

TCOW

Tribal Compliance and Operations Workgroup

October 9, 2019

TCOW Agenda

- ▶ Maternity Support Services (MSS) in P1
- ▶ Integrated Managed Care implementation in January, 2020 – do you need assistance contracting with the Managed Care Plans?
- ▶ No Top 10 Rejections this Month, switch focus to Claims Analyses?
- ▶ FAQ & open discussion

Maternity Support Services (MSS) in P1

- ▶ Refer to the [October, 2016 TCOW Slides](#) for background information
- ▶ ProviderOne update to allow payment of the encounter rate for MSS services should be implemented on October 20th
- ▶ Mike will reprocess all previously rejected claims after the P1 update – if you have MSS claims that were eligible for the encounter rate but did not pay, contact mike
- ▶ Contact Heather (heather.weiher@hca.wa.gov) for more information on the MSS program
- ▶ Contact mike for any P1 billing issues

Integrated Managed Care Implementation in January 2020

Integrated Managed Care is coming, what does it mean for clients?

The *Trifurcated system* was in non-integrated regions.

1. Physical Health Care and *below Access to Care* Mental Health is covered through (“MCO”) managed care and AI/AN clients may opt in (or out) of managed care
2. *Above Access to Care* Mental Health and SUD is covered through (“BHO”) managed care and AI/AN clients may opt in (or out) of managed care
3. Dental services are covered without a managed care plan

In Integrated Managed Care regions there is no BHO option

1. Physical Health, Mental Health, **and** SUD services are covered through (“IMC”/”MCO”) managed care and AI/AN clients may opt in (or out) of managed care
2. Dental Services are covered without a managed care plan

If an Apple Health client is not enrolled in a managed care plan that covers the service, the client is in what is commonly referred to as *fee for service* (FFS) for the service, but a more fitting description may be that the client is *enrolled in Apple Health without a managed care plan for the service*

Integrated Managed Care Implementation in January 2020

Integrated Managed Care is coming, what does it mean for **Tribes**?

We also need to consider these variables:

- The category of the service (e.g. Medical, Dental, Mental Health, or SUD)
- Is the client enrolled in a managed care plan that covers the service or in *Apple Health without a managed care plan*?
- Is the client AI/AN or nonAI/AN?
- Is the Tribe a Tribal FQHC or a Direct IHS/Tribal Clinic?

The next few slides will address this question

NOTE: Medicare coverage and commercial insurance coverage are out of scope for these slides because we are focusing on managed care

Integrated Managed Care Implementation in January 2020

Integrated Managed Care is coming, what does it mean for Tribes?

MEDICAL

- Some regions previously did not have managed care coverage for Physical Healthcare (e.g. Clallam county) – clients who were previously not enrolled in managed care plan that covers the service may be enrolled in a managed care plan that covers the service beginning in January (change = clients are now enrolled in managed care)
- If the client is enrolled in a managed care plan that covers the service – the service will need to be billed to the managed care plan as primary payer (no change)
 - AI/AN clients – bill the managed care plan primary then P1 for the balance of the encounter rate (no change)
 - NonAI/AN clients
 - Direct IHS Clinics and Tribal Clinics – bill the managed care plan, there is no provision for the balance of the encounter rate (no change)
 - Tribal FQHC – bill the managed care plan primary then P1 for the balance of the encounter rate (this is a change that is made available due to the Tribal FQHC SPA)
- If the client is not enrolled in a managed care plan that covers the service – bill P1 directly at the encounter rate (no change)

Is a contract required with the managed care plan?

- For AI/AN clients, follow [WAC 284 170 200](#), which indicates that a contract is not required (no change)
- For nonAI/AN clients, contracts with the managed care plans will be required. Why the difference? The WAC mentioned above does not offer the same protections for nonAI/AN clients (no change)

Integrated Managed Care Implementation in January 2020

Integrated Managed Care is coming, what does it mean for Tribes?

DENTAL

- Dental services are not covered through managed care
- Since there is no dental managed care – bill P1 directly at the encounter rate (no change)

Integrated Managed Care Implementation in January 2020

Integrated Managed Care is coming, what does it mean for Tribes?

MENTAL HEALTH

- Some regions previously did not have managed care coverage for Below Access to Care Mental Health (e.g. Clallam county) – clients who were previously not enrolled in managed care plan that covers the service may be enrolled in a managed care plan that covers the service beginning in January. (change = clients are now enrolled in managed care)
- Prior to 2020 - Mental Health services for AI/AN clients who are enrolled in managed care did not have to be billed to the managed care plan, the Tribe had *a choice* and services could be billed directly to P1 or billed to managed care primary then P1 for the balance of the encounter rate. *The choice* exists for a reason – the BHOs are not able to support the Tribes. Mental Health services for nonAI/AN clients who are enrolled in managed care need to be billed to the managed care plan as primary payer.
- Beginning in January, 2020 - If the client is enrolled in a managed care plan that covers the service – the service will need to be billed to the managed care plan as primary payer (change = removal of the choice)
 - AI/AN clients – bill the managed care plan primary then P1 for the balance of the encounter rate (change = removal of the choice)
 - NonAI/AN clients
 - Direct IHS Clinics and Tribal Clinics – bill the managed care plan, there is no provision for the balance of the encounter rate (no change)
 - Tribal FQHC – bill the managed care plan primary then P1 for the balance of the encounter rate (this is a change that is made available due to the Tribal FQHC SPA)
- If the client is not enrolled in a managed care plan that covers the service – bill P1 directly at the encounter rate (no change)

Is a contract required with the managed care plan?

- For AI/AN clients, follow [WAC 284 170 200](#), which indicates that a contract is not required (no change)
- For nonAI/AN clients, contracts with the managed care plans will be required. Why the difference? The WAC mentioned above does not offer the same protections for nonAI/AN clients (no change)

Integrated Managed Care Implementation in January 2020

Integrated Managed Care is coming, what does it mean for **Tribes**?

SUBSTANCE USE DISORDER SERVICES

- Some regions previously did not have managed care coverage for SUD services (e.g. Clallam county) – clients who were previously not enrolled in managed care plan that covers the service may be enrolled in a managed care plan that covers the service beginning in January. (change = clients are now enrolled in managed care)
- Prior to 2020 – Outpatient SUD services for AI/AN **and** nonAI/AN clients who are enrolled in managed care did not have to be billed to the managed care plan, the Tribe had *a choice* and services could be billed directly to P1 or billed to managed care primary then P1 for the balance of the encounter rate. *The choice* exists for a reason – the BHOs are not able to support the Tribes.
- Beginning in January, 2020 - If the client is enrolled in a managed care plan that covers the service – the service will need to be billed to the managed care plan as primary payer (change = removal of the choice)
 - AI/AN clients – bill managed care plan primary then P1 for the balance of the encounter rate (change = removal of the choice)
 - NonAI/AN clients
 - Direct IHS and Tribal Clinics – bill the managed care plan, there is no provision for the balance of the encounter rate (two changes, removal of the choice and services are no longer payable at the encounter rate per SS Act 1932 (h2c))
 - Tribal FQHC – bill the managed care plan primary then P1 for the balance of the federal share of the encounter rate (this is a change that is made available due to the Tribal FQHC SPA)
- If the client is not enrolled in a managed care plan that covers the service – bill P1 directly at the encounter rate (AI/AN clients) or at the federal share of the encounter rate (nonAI/AN clients) (no change)

Is a contract required with the managed care plan?

- For AI/AN clients, follow [WAC 284 170 200](#), which indicates that a contract is not required (no change)
- For nonAI/AN clients, contracts with the managed care plans will be required. Why the difference? The WAC mentioned above does not offer the same protections for nonAI/AN clients (no change)

Integrated Managed Care Implementation in January 2020

Integrated Managed Care is coming, what does it mean for Tribes?

SUMMARY

- For Tribes serving AI/AN clients
 - The newly integrated regions may see that some AI/AN clients that were previously not in managed care will be in managed care (client opt in/out rights are maintained)
 - Behavioral Health (Mental Health and Outpatient SUD) will need to be billed to the managed care plan if the client is enrolled in a managed care plan that covers the service
 - Contracts with the managed care plan are *not required* per WAC 284 170 200
- For Tribes serving nonAI/AN clients
 - The integrated regions will see that most nonAI/AN clients are enrolled in managed care (previously no *MCO* coverage in the area)
 - Behavioral Health (Mental Health and Outpatient SUD) will need to be billed to the managed care plan if the client is enrolled in a managed care plan that covers the service
 - **In order to be able to continue to claim the encounter rate the Tribe must:**
 - **Be a Tribal FQHC with WA Apple Health**
 - **Contract with the Managed Care Plan(s) in order to receive payment from the Managed Care Plans**

Integrated Managed Care – January 2020

P1 Client Benefit Inquiry – identification of the types of managed care plans and what they cover

If the Client is enrolled in any of these managed care plans:

- AMG Fully Integrated Managed Care
- CCC Fully Integrated Managed Care
- CHPW Fully Integrated Managed Care
- Coordinated Care Healthy Options Foster Care
- MHC Fully Integrated Managed Care
- UHC Fully Integrated Managed Care

Then

- Medical, Mental Health and SUD services are billed to the managed care plan as the primary payer
- Dental is covered without a managed care plan

If the client is enrolled in any of these managed care plans:

- AMG Behavioral Health Services Only
- CCC Behavioral Health Services Only
- CHPW Behavioral Health Services Only
- MHC Behavioral Health Services Only
- UHC Behavioral Health Services Only

Then

- Mental Health and SUD services are billed to the managed care plan as the primary payer
- Medical and Dental services are covered without a managed care plan

Tribal FQHC – Billing Comparisons and Overview

The next two slides present the “Draft IHS Encounter Payment Table” that Mike has shared for a few years. The table is now split into 2 separate tables

1. Direct IHS Clinics and Tribal Clinics
2. Tribal FQHC

Tribal FQHC – Billing Comparisons and Overview

The slides will go into greater detail on the next two slides

These slides ask if the combination of parameters (eg. Managed care vs FFS, AI/AN vs NonAI/AN, etc) are eligible for the IHS Encounter Rate

- Left side is Direct IHS and Tribal Clinic -- Right side is Tribal FQHC
- Notice that the AI/AN column answer is always “yes”
- Notice that the non-AI/AN column answer is sometimes “no” for Direct IHS and Tribal Clinic and always “yes” for Tribal FQHC

Apple Health (Medicaid) Billing Direct IHS and Tribal Clinics (not Tribal FQHC) and IHS Encounter Rate

AI/AN & non-AI/AN clients and Managed Care vs “fee for service” – is the service eligible for the encounter rate?							
Encounter Type:	Program:	AI/AN Clients			Non-AI/AN Clients		
		Medicaid Only	Medicaid + Medicare	Medicaid + Private Insurance	Medicaid Only	Medicaid + Medicare	Medicaid + Private Insurance
Medical	Not in MCO	YES – Bill P1	YES – Bill Medicare then P1 for balance	YES – Bill private insurance then P1 for balance	YES – Bill P1	YES - Bill Medicare then P1 for balance	YES – Bill private insurance then P1 for balance
	MCO	YES – Bill MCO then P1 for balance	YES – Bill Medicare, then MCO, then P1 for balance	YES – bill private insurance, then MCO, then P1 for balance	No	No	No
Dental	Dental is all “FFS” in P1	YES – Bill P1	YES – Bill P1 (if Medicare covers the service, bill Medicare, then P1 for balance)	YES – Bill private insurance then P1 for balance	YES – bill P1	YES – Bill P1 (if Medicare covers the service, bill Medicare, then P1 for balance)	YES – Bill private insurance then P1 for balance

Apple Health (Medicaid) Billing Tribal FQHC (not Direct IHS or Tribal Clinic) and IHS Encounter Rate

AI/AN & non-AI/AN clients and Managed Care vs “fee for service” – is the service eligible for the encounter rate?							
Encounter Type:	Program:	AI/AN Clients			Non-AI/AN Clients		
		Medicaid Only	Medicaid + Medicare	Medicaid + Private Insurance	Medicaid Only	Medicaid + Medicare	Medicaid + Private Insurance
Medical	Not in MCO	YES – Bill P1	YES – Bill Medicare then P1 for balance	YES – Bill private insurance then P1 for balance	YES – Bill P1	YES - Bill Medicare then P1 for balance	YES – Bill private insurance then P1 for balance
	MCO	YES – Bill MCO then P1 for balance	YES – Bill Medicare, then MCO, then P1 for balance	YES – bill private insurance, then MCO, then P1 for balance	YES – Bill MCO then P1 for balance	YES - Bill Medicare, then MCO, then P1 for balance	YES – bill private insurance, then MCO, then P1 for balance
Dental	Dental is all “FFS” in P1	YES – Bill P1	YES – Bill P1 (if Medicare covers the service, bill Medicare, then P1 for balance)	YES – Bill private insurance then P1 for balance	YES – Bill P1	YES – Bill P1 (if Medicare covers the service, bill Medicare, then P1 for balance)	YES – Bill private insurance then P1 for balance

Apple Health (Medicaid) Billing

Direct IHS and Tribal Clinics (not Tribal FQHC) and IHS Encounter Rate

AI/AN & non-AI/AN clients and Managed Care vs “fee for service” – is the service eligible for the encounter rate?							
Encounter Type:	Program:	AI/AN Clients			Non-AI/AN Clients		
		Medicaid Only	Medicaid + Medicare	Medicaid + Private Insurance	Medicaid Only	Medicaid + Medicare	Medicaid + Private Insurance
Medical	Not in MCO	YES – Bill P1	YES – Bill Medicare then P1 for balance	YES – Bill private insurance then P1 for balance	YES – Bill P1	YES - Bill Medicare then P1 for balance	YES – Bill private insurance then P1 for balance
	MCO	YES – Bill MCO then P1 for balance	YES - Bill Medicare, then MCO, then P1 for balance	YES – bill private insurance, then MCO, then P1 for balance	No	No	No
Dental	Dental is all “FFS” in P1	YES – Bill P1	YES – Bill P1 (if Medicare covers the service, bill Medicare, then P1 for balance)	YES – Bill private insurance then P1 for balance	YES – bill P1	YES – Bill P1 (if Medicare covers the service, bill Medicare, then P1 for balance)	YES – Bill private insurance then P1 for balance

Apple Health (Medicaid) Billing

Direct IHS and Tribal Clinics (not Tribal FQHC) and IHS Encounter Rate

AI/AN & non-AI/AN clients and Managed Care vs “fee for service” – is the service eligible for the encounter rate?

Encounter Type:	Program:	AI/AN Clients			Non-AI/AN Clients		
		Medicaid Only	Medicaid + Medicare	Medicaid + Private Insurance	Medicaid Only	Medicaid + Medicare	Medicaid + Private Insurance
Mental Health	Not in MCO	YES – Bill P1	YES - Bill Medicare then P1 for balance	YES – Bill private insurance then P1 for balance	YES – Bill P1	YES - Bill Medicare then P1 for balance	YES – Bill private insurance then P1 for balance
	MCO	YES – Bill MCO then P1 for balance	YES –Bill MCO then P1 for balance (if Medicare covers the service, bill Medicare before MCO)	YES - Bill private insurance, then MCO, then P1 for balance	No	No	No
Substance Use Disorder	Not in MCO	YES – Bill P1	YES – Bill P1 (if Medicare covers the service, bill Medicare, then P1 for balance)	YES – Bill private insurance then P1 for balance	YES – bill P1 at the FMAP rate (CPE required)	YES – Bill P1 at the FMAP rate (if Medicare covers the service, bill Medicare then P1) (CPE required)	YES – Bill private insurance then P1 for balance of the FMAP rate (CPE required)
	MCO	YES –Bill MCO then P1 for balance	YES –Bill MCO then P1 for balance (if Medicare covers the service, bill Medicare before MCO)	YES – Bill private insurance, then MCO, then P1 for balance	No	No	No

Apple Health (Medicaid) Billing Tribal FQHC (not Direct IHS or Tribal Clinic) and IHS Encounter Rate

AI/AN & non-AI/AN clients and Managed Care vs “fee for service” – is the service eligible for the encounter rate?

Encounter Type:	Program:	AI/AN Clients			Non-AI/AN Clients		
		Medicaid Only	Medicaid + Medicare	Medicaid + Private Insurance	Medicaid Only	Medicaid + Medicare	Medicaid + Private Insurance
Medical	Not in MCO	YES – Bill P1	YES – Bill Medicare then P1 for balance	YES – Bill private insurance then P1 for balance	YES – Bill P1	YES - Bill Medicare then P1 for balance	YES – Bill private insurance then P1 for balance
	MCO	YES – Bill MCO then P1 for balance	YES - Bill Medicare, then MCO, then P1 for balance	YES – bill private insurance, then MCO, then P1 for balance	YES – Bill MCO then P1 for balance	YES - Bill Medicare, then MCO, then P1 for balance	YES – bill private insurance, then MCO, then P1 for balance
Dental	Dental is all “FFS” in P1	YES – Bill P1	YES – Bill P1 (if Medicare covers the service, bill Medicare, then P1 for balance)	YES – Bill private insurance then P1 for balance	YES – Bill P1	YES – Bill P1 (if Medicare covers the service, bill Medicare, then P1 for balance)	YES – Bill private insurance then P1 for balance

Apple Health (Medicaid) Billing Tribal FQHC (not Direct IHS or Tribal Clinic) and IHS Encounter Rate

AI/AN & non-AI/AN clients and Managed Care vs “fee for service” – is the service eligible for the encounter rate?

Encounter Type:	Program:	AI/AN Clients			Non-AI/AN Clients		
		Medicaid Only	Medicaid + Medicare	Medicaid + Private Insurance	Medicaid Only	Medicaid + Medicare	Medicaid + Private Insurance
Mental Health	Not in MCO	YES – Bill P1	YES - Bill Medicare then P1 for balance	YES – Bill private insurance then P1 for balance	YES – Bill P1	YES - Bill Medicare then P1 for balance	YES – Bill private insurance then P1 for balance
	MCO	YES – Bill MCO then P1 for balance	YES –Bill MCO then P1 for balance (if Medicare covers the service, bill Medicare before MCO)	YES - Bill private insurance, then MCO, then P1 for balance	YES – bill MCO then P1 for the balance	YES –Bill MCO then P1 for balance (if Medicare covers the service, bill Medicare before MCO)	YES, bill private insurance, then MCO then P1 for the balance
Substance Use Disorder	Not in MCO	YES – Bill P1	YES – Bill P1 (if Medicare covers the service, bill Medicare, then P1 for balance)	YES – Bill private insurance then P1 for balance	YES – Bill P1 at the FMAP rate (CPE required)	YES – Bill P1 at the FMAP rate (if Medicare covers the service, bill Medicare then P1) (CPE required)	YES – Bill private insurance then P1 for balance at the FMAP rate (CPE required)
	MCO	YES –Bill MCO then P1 for balance	YES –Bill MCO then P1 for balance (if Medicare covers the service, bill Medicare before MCO)	YES – Bill private insurance, then MCO, then P1 for balance	YES –Bill MCO then P1 for balance of the FMAP rate (CPE required)	YES –Bill MCO then P1 for balance of the FMAP rate (if Medicare covers the service, bill Medicare before MCO) (CPE required)	YES – Bill private insurance then MCO then P1 for balance at the FMAP rate (CPE required)

No Top 10 Rejections This Month – Switch to Claims Analyses?

We usually present a list of the most common reasons for claims to reject in P1 & make 'plain talks' the issues

After conducting a Claims Analyses this month for [Anon], I noticed that [Anon] had

- Average payment percentages compared to the other Tribes but very few of the P1 rejections were in the top 10 lists
- A lot of paid claims (not rejections) that didn't pay at the encounter rate. The (fixable) financial impact was greater on the paid claims than on the rejected claims

I want to start devoting more time to Claims Analyses, this is where the Tribal Affairs office is able to provide the greatest assistance

For a Claims Analysis I retrieve all claims in the past year and

- If the claim paid at the encounter rate, I skip over it. There may be issues inside the claim but (for now) we focus on financial impacts
- If the claim did not pay at the encounter rate, I look at it.
 - It takes about 2-5 minutes per claim to review it in P1 and look for fixable issues
 - Duplicate claims submissions hinder Claims Analyses, sometimes to the point where a Claims Analysis may not be feasible
- It takes about 2 weeks to complete a Claims Analysis, this means that I will be able to complete about 1 Claims Analysis per year (per Tribe)
- Claims Analysis requests are prioritized, the folks with the lowest payment percentages are always given higher priority

FAQ and Open Discussion

Q. We just updated a provider's license but P1 indicates that it is not complete and *license is required. Did we do the license update wrong?*

A. No. This is a P1 issue. I do not have an ETA on when it will be fixed

If you need to fix a provider's license in P1 – contact the Enrollment folks, they have to help nudge it along until P1 is updated

800 562 3022 ext 16137 or providerenrollment@hca.wa.gov

Subject line = (the NPI) + *error popup while adding license*

Body of email = include the NPI and just indicate that you are getting an error when trying to update the license

FAQ and Open Discussion

Q. If our supervising doctor (or ARNP, MHP, Dentist, etc) is not in the office when services are rendered, can the claim be billed to P1 with the supervising doctor as the servicing NPI?

A. Previously, Mike would attempt to read and interpret the *scope of practice* rules but these are DOH (Department of Health) rules and need to be referred to DOH

Mike rewords the question:

Q. When is it OK for the servicing NPI on a claim to not be the person who served the client on that date?

A. As much as Mike would like to answer with a yes or no -- This is a *scope of practice* question, I have to defer to DOH

FAQ and Open Discussion

Q. How come P1 paid the immunization administration (CPT 90471), which is a lower-dollar service but rejected the E&M (CPT 99213) which is a higher-dollar service? The immunization administration doesn't even qualify for the encounter rate, is this rejection valid?

A. Yes, it is valid per NCCI rules. No, it is not valid per mike's common sense.

I see this frequently with [NCCI](#) – the PTP (Procedure to Procedure) rules will indicate to pay the “lower-dollar” service but reject the “higher-dollar” service. If we are working with encounter services the high/low dollar doesn't matter unless the payable code is in the list of services that do not qualify for the encounter rate. I do not have a solution and I will not suggest to omit the “lower dollar” (e.g. 90471) code from the claim

FAQ and Open Discussion

Q. Are Advanced Directives ('end of life' treatment) covered?

A. Yes. Refer to the [Physician-Related billing guide](#) (p 48).

These services do qualify for the encounter rate (notice that these are payable *in addition to* the E&Ms)

Advance directives/physician orders for life-sustaining treatment

The agency covers for counseling and care planning services for end of life treatment when conducted by a licensed health care provider.

End of life service should be evidence-based and use tested guidelines and protocols. This service may include assisting the client or the client's authorized representative to understand and complete advance directives and/or a physician orders for life-sustaining treatment (POLST) form.

The agency pays separately for this counseling and planning in addition to the appropriate E/M code. Bill for this service using one of the following procedure codes, as appropriate:

Procedure Codes	Short Descriptions
S0257	End of life counseling
99497	Advncd care plan 30 min
99498	Advncd care plan addl 30 min

This service may include:

- Assessing client readiness.
- Educating the client on their health status.
- Helping the client choose a suitable surrogate and involving the designated surrogate in the conversation if appropriate.
- Discussing and clarifying values (e.g., "If you were in X situation, what would be most important to you?").
- Documenting the advance care plan with an advance directive and POLST if appropriate.

FAQ and Open Discussion

Q. We heard that Medicare is going to cover Substance Use Disorder Services beginning in 2020, is that true?

A. mike does not know the answer. Question forwarded to HCA's "medicare team". The guidance that I have is -- if the service is covered by Medicare – bill Medicare. If a service is billed directly to P1 and it is later found that Medicare covers the service, HCA may recoup payment (they are just following the payer of last resort rules). I don't want anybody to get tangled up in a large recoup due to this so, "stay tuned"

FAQ and Open Discussion

Q. What if Medicare Advantage plan denies a behavioral health claim?

A. Generally, if the service is covered by Medicare then p1 will reject the claim to bill Medicare. There are some services that are NEVER covered by Medicare (e.g., dental) and those services may be billed directly to P1.

- At this time, SUD (defined by taxonomy 261QR0405x and 324500000x and 3245s0500x) are coded in P1 as never covered by medicare but this might be changing in 2020.
- At this time, mental health by certain MHPs who cannot enroll in Medicare (e.g. 106H00000x 101YM0800x, 104100000x) are also coded in P1 as never covered by medicare
- There are about 1,000 other “at this time” scenarios in the medicare coding rules inside P1 -- if you have a specific scenario, just reach out for help and ask (include the data/coding if possible)

FAQ and Open Discussion

Q. Regarding the managed care IMC changes that are coming in January 2020 -- are the billing changes based on date of service or date of submission

A. It will be based on date of service

Q. Wait? Can you give me an example of something that is based on date of submission?

A. Yes, the FMAP (e.g. the nonAI/AN SUD FMAPs) are based on date of submission/payment

FAQ and Open Discussion

Q. Can an OTP be set up as part of a Tribal FQHC even if it is a separate address?

A. Yes. The Tribal FQHC can have a single NPI and “unlimited” sites as far as the Tribal FQHC rules are concerned. Some services/sites need to be approved by DOH (e.g. SUD)

FAQ and Open Discussion

Q. Regarding the managed care changes in January, 2020 – are we required to bill the MCO for AI/AN clients or all clients?

A. All clients

If a client is enrolled in a managed care plan that covers the service – the managed care plan is the primary payer

FAQ and Open Discussion

Q. Can Tribal Members opt out of managed care plans?

A. Yes. AI/AN clients have the right to opt in or out of managed care. AI/AN clients are no longer automatically assigned to managed care (auto-assignment was halted a few years ago)

FAQ and Open Discussion

Q. Is P1 going to pay SUD claims at the encounter rate when a claim is denied by MCO for 'non-covered benefit'?

A. No. SUD services are covered and listed in the billing guide. If the MCO rejects for 'non-covered' then the service should be really 'non-covered'. If the rejection was an error the error needs to be corrected

FAQ and Open Discussion

Q. Why are our Native patients placed in an MCO and not provided an open coupon?

A. The auto-assignment to managed care stopped a few years ago in P1. if the client is not 'coded' as AI/AN in P1 then the client will most likely get auto-assigned.

FAQ and Open Discussion

Q. During the September TCOW you mentioned that self-attest is an issue, can you explain?

A. yes, there are two different ways to look at self-attest

1. When a client is signing up for healthcare, their demographics (AI/AN) may be reported. This is the self-attest. WA Medicaid accepts self-attestation of demographic information (QHPs do not accept self-attest but QHPs are out of scope for now)
2. When a claim is billed to P1, the AI/AN or nonAI/AN *modifiers* that are added to the claim need to be determined whether the client is eligible for IHS funding or not. We can't use self-attest for the modifiers. If HCA were to claim 100% FMAP on clients who are not IHS eligible, that would become an issue

FAQ and Open Discussion

Q. Is dental hygiene eligible for the encounter rate for a Tribal FQHC

A. Yes. This is a great example of why many folks are still concerned. Back in 2017, when HCA was initially researching the FQHC option, we were under the guidance that all FQHCs follow the same rules, this is not a true statement for Tribal FQHCs

The only 2 differences between a Tribal Clinic and a Tribal FQHC are

1. Tribal FQHC is not bound by the 4-walls rule
2. Tribal FQHC is eligible for the encounter rate for nonAI/AN in managed care (hygienists are a medicaid covered provider and OK for the encounter rate per the State Plan)

FAQ and Open Discussion

Q. Are there any changes with Tribal FQHC billing when providing services for incarcerated patients?

A. No. if a client is incarcerated – healthcare is the responsibility of the jail system.

FAQ and Open Discussion

Q. For physical therapy – can we request more visits if we need more than the benefit showing in provider guidelines

A. Yes

- Physical Therapy ([billing guide](#)) is covered for 24 units (6 hours) per calendar year
- If a client has a condition that meets the criteria listed on page 20 – add the EPA number to the claim(s) for an additional 6 hours per year
- If a client does not have a condition that meets the EPA criteria but extra visits may be necessary, a Limitation Extension (form of prior auth) may be requested

FAQ and Open Discussion

Q. For well child visits, it looks like they are only covered once per year but what if we see a new child in our office, can we bill out for a well child check even if seen elsewhere?

A. No. [EPSDT billing guide](#) has a frequency schedule for well child visits, the frequency schedule is ‘per client’

Age 0 through 0 – 5 checkups

Age 1 through 2 – 3 checkups

Age 3 through 6 – one checkup each year

Age 7 through 20 – one checkup every other year (note: MCO coverage allows one per year for MCO-enrolled clients but FFS is one every other year, this will be important to remember when the MCOs pay at the encounter rate, the encounter rate is only for the title xix (e.g.”P1”) covered services)

HCA does indicate that they offer a “client limit benefit inquiry” to see if a service is over limits (more on page 45 of the [P1 Billing and Resource Guide](#))

FAQ and Open Discussion

Q. Once we request to become a Tribal FQHC, is there a renewal date too?

A. No. There is no need to renew. Once HCA receives the request to be a Tribal FQHC, the updates will happen and there is no need to renew. If, for some reason, Tribe wishes to no longer be a Tribal FQHC just send in a request to no longer be a Tribal FQHC.

FAQ and Open Discussion

Q. Should we continue to send questions to you or to Tribalaffairs@hca.wa.gov

A. Mike is forwarding all questions to the ticket system at tribalaffairs@hca.wa.gov and is working all questions as fast as he can but he is just one person (for P1 questions). I understand that sometimes issues cannot wait so I would like to share other HCA contact information

- The provider Enrollment team has a large staff and may be reached directly at providerenrollment@hca.wa.gov
- The Apple Health call center has a large staff and may be reached directly at 800 562 3022 or via the [Contact HCA](#) portal
- The HCA security desk (for P1 lock outs) may be reached at provideronesecurity@hca.wa.gov

FAQ and Open Discussion

Q. Can an outpatient SUD facility bill Medicaid if the service was rendered outside of the DOH/DBHR approved outpatient facility?
A. (from DOH) *An agency may provide services at “offsite” location. The definition of “offsite” location is: the provision of services by a provider from a licensed behavioral health agency at a location where the assessment or treatment is not the primary purpose of the site, such as in schools, hospitals, long-term care facilities, correctional facilities, an individual's residence, the community, or housing provided by or under an agreement with the agency. Additionally, if an agency provides services “offsite” they must follow the requirements in [WAC 246-341-0342](#)*

NOTE: the [SUD Billing Guide](#) (p 31) still indicates that services are only covered in POS 05 (IHS), 07 (638), 50 (FQHC), or 55 (residential facility). Mike requested billing guide update for January

Reminder:

- The CMS 4-walls rule is applicable to Direct IHS and Tribal Clinics, services must be rendered inside the 4-walls of the facility that was on the annual funding agreement
- The CMS 4-walls rule does not apply to Tribal FQHCs and cost-reporting FQHCs

FAQ and Open Discussion

Q For WVA vaccines we bill the vaccine code with modifier SL but how do we bill if the doctor provides counseling, codes 90460-90461? These should be paid at the encounter rate, face to face time with the doctor. Not eligible for the encounter rate but the FFS rate for 90460-90461 should pay higher than 90471-90472 but no way to report with the current rule of adding SL to the vaccine code

A. Stay tuned

Jessie Dean

Tribal Affairs Administrator
Phone: 360.725.1649
Email: jessie.dean@hca.wa.gov

Lucilla Mendoza

Tribal Behavioral Health Administrator
Phone: 360.725.1834
Email: lucilla.mendoza@hca.wa.gov

Mike Longnecker

Tribal Operations & Compliance Manager
Phone: 360.725.1315
Email: michael.longnecker@hca.wa.gov

Lena Nachand

Tribal Liaison – Medicaid Transformation
Phone: 360.725.1386
Email: lena.nachand@hca.wa.gov

Melissa Livingston

Senior Policy Analyst, Tribal Affairs
Phone: 360.725.9832
Email: melissa.livingston@hca.wa.gov

Raina Peone

Regional Tribal Liaison
Phone: 360 584 6072
Email: raina.peone@hca.wa.gov

Web: <http://www.hca.wa.gov/tribal/Pages/index.aspx>

Thank you!

- The bottom-left corner of each slide will contain either I/T (impacts IHS and Tribal) or I/T/U (impacts IHS, Tribal and Urbans) or U (only impacts Urba
- If there is a difference between any information in this n) webinar and current agency documents (e.g. provider guides, WAC, RCW, etc), the agency documents will apply.