May 2024 Third Party Changes of Significance

MISSISSIPPI MEDICAID

<u>Eligibility Verification Information.</u> Late Breaking News. Mississippi Division of Medicaid. May 16, 2024

"The Web Portal has been updated to include some additional information on the Eligibility Verification tab to assist with determining the patient's coverage.

Eligibility Verification:

1. A link is added on the top right section of the Eligibility Verification Request panel that will open a new window on the user's browser showing the Job Aid with detailed coverage description on the DOM's website.

2. The Eligibility Verification Response section is updated to display the following additional information for the member in the header section:
   a. Head of household name
   b. Authorized Rep indicator
   c. Authorized Rep Name
   d. Authorized Rep phone number

3. The Benefit Details will also display the Aid Category code and the member's coverage can be viewed by hovering over the Aid Category description.

Should you need assistance, please contact the Provider and Beneficiary Services Call Center at (800) 884-3222 or use the Provider Field Representative list on Medicaid's website to identify your designated representative.
The Provider Field Representative list includes email addresses and phone numbers for each representative. This resource document is located at https://medicaid.ms.gov/wp-content/uploads/2024/03/Provider-Field-Representatives-1.pdf. Find more Late Breaking News at: https://medicaid.ms.gov/late-breaking-news/."

Medicaid to implement single Pharmacy Benefit Administrator for all pharmacy claims on July 1. Late Breaking News-Mississippi Division of Medicaid. May 15, 2024

"On July 1, the Mississippi Division of Medicaid (DOM) will implement a single Pharmacy Benefit Administrator (PBA) to streamline and enhance the processing and management of pharmacy claims for all Medicaid members, including those enrolled in MississippiCAN.

Operated by Gainwell Technologies, the PBA will also assume all pharmacy prior authorization responsibilities for drugs submitted on pharmacy claims. DOM will continue to require the use of the Universal Preferred Drug List (PDL). This decision comes after careful consideration and evaluation of various factors aimed at enhancing efficiency and transparency in the Medicaid delivery system.

Members should notice no disruption in their care if providers are prepared for this change.

WHAT YOU NEED TO KNOW AND DO

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Prescribing Providers:

DOM requires most prior authorization (PA) requests be signed/submitted by prescribers.

Prescribers and their administrative staff must submit all requests to Gainwell on July 1, 2024, and thereafter.

The preferred method of submission is via the MESA Portal for Providers.

PA requests may also be faxed to Gainwell at 866-644-6147. If PA assistance is needed providers can call 833-660-2402.

General Prior Authorization Instructions can be found on DOM's website at https://medicaid.ms.gov/wp-content/uploads/2022/09/DOMPriorAuthorizationInstructions-Gainwell.pdf.

PA reconsideration requests and appeals can also be sent to Gainwell directly via fax at 866-644-6147. More details regarding the PA transition will be shared before July 1, 2024.

Find more Late Breaking News at: https://medicaid.ms.gov/late-breaking-news/."

Wellcare Claims To Be Reviewed for Coordination of Benefits by Rawlings. Magnolia Health. May 3, 2024

" you for your continued partnership with Magnolia Health Plan. As you know, we are committed to continuously evaluating and improving overall Payment Integrity solutions as required by State and Federal governing entities. We are writing today to inform you of an additional review that will go into place on or after 6/15/2024:

Description of Changes

Wellcare claims will be reviewed for coordination of benefits by Rawlings, an external vendor. In accordance with policy CC.PI.09 (Coordination of Benefits/Third Party Liability/Subrogation), providers will begin seeing correspondence from Rawlings when these claims are identified as being incorrectly paid for members with other primary coverage. Instructions for next steps and how to outreach for additional information will be included in the letters that Rawlings will send to the providers. (Product line: Wellcare.)"

www.magnoliahealthplan.com

Resolving Payment Discrepancies on Claims [AmBetter]. Magnolia Health. May 3, 2024

Understand what happened and steps we will take to rectify the issue

In Q3 of 2023, we identified members enrolled in Ambetter from Magnolia Health and Magnolia Health (MSCAN) that were not identified in our third-party liability (TPL) claims process, which triggers the Coordination of Benefits (COB). As a result, claims submitted by the provider to Ambetter from Magnolia Health for the impacted members were processed and paid under the member's Magnolia Health (MSCAN) coverage rather than coordinating and adjudicating under the member's Ambetter Marketplace coverage.

Our commitment to resolution

We value our member and provider partnerships and are committed to resolving this in a manner that mitigates member and provider impact. The process was corrected in December of 2023, and claims are coordinating correctly between Ambetter from Magnolia Health and Magnolia Health (MSCAN).

- No refunds or rebilling: No need to worry about refunding previously paid claims or rebilling of claims.

- Claims repricing and processing: Impacted claims received between 1/1/2022 and December 2023, will be reprocessed and paid by Ambetter according to Ambetter payment rules and applicable reimbursement. Reprocessed claims that result in payment amounts greater than what Magnolia Health (MSCAN) paid will result in payment of the additional amount owed. An Explanation of Payment (EOP) will be provided with the explanation code EXmk and the provider's patient control number from the original paid claim to support with reconciliation to the claim paid on the EOP.
- Protecting payments: Should reprocessing result in a denial or lower payout, we will not recoup funds and previous payments will remain unchanged.

Mitigating member impact

Your patients won't face extra financial burdens:

- Waived cost shares: We plan to waive any cost share the member may have accrued had the claims processed under Marketplace. This is to minimize any inconvenience to our members.
- Provider payments: We intend to reimburse the provider any applicable member cost share amounts when the claim is reprocessed.

Timeline for adjudication

Repricing will begin in early March 2024. Our goal is to adjudicate all impacted claims by June 1, 2024.
Please contact Ambetter Provider Services at 1-833-993-2426 or your Provider Engagement Representative for questions.

www.magnoliahealthplan.com

Provider Recredentialing Mississippi Medicaid Managed Care Programs. Mississippi Medicaid Bulletin. April 2024

"All providers participating in MississippiCAN or the Children's Health Insurance Program (CHIP) are required to be credentialed by the Mississippi Division of Medicaid. Failure to complete credentialing/recredentialing will result in termination from these programs. There are a significant number of providers currently due for recredentialing that need to complete the process.

During the 2021 Mississippi Legislative Session, Senate Bill 2799 was enacted into law that requires the Medicaid Coordinated Care Organizations (CCO) to follow a uniform credentialing process for provider enrollment in the Managed Care Programs. On July 1, 2022, in accordance with this new requirement, the Mississippi Division of Medicaid (DOM) amended the CCO contracts to require the CCOs to accept DOM's provider enrollment and screening process, and not require providers be credentialed by CCOs for Medicaid or CHIP. … "

https://medicaid.ms.gov/wp-content/uploads/2024/05/April-2024-Provider-Bulletin.pdf

CMS, NOVITAS, RAILROAD MEDICARE

Evaluation and Management Services Checklist. Railroad Medicare-Palmetto GBA. May 1, 2024

"This Evaluation and Management Services Checklist (PDF) is provided as a reminder of what to include when responding to a request for records for CPT® codes 99213, 99214, 99215, 99222, 99223 and 99232."

https://www.palmettogba.com/palmetto/rr.nsf/DID/1E5TU5WXRE#ls

Which Form Do I Use?. Railroad Medicare-Palmetto GBA. May 2024

"Find resources, links and instructions to assist you with selecting the proper appeals form. Find Railroad Medicare fillable and printable paper forms on our Forms page. Please review this updated article and share it with your staff."

https://www.palmettogba.com/palmetto/rr.nsf/DID/29PQQRO3AE#ls

Comprehensive Error Rate Testing Program: Reduced Sample Size Starting RY 2025. Railroad Medicare – Palmetto. May 7, 2024

"CMS will permanently reduce the Comprehensive Error Rate Testing (CERT) program sample size starting with reporting year (RY) 2025. The sample size for improper payment measurement review will decrease from 50,000 to 37,500 claims annually. Please review this information and share it with your staff."

https://www.palmettogba.com/palmetto/rr.nsf/DIDC/R0HZUSS354~Comprehensive%20Error%20Rate%20Testing%20(CERT)~Announcements%20and%20Reports

Comprehensive Error Rate Testing (CERT) Question and Answer Fact Sheet. Railroad Medicare- Palmetto. May 7, 2024

"This article includes questions and responses about the Comprehensive Error Rate Testing (CERT) program. Please review this information and share with your appropriate staff."

https://www.palmettogba.com/palmetto/rr.nsf/DIDC/AKJNDQ5022~Comprehensive%20Error%20Rate%20Testing%20(CERT)~Frequently%20Asked%20Questions

Stay of Enrollment. CMS MLN Matters MM13449. Effective Date: May 30, 2024 Implementation Date: May 30, 2024

- A new provider enrollment status called a stay of enrollment
- Updates to the Medicare Program Integrity Manual, Chapter 10

"Stay of enrollment is a CMS action that's less burdensome on providers and suppliers than a deactivation or revocation of your Medicare enrollment. A stay of enrollment (or "stay") is a preliminary, interim status representing a pause in enrollment."

https://www.cms.gov/files/document/mm13449-stay-enrollment.pdf

CMS Issues Final Rule To Boost Integrated Medicaid-Medicare Coverage. AOA First Look. May 10, 2024

"Modern Healthcare (5/9, Tepper) reports, 'A new federal policy promoting integrated Medicare and Medicaid coverage seems poised to boost health insurers such as Centene and Molina Healthcare with Medicaid experience and large numbers of high-needs Medicare Advantage members.' Under the rule, 'CMS aims to improve health and cut costs by more tightly coordinating Medicare and Medicaid benefits. By 2030, the agency will limit most D-SNP enrollment to a single integrated Medicare-Medicaid plan per geographic service area, usually defined as one county.'"

https://www.modernhealthcare.com/insurance/medicare-advantage-medicaid-dsnp-centene-molina

Diabetes Screening and Definitions Update: CY 2024 Physician Fee Schedule Final Rule. CMS MLN Matters MM13487. Released May 2, 2024. Effective January 1, 2024.

Make sure your billing staff knows about: the revised definition of diabetes, revised diabetes screening frequency limitations and coverage of the Hemoglobin A1c (HbA1c) test for diabetes screening.

https://www.cms.gov/files/document/mm13487-diabetes-screening-definitions-update-cy-2024-physician-fee-schedule-final-rule.pdf

OTHER

UnitedHealthcare Reimbursement Policy Update Bulletin: May 2024

RHW: Please review for details on reimbursement policy changes

Commerical Plans: https://www.uhcprovider.com/content/dam/provider/docs/public/policies/comm-reimbursement/rpub/UHC-COMM-RPUB-May-2024.pdf

Community Plans: https://www.uhcprovider.com/content/dam/provider/docs/public/policies/medicaid-comm-plan-reimbursement/rpub/community-plan-reimbursement-update-bulletin-may-2024.pdf
Individual Exchange Plans:
https://www.uhcprovider.com/content/dam/provider/docs/public/policies/exchange-reimbursement/erpub/UHC-Exchange-RPUB-MAY-2024.pdf
Medicare Advantage Plans: https://www.uhcprovider.com/content/dam/provider/docs/public/policies/medadv-reimbursement/rpub/UHC-MEDADV-RPUB-MAY-2024.pdf

HITRUST Bulletin: Multi-Factor Authentication. HITRUST. May 2, 2024

"HITRUST has received multiple questions from customers, assessors and relying parties following recent testimony before the Senate Finance Committee and the House Energy and Commerce Oversight and Investigations Subcommittee and is providing this bulletin to the HITRUST community in support of our ongoing commitment to cyber resilience, continuous learning, and continuous improvement.

Does HITRUST Require Support for Multi-Factor Authentication?

Yes, the HITRUST CSF and all HITRUST Assurance Reports require multi-factor authentication for remote access. Specifically,

- The organization requires multi-factor authentication for network and local access to privileged accounts.
- The organization requires multi-factor authentication for access to non-privileged accounts from remote networks (including accounts in Web applications and in remote access solutions such as VPNs)

Which HITRUST Certifications include Multi-Factor Authentication?

All HITRUST certifications include the above requirements for multi-factor authentication for access to privileged accounts and non-privileged accounts from remote networks for implemented systems in the scope of a certification. This includes:

- HITRUST Essentials, 1-year (e1) Assessment: Foundational Cybersecurity - The e1 provides entry-level assurance focused on the most critical cybersecurity controls to demonstrate that essential cybersecurity hygiene is in place. The e1 focuses on a curated set of 44 core requirement statements which encompass those fundamental cybersecurity practices. These practices have been shown to represent the core controls that any organization must apply to provide a basic level of trust.
- HITRUST Implemented, 1-year (i1) Assessment: Leading Practices - The i1 builds on those 44 requirements in the e1 by adding 138 requirement statements which address a broader range of cyber threats. The i1 provides a moderate level of assurance through the inclusion of controls that are generally recognized as leading cybersecurity practices.
- HITRUST Risk-based, 2-year (r2) Assessment: Expanded Practices - The r2 is a risk-based and tailorable assessment that provides the highest level of assurance for situations with greater risk exposure due to data volumes, regulatory compliance, or other risk factors. The r2 includes all 182 core requirements from the i1 as a baseline along with additional requirement statements based on the risk analysis HITRUST performs when an organization prepares for an r2 assessment.

Please feel free to review frequently asked questions about security events and HITRUST certifications at https://info.hitrustalliance.net/security-events-faq.
HITRUST customers are also welcome to contact their Customer Success Manager if they have further questions.

Biden Administration Expands Healthcare Coverage For DACA Recipients. AOA First Look. May 6, 2024

"The AP (5/3, Seitz) reported, "Roughly 100,000 immigrants who were brought to the U.S. as children are expected to enroll in the Affordable Care Act's health insurance next year under a directive the Biden administration released Friday." The move will "allow thousands of people, known as 'Dreamers,' to access tax breaks when they sign up for coverage after the Affordable Care Act's marketplace enrollment opens Nov. 1, just days ahead of the presidential election."

NBC News (5/3, Acevedo) reported, "An estimated 580,000 young adults who lack legal immigration status and have lived in the U.S. since they were children are currently working or studying without fear of deportation under DACA." Of those, HHS "estimates that over 100,000 young immigrants who lack health insurance will now have a shot at accessing affordable health care."

Reuters (5/3, Hesson) reported, 'Previously, DACA recipients were not allowed to enroll in the reduced-cost plans...but they could receive health insurance from an employer, buy private insurance or in some places access programs funded by states and cities.'"

AP: https://apnews.com/article/health-care-insurance-migrants-obamacare-biden-a38541478bc1f6b7662b3901cefc9e93
NBC News: https://www.nbcnews.com/news/latino/biden-daca-healthcare-coverage-new-rule-rcna150473
Reuters: https://www.reuters.com/world/us/biden-expands-health-insurance-access-daca-immigrants-2024-05-03/

Providers Accepting CHAMPVA: Enroll in Direct Deposit Now. CMS MLNConnects. May 9, 2024

"Are you a health care provider who submits claims to Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA)? Enroll in direct deposit to get your claim payments by electronic funds transfer (EFT). Getting paid by EFT is convenient, but it's also a federal requirement.
EFT is secure, efficient, and helps safeguard Veterans' family members' access to benefits.
If you haven't already:
Visit the VA Financial Services Center Customer Engagement Portal
Enroll using the Payment Account Setup web form
Your payments will be automatically deposited into a bank account.
If you aren't enrolled in EFT, your claims payments will be paused until you are. Make the move today.
For assistance with the webform, call 877-353-9791.
About CHAMPVA
CHAMPVA is a health care program for qualified spouses, widows(ers), and children of eligible Veterans. Through CHAMPVA, VA shares the cost of certain health care services and supplies with eligible beneficiaries.
More Information:
CHAMPVA – Information for Providers webpage
U.S. Department of Veterans Affairs webpage"
https://www.cms.gov/training-education/medicare-learning-network/newsletter/2024-05-09-mlnc#_Toc166060187

Assistant Attorney General Jonathan Kanter Announces Task Force on Health Care Monopolies and Collusion. US Department of Justice. May 9, 2024

"The Justice Department today announced the formation of the Antitrust Division's Task Force on Health Care Monopolies and Collusion (HCMC). The HCMC will guide the division's enforcement strategy and policy approach in health care, including by facilitating policy advocacy, investigations and, where warranted, civil and criminal enforcement in health care markets."
https://www.justice.gov/opa/pr/assistant-attorney-general-jonathan-kanter-announces-task-force-health-care-monopolies-and

Clarification on Prior Approval Requirements from Premier, the medical and well vision subcontractor for WellCare Medicare. May 29, 2024

"Premier is contracted for Routine Vision services (annual comprehensive eye exam and eyewear) in 36 states with Centene/WellCare. For 2024 we are contracted for medical services provided by Optometrists only (OD Medical) in the following states: AL, GA, IL, MA, MI, MO, NC, NE, NJ, NM, NV, OK, PA, SC, TN and TX.

Routine Vision services or "well vision exams" do not require prior authorization. This is an annual comprehensive eye exam, available January first of each year, that includes refraction and a dilated retina exam. Providers check eligibility on Premier's provider portal, administer this once a year benefit, and submit claims to Premier for processing and reimbursement.

For medical services provided by Optometrists (OD Medical) prior authorization is required for all services provided. Premier is delegated with Centene/WellCare for medical necessity review for all medical services provided. Premier's provider portal is available to providers around the clock and 7 days a week for access. With the provider portal, provider support staff do not spend time on the phone or need to use faxes to obtain prior authorization. Prior authorizations are submitted on the portal at the convenience of the provider before the member's scheduled visit. Premier's turnaround time is historically 2-4 days, which well exceeds Medicare's guideline of 14 days. Further, the Premier provider portal is convenient and easy to use."