12.8.21 - NE Tribal/Medicaid Monthly Call Agenda

Conference Access Number **(888) 820-1398**

Attendee Code- **7300221**

Present: Jacob Kawamoto, Danielle Trejo, Catherine Gekas Steeby, Director Bagley, Chris Morton, Aaron Reece, Travis Beck, Terri Mentink (Winnebago), Becky Crase (Ponca), Crystal Appleton (Omaha), Nancy Mackey (Santee), Vietta Swalley (Santee), Julie Willcuts (IHS), Beau Boryca (UIHC) RickyAnn Fletcher (MCNA), Tracy Nelson (MCNA), Jennifer Newcombe (NTC), Mariana Johnson (NTC), LeAnn Ortmeier (UHC), Jenn Nelson (UHC), Stacey Steiner (CMS), Sam Hasan

Managed Care RFP Listening Tours – Director Bagley

Director Kevin Bagley – previously worked in Utah in the Medicaid program and has been in his current role at NE for a year now.

- Managed Care procurement process will begin formally in April 2022, and by July MLTC plans to announce the 3 new plans moving forward.
- In January, Director Bagley and his team will be touring the state to receive Stakeholder feedback and understand what has been working well and what has not up to this point regarding the managed care system and plans. Are there things NE can improve on and change and reset expectations around? Director Bagley is open to hearing feedback.
- Medical Care Advisory Committee – also restarting in January. This is being revamped under a new structure, with providers and members. The Director wants to be sure there is Tribal representation on the committee. Formal outreach will be sent out for the Tribes to make recommendations for candidates and Tribal representation. Obligation of time would be only a few hours a month.
- Jacob and Chris will also provide the cities, dates, and times for the upcoming listening tours.
    - QUESTION: (Nancy) Is there a reason NE needs to contract with 3 MCOs?
        - A: There is not any formal requirement or regulation to have 3 MCOs. NE has found that this is a good number for our state and Medicaid program. For example, if NE went with just one, the risk is if it is a poor performing MCO, it is difficult to move away from this because you are locked into working with them. This puts the agency fully reliant on one plan. With two, there may be similar issues, and with too many it is too burdensome for the agency and providers to manage. 3 offers members a choice without being overwhelming to the agency and providers, and has proven to work well.
    - Q: (Sam H.) The amount of work it takes providers to authorize services and having to follow standard operating procedures from the three MCOs is difficult. Is there a way to standardize the process, authorization, and services to make it easier for MCOs? This would save a lot of time and improve access to care.

        - A: Not sure there is an easy answer, but this is something NE would want to look at moving forward. NE wants to get the benefits of choice and accountability of having 3 managed care plans, but minimize administrative burden.
        - A: Provider enrollment is a fairly standardized process, but things like care management may be unique to each MCO and that actually helps them. NE wants to strike a balance to allow for innovations for the plans, but also not allow undue burden for the providers.
    - Q: (Nancy) someone was talking about Iowa Medicaid cases, and there were a lot of services that were denied that should have been approved. If the MCOs are approving prior authorizations, there must be a way to validate this.
        - A: This is something NE and IA directors have discussed. Both want to coordinate better with stakeholders in states to strike the right balance with regards to utilization management and prior authorization. Some prior authorizations may function a certain way because of expense, and there are some in place as a mechanism to follow a good standards of care. But in those cases, it could be worthwhile to also provide the standard of care that underlies that decision to providers. Providers should have a sense of if their prior authorizations requests are going to be approved or not and the standards that under lie the MCO's authorization process. This shouldn't be unknown.
    - Q: (Vietta) If/when the in-person quarterly meetings resume, can the Director come to one so the he can meet the Tribes, they can put a face to the name, and there can be more open discussion?
        - A: Yes, Director Bagley will plan to attend.
- Closing remarks:
    - Thanks for allowing the Director to be on the call and for discussing with him. Sharing stakeholder experience is critical to his decision making. He is happy to participate on these calls anytime the Tribes would like him to. The Tribes can also provide feedback to him in writing as well. However the Tribes would like to provide it is great.

SPA/Waiver Updates

- SPA
    - NE 21-0016 – Recovery Audit Contractor waiver
    - NE 21-0013 – NEMT
    - NE 21-0015 – Third Party Liability
- Waiver Authority
    - COVID-19 Section 1115(a) Demonstration

Additional Items

- Provider Bulletin 21-21
    - https://dhhs.ne.gov/Medicaid%20Provider%20Bulletins/Provider%20Bulletin%2021-21.pdf

    - Tribal Clinics will be paid the all-inclusive rate for the administration of COVID-19 vaccine booster doses.
- Resuming In-Person Meetings
    - What are the Tribes thoughts on potentially resuming quarterly in-person consultation meetings starting Spring 2022?
        - Vietta: would be comfortable tentatively scheduling for Spring 2022. The Tribes generally feel they accomplish more face-to-face.
        - Crystal: Agrees with Vietta.
            - MLTC will plan for in-person, official Tribal consultation to resume in Spring 2022, and if meetings need to be cancelled down the road due to COVID-19 cases spreading, they always can be. There will also be a virtual/telephone option available for those who can't make the in-person meetings.
- Multiple Encounters procedure per the State Plan
    - Under the state plan, multiple encounters in the same day are reimbursed as a single encounter at the all-inclusive rate.
        - However, there is an exception for multiple encounters in the same day for services provided for distinctively different diagnoses.
    - The Tribes are seeing multiple encounters in the same day more often, and as a result are running into more issues regarding correct reimbursement.
        - This is especially prevalent with the COVID clinic in the evening. Sometimes there is a WellChild visit in the morning, and COVID vaccine in the evening. What if it was child immunizations in the morning, and COVID vaccines in the evening?
    - Ponca uses a modifier when submitting a claim in order to show the distinction between services for multiple encounters in the same day.
        - Ponca uses a different system for billing.
        - Can Santee can use modifiers?
            - Yes, but with their different billers within the clinic, there is no way to know in their billing system if the beneficiary was seen by a different practitioner already that day. Thus, the biller would not necessarily know to add a modifier.
            - Many of the clinics are similarly unable to track multiple visits in the same day the way that the Ponca Tribe does.
    - Why aren't different codings being picked up (For example mental health providers vs OB)? Are the MCO systems able to pick up codes with different providers/practitioners included on the same claim?
        - Gelisha – Per DHHS billing guide, as long as there are two separately identifiable encounters, they will be reimbursed separately.
        - LeAnn UHC – the trouble is when there are similar diagnosis groupings (ie. treatment for a cough and then bronchitis).
        - Jennifer with NTC – Behavioral health vs physical health diagnoses are different and easy to distinguish. But with COVID, if a member is going in for a COVID test, and then later they go in for something similar (like a sore throat), the key is

different the provider and provider type. NTC manually reviews these claims to be sure encounters are distinct and reimbursed as such when appropriate.
    - For any claims that are denied for same date of service, but should not be, send to Jennifer for further review.
  - The Tribes would like to see similar procedures put in place in order to ensure distinct claims are paid appropriately. It would be good to see all MCOs manually review the same date of service claims manually the way NTC does.
- Beau Boryca – discussed contact information with Gelisha to discuss later.

- Medicare Crossover Claims – Update
  - Jacob sent out a list of the fee-for-services (FFS) claims in an excel sheet that the MLTC finance team pulled for each Tribe, and was notified that it does not include all the claims for fee-for-service since July 2017.
    - For the claims that were sent out in the excel sheet, the Tribes should respond by providing the initial coding that was used to bill those claims in order to see how those claims were billed. This will help finance refine their searches and understand the entire claims process for the crossover claims.
    - Any information would be helpful. The current list is just fee-for-services cross over claims from 2017-present
  - When the Tribes upload the claims there is an electronic file that comes back to the state with the EOB information on it. This could be helpful to the finance team.
  - It might also be the case that some of the claims did not cross over to Medicaid due to system configurations and prior payment methodologies. This means that the team might have to refine the way they are searching for the outstanding FFS crossover claims.
  - The Tribes would be able to provide the individual's names with their Medicaid number for beneficiaries who are dually eligible.
    - An issues is some of these individuals are deceased now and the Tribes may no longer have their claims data
    - The Tribes can start with a list of those who are still active and if possible to include the original billing code on their past claims.
      - The claims are billed FFS so Tribes believe this might not be helpful
  - If there is any information on how the tribes bill Medicaid please send to Jacob (for the crossover claims)
  - The finance team is trying to understand how the claims are going through the system and if they should override the system or just reconcile FFS Tribal crossover claims quarterly, so the original billing information would be helpful for these operations and to improve their understanding of the process.
    - There are no system updates at this time and finance team is still researching to see if there needs to be any made
    - The claims that Jacob sent start from July 2017
  - The Medicaid portion of the payment has to be paid up to the all-inclusive rate, and now it is just a matter on how to updates the state's systems. So the billing information would be helpful in order to understand this process from start to finish.

        - Santee will send additional billing information to the state that might help the finance team understand the entire crossover claims process from start to finish.
- Update: St. Luke's contracting with UHC has been completed!