ARKANSAS TOTAL CARE

Looking at extending Transition Period past 6/1/2019

Will be attending the DDPA Spring Conference and the Waiver Conference to provide information to providers and answer questions

Will provide opportunities for testing before moving into next phase

Behavioral Health Providers

1. H2017 codes are being denied for duplicate claims regardless of the modifiers. ATC is doing an internal review and will implement edits so that claims are not being denied as duplicates when the H2017 code has different modifiers which indicates different services
2. Provider cannot get the correct CPT codes and modifiers for Adult Life Skills done by QBHPs. New OBH codes – working with DHS to make sure the PASSEs all have the correct codes, reimbursement rates and payment criteria/edits
3. Required taxonomy code for rendering provider and the facility, but did not communicate that in advance. ATC believes this has been resolved
4. Group therapy is not paying correctly— paying at $13.73 or $5.75 but should be $47.76. Should have fix completed in two days, ATC will reprocess claims and pay correctly
5. NCCI edit for multiple services on same day. Even though a 59 modifier is allowed so that both pay, ATC says both services must be on the same claim. ATC is requiring provider to appeal the denials and submit medical records to prove necessity of more than one service (for example, individual and group therapy on same day). ATC is going to do research on this one and then will do outreach to providers
6. Confusion about authorizations. Originally said they would not honor EQ Health authorizations, but now say they will honor those until June 1, when a new ATC authorization will be required. This issue has been resolved. ATC will make sure communication goes out to providers so that all are aware of prior authorization timelines
7. Cannot submit authorization or extension of benefits requests online— must be faxed to ATC. This was an issue the first few weeks of go-live but has been resolved. ATC will do provider outreach
8. Three-entity authorization process results in provider receiving contradictory information. For example, referral specialists requests every procedure code annotated on fax cover sheet; UR nurses say they just want a blanket CPT code. A) ATC will review blanket CPT code (90806) being requested by ATC UR nurses; B) Medicaid ties the prior authorization to the billing provider not the individual practitioners - ATC will review current configuration and fix so that when prior authorizations are issued they are issued to billing provider
9. Care coordinator told a member (incorrectly) that their provider was out of network and they had to get a new provider. ATC continuing to educate care coordinators - have weekly staff meetings. Network still in development and contracts being signed and entered in ATC network everyday.
10. Pharmacy system requires each provider to register and log in every time and is not user-friendly. Pharmacy system is a secure system that is used nationwide; ATC needs more information in order to determine and evaluate problem and next steps. Robert Wright to

get ATC the name(s) of providers experiencing this problem so it can be addressed with specific providers.

11. Requires an application for QBHPs but has not created one. The licensed provider application is not appropriate. ATC to do more training; honoring existing Medicaid provider enrollment for first 12 months. Credentialing processes are still in development; all 3 PASSEs are working together, combined meeting scheduled for May 2019

Inpatient Psychiatric Hospitals

1. ATC is not paying Residential Treatment Center claims. ATC says the provider cannot charge for ancillary charges, which they are not doing. ATC has paid $1.5 million to date in RTC claims. Bess/Robert to get ATC names of providers still having issues.
2. Numerous front-end rejections. Information on portal does not match what provider is told when they call to get the member ID# , so claims reject. Per ATC this has been corrected to show both the ATC beneficiary ID (11 digits) and the beneficiary's current/active Medicaid ID # - can use either to submit claims to ATC
3. Cannot retrieve authorizations from the portal. Provider must call to get authorizations or retrieve from authorization letters or fax. ATC to develop tutorials and provide training to providers
4. Paying acute claims at lower residential rate. Robert to get ATC the names of the providers this is occurring on
5. No working portal to which authorization requests can be submitted; requests must be faxed. Prior authorizations can be submitted to portal; ATC to develop processes and do trainings that include both webinars and large group in-person trainings in each regions of the state

DD Providers

1. PDF remittance advices cannot be sorted by procedure code or alphabetical order. Providers should register for EFT with Payspan that will include an electronic remittance
2. No electronic billing available for ICFs. Have identified that Bill Type accepted by Medicaid (613) is not a current Bill Type (was discontinued by CMMS several years ago) which is why all of the claims were not being accepted by each PASSE – Providers need to use Bill Type 65X or 66X.
3. Waiver claims are not being paid for two weeks after processing. Providers should register for EFT with Payspan. ATC is paying claims three times a week. Paper checks are mailed out of Missouri. It takes two days from time of ATC receipt to process through all edits and release payments. Need to receive claim before 5:30 pm each day to start the two day turnaround process. Have providers contact Michelle Hughie (Provider Relations Manager)
4. No clear process initiating services for new members. ATC stated that process was in place. Providers re-iterated that process/timelines need to be documented and communicated more effectively (in person verses webinars which provide minimal information and do not allow for complete dialogues and exchange of questions/answers so everyone is getting the same information.

EMPOWER HEALTHCARE SOLUTIONS

Going to roll-out stakeholder meetings in the next couple of weeks in the form of town hall meetings in various locations around the state (Jonesboro, Little Rock, etc.)

Existing DD Waiver plans are approved through 8/31/19

Behavioral Health Providers

1. For members who have Medicare, claims are being denied "services not provided by network/primary care providers; however, the claims cannot be sent to Medicare because Medicare does not cover the particular CPT code. Medicare codes on Empower's provider portal; Medicare codes approved by DHS do not require a denial. Edits have been built into Empower claim's system.
2. Not paying for atypical providers, physicians, and APRNs. Claims submission must match the master provider file from DHS. Resolution is pending answers from DHS on how the atypical/NPI issue will be resolved so this does not continue to be a problem.
3. Added Z modifiers to many of the Medicaid codes, causing provider to make a lot of system changes. When the provider billed those Empower-unique codes, Empower's system did not recognize the codes and denied them. Clearinghouses do not recognize these foreign modifiers, and as a result, some claims stay in the clearinghouses and do not get submitted.
4. Requires Medicaid ID number on all atypical providers, requiring additional system programming by program vendor. See # 2 above
5. First batch of claims submitted to Empower denied for no apparent reason. Issue has still not been resolved by Empower. Robert will get Empower the name of the specific provider with this issue
6. Denials due to provider information not matching Medicaid information. We do not have access to the Medicaid information and this was not a problem when billing Medicaid. We have to call Medicaid to compare the information to be sure it matches. See # 2 above
7. Treatment Plan S0220 U4 paid for only one unit when we billed two. Empower says it is an NCCI unlikely edit, but Arkansas Medicaid was paying for two units. Change to 90885. Updated fee schedule received from DHS last week. Will have to check to see if retro to 3/1/2019.
8. Batch billing is accepted but cannot be located in their system. Empower to work with clearinghouse.
9. Care coordinators not trained properly. They continue to tell providers and parents that setting up reassessments is the provider's responsibility. Expecting therapists to have annual face-to-face meeting with beneficiary and Empower to develop PCSP. This is non-billable time when the therapist could otherwise be seeing patients. Empower continuing to educate care coordinators and will clarify responsibilities for independent assessments, how to conduct a PCSP, etc.Network still in development and contracts being signed and entered in ATC network everyday.
10. Change in authorization end dates without notifying providers. Robert to provide specific provider experiencing this issue
11. Authorization criteria are not posted on website because Empower says it is "proprietary" information. This is likely a violation of Arkansas Statute. Even private managed care

companies provide these criteria. Empower is actively working to get this information posted , estimated ETA is within the next thirty days.

12. Inconsistencies in prior authorizations on medications. As required by contract between DHS and Empower, Empower is following state PDM and formularies
13. Care coordinators are sending PHI that is not encrypted. Robert will provide specific provider who has experienced this issue
14. Pharmacy system requires each provider to register and log in every time and is not user-friendly. Robert will provide specific provider who has experienced this issue

Inpatient Psychiatric Providers

1. Paying acute claims at residential rate. Robert to provide specific examples
2. Empower requires a different revenue code than the other two PASSEs. This is correct. Empower had to do this in order to get claims to pay correctly. Empower has posted provider alerts and provided training on this issue.
3. Initial acute authorizations are very short— most are five days or less, with residential rate approved after that. Empower is following national standard of 5 days, provider can submit prior authorization request for continued stay. Will not be authorizing an initial 7 days.
4. Cannot bill facility claims through their portal. They had no idea of the volume of providers who do not use a clearinghouse to bill facility claims and thus need the portal to bill those claims. Empower had no idea of the number of providers who would use the portal to bill. Empower is working on fixing this but it will be up to 90 days before it will be ready for providers to bill through portal. Providers must bill by paper claims until portal is fixed unless they have a clearinghouse they can bill through.
5. Remittance advice is in pdf format, so cannot be sorted.

DD Providers

1. Difficult to get clear and consistent responses from customer support agents. Empower is doing additional training; all call are recorded so a specific call can be reviewed and training targeted
2. Not set up to receive claims from atypical providers. See # 2 under Behavioral Health Providers
3. Not set up to receive ICF claims Have identified that Bill Type accepted by Medicaid (613) is not a current Bill Type (was discontinued by CMMS several years ago) which is why all of the claims were not being accepted by each PASSE – Providers need to use Bill Type 65X or 66X.
4. Lack of responsiveness to providers' billing vendors. Empower working with various billing vendors; need to get specific vendors that are not being responded to
5. Cannot get approval of new plans or revisions to existing plans. Have to talk to multiple individuals, and still no plan approval. Empower stated for providers to contact Latasha Brown during the interim. Providers in meeting re-iterated that processes need to be documented, tested and then all providers trained in group settings that provide for

substantive dialogue and question/answer exchange that insures consistency of information and how all providers are trained

6. Asking individuals, families and providers to sign PCSPs that do not include all current services. Empower trying to get 18,000 PCSP done by June 1. Providers re-iterated that the first PCSP should be well thought out and the foundational and comprehensive document for all services and not just a form that has boxes checked based on copies of existing treatment plans. Providers also stated that every beneficiary should have the opportunity to have an in-person meeting with the care coordinators, their providers and whoever else they want to attend – the June 1 date needs to be re-considered.

SUMMIT COMMUNITY CARE

DD Provider webinar scheduled for April 30; will have some DD providers part of the development and review of material to make sure complete and answers questions of processes and timelines

Summit has paid $2.4 million in prospective/advance payments as of 4/17/19 (for services provided by providers but claims have not been cleanly processed due to all of the underlying billing issues)

Summit is developing a formal communication plan so that once an issue is resolved, a communication is sent to all providers explaining what steps Summit has taken and if the provider needs to do anything (Communication on EFT and Span Billing issues should go out this week)

Summit Board has been presented with the identified systemic billing and PCSP problems and utilizing provider board members as well as other providers to find resolution and test resolution to make sure the problems are fixed before releasing to providers

Outpatient Behavioral Health Providers

1. Claims denying for missing authorization for Therapeutic Communities Per Diem notes. Summit stated this has been fixed – system was not recognizing the modifiers but is now. Robert to provide names of specific providers who are still experiencing this issue.
2. Two CPT codes denying as not covered by managed care provider. Robert will provide names of providers (and the codes) who are experiencing this issue
3. No hospital or primary care physician in Conway County. CHI St. Vincent contract in process as well as the PCPs in that area
4. Cumbersome and time-consuming process to obtain authorizations for prescriptions and pharmacies not participating in network. When DHS sent original information, Medicaid did not give edits that override the PA requirement for prescriptions. They have since provided the necessary edits.
5. Problems getting paid for atypical provider numbers and physicians. Summit implemented changes 4/1 and 4/10 to allow provider Medicaid numbers to come through
6. Still waiting on EFT approval. Summit acknowledged this is an issue with their vendor (CAQH) and they are working through with each provider. Will send out a communication to providers to make sure they know to select Amerigroup when completing their EFT enrollment
7. Provider cannot get the correct CPT codes and modifiers for Adult Life Skills done by QBHPs. New OBH codes – working with DHS to make sure the PASSEs all have the correct codes, reimbursement rates and payment criteria/edits
8. Summit's decision to not start processing authorization requests until two weeks before May 1 will cause further untimely payments. Summit is reconsidering delaying the start date of new prior authorizations

9. Refuses to allow retroactive approvals. Provider is required to submit a written retro review request along with documentation. This unnecessary step will further delay payments. Summit is developing processes and workflows and timelines that will be communicated to providers as well as training
10. Inconsistencies with medication authorizations. Edits have been lifted
11. Payment of claims with CPT Code 99213 is problematic. Robert to provide specific provider(s) experiencing this issue
12. One provider is shown as out-of-network, and neither the provider nor Summit can determine why. As a result, the provider is required to submit PAs by phone or fax, which wastes time and resources. No PAs are required during this transition period; Robert to provide specific provider experiencing this issue
13. Denying claims because they cannot verify licensure of clinicians, even though the clinicians were on the initial credentialing spreadsheet submitted to Summit during network application process, and claims for these clinicians process fine with Medicaid. See # 5 above
14. Initial claims paid at incorrect rate; have not been reprocessed for payment. Initial code/fee schedule from Medicaid incorrect; Summit will reprocess when codes/fees have been verified as correct
15. Care coordinator inappropriately demanding to be included in individual therapy sessions; another care coordinator questioning tier levels and requesting to meet with treating psychiatrist because services seem excessive. Summit will meet with care coordinators and provide more training; Robert to provide specific provider experiencing this issue
16. Difficulty finding the right person to send updated provider rosters to. Have sent to multiple individuals, but everyone says they are not the one to receive them. Summit will have instructions and place on portal for providers to submit servicing provider rosters - do not have ETA

Inpatient Psychiatric Hospitals

1. Long turn-around (7-8 days) for Residential Treatment. Summit's goal is 5 days
2. Numerous erroneous denials— "service not paid because member's coverage not in effect at time of service." Provider has to call and then resubmit claim for processing. Robert to provide specific provider who is experiencing this issue
3. Cannot request continued stays through the portal— must be done by fax. Communication regarding authorizations is often delayed. Summit working on portal to fix this issue - no ETA

DD Providers

1. Inadequate customer support for billing. Providers spending hours on the phone trying to find out how to address problems. Claims systems was not accepting span billings. This has been fixed and Summit will reprocess all claims denied that were related to this issue.
2. Billing system does not accept claims from atypical providers. See # 5 above in Outpatient Behavioral Health Providers
3. Not set up to process ICF claims. Asked for information on a spreadsheet. Have identified that Bill Type accepted by Medicaid (613) is not a current Bill Type (was discontinued by

CMMS several years ago) which is why all of the claims were not being accepted by each PASSE – Providers need to use Bill Type 65X or 66X.

4. EFT still not set up for many providers. See # 6 above in Outpatient Behavioral Health Providers
5. Auto-assignment of PCPs and lack of appropriate PCPs in network have resulted in assignment to PCPs with which member has not history, in another town or county, etc. Can change PCP anytime; can still see new PCP without changing in portal; Summit still processing contract of providers to be added to network
6. Cannot get new consumer or revision plans approved since March 1. Documented processes, workflows, timelines and trainings are still in development. For right now, email Jason if an emergency plan or new plan is needed until processes are established and providers trained
7. Care coordinators asking clients, families and providers to sign off on plans that do not include all services or have wrong frequency or duration of services. Providers re-iterated that this problems is a result of no documented processes, workflows, and timelines with substantive provider and care coordinator training