Managed Care Q&A

Behavioral Health Advisory Committee

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* **Contact and Resource Information**

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Links to all handbooks, provider directory, benefits, etc.:

[Health Plans (oklahoma.gov)](https://oklahoma.gov/ohca/soonerselect/health-plans.html)

Link to Oklahoma Complete Health Manual:

[Manuals, Forms and Resources (oklahomacompletehealth.com)](https://www.oklahomacompletehealth.com/providers/resources/forms-resources.html)

* Clarification might be helpful to assure providers we are still able to bill for case management services, and they will not be taken over by the entities.
  + Case management will not be taken over by the entities. All services currently compensable by Medicaid will continue to be billable by providers.
  + Aetna: An additional service to you all; it is intended to supplement. We have other internal teams that may be a resource to you all. Currently have a behavioral health team for recovery and resiliency and veteran health, etc. The goal is to provide support.
  + Humana: Have a team of behavioral health professionals and nurses here to assist as needed. The goal is not to take over but to be used as a resource to assist in anyway as needed. Can provide a list of those care managers. Providers will still be allowed to bill Case Management services.
  + OK Complete Health: To aid but are not providing direct care services.
* Providers would like assurance that our mental health and SA PAs will continue to be approved for 6 months.
  + The 6-month prior authorizations currently required for most outpatient services by DMH will not continue for SoonerSelect members (though CDC submission will continue for DMH contractors). Most outpatient services will not have a prior authorization. For services which are prior authorized now and continue to be prior authorized by the plans, those previous prior authorizations will be honored for 90 days.
  + Humana: Will have prior auth list soon (PAL=Prior Auth List) There will be specific time authorizations on that list. Length of a prior authorization will be determined by medical necessity and clinical justification.
  + Aetna: Website goes live 3/14 and will have the manuals as well as prior authorization information.
  + A prior authorization will be required for PHP (all plans).
* Would you please get confirmation that entities will be using Medicaid HCPCS codes?
  + Yes; the codes will not be changing.
* Claims payment turnaround time
  + Requirement is 90% clean claims within 14 days.
* Should we bill daily to each entity, so as to get repayment in the soonest timeframe possible?
  + That is at the discretion of your agency.
* Do all providers have to report Critical incidents for all clients to each of the entities?  (We already provide SA Critical Incidents to DMH.)
  + Critical incident reporting to managed care entities applies ONLY to enrollees receiving services at a PRTF (Psychiatric Residential Treatment Facility). Providers who are not providing PRTF services do not have to report critical incidents to managed care entities and should follow their current processes for incident reporting.
* EFT set up confirmation:
  + OK Complete Health = Payspan Health [Payspan | Login Page (payspanhealth.com)](https://www.payspanhealth.com/nps)
  + Aetna = Availity
  + Humana = Availity
* Regarding authorizations-Outpatient will need a CDC and then the managed care entity authorization?  Two separate actions to request authorization?
  + The CDC will continue to be required for all DMH contracted providers only. However, the CDC will not produce a prior authorization for SoonerSelect members, as those prior authorizations will now come from the appropriate health plan.
  + Please reference the fact sheets provided for more information.
* The recent security breach at Change Healthcare has taken down PayerEnrollServices.com, the site that Aetna states to use to enroll in EFT/ERA.  Is there an alternate process to submit our information?
  + Traci Bartley w/ Aetna will follow-up.
* When we are billing services rendered by candidates for licensure, do we bill under the supervisor's NPI or the candidate's NPI?
  + The candidate's NPI will be utilized as it is now.
* Do we use the HCPCS codes like we do today with OHCA or are we going to use CPT codes?  For example, 60 min of therapy is H0004 vs 90837.
  + No codes changing. We currently use a mix of CPT and HCPCS codes, and those codes will remain the same.
* Will we be able to check eligibility before April 1st?
  + No (this was re-confirmed by OHCA)
* What's the process to test the billing files before April 1st?
  + Claims testing is currently underway.
    - Aetna testing w/ Grand MH and Creoks
    - OK testing w/ Red Rock and Creoks
    - Humana is testing 8 providers (Carl Albert, Grand, Gateway,etc.)
* Regarding SHOPP Payments: Will there be actions this month to clearly disseminate information about inpatient payments, directed payments and other essential elements to help inpatient providers with forecasting and planning?   Who is the best resource to contact in these matters?
  + Humana: SHOPP payments are being set up right now. Reps. have reached out to collect information. If you have not received the information or have not responded, please contact Humana as soon as possible (dpyeatt@humana,com). A W-9 and cancelled check or bank letter is required.
  + Nothing Changing (Tanesha w/ OHCA)
* For inpatient services will we be accessing OHCA portal for updates, or will each entity have their own portal?
  + Availity will be used for SoonerSelect (managed care) members
* It is my understanding that tribal citizens that didn’t opt in, will continue to have Soonercare. Is that correct? Does that mean we would continue to bill OHCA for op behavioral services?
  + Yes, tribal members have the option to opt in or out of SoonerSelect (managed care) at any time. For those tribal members who do no opt in to SoonerSelect, you will continue to bill as you do now.
* How quickly will we know if a claim is not “clean”?
  + OK Complete Health: Have 14 days to notify although average turnaround is approx. 7 days.
  + Humana: If using a clearinghouse you will know within 30 minutes of submission in Availity whether or not a claim is “clean”. You can also look at your reports section for denials daily, weekly, monthly, etc.
* Will the prior authorization process be the same for each CE or are they specific to the individual company? (For IP or PRTF stays)
  + Each plan may have different criteria, but Availity will be used to submit prior authorizations to all three plans.
* Can children switch?
  + Children not in the Specialty Plan can switch like other populations. Children enrolled in the Specialty Plan would only switch if they were no longer eligible for that plan (aged out, no longer in custody, etc.)
* Is there a limit to the number of times within the 90-day initial period for the regular members to change plan enrollments?
  + Members can only change one time within the 90-day period.
* For agency outpatient programs, will DMH certification be an allowable credential?
  + The current requirements for credentialing/certification of agencies and individuals will continue.
* If a provider has a MCD and a DMH contract, will they be required to submit CDC’s for clients or will they only bill MCD claims?
  + DMH contracted providers will be required to submit CDCs for all individuals.
* Can someone please clarify for outpatient behavioral health agencies if TX plans are still required for services? If not, we will be losing the revenue for TX plan development- initial, and TX plan extensions?
  + Treatment plans will remain billable. However, they may or may not be required to be submitted as part of a prior authorization request, depending on the service and the health plan.