ or contact the CCBHC Project Director Amy Swanson at amy.swanson@dmh.ms.gov.

Rates Increased for Graduate Medical Education Reimbursement

State Plan Amendment 23-0017, effective July 1, 2023, increased Graduate Medical Education (GME) reimbursement. The increase in payments for providers approved for GME reimbursement for this fiscal year will be $13,189,900, or an increase of 31.8%. Two new hospitals were approved for GME payments in FY 2024, and there was an increase of 61 additional residents funded through this payment in FY 2024, or an increase of 7.8%.

FY 2023 GME Payments:
41,468,600 for 12 hospitals supporting 780 residents.

FY 2024 GME Payments:
54,658,500 for 14 hospitals supporting 841 residents.

COORDINATED CARE NEWS

Magnolia Health MississippiCAN Provider Grievance and Appeals vs. Claim Appeals

Complaints and grievances are essential for identifying concerns and dissatisfaction within our provider network. Provider grievances are processed to ensure a timely and thorough investigation.

A provider complaint or grievance is dissatisfaction expressed by the provider to the Plan orally, or in writing about any aspect of the Plan, or its operation other than an adverse benefit determination.

Examples of complaints and grievances include:
- Aspects of interpersonal relationships, such as rudeness of health plan staff, a provider, or an employee.
- Failure to respect the provider's rights, regardless of whether remedial action is requested.

A complaint or grievance should be in writing or by phone (1-866-812-6285) within **thirty (30)** calendar days of the event causing the dissatisfaction.

Written complaints or grievances should be submitted to the following:

Magnolia Health Medical and Behavioral ` Health Provider
Attn: Provider Services Complaints Grievances
1020 Highland Colony Parkway, Suite 502
Ridgeland, MS 39157

Provider Complaint/Grievance Form
https://www.magnoliahealthplan.com/content/dam/centene/Magnolia/medicaid/pdfs/PrvderComplaintGrivnceForm%20-%20508.pdf

Magnolia staff will acknowledge, document, and attempt to resolve the complaint immediately. For written grievances, Magnolia will notate the date received and send an acknowledgment letter, which includes a description of the grievance procedures resolution time frames, within **five (5)** business days of receipt.

Provider Claim Dispute
A **request for reconsideration** is a written communication from the provider about a disagreement of a processed claim.

Reconsiderations are optional in the claim dispute process. Reconsiderations must be submitted within 90 days of the Explanation of Payment or Denial. Request for Claim Reconsideration can be submitted by logging into your Magnolia Secure Provider Portal or by mail to **Magnolia Health, Attn: Reconsideration, PO Box 3090, Farmington, MO 63640-3800.** Magnolia encourages providers to utilize the Secure Web portal or the Reconsideration Dispute form when submitting a reconsideration request.

A request for reconsideration is a written communication from the provider about a disagreement of a processed claim.

Request must include sufficient identifying information, including the patient's name, ID number, service date, total charges, and provider name.

Documentation must also include a detailed description of the reason for the request.

A claim appeal is a written request to review an adverse benefit determination and must be accompanied by the Claim Appeal Form, which can be obtained at www.magnoliahealthplan.com.

The claim appeal process should be followed when the provider is dissatisfied with the outcome of a claim reconsideration. The claim appeal should be filed within thirty (30) calendar days of receiving Magnolia's notice of adverse benefit determination.

Medical providers may submit their claims appeal to:

Magnolia Health Medical and Behavioral Health Providers
Magnolia Health, Attn: Appeals
P.O. Box 3090
Farmington, MO 63640-3825

Behavioral health providers may submit their claims appeal to:

Magnolia Health Medical and Behavioral Health Provider
Magnolia Health, Attn: BH Appeals
P.O. Box 6000
Farmington, MO 63640-3809

COORDINATED CARE NEWS

Continued

A claim appeal acknowledgment letter will be issued to the provider within **ten (10)** days of receipt. A resolution letter will be sent to the provider within **thirty (30)** days of receipt. If the claim appeal results in an adjustment, the provider will receive a revised Explanation of Payment (EOP), and a letter detailing the appeal results.

If the original decision is upheld, the provider will receive a revised EOP and letter detailing the decision and steps for a state fair hearing.

State Administrative Hearing
State Administrative Hearing: A hearing conducted by the Division of Medicaid (DOM) or its subcontractor. Any provider appeal of an adverse benefit determination not resolved wholly in favor of the provider by the contractor may be appealed by the provider or the provider's authorized representative to DOM for a state administrative hearing once the provider has exhausted the contractor's appeals process.

A request for a state administrative hearing should be submitted within **thirty (30)** calendar days of the final decision by Magnolia Health to the Division of Medicaid at the following address:

Division of Medicaid, Office of the Governor
Attn: Office of Appeals
550 High Street, Suite 1000
Jackson, Mississippi 39201
Phone: (601) 359-6050 or 1-800-884-3222
Fax: (601) 359-9153

Related Links

Magnolia Website
https://www.magnoliahealthplan.com

Magnolia Provider Manual
https://www.magnoliahealthplan.com/content/dam/centene/Magnolia/medicaid/pdfs/Prvdr-Manual-AddressUpdate05182023.pdf

Provider Complaint/Grievance Form
https://www.magnoliahealthplan.com/content/dam/centene/Magnolia/medicaid/pdfs/PrvderComplaintGrivnceForm%20-%20508.pdf

REMINDER – NIA Update

Magnolia Health recently expanded our partnership with National Imaging Associates, Inc., (NIA) to provide utilization management for outpatient rehabilitative and habilitative physical medicine services on behalf of Magnolia Health membership in Mississippi. This program is consistent with industry-wide efforts ensuring that physical medicine services provided to our members are consistent with nationally-recognized clinical guidelines.

Magnolia Health services managed and authorized by NIA include:

- Physical Therapy, Occupational Therapy, Speech Therapy (including members under 12 years of age)
- Interventional Pain Management (IPM)
- Left Heart Catheterization
- Complex Imaging
- MRA
- MRI
- PET
- CT Scans

To reach NIA and obtain authorization, please call 1-877-864-7237 and follow the prompt for radiology authorizations. NIA also provides an interactive website which may be used to obtain online authorizations. Please visit **RadMD.com** for more information.

Molina Help Finder: Helping Your Patients 24-7

Molina Healthcare (Molina) is proud to offer Molina Help Finder – a one-stop resource powered by FindHelp – to assist Molina members in finding the resources and services they need, when they need them, right in their communities.

With Molina Help Finder, providers can also refer patients in real-time, right from Availity Essentials. Simply search by category for the services needed (such as food, childcare, education, housing, employment, etc.). Results can then be narrowed by applying personal and program-specific filters. Contact your local provider services team if you have any questions about Molina Help Finder. You can also visit MolinaHelpFinder.com to learn more.

COORDINATED CARE NEWS

Prior Authorization

Molina requires prior authorization for specified services as long as the requirement complies with federal or state regulations and the Molina Hospital or Provider Services Agreement. The list of services that require prior authorization is available in narrative form, along with a more detailed list by CPT and HCPCS codes. Molina Prior Authorization documents are customarily updated quarterly, but may be updated more frequently as appropriate and are posted on the Molina website at MolinaHealthcare.com.

Providers are encouraged to use the Molina prior authorization form provided on the Molina website at MolinaHealthcare.com.

If using a different form, the Prior Authorization request **must** include the following information:

- Member demographic information (name, date of birth, Molina ID number)
- Provider demographic information (referring Provider and referred to Provider/facility, including address and NPI number)
- Member diagnosis and ICD-10 codes
- Requested service/procedure, including all appropriate CPT and HCPCS codes
- Location where service will be performed
- Clinical information sufficient to document the medical necessity of the requested service is required, including:
  - Pertinent medical history (including treatment, diagnostic tests, and examination data)
  - Requested length of stay (for inpatient requests)
  - Rationale for expedited processing

Prior Authorization will be required before providing the following services, regardless of the CPT/HCPCS code:

- Non-Participating Provider Requests
- Non-Covered State Codes
- Request for Elective Inpatient Admissions to Acute Hospitals
- Generic, Miscellaneous, or Not Otherwise
- Specified (NOS) Codes

Availity Essentials is Molina Healthcare's Exclusive Provider Portal

Availity Essentials is Molina Healthcare's official, secure provider portal for traditional (non-atypical) providers. Some core features available in Availity Essentials for Molina Healthcare include eligibility, benefits, attachments, claim status, smart claims, and Payer Space (submit and check prior authorizations and appeal status and appeal/dispute).

If your organization is not yet registered for Availity Essentials, and you're responsible for the registration, please visit **Availity.com/MolinaHealthcare**, and click the Register button.

Not registered with Availity Essentials?

Several new features and enhancements have recently been added to Availity Essentials for Molina Healthcare providers. In case you missed it, check out the latest enhancements that were designed to simplify your workflows and reduce administrative burden: **Availity.com/MolinaHealthcare**.

Call Availity Client Services at (800) AVAILITY (282-4548) for registration issues. Assistance is available Monday through Friday, 8 a.m. to 8 p.m. EST.

COORDINATED CARE NEWS

What's new?	How does it benefit me?
Claims Corrections	Molina providers can now access a new claims correction feature from the claim status page. Claims Correction allows you to correct and re- submit a paid or denied claim from the claim status response page.
Overpayments	Eliminate mail and fax for faster dispute resolution and ensure overpayment requests are current. View the status and details of any claim Molina has identified as an overpayment. Request additional information, dispute, or resolve the overpayment.
Patient Search	Save time entering patient information for eligibility and benefits inquiries. Enter the patient's member ID or last name, first name, and date of birth, and select the patient matching the criteria. The information will automatically populate on the request.
Molina Medicare Now Included in Molina Healthcare Payer Option	Select only one option in the payer field. The Molina Medicare option no longer displays in the payer field. When you select the Molina Healthcare option for the region, the plan coverage for the member includes Medicaid, Dual-Eligible, Marketplace, and Medicare.

COORDINATED CARE NEWS

Payment Solutions

Molina Healthcare has partnered with our payment vendor, Change Healthcare, to disburse all payments and payment support via the ECHO Health platform. Access to the ECHO portal is accessible to providers for free, and we encourage you to register after receiving your first payment from Molina.

The ECHO payment platform offers enhanced functionality to serve Molina providers, such as e-check and virtual credit cards (where available). Additionally, 835s will be generated and available to you for every transaction. You will also have access to yearly 1099s directly through your account.

ECHO support is available to answer questions regarding registration and 835s. They can be contacted at (888) 834-3511.

Log in or register for the ECHO payment platform today: providerpayments.com/Login.aspx.

United Healthcare

Helping You Coordinate Patient Care

UnitedHealthcare members may receive services from multiple healthcare professionals or undergo transitions in healthcare settings. Care coordination among all healthcare professionals involved in a member's care can help improve health outcomes and overall experience.

Point of Care Assist
One way to coordinate care for UnitedHealthcare members is by using Point of Care Assist®, which adds real-time patient information — including clinical, pharmacy, labs, prior authorization, and cost transparency — to your existing electronic medical records (EMRs) to make it easier for you to understand what patients need at the point of care. In addition to Point of Care Assist, we offer several care coordination programs detailed in the **2023 UnitedHealthcare Care Provider Administrative Guide** > Chapter 13: Health and disease management. Examples of our care coordination programs include:

Controlled Substance Monitoring
This program helps providers identify members who may benefit from prescription pain management regimens. Through this program, providers receive a comprehensive member-specific report that includes:

- The clinical issue of concern
- Prescription utilization details
- Recommended action(s)

Providers are encouraged to contact identified members to discuss and re-evaluate their pain management regimens and coordinate appropriate treatment if indicated.

Timely Postpartum Care and Maternity Support
Timely postpartum care can help contribute to healthier outcomes for women after delivery. We use HEDIS® guidelines to measure postpartum visit compliance. The standard is a postpartum visit between seven and 84 days after delivery. Members can access maternity support resources on **myuhc.comopen_in_new**.

Kidney Disease Program
This program is designed to help improve clinical outcomes for members with end-stage renal disease (ESRD). The program coordinates care among the member's care providers to help manage co-morbid conditions, as well as dialysis therapy. Goals include: reducing inpatient hospitalizations, emergency room visits, transplant education and recommendations, and mortality while improving quality of life.

Diabetic Eye Exam
Regular eye exam screenings for members with diabetes may help detect diabetic retinal disease. We use HEDIS guidelines to measure retinal eye exam performance for members ages 18-75 who have type 1 or type 2 diabetes. Continuity and coordination of care may be monitored through communication between the member's primary care physician (PCP) and the eye care professional performing the dilated retinal exam.

Coordination of Care Survey Questions
We ask members and healthcare professionals to provide feedback on the coordination of care through regular surveys. These surveys give us valuable information about their experience so we can continue to improve our care coordination programs.

COORDINATED CARE NEWS

Continued

Transitions of Care
Follow-up visits after a member is discharged from the hospital should be timely, especially for members with complex care and after-care needs who are at risk for relapse and rehospitalization. This includes members with behavioral health or substance use disorders.

Questions?
The availability of care coordination activities may vary by health care plan. **Contact us** for more information.

PCA-1-23-01257-Clinical-News_05012023

Stay Covered!

With the end of the COVID-19 public health emergency, Medicaid has resumed annual renewal reviews for members

If you receive a renewal form in the mail, members need to make sure to complete the form and return it to Medicaid in any of these ways — by mail, in-person by visiting your nearest regional office, online, or by fax or telephone.

Learn more at **www.medicaid.ms.gov/staycovered.**

How You Can Help: Coverage Champions

The Mississippi Division of Medicaid (DOM) will take 12 months to initiate renewals and 14 months to complete renewals for each of the approximately 880,000 Mississippians currently enrolled. It's essential that members update their contact information so they receive and return renewal packets to make sure they keep their Medicaid and CHIP coverage if they are still eligible.

DOM encourages your partnership to ensure eligible members can keep their health coverage and those who no longer qualify know where they can go for affordable coverage resources.

Click here to sign up to be a Coverage Champion and help DOM share important information and resources.

CALENDAR OF EVENTS

OCTOBER 2023

MON, OCT 2	Checkwrite
THURS, OCT 5	EDI Cut Off – 5:00 p.m.
MON, OCT 9	Checkwrite
THURS, OCT 12	EDI Cut Off – 5:00 p.m.
MON, OCT 16	Checkwrite
THURS, OCT 19	EDI Cut Off – 5:00 p.m.
MON, OCT 23	Checkwrite
THURS, OCT 26	EDI Cut Off – 5:00 p.m.
MON, OCT 30	Checkwrite

NOVEMBER 2023

THURS, NOV 2	EDI Cut Off 0 5:00 p.m.
MON, NOV 6	Checkwrite
THURS, NOV 9	EDI Cut Off – 5:00 p.m.
MON, NOV 13	Checkwrite
THURS, NOV 16	EDI Cut Off – 5:00 p.m.
MON, NOV 20	Checkwrite
THURS, NOV 23	EDI Cut Off – 5:00 p.m.
MON, NOV 27	Checkwrite
THURS, NOV 30	EDI Cut Off – 5:00 p.m.

DECEMBER 2023

MON, DEC 4	Checkwrite
THURS, DEC 7	EDI Cut Off 0 5:00 p.m.
MON, DEC 11	Checkwrite
THURS, DEC 14	EDI Cut Off – 5:00 p.m.
MON, DEC 18	Checkwrite
THURS, DEC 21	EDI Cut Off – 5:00 p.m.
MON, DEC 25	Checkwrite
THURS, DEC 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 https://portal.ms-medicaid-mesa.com/MS/. Funds are not transferred until the following Thursday.

UPCOMING DOM HOLIDAYS

SAT, NOV. 11	Veteran's Day
THURS, NOV 23	Thanksgiving Day
MON, DEC 25	Christmas Day

Office Closures
November 23, 24
December 25

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

Medicaid Provider Bulletins are located on the Web Portal at https://medicaid.ms.gov/providers/provider-resources/provider-bulletins/

CONTACT INFORMATION

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Jackson, MS 39201
601-359-6050

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AREA 7
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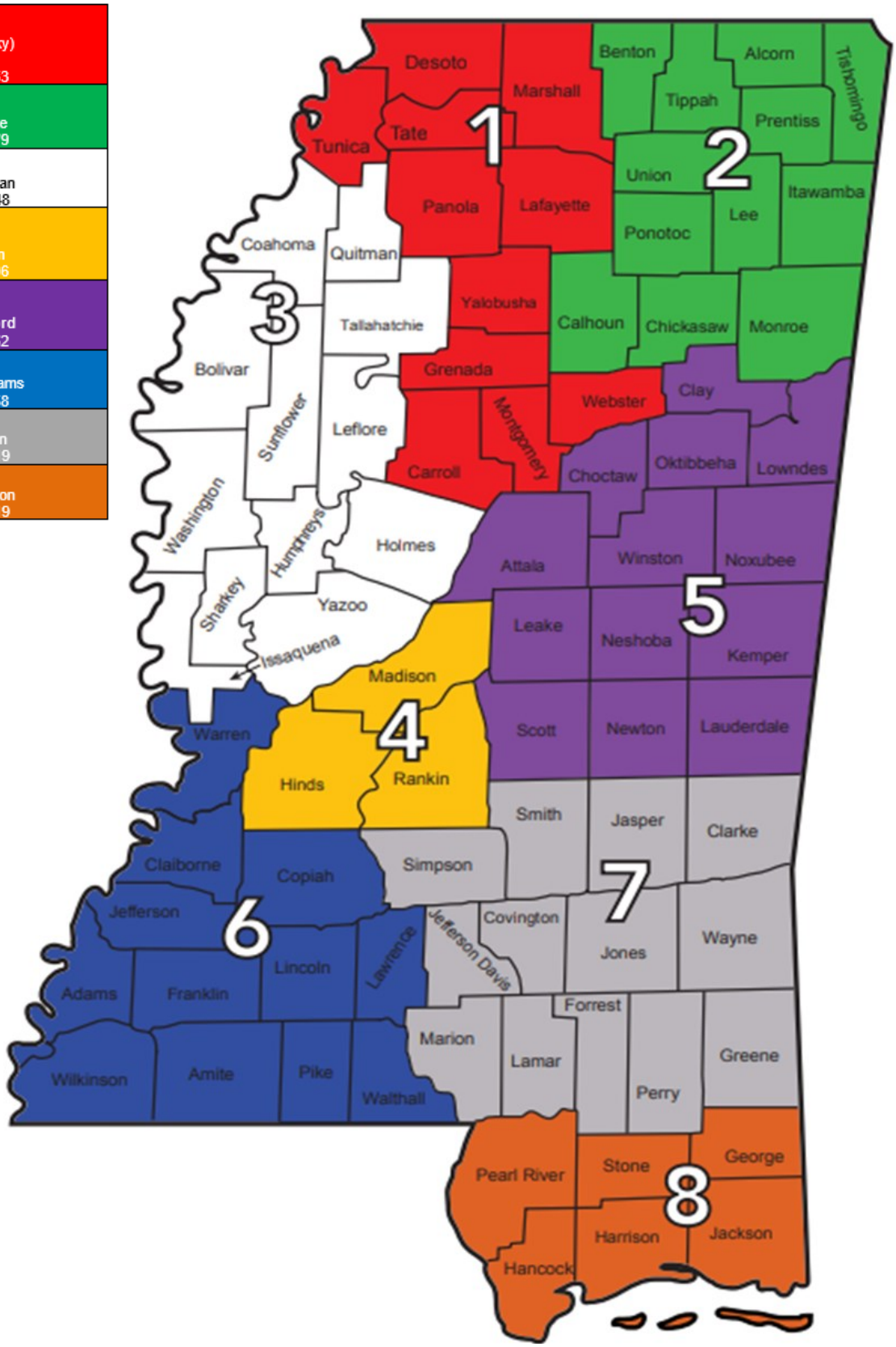

PROVIDER FIELD REPRESENTATIVES

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County	**County**	**County**
Carroll	Alcorn	Bolivar
Desoto	Benton	Coaho-
Grenada	Calhoun	Holmes
Lafayette	Chickasaw	Hum-
Marshall	Itawamba	Is-
Montgomery	Lee	Leflore
Panola	Monroe	Quitman
Tate	Pontotoc	Sharkey
Tunica	Prentiss	Sunflow-
Webster	Tippah	Tallahat-
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Madison	Choctaw	Amite
Rankin	Clay	Claiborn
	Kemper	Copiah
	Lauderdale	Franklin
	Leake	Jefferson
	Lowndes	Law-
	Neshoba	Lincoln
	Newton	Pike
	Noxubee	Walthall
	Oktibbeha	Warren
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Covington		Hancock
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Greene		Jackson
Jasper		Pearl
Jefferson Davis		Stone
Jones		
Lamar		
Marion		
Perry		
Simpson		
Smith		
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