Bayou Health--Behavioral Health Noon Provider Calls Q&A

Question #	Questions	Answer	UPDATED
1	Can you please tell me where we can go to verify which Bayou Health Plan a member has chosen? Is it the Molina website? How do BH providers get access to Molina so that we can determine what BY plan our consumers are in as well as their eligibility for Medicaid reimbursable BH services?	Providers may use the eMEVS secure web-based portal starting Monday November 16 to verify Health Plan name. For more information on registering to use eMEVS to verify the member's Bayou Health Plan, please see Bayou Health Informational Bulletin 15-13: http://new.dhh.louisiana.gov/assets/docs/BayouHealth/Informational_Bulletins/IB15-13.pdf	
2	If the member has not chosen a health plan, which one is selected for them?	The method used for auto-assignment of persons not already in a Bayou Health Plan will seek to enroll family members in the same Health Plan. DHH will also use claims information to assist in enrolling a person who has been receiving specialized behavioral health services in a Health Plan that has in-network the provider he/she receives the most services from. If neither of these factors in applicable, Medicaid recipients will be assigned equally among the five Plans.	
3	Do you have any recommended points of contact for who would be helpful to discuss specifics about assessments, plans of care, and issuing authorizations at each of the 5 Bayou Health plans?	DHH has issued Informational Bulletin 15-15 http://new.dhh.louisiana.gov/assets/docs/BayouHealth/Informational_Bulletins/IB15-15.pdf that describes more specifics about how Health Plans will obtain necessary assessments ; DHH will issue an Informational Bulletin on authorization decisions made by Magellan before 12/1/15 and how long those will be valid prior to November 1. Informational Bulletin 15-14 summarizes each Health Plan's requirements for timely notification of inpatient admissions. http://new.dhh.louisiana.gov/assets/docs/BayouHealth/Informational_Bulletins/IB15-14.pdf Each Health Plan is finalizing their Provider Manual which will be posted on their website. DHH will continue to identify topics for Informational Bulletins and other work aids and make those available at the website www.MakingMedicaidBetter.com	
5	I am a durable medical equipment provider for special needs clients, a large number of my clients located throughout the state have the “opt out” option of Bayou health. Will this integration of behavioral health require my clients to be enrolled in a bayou health plan or Can they still “opt out”? If so how does that work with the enrollment deadline in November?	Some Medicaid enrollees (about 2,000 under age 18) for whom enrollment in Bayou Health is currently voluntary will be enrolled in a Bayou Health Plan to receive their durable medical equipment and other current Bayou Health services beginning December 1 (as well as to receive any needed specialized behavioral health and non-emergency medical transportation. Individuals who are enrolled in a Medicaid waiver or those age 3 to 21 who are on Registry waiting to get Medicaid waiver services still have the choice to enroll in Bayou Health or enroll in fee-for-service Medicaid. However if they choose fee-for-service Medicaid, they will be enrolled in a Bayou Health Plan for any specialized behavioral health and non-emergency medical transportation.	
6	Is ABA going to be moved from Molina into the Bayou Health plans as a part of this integration or in the near future?	Applied Behavior Analysis will not be transitioned from the current fee-for-service model to Bayou Health as a part of the 12/1/15 integration. The Agency anticipates moving ABA to the managed care delivery model but the projected date for doing so has not been determined.	
7	The Mental Health Parity and Addiction Equity Act, amended by the ACA, requires for health plans that offer both Medical/surgical benefits and mental health/substance use disorder benefits, and the plan or coverage provides for out of network medical/surgical benefits, the plan must also provide for out of network mental health/substance abuse benefits. I realize this was not an issue when behavioral health and medical services were separated. But once integrated, will behavioral health services also be reimbursed out of network, as medical services are currently in Bayou Health?	The requirements will be the same for specialized behavioral health service as for other Medicaid benefits and services providers through the Bayou Health Plan.	
8	Is the state still pursuing MLTSS for I/DD? This will facilitate a movement of a large percentage of our current patients if so. We are looking ahead to any additional changes in billing or credentialing.	Our Office for Citizens with Development Disabilities continues to actively work on the design and development of a totally integrated health care delivery model for individuals with intellectual and developmental disabilities.	
9	We are a mental health facility will Bayou Health Plans cover qualitative urine drug screen (80301)? Magellan stated it’s not covered service because we are a mental health provider to send claims to medical however; claims were forwarded to Molina and claims were denied stating send claims to mental health provider which is Magellan.	80301 is not a covered service under the Louisiana Medicaid State Plan and therefore the Contract between Medicaid and the Health Plans do not mandate that this be covered.	
10	My question is: If my authorization ends in February 2016 with Magellan…Do I still have to submit another authorization before December 1, 2015	You do NOT have to request another authorization from Magellan prior to December 1. The Health Plan will need to reauthorize services after December 1 but prior to the expiration date in February. Providers should follow the authorization request process for each Health Plan to ensure there is no interruption in services.	**UPDATED 10-1-15**
11	In listening to the call on today I believe I heard one of the presenters state that the transportation services would no longer be a "fee for service entity". I am confused as to what this means. Does this mean that the transportation services will no longer be a reimbursed program of Medicaid? I am asking this question because my agency was considering becoming a transportation provider due to the clinics location. The individuals we serve are in five rural parishes that does not have public transportation services. Please advise as this venture could become very costly.	Non-emergency medically necessary transportation will continue to be a covered service under Medicaid . However, these services will be provided only through the Bayou Health Plans and no longer directly managed/arranged by the Medicaid agency. We recommend you contact the Health Plans regarding your interest in providing NEMT and they can direct you to their NEMT subcontractor (Logisticare or SoutheastTRAN) for information on enrolling as a provider.	

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Question #	Questions	Answer	UPDATED
12	How will LPC's get reimbursed from Bayou Health for outpatient therapy services provided to Qualified Medicare Beneficiaries (QMB's)? My credentialing application is rejected by Medicare, as well as Molina. I can't even access the LA Medicaid website, nor am I able to able to check a member's Bayou Health Plan through Molina. I am forwarding an email I recently received from Senator Vitter. Thanks in advance for your response.	They will not be reimbursed for Qualified Medicare Beneficiaries (QMB) outpatient therapy services if you are not paid for the service by Medicare. QMB recipients are not eligible to receive services that are covered by Medicaid only and not by Medicare. QMB covers **only** Medicare deductibles and Medicare co-payments. If you are enrolled as a provider with one or more Bayou Health Plans, beginning November 16, 2015 you will be able to register as a provider to verify a member's Bayou Health Plan.	
13	When we have our data extracted on 10/1, will it still be available in CA until 3/1/16, or will it be erased from CA all together once it is extracted?	Data will remain available on CA until 2/29/2016. You can extract data as many times as needed.	
14	Do providers need to enter new clients and their progress notes into CA all the way up until 12/1, or can we stop using CA once we extract date between 10/1-12/1?	A provider can stop using CA at any time and submit claims through Magellan's Claims Courier.	
15	We normally submit out requests for reauthorization to Magellan 10 business days before the PA period ends because that it when they are "due" to Magellan.	Magellan will be sending out a provider communication regarding the service authorization process. If your question is not answered in the instruction they provide, please resubmit your question	
16	Currently, there does not appear to be any requirements related to what treatment plan forms that providers are using. Will this continue or will Medicaid have a specific treatment plan form they want MHR providers to use?	Medicaid will not require a specific treatment plan form be used by the Bayou Health Plans.	
17	As for the initial authorization and reauthorization process for each of the 5 Bayou Health Plans…..when will the plans let us know what the process is to request authorization from them, including which forms to use, and deadlines to submit the request to avoid lapses in service? We would really need to have all of this information, including their forms, by mid October so that we can get prepared to begin submitting requests to them the following month.	DHH will work to make this information available to providers and stakeholders prior to November 1.	
18	Currently if a patient is enrolled with Medicaid and they are a prisoner we are allowed to bill Molina for all inpatient stays – is this still the process?	The facility should check MEVS/REVS for the responsible party in order to determine where to submit the bill.	
19	I work at an agency that has long term substance abuse residential treatment (levels III.III and III.I) in Lafayette Louisiana. I understand that we will need to pre-authorize our Medicaid clients with the Bayou Health agencies. We also have a state contract for treatment of indigent clients that is administered through the Acadiana Area Human Services District. We have been prior authorizing the indigent clients with Magellan. We have not yet heard anything as to how we should prior authorize these clients on 12/1/15. When should we expect a plan for these contract clients?	The Bayou Health plans will NOT be prior authorizing for the indigent population. The Office of Behavior Health will issue further guidance.	**UPDATED 11-30-15**
20	I'm inquiring about the changes in Louisiana Medicaid secondary to Medicare, I'm a provider that performs mri's and ct's and needing to know if a patient has Medicare primary and a bayou health plan as secondary, will we as the provider need to get that mri or ct precerted as well.	Dual Eligibles are going to receive **only** their specialized behavioral health services and non-emergency medical transportation through the Bayou Health plans. Medicare remains primary and you will not have to coordinate care with the Bayou Health plans for a non-specialized behavioral health service such as MRIs and CTs.	
21	If we have clients with PA issues (PA approval gaps that are unresolved, PA approvals that have yet to be given, & other various issues with receiving PAs) that are still unresolved after Magellan's last day on November 30th will they still be eligible for approval with the appropriate backdating? If so, who will we dispute the PA issues with after November 30th and how do reach them (contact number, email, & fax number)?	Please refer the various communications issued by Magellan regarding service authorizations. If your questions are not answered, please resubmit them to Bayouhealth@la.gov.	**UPDATED 11-30-15**
22	The policy with Magellan has been to send referrals to pathways for 1915i a month in advance. For our 1915i Adult clients who expire in December and January, knowing that it takes quite some time for approvals, we're worried about how soon we can expect to find out the "new process" on how to have them assessed and approved for services?	Please refer to question number 21.	**UPDATED 11-30-15**
23	For our clients with 1915is that expire in November, we've already sent the referrals into pathways but are concerned because historically it has taken over a month for approval. Can we expect to receive approvals from Magellan and have the Bayou's honor them for 90 days even in our approval is granted after December 1?	Please refer to question number 21.	**UPDATED 11-30-15**

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Question #	Questions	Answer	UPDATED
24	When will we receive a signed contract from United/Optum?	Please follow up with each health plan directly. For a contact name and contact information for each health plan network staff, visit Makingmedicaidbetter.com. Select Medicaid Behavioral Health Provider Resources Select Bayou Health Contacts for Behavioral Health Providers If you do not get your contract issues resolved, resubmit your issue to Bayouhealth@la.gov.	**UPDATED 11-30-15**
25	What impact will the transition have on nursing homes?	All Nursing home residents enrolled in Louisiana Medicaid will be enrolled in a Bayou Health Plan to receive 1. Non-emergency **ambulance** medical transportation services 2. Any needed specialized behavioral health services (mental health and substance use treatment) they may need 3. PASSR Level 2 Screening Responsible Parties have received letters giving them the opportunity to choose from among the five Plans. If the Medicaid enrollees did not make a choice by November 6th, they were auto assigned on November 7th. They will still have until February 27 to change to a different Plan before they are "locked in" to that Plan until 2016 Open Enrollment	**UPDATED 11-30-15**
27	What changes will take place regarding the adult program/1915(i)?	DHH requested approval from CMS to simplify and streamline and increase access to services currently included through the 1915(i) program. Changes are: 1. Mental health diagnosis and score at least a level 2 on the LOCUS. (Currently requires Level 3) 2. Health Plans will have the option to obtain initial assessments and reassessments from providers of services with whom they contract, their own employees, or another qualified vendor. 3. Medicaid enrollees age 21 and above will be able to receive services from a licensed mental health practitioner without the need of a LOCUS assessment. The health plans will determine the medical necessity for individual, family, group, and testing services.	**UPDATED 11-30-15**
28	Will PAs with an end date of 11/30/15 be included on the PA file MGLN is sending to the plans? Is MGLN authorizing PAs effective 12/1 with a lower number of units for a shorter periods of time?	All PA were sent to the Health Plans. Magellan issued authorizations for the full appropriate time, however, the authorization is broken down based on the appropriate units per week based on the appropriate amount, direction and frequency as identified through the plan of care.	**UPDATED 11-30-15**
29	Will each health plan be able to determine if the adult services assessment will be independent? Who will be allowed to complete the assessment (Do they need to have special training? Just be licensed?)	Health Plans will have the option to obtain initial assessments and reassessments from providers of services with whom they contract, their own employees, or another qualified vendor. Please see Bayou Health Informational Bulletin 15-15 http://new.dhh.louisiana.gov/assets/docs/BayouHealth/Informational_Bulletins/IB15-15.pdf **NOTE: Informational Bulletins that summarize policies and/or procedures of each Plan are intended for quick reference and are accurate on the date they are issued. However, you should always check each Health Plan's Provider Manual-- once it is finalized and posted on their website-- as well as your actual contract as requirements may differ or change.**	**UPDATED 10-1-15**
30	Are recipients with Medicare as their primary required to enroll in Bayou Health for behavioral health services?	Yes, they will need to enroll for behavioral health and NEMT.	**UPDATED 11-30-15**
31	Will OBH provide LOCUS training?	OBH provided two sessions in November 2015. OBH will assist the MCOs as needed during the integration. Check with each MCO and the Makingmedicaidbetter.com website for training dates and times. BHSF (Medicaid) and OBH will work with Health Plans to maintain a master list of individuals who have completed and have been certified in LOCUS. LMHP staff are expected to complete the training once for all health plans.	**UPDATED 11-30-15**
32	Will psychological testing that is court ordered but not medically necessary be covered?	No--services must be medically necessary in order for Medicaid --included our contracted Health Plans--to reimburse for the services and the individual being tested must be enrolled in Louisiana Medicaid. There is no change in that policy with the transition from Magellan to Bayou Health.	
33	Do all claims for duals go to Medicare? How should claims for dual eligible be submitted?	The following response differs from and supersedes information provided during the call All claims for a Medicare covered service must first be submitted to Medicare. The claims will then be submitted by Medicare to Molina in a "crossover" file for further adjudication. If the claim is known by DHH/Health Plans to **not** be payable by Medicare, it can be sent directly to the Bayou Health Plan and a denial from the primary payer Medicare is not required. Refer to IB 15-17 Billing for Specialized Mental Health and Substance Use Services for Dual Eligibles.	**UPDATED 11-30-15**
34	Can you explain how authorizations will be handled during the transition?	Please refer to IB 15-18 and IB 15-19 posted on the Makingmedicaidbetter.com website for details. Also posted on the website are slides and a video presentation that addresses both information bulletins.	**UPDATED 11-30-15**

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Question #	Questions	Answer	UPDATED
35	Should claims for professional services be submitted to Medicare?	All claims for a Medicare covered service must first be submitted to Medicare. The claims will then be submitted by Medicare to Molina in a "crossover" file for further adjudication. If the claim is known by DHH/Health Plans to not be payable by Medicare, it can be sent directly to the Bayou Health Plan and a denial from the primary payer Medicare is not required. Refer to IB 15-17 Billing for Specialized Mental Health and Substance Use Services for Dual Eligibles.	**UPDATED 11-30-15**
36	When will Magellan stop authorizing services?	Please refer to question number 21.	**UPDATED 11-30-15**
37	When can we get specific information from each MCO on how they plan to handle authorizations, assessments, etc.?	Refer to Informational Bulletin 15-15 and future Informational Bulletins regarding authorizations. **NOTE**:Infomational Bulletins that summarize policies and/or procedures of each Plan are intended for quick reference and are accurate on the date they are issued. **However, you should always check each Health Plan's Provider Manual-- once it is finalized and posted on their website-- as well as your actual contract as requirements may differ or change.**	**UPDATED 10-1-15**
38	If a PA starts on 12/1/15, will the MCO honor the entire authorization of just 90 days?	Please refer to question number 34	**UPDATED 11-30-15**
39	Will health plans begin to authorize services on 12/1?	Yes	
40	When will providers begin submitting authorization requests to the MCOs?	MCO's that require prior authorizations began accepting authorization requests for outpatient services on November 23, 2015.	**UPDATED 11-30-15**
42	When will providers receive their contracts?	Medicaid has posted primary Health Plan contacts for Contracting-related questions at http://new.dhh.la.gov/assets/docs/BayouHealth/MCO_POCs_Behavioral_Health_Provider_Contracting.pdf and recommends the provider contact the Health Plans as soon as possible to enroll as a provider, complete credentialing, and enroll for EFT if applicable to avoid interruptions in cash flow	
43	Will there be an excluded population? What about Medically Needy Spend Down?	Medically Needy spend-down will not be enrolled in Bayou Health. All claims should continue to be sent to Molina. Other Medicaid enrollees excluded from Bayou Health are those not eligible to receive specialized behavioral health: Take Charge Plus, GNOCHC, as well as other eligibilty groups.	**UPDATED 11-30-15**
44	Will IOP services be covered?	Yes. Intensive Outpatient Patient Treatment [defined as > 6 but less that 20hrs/week of contact with a SUD Provider, and intermediary between Residential and non-Intensive Outpatient treatment (6 or less than contact hrs/week)], MUST be a covered service with integration. It is a core service for SUD treatment and was inadvertently left out of the Service Definition Manual and , therefore was covered by Magellan as an in lieu of.	
45	If member is receiving inpatient care in 11/2015 and still in the hospital on 12/1, who should the provider bill?	Please refer to question number 34 with a focus on IB 15-19.	**UPDATED 11-30-15**
46	How long will Magellan continue to pay claims?	Refer to question number 21.	**UPDATED 11-30-15**
47	Will providers send new and retro authorization to MCO?	Please refer the various communications issued by Magellan regarding service authorizations. If your questions are not answered, please resubmit them to Bayouhealth@la.gov. Also refer to question number 34.	**UPDATED 11-30-15**
48	What are the hours of operation for the MCOs?	The plans are also required to maintain a 24/7 crisis line for members answered by a live person. Plans are required to maintain a 24/7 line for providers to request emergency authorizations.	
49	Will anything change regarding payment of services for inmates?	No change in coverage for inmates.	
50	Can hospital staff administer the LOCUS tool?	Any individual administering LOCUS must be 1) a Licensed Mental Health Professional (LMHP); 2) complete required training and certification. Please contact the Bayou Health Plans for additional information	
51	Will there be a consideration for paper and electronic claims?	Please refer to Informational Bulletin 12-13 at www.makingmedicaidbetter.com . The Health Plans prefer electronic claims.	
52	Will providers need to submit authorizations on holidays or weekends? Magellan requires the authorizations must be submitted within the required timeline. Will providers need to have staff available 24/7?	The requirements for Bayou Health Plans differ as do the recognized holidays. DHH is has issued Informational Bulletin http://new.dhh.louisiana.gov/assets/docs/BayouHealth/Informational_Bulletins/IB15-14.pdf with each Health Plan's policy. **NOTE Informational Bulletins that summarize policies and/or procedures of each Plan are intended for quick reference and are accurate on the date they are issued. However, you should always check each Health Plan's Provider Manual-- once it is finalized and posted on their website-- as well as your actual contract as requirements may differ or change.**	**UPDATED 10-1-15**
53	Will providers need to send claims to Bayou Health and behavioral health plan?	No. Claims for all services provided by the Bayou Health Plan should be sent to the same address.	
57	With the change from Magellan to the Bayou health plans, we are making arrangements to continue services for new clients. What is the deadline to have new assessments turned in to Magellan? Will we need to have assessments turned in prior to November 30th to ensure approval?	Please refer to question number 21.	**UPDATED 11-30-15**

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Question #	Questions	Answer	UPDATED
58	For clients that need an IA/POC leading up to 12/1/15, if Magellan has not processed and authorized both 1915i and the POC by 11/30/15, what will providers need to do on 12/1 under Bayou Health to get an authorization for those services? If these are not processed, can we complete authorizations with new Health Plan prior to 12/1 so those authorizations will be in place on 12/1 to prevent further delay/lapse in services?	For any authorizations/ assessments that end 12/1/15 through 12/29/15 there will be a 30 day grace period through 12/30/15 during which services at the level authorized as of 11/30 can continue and to allow time for the provider to submit authorization request to Bayou Health Plan. Please refer to IB 15-18 for more details.	**UPDATED 11-30-15**
59	Are there any measures being taken at Magellan/Medicaid to speed up the processing time for IAs and POCs that are being submitted from now until 11/30/15 so to prevent lapses in eligibility and authorizations? The timeline often takes up to 8 weeks now and this often causes lapses and backdating by Magellan.	Please refer to question number 21.	**UPDATED 11-30-15**
60	For FFT, MST and CPST, these programs are authorized currently through Magellan for a specific period of time and number of units. Medicaid pays a certain rate per unit for these services. In the past, Magellan had told us that if these clients have another primary Insurance (other than Medicaid), that we could send our claims directly to Medicaid (the secondary payer) for these specific programs only. We would not have to send them to the primary insurance because the program is Medicaid billed only. Will that stay the same with the Bayou Health Plans?	Yes	
61	Authorizations-I understand that the Bayou Health plans will honor authorizations until 2/29/16. However, for example with MST, the authorization period is 5 months. So that means that we currently have authorizations with Magellan in which the 5 month authorization time frame will end AFTER 2/29/15. Will Bayou Plans honor the end date of the authorization (ex. March 30), or will providers have to do a new authorization on 2/29/16 for the last 1-2 months of a 5 month authorization?	Providers will need to submit authorization requests to the Bayou Health Plan for all dates of service 3/1/16 and beyond. Previously issued authorizations will not be considered valid. Please refer to IB 15-18 posted on Makingmedicaidbetter.com for additional details.	**UPDATED 11-30-15**
62	To clarify-there will be 1 website where all authorizations are done for all 5 Bayou Plans?	No. There is not a single website for submitting authorization requests to all five Bayou Health Plans. Each Plan will have their own requirements and, if applicable, their own website.	
63	We are writing you in regards of setting up EFT for the 5 bayou health plans. Can you direct us in setting it up with the 5 plans?	Refer to Informational Bulletin 12-13 (Revised April 1, 2015) http://dhh.louisiana.gov/assets/docs/BayouHealth/Informational_Bulletins/IB12-13.pdf **NOTE Informational Bulletins that summarize policies and/or procedures of each Plan are intended for quick reference and are accurate on the date they are issued. However, you should always check each Health Plan's Provider Manual-- once it is finalized and posted on their website-- as well as your actual contract as requirements may differ or change.**	
64	What will be the criteria for ACT services? Will they be the same across all plans?	The service authorization criteria may vary between each MCO for each service including ACT. The authorization criteria will be made available to providers through their Provider Handbooks by the middle of November 2015.	
65	What assessment will we be using in conjunction with the LOCUS to determine eligibility/authorization?	DHH is requiring that all Health Plans use the current assessment form (designed by DHH and used by Magellan) for the first six months (through May 31, 2016). Revisions could be made to the form after that but there will continue to be one form.	
66	Who will be allowed to complete the assessment (Do they need to have special training? Just be licensed?)	Assessments must be completed by licensed mental health professionals. Additionally, assessments and reassessments for adult rehabilitation services must be completed by LOCUS certified LMHPs.	**UPDATED 11-30-15**
67	Will we have to complete new assessments for all existing clients?	Providers will need to submit authorization requests to the Bayou Health Plan for all dates of service 3/1/16 and beyond. Previously issued authorizations will not be considered valid.	
68	Will authorizations continue to be done a year at a time for ACT services?	Contract/RFP, Rules, SPA, and Manual are silent on this for ACT. Magellan typically authorized ACT, based on the submitted plan of care for 12 months at a time. Bayou Health Plans will have flexibility to prescribe their own time lines for authorization of ACT.	
69	What are the time frames for submittal of assessments/LOCUS for new clients?	In association with LOCUS score submissions for those seeking rehabilitation services like CPST, PSR, ACT, and CI, Behavioral Health Assessments must be updated at least every 365 days or as needed any time there is a significant change to the enrollee's circumstances.	
70	Is there a time frame that we can expect to start receiving information from each of the plans. This is assuming we are contracted with each one (which we will be)?	Now that Health Plans have received all requirements from DHH related to specialized behavioral health services (on September 26) they will be finalizing their Provider Manuals. We anticipate that Health Plans will have the information providers need to know on their website well in advance of 12/1.	

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Question #	Questions	Answer	UPDATED
71	I would like to get some clarity on a question that we are unclear about per the call last week. Beginning Dec.1, should we bill claims to the individual Bayou Health plans depending on the plan the member has or will the claims be billed to Medicaid and forwarded to the correct plan?	Claims for dates of service on or after 12/1/15 must be sent to the Bayou Health Plan for which the member was enrolled on the date of service.	
72	Currently we login daily to the Magellan website to download new PA's. After 12/1, will providers have to login to all 5 health plan websites to get new PA's issued by each health plan ? or will providers be able to login to the Bayou Health Plan website to get new PA's issued from all 5 health plans (in other words, will there be one centralized location for providers to access PA's like we currently have with Magellan website).	Each Bayou Health Plan maintains their own provider portal.	
73	For new clients, will the Bayou Health Plans backdate PA's to the day the Freedom of Choice was signed, like Magellan currently does, so that services with new clients can begin immediately?	For adult services, the Freedom of Choice form will no longer be required after 12/1/15 as this form is required only for Medicaid waiver and waiver-like services, including 1915(i) services. The only except will be for authorizations for new recipients for adult rehabilitation services. Prior to December 1, 2015, Magellan will begin the authorization back to the date of the freedom of choice. Magellan will continue the current processes relative to Freedom of Choice forms for CSoC waiver services.	**UPDATED 11-30-15**
78	If there is an increase in the TGH rates, where are these rates posted?	N/A	
79	How will children under the state custody of DCFS and OJJ be assigned to the Bayou Health Plans?	The Bayou Health Plan will be selected by DCFS or OJJ (custodian of the child/youth)	
80	Our children living in our TGH home are currently assigned a Bayou Health Plan for medical services, will their Plan assignment remain the same for their Behavior Health services?	Yes, members will receive medical and behavioral health services from the same Plan. However, their health plan may have changed as a result of the annual Open Enrollment which provides members to change Health Plans. Check the eMEVs system to determine the health plan for each of your members. For information on how to access this system, refer to IB 15-13.	**UPDATED 11-30-15**
81	How do we obtain authorization for the clients currently living in our TGH home on November 29th	After November 30, 2015, authorization requests should be submitted to the member's Bayou Health Plan. Refer to IB 15-19 posted on Makingmedicaidbetter.com for details regarding transitional authorizations. ▯	**UPDATED 11-30-15**
82	It is my understanding that if we do not yet have signed contracts in place, we are unable to begin EFT application. If providers receive contracts at the last minute, there will be an influx of EFT/ERA applications, which will slow down processing. Do you have any recommendation as to how to best approach this?	DHH recommends that providers work to get all their contracts executed as soon as possible and make certain that Health Plans have everything necessary and are not waiting on additional information. Each Plan is working to get approximately 2000 contracts in place prior to 12/1 so providers may wish to follow up to assure receipt and that nothing is still needed.	
84	Regarding community based services that are only paid for by Medicaid and not Medicare, do we send the claim to Medicare first?	Please refer to IB 15-17 for details.	
85	Will providers need to enroll separately with each health plan for electronic fund transfer?	Please refer to Informational Bulletin # 12-13 (Revised April 1, 2015) http://dhh.louisiana.gov/assets/docs/BayouHealth/Informational_Bulletins/IB12-13.pdf **NOTE Informational Bulletins that summarize policies and/or procedures of each Plan are intended for quick reference and are accurate on the date they are issued. However, you should always check each Health Plan's Provider Manual-- once it is finalized and posted on their website-- as well as your actual contract as requirements may differ or change.**	
86	Will each health plan require a new full assessment at the end of 90 days for 1915(i) services?	DHH's contract with the Health Plan does not require them to do so for specialized mental health services for certain adults. Refer to each Health Plans Provider Manual or contact their Provider Call Center.	
87	How will the plans handle authorizations with an end date of 11/30/15 and a begin date of 12/1/15? Will the plans honor authorizations dated in this manner?	Bayou Health Plans will be receiving a file with the ending date of authorization and that date (rather than start date) will be used to determine if services were authorized by Magellan prior to 12/1.	
88	What will happen to existing authorizations on 12/1/15 if a member switches MCOs?	All Medicaid enrollees--with the exception of ~ 2000 children and youth enrolled in CSoC--will receive any authorized behavioral health services from a different Health Plan 12/1/15 as Magellan will no longer be operating as a Health Plan. The receiving Health Plan will honor authorizations issued by Magellan for up to 90 days. Refer to IB 15-18 and IB 15-19 posted on Makingmedicaidbetter.com for more details.	**UPDATED 11-30-15**

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Question #	Questions	Answer	UPDATED
89	Is there a record of staff certified to administer the LOCUS? Will this list be shared with the plans?	DHH will create and maintain a master list of LMHPs trained and certified to administer the LOCUS and will provide this information with the Bayou Health Plans. The Plans are encouraged to post the list on their secure provider portal for viewing by their providers.	
90	Has a deadline been imposed to the plans to finalize provider contracts?	DHH is closely monitoring completion of contracts and receiving weekly reports from each Health Plan on the # of completed contracts, # of contracts in process, and # of providers who have indicated they do not wish to contract with the Plans Providers who have submitted all necessary documents and information may wish to follow up with Plans to determine status.	**UPDATED 11-30-15**
91	Will OBH continue to certify providers?	No. Each Health Plan is required to be NCQA accredited and --at a minimum-- conduct credentialing according to NCQA requirements.	
92	Is it true that after 12/1/15 a referral from the PC will be required before the psychiatric prescriber affiliated with a behavioral health provider who also provides medication management by a licensed prescriber cannot see a member unless the PCP makes a referral for psychotropic medications or med management? Our understanding is that a member/guardian has the freedom to choose who will manage psychotropic medications and that the PCP and Behavioral Health provider need to collaborate on all services.	This is not a DHH contractual requirement and we are not aware of any such Bayou Health Plan policy, nor do we anticipate that DHH would approve such policy.should it be submitted for consideration.	
93	I think I figured out that each health plan will have their own individualized forms that need to be completed in order to phone in for an authorization for level 3.7 (Detox) or 3.5 (Rehab) services. This will be time consuming at best. Is this truly the case, and if so, any idea when we might be able to begin to familiarize ourselves with the new individualized sets of documents?	Each Bayou Health Plan will have details regarding their service authorization process for all levels of care posted on their website and in their Provider Handbook. When practical, DHH will work with the MCOs to standardize forms and processes across MCOs. The MCOs will finalize their Provider Handbooks no later than early November as they are currently waiting for approval from DHH.	
94	Based on the DHH call today, it sounds like a Licensed Mental Health Professional (LMHP) is the only credential that can administer a LOCUS/CALOCUS for authorizations for CPST/PSR level of care. Reviewing the information from the developers they state that an "MHP or individuals under the supervision of an MHP can administer" (see below). Can you confirm if the LOCUS/CALOCUS will need to be administered by a fully licensed LMHP for the Bayou Health Plans? When will more specific details about this process be available?	A licensed mental health professional will be required to rate the LOCUS. Providers can expect more information about the assessment process for adult rehabilitation services from Medicaid during provider calls and provider forums and in MCO Provider Handbooks.	
95	After the Licensed Mental Health provider does the assessment, submits it to the appropriate Bayou Health Plan, how can we be sure that a person is actually approved for the CPST/PSR services even though we, the assessor, know that the person does/doesn't meet criteria.	This is an operational detail that will be included in each MCO's Provider Manual. If the member meets the eligibility criteria to receive the service, providers can anticipate receiving an authorization for services.	
96	If they don't meet the criteria, then do we submit anyway and the Bayou Health Plan notifies the member or do we?	The Bayou Health Plans are required to provide written notice to members of all service authorization decisions.. The reason for the decision if requested services are denied in full or in part, and their appeal rights.	
97	If they do meet the criteria (MH diagnosis and LOCUS level 2), do we proceed to an actual authorization request?	If you have a member who does not qualify for adult rehabilitation services, which are intensive community base interventions, but may need other mental health or substance use services, an authorization request (if required) can be made to their Bayou Health Plan.	
98	What form do we submit to get services authorized?	The authorization process and forms should be posted on each MCO's website. Details of the authorization process will also be included in each MCOs Provider Manual.	**UPDATED 11-30-15**
99	Will the authorization resemble the authorizations today based on an amount and time span? Example: 200 units of CPST and 200 units of PSR from 10/5/15-10/5/16	The number of service units and the length of the service authorizations will likely vary between each MCO. The specific details should be available before the middle of November 2015.	
100	How will the amount of units be determined?	The process of requesting additional service units will vary between the MCOs. This level of detail will be part of the authorization process DHH expects the MCOs to post on their website and include in their Provider Handbook	
101	Will agencies be allowed to request additional units? What will be that process?	The process of requesting additional service units will vary between the MCOs. This level of detail will be part of the authorization process DHH expects the MCOs to post on their website and include in their Provider Handbook	
102	You mentioned that the provider will be responsible for the treatment plan. Will we use the existing Plan of Care or will the agency Treatment Plan suffice?	Please check with each health plan for required forms including treatment plans.	**UPDATED 11-30-15**

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103	Will crisis units be allowed and if so, what will that process be?	Crisis Intervention will continue to be available for youth and adults with procedure codes 90839 and 90840. The MCOs are expected to make both codes available and reimburse the minimum Medicaid rates. The specific authorization process for each code may vary between each MCO. The details will be included in the service authorization criteria for each MCO. Additional details should be available before the middle of November 2015.	
104	Will any of the Medicaid rules change for Behavioral Health services? At this time, Behavioral Health providers cannot bill phone calls or indirect work despite the importance in the member's care.	This has not changed in the Louisiana Medicaid State Plan.	
105	Will a Freedom of Choice still be required? If so, will the provider be able to get the member to sign our own FOC?	The Freedom of Choice Plan will be applicable **only** for children and youth enrolling in the CSoC 1915 c and 1915 b(3) waivers.	
106	If so, will there be a standardized form provided by each health plan for the FOC?	There will be a standardized Freedom of Choice Form for CSoC, which will continue to be managed by Magellan until it can be transitioned to the Bayou Health Plans	
107	Do we need to show proof of application, of some sort, for each client, to one or some or all of the 5 new agencies...even though we may never be able to bill them because of lack of CARF certification?	Bayou Health Plans are contractually required to follow current DHH policy in requiring that agencies offering mental health rehabilitation services (CPST, PSR and/or CI), PRTFs, TGHs and residential addiction treatment facilities supply proof of accreditation or proof that the applicant applied for accreditation and paid the initial application fee for one of the national accreditation organizations listed below. New agencies must present proof of full accreditation within eighteen (18) months following the initial contracting date with: • The Council on Accreditation (COA); or • The Commission on Accreditation of Rehabilitation Facilities (CARF); or • The Joint Commission (TJC).	
109	Will we after December 1st be required to include in each client's file a likewise similar proof of application(s) of sorts (in lieu of Medicaid) to pass our quarterly LCS-ATR review?	Yes, ATR providers must have documentation in each file of a client's Medicaid status even if the provider has chosen not to enroll with the five Bayou Health plans and bill Medicaid.	
110	When will the other two plans make a decision regarding assessments? When will we receive more information from the health plans on other transition issues?	All five Plans have indicated their intent to have their network providers who meet the requirements of being LMHP and completion of LOCUS training to complete assessments.	
111	How long will the eligibility period last for those members currently approved to receive 1915(i) services?	A new assessment must be completed every 365 days from the time the previous assessment was completed. Assessments are valid for one year. Our intention is to continue to require a new assessment every 365 days unless there is a change in the member's condition.	
112	Can we get more information on the authorization process? Will we receive more information about the authorization process prior to the roadshows?	Refer to IB 15-15 for some preliminary information, which DHH will be updating, as additional information becomes available into a grid for provider reference . We are also requesting that each Health Plan complete **a** one page work aid with the most important things providers need to know about the authorization process and will use the questions about authorization submitted by providers in creating the template for those one pagers. http://new.dhh.louisiana.gov/assets/docs/BayouHealth/Informational_Bulletins/IB15-15.pdf	
113	Will providers continue to use the current assessment form?	Independent Behavioral Health Assessment form and LOCUS are required. We are streamlining the process effective 12/1/15. During the first few months of the transition, we will use essentially the same five page form used by Pathways. The assessment form is CARF compliant. LGEs are allowed the use of any electronic health record version of the assessment they are currently using, along with the standard LOCUS scoring sheet. The goal is a single statewide standardized Bayou Health Assessment Form for Adults in the future.	**UPDATED 11-30-15**
114	It was announced today that the Fee Schedule was posted. I am unable to locate. Please advise.	Select the link below, to access the "Provider Call Resources" page. The first bullet under the "Resources" sub-heading is the Specialized Behavioral Health Fee Schedule. http://new.dhh.louisiana.gov/index.cfm/page/2248	
115	Did I just hear that all children's authorizations that end between now and 2/29 are being "automatically extended" to 2/29? If so, does this mean if we have a PA for a child ending in December, January or February, then we do not have to request authorization until end of February (it will be extended without a reauth request)?	For children not enrolled in CSoC who are currently receiving CPST and/or PSR with an authorization expiration date between September 21, 2015 and November 30, 2015, Magellan entered a new authorization to the current provider for CPST and/or PSR services. These authorizations extend up to February 29, 2016. No, any authorization expiring after Magellan's contract ends would be subject to the Health Plans for reauthorization.	**UPDATED 11-30-15**

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Question #	Questions	Answer	UPDATED
116	Is there a specific assessment instrument for intensive Outpatient Alcohol and Drug Services? It looks like the codes remain the same.	The Addiction Severity Index (ASI) is a 7 domain, semi-structured assessment instrument, which provides clinical diagnoses, and a determination of severity in all 7 areas of functioning, which helps inform the recommended ASAM Level of Care (ie., outpt, residential or hospital.) The 7 domains of functioning are: Alcohol Use, Drug Use, Family/Social, Psychiatric, Medical, Legal, and Employment/Educational. Each area is scored for level of problem and problem potential, with a full narrative explanation of recommended care. The ASI has been the required instrument for all publicly funded providers of SUD/Addiction Services. Assessment duration is approximately 1-1.5hrs. The ASI is in the public domain and internet based (there is a proprietary "light version").	
119	Currently, we only need to provide information regarding functional impairment and a diagnosis in order to get a child client approved for services. Before Magellan, the CALOCUS score was a requirement for getting new clients (children 0-20 years old) authorized for services. Will this be required again?	DHH does not intend to require the MCOs to use the CALOCUS.	
120	I know clients will be able to change Bayou Health Plans, and this change will only go into place the 1st of each month. If a client was authorized for services through a bayou plan and switches to another bayou plan, will we have to get them authorized with the bayou plan in which he or she switched to? If so, will this be like a new authorization/assessment process each time the client changes bayou health plans?	Yes; however, the "receiving" Health Plan will honor authorization of services by the "relinquishing" Plan for a minimum of 30 days, including paying a non-network provider during that period. We do not expect that a significant number of members will be changing Plans and it will become very rare after March 16 when members are "locked in" to their Plan until the next open enrollment in fall of 2016.	
121	I need a better understanding of the Assessment Process—specifically how long the actual assessment dates are good for. I got the impression on Monday's call that a Medicaid assessment is good for a year; therefore, anyone that was assessed under the current process will remain good until their actual yearly assessment unless there is medical necessity that another assessment is required. If this is the case, will we work from the 1915i date or the actual date the assessment was conducted? These two dates differ.	The date of the assessment . It is the completion of the assessment that must be done no less often than every 365 days.	
122	Based on the DHH call today, it sounds like a Licensed Mental Health Professional (LMHP) is the only credential that can administer a LOCUS/CALOCUS for authorizations for CPST/PSR level of care. Reviewing the information from the developers they state that	First, the CALOCUS will not be required by the state for members under 21 years old. To assess adults 21 years and older for rehabilitation services, the assessor must be an LMHP and certified in using the LOCUS.	**UPDATED 12-1-15**
123	Authorizations---does everyone need a new authorization by 2/29/15 or will the current authorizations last until the annual assessment dates expire?	Providers should assume that no authorizations decisions made by Magellan will be valid after 2/29/16 for children or adults.	
124	If clients have the option of changing plans on the 1st of every month, how will providers know which BH plan to send reauth requests to in advance? For ex, if a PA expires on 12/2, providers would normally send in a request a couple of weeks in advance.	DHH requires that Bayou Health Plans do the following to avoid disruptions in medically necessary specialized behavioral health services for members who change Health Plans: If the member is receiving services the day before MCO enrollment that were authorized by another Bayou Health Plan, the new Plan must *provide continuation/coordination of such services up to ninety (90) calendar days or until the member may be reasonably transferred without disruption, whichever is less. The MCO may require prior authorization for continuation of the services beyond thirty (30) calendar days; however the MCO is prohibited from denying authorization solely on the basis that the provider is non-contract provider.* This means that during the thirty days, they will pay for the previously authorized services to non-network as well as network providers.	
125	Are the BH plans going to expedite authorizations in these cases when providers have no other choice than to send in a request with only a day or two notice and also backdate them for us to avoid claim denials?	If the standard service authorization timeframes (80% of decisions in 2 business days of receiving all needed clinical information and 100% of determinations within 14 days of receipt of PA request) could "seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function", the Bayou Health Plans are required to make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires, but no later than seventy-two (72) hours after receipt of the request for service. d If an expedited authorization is being requested, it is important to clearly communicate that to the Bayou Health Plan. Expedited appeals can be requested as well.	
126	Is there any way to limit allowing plan changes to once a year like most people who have private insurance? Open enrollment is generally just once a year. This is going to be really hard for providers to keep up with monthly changes of plans.	Current Medicaid members will be "locked in" to a Bayou Health Plan beginning March 1, 2016. After that, it will be like private insurance with an annual open enrollment (2 month opportunity from September to November each year) or that they member was able to show good cause for changing. Once the transition is complete you can expect to see a lot more stability.	
127	Where can providers find the definitions for the service codes? Is the codes manual posted?	The Service Definitions Manual and all other relevant resources for specialized behavioral health providers can be linked to at DHH's Making Medicaid Better website http://new.dhh.louisiana.gov/index.cfm/page/2248 We are continuing to conduct gap analysis to make sure that the information is accurate and up-to-date.	**UPDATED 12-1-15**
128	We received an email today from Magellan stating that authorizations for 1915(i) services will be "broken up". Has there been any resolution regarding Magellan issuing authorizations that end 11/30/15 and authorizations that begin on 12/1/15?	Refer to question number 21.	**UPDATED 12-1-15**

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129	Can the health plans be urged to provide examples of the PA request form well in advance of 12/1 so that we can be prepared to submit new authorization request on 12/1?	We have communicated this need to the Health Plans	
130	When will the other plans begin accepting authorizations?	The health plans began accepting authorization requests on 11/23/2015. Outpatient services for which authorization is expiring 12/1 through 12/29 will have a 30 day grace period (through December 30 2015), effectively "turning off" PA during the transition month.	UPDATED 12-1-15
131	Do the plans have a deadline for releasing their policy for accepting authorizations?	The deadline for the plans to submit their policies and procedures to DHH was 10/9/15. DHH is currently reviewing MCO's policies and procedures to make sure that the policies and procedures are in compliance with our Contract and upon approval, these will be released by Providers via their Provider Handbook and websites.	
132	Will the criteria for receiving children's services change?	No changes have been made regarding the criteria for children's services. Youth in CSoC will continue to have their specialized behavioral health services authorized by Magellan with the exception of PRT, TGH, and SUD residential. Authorizations for children's services have been extended through 2/29/16.	UPDATED 12-1-15
133	Can providers access eMEVs prior to 11/16/15?	Effective November 16, 2015 all providers with an NPI and a contract with at least one health plan should be able to access eMEVS.	UPDATED 12-1-15
134	When can we start submitting PA requests for those whose assessment expires during the transition? How can we get them assessed immediately? Can PAs be turned off during the transition to avoid a lapse in services?	PA requests can be submitted beginning Monday 11/23/15; however, for purposes of timely decisions, DHH considers any request accepted by a Bayou Health Plan prior to 12/1/15 to be received 12/1. Outpatient services for which authorization is expiring 12/1 through 12/29 will have a 30 day grace period (through December 30 2015), effectively "turning off" PA during the transition month.	
135	Will authorizations continue to start on the same day the authorization is requested or will they begin on the date approved?	Yes; all Bayou Health Plans indicate that the effective date of authorization will be the date the request is received by the Health Plan	
136	Beginning 12/1, how will authorizations for services be handled when client's change Bayou Health Plans?	Any services the members is authorized to receive as of the day prior to transfer will be deemed to be authorized for 30 calendar days whether the provider is participating or non-participating with the receiving Bayou Health Plan.	
137	Will there be a grace period that the Bayou Health Plans have to honor the authorization on file from the previous Bayou Health Plan to allow time for providers to become aware of the change and submit an authorization request to the newly selected Bayou Health Plan?	For adults: 90 days unless the authorization expires before the 90th day following 12/1/15 For children and youth under age 21: 90 days; all authorizations have been extended through 2/29/16	
138	Will authorizations be dated to start on the day the provider submits the request or on the day the Bayou Health Plan approves the request?	The date the request is received by the Bayou Health Plan (	
139	How will this transition affect MST services? I was told that Magellan will continue to reimburse Evidenced-Based programs (i.e. FFT, MST, etc) through February, 2016 and then the Bayou Health initiative will roll over?	For dates of service 12/1/15 and after, Magellan will continue to manage specialized behavioral health services for children and youth enrolled in in CSoC waivers only. with the exception of PRTF and TGH. All other specialized behavioral health services will be reimbursed by the member's Bayou Health Plan on the date of service. Magellan will be responsible for paying claims for dates of service on or after 12/1/15 for four types of 24-hour behavioral health services o Non-ambulatory detox services as authorized through December 6, 2015 or the first concurrent review after November 30, 2015, whichever comes first. o Inpatient psychiatric services as authorized through December 7, 2015 or the first concurrent review after November 30, 2015, whichever comes first. o Substance use residential (ASAM Levels 3.1, 3.3, 3.5, 3.7 and 3.7D) services as authorized through December 13, 2015 or the first concurrent review after November 30, 2015, whichever comes first. o Psychiatric Residential Treatment and Therapeutic Group Home services as authorized through December 13, 2015 or the first concurrent review after November 30, 2015, whichever comes first.	
140	By now, the vast majority of Medicaid and LaChip recipients should've chosen a Bayou Health plan (or had one selected for them via auto-selection.) With that said, because this is a new integration, we're concerned about prolonged stopgaps of Medicaid reimbursements from Bayou Health. We understand that no system is perfect, but what have you done to ensure that providers are being reimbursed as quickly (and efficiently) as possible?	The auto assignment of members who have not chosen a Plan (and this will only for persons new to Bayou Health) is scheduled for November 6th. Health Plans are engaged in testing to assure that their claims processing systems are properly configured. See Informational Bulletin 12-13 for information on enrolling in EFT which is another step providers can take now to avoid interruptions in cash flow. DHH and Health Plans will be in "rapid response" mode to quickly address and resolve reimbursement-related issues as we are working to minimize-- to the maximum possible extent-- interruptions in cash flow for providers. http://dhh.louisiana.gov/assets/docs/BayouHealth/Informational_Bulletins/IB12-13.pdf	

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141	Is there a copy of the Bayou Health Billing and Reimbursement scales, rates for MST services, submission dates, and EFT provider reimbursement dates?	Yes FeeSchedule:http://new.dhh.louisiana.gov/assets/docs/BayouHealth/BHIntegration/SpecializedBehavioralHealthFeeSchedule.pdf EFT Provider Reimbursement Dates: See IB 12-13 http://dhh.louisiana.gov/assets/docs/BayouHealth/Informational_Bulletins/IB12-13.pdf	
142	If we encounter a child that meets our criteria for MST services (DSM IV diagnosis), but they have their own insurance plan, can we still provide services correct? We would bill the insurance company directly correct?	Yes	
143	What will the process be with the bayou health plans if a client who wants MHR services (PSR and CPST) has both Medicaid and private insurance? Will the claims be approved given private insurance plans do not pay for MHR services?	If a service is reimbursable by Medicaid and private insurance does not pay for the service, the claim would need to be sent to the primary insurer and denied and then submitted to the Bayou Health Plan. Our contract requires them to coordinate benefits for these services and not pay without a denial.	
144	I'm writing to obtain clarification for completing 1915i/POCs that has authorizations expiring in December 2015. Historically, 1915i/POCs could be submitted in 60 days in advance, which means authorizations expiring in December could be submitted within the month of October. I've received several requests from providers to complete 1915i/POCs with authorizations expiring in December. I'm unsure if I'm able complete assessments with authorizations expiring in December with the transition to Bayou Health. I've emailed Provider Liaison with Magellan whom referred me to DHH.	Any adult outpatient/community behavioral health services (non-residential services) set to expire prior to December 31 2015, will be automatically extended/approved by the receiving Bayou Health Plan through December 30, 2015. Any such services set to expire between December 31, 2015 and February 29, 2016 must be reviewed and reauthorized by the receiving Bayou Health Plan if they are to continue beyond the service authorization expiration date originally set by Magellan For any services authorized by Magellan <u>beyond February 29, 2016,</u> the receiving Bayou Health Plan will review and reconsider the medical necessity of the services before February 28, 2016 and send notification to the provider and member. Otherwise the Magellan-authorized community/outpatient behavioral health services may continue until the Bayou Health Plan formally renders an authorization decision at some point after February 28, 2016.	
145	Will FOC no longer be needed for children receiving MHR services?	The Freedom of Choice form will be required for CSoC services only. No other mental health services are being provided through a Medicaid waiver program.	
146	Will providers be required to register with CAQH (Council for Affordable Quality Healthcare)?	Registration with CAQH is not a requirement but is helpful to have a single source that provides a central location for entering your credentialing information. However, the MCOs will not automatically contact you as a result of your registration. You sill still be required to submit an application with the health plans.	
147	Magellan has offered a Medicare Opt-Out letter which allow providers to submit claims without providing proof of a Medicare denial. Will this option be available from the health Plans?	If the person for whom you are billing has Medicare coverage, the claim must first be submitted to Medicare with the exception of claims for which we know Medicare does not pay. See Informational Bulletin 15-17 for a list of those codes. http://new.dhh.louisiana.gov/assets/docs/BayouHealth/Informational_Bulletins/IB15-17.pdf	
148	Will the plans allow providers to submit assessments that have been completed within the past 365 days?	If the assessment has been completed within the past year, our expectation is that it will be honored by the Bayou Health Plan unless they have information regarding a change that would indicate the need for a new assessment.	
149	How far in advance can we submit reassessments?	Bayou Health Plans will begin accepting requests for authorization beginning Monday November 23rd. , F*or Contract compliance purposes and determining timeliness of authorization decisions , DHH will consider any request accepted by the Bayou Health Plan prior to Tuesday, December 1 201* 5 *to have been received on December 1*	
150	Magellan currently tracks authorizations for indigent, uninsured patients. Will the plans track this same information?	No--Bayou Health reimburses services for persons enrolled in Louisiana Medicaid only. OBH has issued an RFP seeking an entity that would be able to handle authorizations for medical necessity for indigent patients. Additional information will be made available to providers once it becomes available.	
151	What is the best way to determine what will be necessary for prior authorization for psychological testing for all 5 plans as of 12/1/2015?	Policies, procedures, and work processes for authorizations will be included in each Health Plan's Provider Handbook which must be posted on their website and made available to the provider on request. Until the Provider Handbooks can be finalized and posted, DHH surveyed Health Plans on 10/9/15 and they provided preliminary information. See summary of responses from Bayou Health Plans at this link:	
152	Will the Bayou Health plans date authorizations for service to begin on the date that the client signs the freedom of choice form and the initial intake is completed or will services be placed on hold until the authorization has been processed by the plan?	The Freedom of Choice form will not be required except for children and youth in the CSoC waivers. T*his form is required by Medicaid rules if the state is providing a service only to persons who must first meet all 1915(i) requirements. Our expectation is that starting 12/1/15 we will no longer be limiting the benefits to persons through the 1915(i) special requirements.* We surveyed the Plans the week of October 5 and all five Plans have indicated authorizations can be retroactive to the date the Plan receives the request.	

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153	When can I expect to receive the actual Assessment Form and Authorization request from each of the Bayou Health plans?	The adult assessment form for rehabilitation services is posted on the makingmedicaidbetter.com website along with the LOCUS score sheet. For other forms and authorization tools and assessments, contract each Bayou Health plan.	
154	Can I get some clarification on what I should include in my spreadsheet to be able to find out what Bayou Health plan our members have chosen? We then can send it securely once we have this information.	A file layout has been posted on Makingmedicaidbetter.com. Select-Medicaid Behavioral Health Provider Resources. The file name is *Bayou Health Prior Authorization Inquiry*	
156	Will the plans increase units to accommodate the extension of PAs through the 12/30/15 date?	Contact each Bayou Health Plan.	
157	How will reassessments for 1915(i) services be handled since Pathways is no longer completing assessments?	For those already deemed eligible for 1915(i) and are up for renewal, Magellan will allow servicing providers to complete the assessments and LOCUS without being an independent assessor. Provider staff completing the assessment must meet the same qualifications as independent assessors. Magellan staff will review and act as the independent reviewer. We will conduct additional follow-up and provide an update on tomorrow's call.	
158	For authorizations with approval dates that extend beyond 3/1, how will the plans know how many units are remaining on the authorization?	New authorizations should be issued for services on or after 3/1/16. In the event a new authorization is not issued, each Bayou Health Plan will receive an authorization file from Magellan that includes the start/end date of the authorization and the number of units for each service authorized.	
159	Will LOCUS training be provided before 12/1?	DHH will host a training in Shreveport on 11/30/2015. Visit Makingmedicaidbetter.com Select Behavioral Health then select Behavioral Health Informational Sessions and Training for training details.	
160	How will Magellan and Pathways work through issues with lapses related to 1915(i)?	While formal responses to pre-12/1/15 authorization requests may take as long as 21-28 days, if all required documentatn is received by Magellan, authorizations will be backdated to date appearing on FOC form.	
161	When members switch providers, should the old provider send the authorization that is currently in place to the new provider?	Each Health Plan will establish the information to be submitted with authorization requests and publish that in their Provider Handbook. In addition, Bayou Health Plans will be providing training such as webinars for their contract providers and DHH strongly recommends providers participate in the Bayou Health Plan-specific training that is offered.	
162	I've been informed that providers that are providing services to children and adolescents can continue providing services through 2-29-16 without concern of stoppage in Medicaid reimbursements from either Magellan or Bayou Health. Regardless of if your contracts with Bayou Health have been executed during that timeframe. Is that true?	This depends on the type of service (outpatient or 24-hour residential) and the data submitted by Magellan on the actual authorization file they are sending to DHH . For <u>outpatient services</u> Bayou Health Plans can require prior authorization at the time of PA expiration following initial 30 day grace period ending 12/30/15. This means if the PA expires 12/31/15 through 2/29/16, a new PA will be required.	
163	Any insight into children's assessments for non-CSOC children. It is my understanding that the child will need the behavioral health diagnosis and an active authorization. Is there any need for a C-LOCUS?	Services will require prior authorization at any point after 12/30/15 that authorization ends or prior to 3/1/16 if current authorization extends beyond 3/1/16 Expect more details in Provider Handbook issued by each Health Plan and in the provider trainings that each Plan will be conducting. DHH is not requiring C-LOCUS	
164	On 10/06/15, Magellan put out an announcement via email stating that Children's authorizations done between 9/21/15-11/30/15 will be allowed to be extended up until 2/29/16. Is this still accurate and if so, when can we see the actual automatically uploaded authorization.	If Magellan has issued an official authorization extension through 2/29/16 and that date is reflected on the PA file then authorization has been extended through that date. If the actual authorization end date on file ends earlier, the grace period for children as well as adults can end any time after 12/30/15 for outpatient services.	
165	How will the Bayou Health plans know what each member has left if they are going to use the already assigned units?	Each Bayou Health Plan will independently determine services needed for their members.	
167	In the initial set-up with Magellan, we were able to submit a Medicare Opt-Out Letter stating that our agency was not a Medicare provider and therefore could not bill for those services. Thereby, we were then able to directly submit claims to Magellan without first showing proof of the Medicare denial. How will this process work with the Bayou Health plans?	Bayou Health Plans will have claims editing in place to permit claims (based on provider type or service) to be submitted directly to the MCO without first submitting the claim for the primary payer Medicare. Refer to Informational Bulletin 15-17 for more details. http://new.dhh.louisiana.gov/assets/docs/BayouHealth/Informational_Bulletins/IB15-17.pdf	

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Question #	Questions	Answer	UPDATED
168	Will the Bayou Health Plans cover Interpretive Services?	Each Bayou Health Plan will be required to offer interpreters.	
169	Do we know yet if Magellan is going to continue to monitor CsOC clients? If so, will providers sign a new contract with them?	Magellan will continue to manage specialized behavioral health services for children and youth in CSoC beyond 12.1.15 for all specialized behavioral health services except PRTF and TGF and Substance Use Residential. A new contract with Magellan will not be required.	
170	I understand that our facility must be credentialed with Bayou Health as well as each of the five Bayou Health plans. Our providers must be credentialed with each as well, is this correct?	The Bayou Health Program is comprised of five MCOs (Aetna, Amerigroup, Amerihealth Caritas, Louisiana Healthcare Connections, and UnitedHealthcare). It is not necessary to be enrolled as a fee-for-service provider in Louisiana's	
171	We have discussed the need for assessors to be certified for LOCUS. What about children? Will we use the CALOCUS? CANS?	The CANS will only be used to assess youth for the Coordinated System of Care. The CALCOUS will not be required for youth.	
172	Who is responsible for claims for the OBH uninsured?	Bayou Health reimburses services for persons enrolled in Louisiana Medicaid only. OBH has issued an RFP seeking an entity that would be able to handle authorizations for medical necessity for indigent patients. Additional information will be made available to providers once it becomes available.	
173	How will authorizations be handled in situations where units have been exhausted before the 12/1-12/30/15 PA period ends?	We are currently discussing expiration of units internally and will respond when a decision has been reached.	
174	Will current per diem rates be honored for inpatient acute care? We've noticed that our individual rate differs from what is on the fee schedule.	DHH assumes that the Louisiana Medicaid fee-schedule for specialized mental health and substance use treatment services initially published on the Medicaid website on 10/6/15 reflects rates currently being paid by Magellan. Providers whose current reimbursement rate differs from the fee schedule	
175	Can you explain what was meant on the call today about a "30 day grace period" for authorizations?	From 12/1/2015 to 12/30/2015 a prior authorization will not be required for outpatient services if the member was authorized to receive these services 11/30/15 by Magellan.. Claims will also not be denied because the provider is not in the MCO's network.	
177	Can you please clarify how authorizations are being handled for outpatient clients. It was difficult to understand on the provider call. For ex, if a client has 7 sessions left in a PA that expires next year, will it expire 2/29 like the MHR authorizations?	Please refer to Information Bulletin 15-18: Authorization of Specialized Behavioral Health Services Effective 12/1/2015.	
178	When is the last day we will be able to requests for Authorizations to Magellan or Will we be able to send requests up to November 30	Magellan will authorize services through 11/30/2015,	
179	Currently , process for requesting MHR services (CPST, PSR) is very different from the process for requesting OT services. Will it remain like this with the 5 Bayou Plans, or will there be just one process for requesting MHR services and OT services	DHH expects the process will be similar but each MCO will have their own system. The authorization process will be detailed on each MCO's website and provider manual.	
180	Some clients are not currently enrolled in a Bayou Health plans. Will they remain without a health plan?	Those members who are eligible to receive behavioral health services will be enrolled in a Bayou Health plan. Some will be enrolled for behavioral health and NEMT services only. A small group of Medicaid individuals who receive waiver services have chosen to not enroll in Bayou Health.	
181	When patients with Medicare as their primary have exhausted their inpatient days for the year, how will payment be handled? We have been sending these claims to Magellan as Medicaid is the secondary but Magellan has not been paying on these claims because the services was not prior authorized.	The claims should be sent to the member's Bayou Health Plan.	
182	Currently, there are limited resources for patients being discharged from inpatient care. Are there any plans to expand services such as IOP and PHP?	The expectation is for the health plans to provide alternatives to reduce readmission. DHH is requesting approval from CMS to simplify and streamline and increase access to services currently included through the 1915(i) program. These changes included: 1) Mental health diagnosis and score of at least a level 2 on the LOCUS. 2) Medicaid enrollees age 21 and above will be able to receive services from a licensed mental health practitioner without the need of a LOCUS assessment. The health plans will determine the medical necessity for individual, family, group and testing services.	
183	We are finding that Magellan is not authorizing a service when the patient has been PEC'd and CEC'd by physicians who have had direct, in-person contact with the patient. Can we expect to see a change with the Bayou Health plans?	Any patient committed under an emergency certificate to inpatient treatment by a facility that provides mental health services must be evaluated by a psychiatrist or medical psychologist in the admitting facility within 24 hours of arrival at the admitting facility. After the psychiatric evaluation, payment of claims shall be determined by medical necessity. Each plan will employ its own interpretation of the Medicaid Medical Necessity definition and will utilize its own prior authorizatoin and/or service access criteria to render authorizatin decisions.	

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Question #	Questions	Answer	UPDATED
184	Is there a requirement for Magellan to extend authorizations for services for children whose authorizations expire in 1/2016?	Magellan will not authorize services beyond 11/30/2015. The extension to 2/29/16 is only for those with authorizations that will expire between 12/1-12/29/15. If the authorization will expire after 12/29, then providers should prepare to submit a new authorization request. Magellan was extending authorizations to 2/29 but they are not required to. The 30 day grace period will not apply to the following four providers PRTF, TGH, Inpatient and Residential Substance Use Treatment due to the need for concurrent review.	
185	Is there an update on DHH's relationship with Optum?	Optum is a subcontractor of United Healthcare.	
186	Can DHH issue an IB to address the 30 day grace period as it relates to adults and children?	We will issue an IB by Monday which will include a grid that details what needs to be submitted and when.	
187	Historically, Magellan has required that a Certificate of Need be on file in order to process a claim. Will the health plans require the same process?	Yes. The Certificate of Need is a federal requirement for those 21 or younger and are admitted to a psychiatric facility. Certification under § 441.152 must be made by terms specified as follows: (a) For an individual who is a recipient when admitted to a facility or program, certification must be made by an independent team that— (1) Includes a physician; (2) Has competence in diagnosis and treatment of mental illness, preferably in child psychiatry; and (3) Has knowledge of the individual's situation. (b) For an individual who applies for Medicaid while in the facility of program, the certification must be— (1) Made by the team responsible for the plan of care as specified in § 441.156; and (2) Cover any period before application for which claims are made. (c) For emergency admissions, the certification must be made by the team responsible for the plan of care	
188	Magellan has been issuing authorizations with an end date of 11/30/15. Will these authorizations be honored by the health plans?	Please see IB # 15-18 and 15-19. If the actual end date of the AUTHORIZATION (as opposed to the units allocated) expires on 11/30 through 12/29/15, a Grace period will be in effect, during which no prior auth will be required until 12/30/15. Claims will not be denied solely because provider is not in network on date of service, and the Bayou health Plan for the member is responsible for payments for service rendered 12/1/15 and after. For further details, please see the informational bulletins.	
189	Will the plans have a better practice in place to enter CONs? Providers are currently faxing the forms to Magellan but Magellan does not always receive the form.	Providers will need to inquire to each plan regarding their preferred method of receiving CONS. Plans may elect to develop processes that allow their own MCO staff to act as the independent team assessors for the purposes of CONs for both inpatient psychiatric hospitalizations and for PRTF admissions, but that will be at each Bayou Health Plan's discretion, staffing, resources, etc.	
190	How many contracts have been approved by the health plans?	There are at least 2,000 unique providers and if each are contracted with all 5 health plans, the approximate number of expected contracts is 10,000. To date, approximately, 80% of the contracts have been executed. Claims will not be denied for the first 90 days due to providers not being contracted. Claims will deny after 3/1/16 if providers are not contracted.	
191	During the noon call today, Dr. Hussey stated that providers can complete adult re-assessments for adults whose 1915i expires between now and 11/30/15. He stated that only the "Pathways" Independent Assessment form needs to be submitted to Magellan; the LOCUS does not need to be done. Does that also mean that a Targeting and Level of Need Determination form does NOT need to be completed? Also, related to this - how early can a provider begin submitting LOCUS assessments to the Bayou Health Plans, knowing that an adult's authorization will expire in December?	Correct. For those RENEWALS, members who have already had a Targeting and Needs Based Assessment, LOCUS and POC completed for 1915(i) services, only a (non-independent) assessment will be required for reauthorization, based on prior LOCUS, POC, etc. New members/initial 1915(i) clients will still need an assessment, LOCUS, and Treatment Plan or POC, and Freedom OF Choice form to be considered for 1915(i) service eligibility. While the approval/auth process may be delayed due to Magellan staffing issues as the contract winds down, Magellan will back date auths to date on FOC form.	
193	I am trying to locate the assessment document that will be able to be utilized by the providers. I think I heard you mention that it was available; however, I cannot locate. Can you please let me know where I can find it? Also, did I understand correctly that if we have a member that has lapsed, for example, since August and we have a copy of the actual IA from Pathways, is it ok when	Assessment link: http://new.dhh.louisiana.gov/assets/docs/BayouHealth/BHIntegration/BHBHA-A.pdf LOCUS Score Sheet Link: http://new.dhh.louisiana.gov/assets/docs/BayouHealth/BHIntegration/locus_score_sheet.pdf Otherwise these can be found at the	
195	Good afternoon. I am writing to follow up on the concern that was raised on the provider call last week regarding the lack of assessors in the Baton Rouge area since Pathways has nobody to do them anymore. I have received several referrals for client who are preparing to discharge from area hospitals and need a 1915i assessment so that they can be picked up by the FACT team. Has any decision been made about whether providers can start doing these assessments early so that we do not have clients who we cannot open or who experience a lag in services?	For any 1915(i) services, including ACT, which are intended to be delivered on or before 11/30/15, please complete an assessment, FOC, LOCUS and Treatment Plan (POC,if you have one or can) and submit to Magellan. While Magellan may take 3-4 weeks to complete the review, they will backdate to the date on the FOC. For services intended to be started on 12/1/15 or after, please submit to the member's Bayou health Plan according to their procedures.	
197	It is our understanding that the bayou health plans are going to honor all authorizations that Magellan gives up to November 30 for 90 days (unless it was initially authorized for less time.) The concerns that we have at this time are: 1. Magellan is currently taking a long time to authorize services. We are concerned that we will not have all of our authorizations for services we are currently providing by November 30. 2. We still don't know the authorization process that each of the Bayou Health plans will require for new clients requiring services starting December 1, or for those clients in FFT, MST or CPST/PSR who will require reauthorizations in December. Are there any updates about these issues?	For new/initial auth requests for services provided on or before 11/30/15, Magellan will back date to the date on the FOC, assuming the assessment, treatment plan, and locus are completed and sent in timely. For renewals of services previously authorized by Magellan, a (non-independent) assessment is required, but no LOCUS POC or tx plan are required. For 12/1/15 and beyond, neither assessment, LOCUS or treatment plans will be required for LMHP services like individual, family or group psychotherapy. (Non-independent) assessments and LOCUS Score Sheets will be required for those adults seeking rehab services (CPST, PSR, CI, ACT). Details of how each Bayou Plan will conduct auths will need to be addressed on a plan-by-plan basis.	
200	Currently , the process for requesting MHR services (CPST, PSR) is very different from the process for requesting OT services. Will it remain like this with the 5 Bayou Plans, or will there be just one process for requesting MHR services and OT services?	For rehab services like CPST, PSR, CI and ACT for adults, a (non-independent) assessment and LOCUS will need to be submitted to the member's health plan. For LMHP services like indiv, family and group psychotherapy, no assessment or locus will be required. Otherwise, processes will vary by plan and service. Check with the individual plan.	

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Question #	Questions	Answer	UPDATED
202	Will the Bayou Health plans accept the assessment and LOCUS completed by Pathways/another Independent Assessor that was completed within the last 365 days as opposed to requiring each provider to complete a new assessment when submitting a new request for authorization of services?	If the LOCUS and assessment were completed by qualified practitioners/assessors within 365 days, the plans should accept them for the purposes of determining eligibility for rehab services like CSPST,PSR, ACT.	
203	As of now, a client can only have 1 CPST/PSR provider. The only exception is that Magellan has allowed two CPST/PSR providers for one client at the same time if one of the providers was a PSH provider providing PSH services. How will this work under the Bayou Health plans?	No change anticipated at this time.	
204	It frequently occurs that clients try to obtain CPST/PSR services from multiple agencies (without knowledge of what they are doing). Presently, the Freedom of Choice form is used to determine which provider is identified as the one CPST/PSR provider who will be authorized and paid for those services. Whatever provider got the most recent FOC signed, then they were the provider that was authorized. How will providers know who is actually authorized for services and when those authorizations change?	While Louisiana Medicaid no longer requires that the FOC form be submitted, one or more of the Bayou Health Plans may choose to continue use of a similar form for other purposes. Each Bayou Health Plan will determine its own process for assuring that such services are not duplicated. Some may employ edits which prevent such duplicate billing. Others may rely on claims analysis or other processes. It should be noted that in some instances, such as those members in Permanent Supportive Housing, more than one rehab provider might be engaged -one for clinical services and another for tenancy supports.	
205	Has the RFP been awarded for non-Medicaid clients?	The Office of Behavioral (OBH) Health has not issued a contract to manage the non-Medicaid population. Please contact OBH for further details.	
206	We assist our client with applying for Medicaid but do not deny services while awaiting approval. Once they receive Medicaid we are able to back bill because we already have the authorization through Magellan. How will this work with the 5 Bayou Health Plans?	Contract each Bayou Health Plan to determine how authorizations and claims will be handled for members who receive services while an eligibility determination is being conducted.	
207	We have been working on planning a credentialing of the new providers and STILL have not been confirmed. Can this be improved?	Contact each health plan to check status. Claims for covered Medicaid services provided to Medicaid-eligible members will not be denied solely based on the provider not being in network until 2/29/2016.	
208	For an adult admitted (in-patient) on 11/29 and discharged on 12/6: Magellan authorizes on 11/29 and 11/30 Who do we call on 12/1 for continued authorization? –Magellan or Bayou Health Plan that member is enrolled in?	Informational Bulletin 15-19 addresses the stay beyond 12/1/2015. However, for a stay beyond 12/6/2015, a prior authorization with the Health Plan will be required	
210	Will prior authorizations (PAs) be required for CPST, PSR, FFT, MST, homebuilders?	Answers vary depending on the individual Health Plans.	
211	Does your plan reimburse for services provided by LPC's, LMFT's and LAC's, assuming they meet your credentialing requirements?	All Health Plans will be required to reimburse for all LMHPs who deliver allowable services within their scope of practice.	
213	Will you pay for same day visits, e.g. A BH and PC visit, in our integrative health centers?	Same day billing for behavioral health and primary care visits in FQHC's and RHC is not anticipated to be in place by 12/1/15.	
214	Would OBH consider increasing the reimbursement rate with an equal reduction in units authorized for PSR and CPST services? Why? This would increase quality and reduce the need for community MH specialists to frantically "chase units" to catch up with the same client 3x/week at school or home.	For services rendered post 12/1/15, the Health Plans will establish rates for services but the minimum floor will be the current Medicaid rate per the fee schedule found at www. makingmedicaidbetter.com	
215	Pathways are no long doing 1915i is their another agency in Baton Rouge that are doing 1915i until the change or until 12/1?	No. Magellan is waiving the Independent requirement for assessments and locus score sheets for new/initial authorizations. For renewals, only a (non-independent) assessment must be sent to Magellan. Auths will be based on previous POC on file.	
217	Will plans accept assessments and LOCUS summary sheets completed by independent assessors (not the contracted provider) that were completed in last 365 days?	Answers vary depending on the individual Health Plan. Please see the MCO Transition Q and A Response chart for details from each of the Health Plans.	
218	Will plans require both a LOCUS and a separate assessment or just the LOCUS?	Answers vary depending on the individual Health Plan. Please see the MCO Transition Q and A Response chart for details from each of the Health Plans.	
224	Do you have a preferred outline for a treatment plan to be included in our electronic medical record (EMR)?	Answers vary depending on the individual Health Plan. Please see the MCO Transition Q and A Response chart for details from each of the Health Plans.	
225	Per company, what specific outcome measures will you be looking for in our documentation in 2016?	Answers vary depending on the individual Health Plan. Please see the MCO Transition Q and A Response chart for details from each of the Health Plans.	
226	Will your company be offering any kind of incentive plan for performance improvement?	Answers vary depending on the individual Health Plan. Please see the MCO Transition Q and A Response chart for details from each of the Health Plans.	
227	Will you be doing a site visit and / or site audit of our four health centers in 2016?	It is possible but depends on the individual Health Plan. Site visits shall be conducted according to a periodic schedule individualized by provider type determined by the MCO and approved by DHH. Schedules for such visits and/or providers who will be visited have not yet been communicated to DHH. These shall take into account the monitoring responsibilities and efforts of the state agencies. Reports will be submitted quarterly to DHH.	
228	Will you require regular "huddles" and dynamic integrated treatment team	Effective communication among team members is critical to coordinate	
229	Which is the default Bayou Health Plan for members who do not choose a plan?	There is not a default Health Plan. Auto assignments are made using an	
230	What is the provider call phone number?	1-888-636-3807, Access Code: 1133472	
231	Which website will the PowerPoint slides be on?	The PowerPoint slides and many other provider resources can be found at www.MakingMedicaidBetter.com. Under the "helpful information" section in the center of the page, click on the "Medicaid Behavioral health Provider Resources" link.	
233	What is the current processing time for submission of renewals with Magellan.	It may take 3-4 weeks. We are expecting a rapid turnaround. The LOCUS will not be required for renewals and we anticipate that this will keep the process moving.	
234	What should providers for members who have run out of units?	Providers should contact Magellan to request a reconsideration. Until 11/30/2015	

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Question #	Questions	Answer	UPDATED
235	How can I get access to a template of the assessment that Pathways used that accompanied the LOCUS so we can use that assessment instrument?	The assessment and the LOCUS score sheet is posted MakingMedicaidBetter.com. Select the Link, Medicaid Behavioral Health Provider Resources. 1. Bayou Health Behavioral Health Assessment-Adult 2. LOCUS Score Sheet.	
236	Since a Freedom of Choice will no longer be required for members who receive CPST/PSR services, how will the Bayou Health plans know when a member changes providers?	Members will still have freedom of choice but will not be required to fill out a form. The MCO's will be responsible to ensure there is no duplication of services by more than one provider. This may be done through prior authorization and claims monitoring.	
238	We understand how PA's will work that expire between now and 2/29. Can you clarify how PA's will be handled that expire after 2/29. For ex, if we currently have a PA that is from 10/15/15 - 4/15/16. Will the end date change to 2/29/15 since the BH plans are only honoring them for 90 days? I ask b/c we received some correspondence from one of the plans that stated existing Pas that expire after 2/29 will be "reviewed", so we were not sure if that meant they may allow us to keep the current PA end date which is past 2/29.	The MCOs are expected to review each authorization prior to 2/29/2015. If not, the original authorization end date will stay in effect until the authorization review is conducted.	
239	As far as the Non-Medicaid (Indigent) population goes, who will be authorizing there care in order to be reimbursed by Office of Behavioral Health?	The Office of Behavioral (OBH) Health has not issued a contract to manage the non-Medicaid population. Please contact OBH for further details.	
240	I am an FQHC provider/s. Do I need prior authorization? I didn't need one prior to this change.	It will depend on the services that are being sought as to whether or not a prior authorization will be needed, as well as the individual Health Plan's requirements.	
241	Preauthorization is currently not required for outpatient substance abuse (only necessary for 10P). Will this be the same with all five health plans?	Answers vary depending on the individual Health Plan.	
242	What tobacco cessation services will be reimbursed?	Contact each Bayou Health Plan.	
245	Will peer support services be reimbursed?	Answers vary depending on the individual Health Plan. Please see the MCO Transition Q and A Response chart for details from each of the Health Plans.	
246	Can the behavioral health agencies complete their own 1915i's?	Beginning 12/1/15, the 1915(i) services will continue under state plan, without need for independent assesmsent, and servicing providers can complete their own behavioral health assesmsents, LOCUS and Treatment Plans. Independent assesmsents are no longer required by Louisiana Medicaid.	
247	What is going to happen to 1915i's? Is something going to replace it?	DHH intends to offer the services that are currently being offered through the 1915(i) as Medicaid State Plan services. We believe that this change will make these services available to more Medicaid members. LMHP services will be available to all adult Medicaid members for whom the services are medically necessary. The rehabilitative services available under the 1915(i) will be available to persons who meet certain criteria and for whom the services are medically necessary. So, all services previously avaiable under the 1915(i) will remain avaiable, but there will be no requirement that assessments or LOCUS be independent.	
248	What is taking the place of the 1915i's?	See response to question #247	
249	If a child is enrolled in CSoC, do we bill Magellan for CPST / PSR services?	Yes.	
250	If we are contracted with the Bayou Health Plan now, can we start filing claims with them instead of Magellan?	Specialized behavioral health services will not be covered by the Health Plans prior to 12/1/2015. Bayou Health Plans began accepting service requests for services that willl be provided on or after 12/1/15 on 11/23/15. Any requests for new services or for services which have prior authorization end dates on or after 12/1/15, should be sent to the member's bayou Health Plan.	
252	When will code H0014 be added to the Medicaid fee schedule (Ambulatory Detox)? It was inadvertently omitted in March 2012 and I've noticed it has not been picked up in the new fee schedule. Magellan added it, but its not on the Medicaid schedule.	The H0014 contract rate in effect under magellan is included in the 12/1/15 updated fee schedule as a contract rate	
253	Currently, Psychiatric Diagnostic Evaluations (90791) and medication management services do not require prior authorization. Will that be staying the same?	Each Plan will determine service-by-service authorization requirements. At the present time, it appears that all Bayou Health Plans have chosen to reimburse for diagnostic evaluations without need for prior authorization. This could change, based on experience for any given health plan or for any given provider.	
254	Will we continue to get the pass thru sessions for children and adults for OT? A. Children/adolescents: 24 sessions without authorization (then 7 at a time with auth) B. Adults: 6 sessions without authorization (then 7 at a time with auth)	There have been no changes to OT, based upon the integration of behavioral health services into the bayou Health Plans.	
255	We're are not seeing clients yet (waiting for the next quarterly MST 5 day training in late November). How does that impact our authorization process with Magellan and BH? Will we still be recognized by BH as a provider?	If MST or any other covered Medicaid service will be delivered on or prior to 11/30/15, authorization requests should be sent to Magellan. Otherwise, if services are not intended to start until 12/1/15 or after, auth requests should go to the member's Bayou Health Plan. Each Health Plan will distribute guidance on this topic before 11/30/15.	
256	We'll we be recognized by BH and be able to begin provide services after 12-1-15 even if the authorization forms aren't submitted?	If services were previously authorized under magellan, then no authorization should be required at least through 12/29/15. Please see IB #15-18 and 15-19 for service-specific detail. If contracted with the Health Plans, authorization and reimbursement for services may be sought. Providers will not be denied solely because of not having signed contract until 2/29/15. Please see IB 15-18 and 15-19 and plan-specific authorization guidance for details.	
259	If Magellan has any authorization forms that were not answered/decided on by 11/30...what happens then? Does BH pick up where you all left off?	Magellan will continue to process Clinical Appeals and Claims Disputes on claims/services provided on or prior to 11/30/2015. Clinical Appeals will be accepted by fax, email or phone by Magellan through 2/29/16, and claims/provider appeals will be accepted by Mageollan through May 31, 2017.	
260	If we're extended, do we need to request additional units? We haven't used any of the ones we've been allotted.	Please see Informatoinal Bulletins 15-18 and 15-19 for details. If avaiable units for any given member are in question, please contact the member's Bayou Health Plan for clarification.	
263	Currently and after Nov 6, 2015 is there a site we can go to pull a list of our current Medicaid recipients that will show the bayou health plan that they are in?	See IB 15-13	

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Question #	Questions	Answer	UPDATED
264	Are adults still going to be limited to 6 visits a year?	Will vary by Health Plan, but there are no Medicaid or DHH-imposed limits. State Plan services are based on Medical Necessity. After 12/1/15, the 6 visit "il lieu of" expanded service offered by Magellan will no longer be in effect and will ot be required, as LMHP services will be available to any Medicaid-eligible adult who has medical necessity for such services.	
265	For patients currently covered with Molina as a secondary coverage, will they be assigned to a Bayou Health plan, or only Magellan patients?	Only dual eligibles who currently receive secondary coverage with Magellan will be able to enroll with a Health Plan or be assigned to a Health Plan if they fail to select a plan by Nov. 6, 2015.	
266	I need more information regarding the statement about Molina – Do I have to be enrolled in Molina to find out which Bayou Health Plan my client is enrolled in? I think that is what I heard.	Please refer to Informational Bulletin (IB) 15-13 which is located at www.makingmedicaidbetter.com. You will find all information regarding how to verify Medicaid eligibility and a patient's Health Plan enrollment in that bulletin. In addition, the bulletin provides instructions on establishing an online account with Louisiana Medicaid in order to access eMEVS, the web-based tool that provides this information to providers.	
268	How can we help speed up the enrollment process? We get many individuals that do not realize that they are Medicaid eligible and are in desperate need of services. They must wait 45 days in some cases for coverage. We're an outpatient substance use treatment facility.	If someone applies on the basis of disability, the Medicaid agency may have to obtain medical records in order to determine if they meet the qualifications for the program. If you have medical records that can be submitted with the application, it may help speed up the process.	
269	Is there an enrollment period or can members change plans month-to-month?	Please refer to Informational Bulletin 15-12 which can be found at www.makingmedicaidbetter.com . The bulletin details the open enrollment process for active Medicaid Bayou Health plan members. Newly enrolled members are able to choose a health plan at the time of initial enrollment and change within the first 90 days of coverage if they choose to do so. Once that 90 day period ends, they are locked into their Health Plan unless there is a for cause reason for changing.	
270	What is a qualifying event that will allow a member to change plans outside of open enrollment?	Most for cause requests stem from members wanting to be assigned to the same Health Plan as other family members. Other for cause reasons include, but are not limited to: member needs related services to be performed at the same time, poor quality of care, lack of access to covered services, lack of access to providers experienced in dealing with the member's specific healthcare needs, and other special circumstances as approved by DHH.	
271	Will there be one website to check eligibility for members?	All Medicaid providers have access to the eMEVS system (Electronic Medicaid Eligibility Verification System) which will provide up-to-date eligibility information on Medicaid Bayou Health Plan members. Details on eMEVS can be found in Informational Bulletin 15-13 located at www.makingmedicaidbetter.com .	
274	What is specialized behavioral health and who provides that service?	This term has less meaning with the integrton/carve-in. In prior contracts with Bayou Plans and Magellan, pre-integration/pre-12/1/15, "specialized behavioral health services" included, but were not limited to services specifically defined in the Medicaid State Plan and provided by psychiatrists, psychologists, licensed clinical social workers, licensed professional counselors, mental health clinics, mental health rehabilitation service providers (public or private). These services were covered by the Statewide Management Organization (SMO)/Magellan for the Louisiana Behavioral Health Partnership (LBHP). Generally speaking at this point, specialized behavioral health services are those provided by behavioral health specialists, like psychitriasts, psychologists, LCSWs, LPCs, LMHPs, LACs, and APRNs with psych specialty training.	
275	Can you clarify how the 24 session pass through sessions work? Will it still be in effect?	It will be up to the individual Health Plans to determine if any "pass through" sessions will remain in place once integration occurs on 12/1/2015, and for which services, if any.	
276	Will certificates of need be used after 12/1/2015?	Yes. CON's are a federal requirement for those under 21 being admitted to inpatient facilities.	
277	Suggestion - Separate FAQs by service types (Inpatient, Outpatient, Residential, MH/SA etc.) Very difficult to find applicable answers because there are so many questions on website	DHH is in the process of categorizing all of the FAQs by topic.	
278	We are an outpatient substance abuse treatment facility. We currently assess using ASI in LASIS. Have a better form from CARF. Do Bayou Health Plans require us to continue to use ASI long form in LASIS or can we use CARF approved assessment?	ASI is required.	
279	Will the Bayou Health Plans require providers to be nationally accredited? Are site visits by the Bayou Health plans an alternative to accreditation?	DHH requires that the following behavioral health provider types be accredited: • Providers of mental health rehabilitation services, i.e. Community Psychiatric Support and Treatment (CPST), Psychosocial Rehabilitation (PSR) and Crisis Intervention (CI); • Providers of Assertive Community Treatment (ACT); • Psychiatric Residential Treatment Facilities (PRTFs); • Therapeutic Group Homes (TGHs); • Residential addiction treatment facilities. DHH approved national accreditation organizations include: • The Council on Accreditation (COA); • The Commission on Accreditation of Rehabilitation Facilities (CARF); • The Joint Commission (TJC). Site visits by the Bayou Health Plans are not an alternative to accreditation.	
280	When will we be able to start seeing client for CPST, PSR, and CI if the Bayou Health Plan are not finished with the credentialing process. I understand for the existing providers of these services will be able to continue the process until the end of February but what about new providers. Also how do we add on Medication Management.	Claims will not be denied solely because provider is not in network on date of service until after 2/29/16.	
281	So, the CSOC programs will not have to pay Magellan for management is that correct? But, the entering of consultation notes from the trainer client will need to go to a type system such as Clinical Advisor or Sharenote is that correct?	Magellan will be the single care management entity managing the csoc program and all providers delivering services to the csoc population. However, clinical advisor system will not be used.	

Bayou Health--Behavioral Health Noon Provider Calls Q&A

Question #	Questions	Answer	UPDATED
282	Can providers complete the 1915i Assessment now that Pathways is no longer completing them?	Yes. Magellan will act as the "independent" reviewer of assessments. LOCUS and Treatment Plans must still be sent on new/initial auth requests. Renewals no longer require LOCUS or POC/Tx Plans be sent for the renewal to be processed. Beginning 12/1/15, independence will no longer be required for assessments or LOCUS Score Sheets.	
283	I know we have until December 7 with the PA's. Who takes over issuing PA's on December 1, 2015 or before December ends?	See IB 15-18 and 15-19	
287	Will we continue to get the pass thru sessions for children and adults for OT? A. Children/adolescents: 24 sessions without authorization (then 7 at a time with auth) B. Adults: 6 sessions without authorization (then 7 at a time with auth)	No changes to OT have been made as a part of this integration process. Contact member's health plan.	
288	On one of the calls it was stated that the rates that we end with Magellan Bayou Health will pick up at the same rate. Can you confirm this?	Yes. Bayou Health Plans must honor rates on published fee schedule.	
292	What e-mail address should be used to submit assessments to Magellan?	The email address is IACBCM@magellanhealth.com. This e-mail address should be used to submit requests for renewals and initial requests for authorization.	
293	What is the target date for the health plans to issue their provider manual, policies, forms, etc.?	Readiness Review with the health plans will be completed by the end of November. Health plans will make this information available on their websites by 12/1/15..	
294	DCFS has linked the clients they serve to a specific health plan. Will other government agencies link their clients to specific health plans?	DCFS is not in a contractual relationship with the health plan they've chosen. DCFS chose to be linked with only one health plan. All of the health plans will work with all state agencies.	
298	How will LPCs receive reimbursement for those members that have Medicaid and Medicare, when Medicare has to be billed? First, only Medicare does not allow LPCs in Louisiana to bill for services?	See Informational Bulletin 15-16	
299	As a sole practitioner, if I provide a counseling session to a recipient on Dec 1, when should I expect funds in my account by EFT?	Answers vary depending on the individual Health Plan. Please see the MCO Transition Q and A Response chart for details from each of the Health Plans.	
301	I have several MHR's that I will be doing adult assessment and plan of cares for. I'm contracted with all five Bayou Health insurances. I need guidance on billing. Thanks!!!	Answers vary depending on the individual Health Plan. Please see the MCO Transition Q and A Response chart for details from each of the Health Plans.	
302	What is the status of same day billing for F.Q.H.C.s and RHCs?	No change form pre-12-1/15. Still of interest to DHH/Mediciad, but further study of PPS, Services manual and ruels need to be undertaken.	
303	Will Medicare dual eligibles now require precert with Bayou Health?	See Informational Bulletin 15-16	
304	How is Primary Care going to be reimbursed for handling Behavioral Med cases? Patients do not have resources to travel to BH providers (exp Shreveport). Any plans for a community Health Center in our service area? (Springhill) what is the closest?	Answers vary depending on the individual Health Plan. Please see the MCO Transition Q and A Response chart for details from each of the Health Plans.	
305	We are a Rural Health Clinic for primary care. If we have patients see the PC for medical diagnosis and mental (exp hypertension schizophrenia) will we be reimbursed at our same RHC rate? Are special visits required?	Answers vary depending on the individual Health Plan. Please see the MCO Transition Q and A Response chart for details from each of the Health Plans.	
306	With the integration of physical and behavioral health, and the focus on the "whole person", will medically necessary medical testing and medical services provided on a psychiatric unit, be reimbursed?	Answers vary depending on the individual Health Plan. Please see the MCO Transition Q and A Response chart for details from each of the Health Plans.	
309	When will the forms for authorization and Re-auth be available by each of the plans? We really need these by 11/15/2015.	Answers vary depending on the individual Health Plan. Please see the MCO Transition Q and A Response chart for details from each of the Health Plans.	
310	Is Magellan still accepting PA's until 11/23?	Magellan accepted PA's until 11/30/15.	
311	Since members can choose to change plans up to Feb. 25th, does this mean that if provider has not yet been credentialed with their provider they can change to a company which you are credentialed with (current provider)?	Members can switch MCO's without cause until 2/26/16. Providers must not "steer" members toweard or away from any MCO, regardless of credentialing status.	
312	What is the best way to check for credentialing status with the five plans?	Aetna: 1-855-242-0802; www.aetnabetterhealth.com/louisiana Amerigroup: 1-800-600-4441; www.myamerigroup.com/la AmeriHealth Caritas:1-888-756-0004; www.amerihealthcaritasla.com Louisiana Healthcare Connections (Cenpatico): 1-866-595-8133; www.louisianahealthconnect.com United Healthcare (Optum): 1-866-675-1607; www.uhccommunityplan.com	
313	If we want to add services after the initial credentialing process, do we need to request to make a change to our contract? What is the process for new services in a new location?	This should be discussed with each Bayou Health Plan. Some services have specific licensing, certification, or training requirements. Some requirements may differ from plan to plan. With regard to location, again, please contact each Bayou Health Plan. Bayou Health Plans may need to update thier network listings and geoaccess maps, etc.	
314	Will there be a loosening of the criterion to receive substance abuse treatment? I still have clients who need help but can only get Women's Health	No substance use disorder criteria changes have been made as part of this integration.	
315	Will Bayou Health Plans reimburse individual assessments or individual counseling for counselors in training or must they be a licensed professional counselor?	Answers vary depending on the individual Health Plan. Please see the MCO Transition Q and A Response chart for details from each of the Health Plans.	
316	Magellan started a program call child parent psychotherapy with LSA serving 0-6 years old and parents. Will this program's participants and new patient be honored?	These programs have been repeately communicated to each Plan by DHH. Each Plan indicated that they have contracted with these providers. MCO's must honor rates pide to such programs under Magellan.	
323	Please address the Issue of Degree. Will agencies be allowed to continue with BA level individuals to perform services in addition to MA level individuals?	There have been no changes to staff qualifications for covered state plan and/or waiver services. Staff qualified to render Medicaid-covered services prior to 12/1/15 will still be able to do so 12/1/15 and beyond.	
324	How will the provider know where to send the CON's to?	Answers vary depending on the individual Health Plan. Please see the MCO Transition Q and A Response chart for details from each of the Health Plans.	
326	For Intensive Outpatient Programs (Not Medicaid) will the crossovers (dual-eligible) Medicare/Medicaid continue to cross over to Molina? - Jill Elias jelias@delhihospital.com	Medicare IOP program services are not covered under Louisiana Medicaid. Only Substance Use IOP programs are included as Medicaid-covered services.	

Bayou Health--Behavioral Health Noon Provider Calls Q&A

Question #	Questions	Answer	UPDATED
329	What is the turn around for processing billing ?	Answers vary depending on the individual Health Plan. Please see the MCO Transition Q and A Response chart for details from each of the Health Plans.	
330	For FQHC's (Federally Qualified Health Centers) and Rural Health Clinics is there a date when a primary care visit and behavioral health visit will be reimbursed on the same day for Medicaid? In hope of true behavioral health integration.	Answers vary depending on the individual Health Plan. Please see the MCO Transition Q and A Response chart for details from each of the Health Plans.	
331	As an FQHC we already integrate Medical + BH as much as possible. We have seen and believe in collaboration. Unfortunately we only get paid for 1 encounter or visit per day regardless of how many fully, licensed providers see each patient. Can we get both disciplines paid per day? -	DHH and Medicaid are supportive of same day billing in FQHC's. In order to facilitate this, changes to policy, procedure, PPS rate methodologies, etc., must be addressed. This wil be taken up separate and appart from this implementioatn at a later date.	
332	Are there programs in place for Residential Programs?	Answers vary depending on the individual Health Plan. Please see the MCO Transition Q and A Response chart for details from each of the Health Plans.	
333	Will all 5 Bayou Plans have direct billing online for 1500 forms to UB04 Claims? -	Answers vary depending on the individual Health Plan. Please see the MCO Transition Q and A Response chart for details from each of the Health Plans.	
334	Who can I contact for specific questions in regard to the integration?	Rapid Response Line number to DHH/Medicaid: (225) 219-4195	
335	We are a rural health clinic. We already have contracts with Bayou Health Plans for medical services. Do we need a different contract for Behavioral Health Services?	Answers vary depending on the individual Health Plan. Please see the MCO Transition Q and A Response chart for details from each of the Health Plans.	
336	Who will be responsible for 1915i assessments; the provider or each Bayou Health Plan?	Post 12/1/15, servicing providers wil be responsible for the assessmnet, LOCUS and Treatment Plan. Independence for thiese is no longer required, and each Health Plan will be responsible for the Plan of Care for those adults seeking rehab services like CPST, PSR, Crisis Intervention and ACT.	
337	Who will do adult assessments in the future?	For adults 21 and over seeking rehab services, servicning providers may do behavioral health assesments and LOCUS. Independence will no longer be required.	
339	Who will be doing assessments for 1915i? 2) Who will be doing new authorizations of 1915?	Post 12/1/15, servicing providers wil be responsible for the assessmnet, LOCUS and Treatment Plan. Independence for thiese is no longer required, and each Health Plan will be responsible for the Plan of Care for those adults seeking rehab services like CPST, PSR, Crisis Intervention and ACT.	
340	If patient is confined 11/29 and discharged 12/15 - who do you bill? Magellan or Bayou Health Plan?	Please see IB 15-18 and 15-19 fr details on split billing	
342	Will the current PAs that we have be terminated on 12/1? If so, how will we obtain Pas from that point on?	Please see IB 15-18 and 15-19 for detals.	
343	Will Substance Abuse 10P authorization sent in by Nov. 1 PA be approved for the 8wks (full authorization) or will it be approved through Dec. 1?	8 weeks. See IB 15-18 and 15-19.	
349	Will all ADRA certified/Licensed staff LAC, RAC, CAC's be certified with all Bayou Health plans for reimbursement (substance use services)?	Answers vary depending on the individual Health Plan. Please see the MCO Transition Q and A Response chart for details from each of the Health Plans.	
351	Will patients be able to see 2 providers on the same day and both providers get paid? Example: Patient would see medical provider and behavioral health provider?	Answers vary depending on the individual Health Plan. Please see the MCO Transition Q and A Response chart for details from each of the Health Plans.	
352	As a provider if you are not completely contracted and cred. But have submitted the paperwork by Dec. 1st will you be able to retroactive bill for services provided to clients between 12/1 and whatever date you are officially contracted on? Or only able to bill services performed after your contracted date?	Answers vary depending on the individual Health Plan. Please see the MCO Transition Q and A Response chart for details from each of the Health Plans.	
353	Can we use our clearing house to file claims for each ins. co.?	Answers vary depending on the individual Health Plan. Please see the MCO Transition Q and A Response chart for details from each of the Health Plans.	
355	Is the reimbursement rate the same between the 6 providers?	Bayou Health Plan contracts require that reimbursement be no less than Medicaid published fee schedule in effect on Date of Service (Medicaid Rate floor). So, all plans will be required to pay at least what has been established under magellan. However, Plans may negotiate to pay higher rates in some circumstances at thier own descetion.	
360	12.) Will health plans uniform processes/requirements?	Some processes will be similar,if not identical, but others wil vary by plan. For example, each plan wil utilize the same Behavioral Health Assesment and LOCUS Score sheets for adults, and CSOC assesmsents wil remain standardized, but there are no uniform asseesments for non-CSOC youths.	
361	Do you have to be LMHP to fill out locees or just locees trained?	LMHP and LOCUS Trained/certified	
363	Will psychological testing be covered by all 5 Bayou Health Plans?	There have been no changes to psychological testing services related to thie integration. These remain covered and will require prior authorization by each plan.	
366	If the Freedom of Choice form is no longer applicable, how will the Bayou Health Plan know which provider is the "choice" of the member? For example, what is 2 providers send in an assessment?	Answers vary depending on the individual Health Plan. Please see the MCO Transition Q and A Response chart for details from each of the Health Plans.	
367	Will manual billing be able to be completed on one website, or will providers have to go on each individual insurance companies' website?	Answers vary depending on the individual Health Plan. Please see the MCO Transition Q and A Response chart for details from each of the Health Plans.	
368	Will clinicians need to complete training/certification to administer the 1915 assessment? If so, what steps need to be taken to get certified?	No assessment training is necessary, but LOCUS training and certifictin wil be required for those who have not already been trained and certified.	
370	If one of our clients are assigned to units with a provider , will their units and application roll over to the Health Care Company.	Please see Informational Bulletins 15-18 and 15-19 for details.	
371	Do we need to enroll in each Bayou Health Plan or will all 5 use the same Application?	Enroll in each health plan separately using their specific applicatin and contract packet.	
377	If Magellan is unable to process requests for authorizations submitted before 12/1/15, will Magellan issue authorizations good through 2/29/16?	Please see IB 15-18 and 15-19 for details per service and auth expiration date. For service requests submitted on or before 11/30/15 Magellan will issue authorizations retroactively. For concurrent authorizations sent in before 11/30, Magellan will process and issue authorizations for the normal length of time. The health plans should contact providers to do a new authorization prior to 2/29/16.	
378	Will authorizations be issued retrospectively for children?	Reference IB 15-18 and 15-19. Otherwise see response to Question #377.	
379	Regarding children and adolescents, should we submit our own assessment and POC in lieu of submitting a standardized form?	For CSOC, providers should submit the same form that is currently used. We are not aware of any standardized form that will be used by the health plans for non-CSOC children and adolescents.	

Bayou Health--Behavioral Health Noon Provider Calls Q&A

Question #	Questions	Answer	UPDATED
381	Can the health plans communicate the names of members who require authorizations between now and 12/30/15?	Please see IB 15-18 and 15-19. Bayou Health Plans should contact providers before current/historuic Magellan authorizaton expires. If no contact is made by the member's Bayou Health Plan to review expiring authorizatoins prior to the expiration date, we recommend contacting the Bayou Helath Plan prior to the expiration date or before 2/29/16, whcihever comes first.	
383	Should hospital staff be LOCUS trained?	Not at this time. If in the future for continuity of care the health plans want to reach out to the inpatient settings to do the LOCUS, then they can set that up. For now, we focus on outpatient providers as required in state plan.	
384	For new clients authorization requests, is it required that a POC be sent to Magellan as part of the initial request packet? We are not an Independent Assessor and have never used a POC document. Pathways is no longer serving our area and in the past they sent in the POC for us. Can we submit a treatment plan instead of a POC?	No. Intermim measures taken by Magellan to assure continuity have dropped the POC requirement. Magellan will utilize prior POC on fime for those who have one, and will request/require that the Assesmsent,LOCUS and a Treatment Plan be submitted for pre-12/1/15 service requests. Magellan will accept a treatment plan and will backdate the authorization to the date on the Freedom of Choice, assuming assessment and LOCUS indicate that the member meets medical necessity/eligibility for the services requested.	
385	If the freedom of choice is being discontinued, how will providers know that a member isn't receiving duplicate services from another agency?	Yes. FOC form is discontinued effective 12/1/15.	
386	On slide 5, it says effective 12/1/15 Magellan will no longer be the SMO for Medicaid specialized behavioral health, with the exception of CSoC children and youth. 1. Does this mean that Magellan will continue to administer specialized behavioral health services for CSoC children and youth? 2. Can you please define/explain CSoC children and youth? Is this a separate Medicaid program?	1. Yes, except for PRTF, Residential Substance Use and TGH. CSOC services are provided under a 1915c Home and Community Based Waiver, and are not state plan services. The waiver allows limited slots for CSOC services (2400 statewide), require independent assesments, and are restricted to certain providers (Wrap Agnecies and Family Support Organizations)	
392	Will reimbursement rates be same or different with each plan? Continued higher rates for kids? I current PA for # of visits with Magellan. That stops 12/1? I am contracted with all plans? With this involving a lot of change following ICDIO- why should I continue to be a Medicaid provider when private insurance reimbursement is also double current Medicaid rates?	Bayou Health Plan contracts require that reimbursement be no less than Medicaid published fee schedule in effect on Date of Service (Medicaid Rate floor). So, all plans will be required to pay at least what has been established under magellan. However, Plans may negotiate to pay higher rates in some circumstances at thier own descetion. Beginning 12/1/15, all requests for new services/authorizatns should be directed to the members' Bayou Health Plan. Medicaid is a jointly funded, Federal-State health insurance program for low-income and needy people. It covers children, the aged, blind, and/or disabled and other people who are eligible to receive federally assisted income maintenance payments. As such, reimbursement cannot compete with commercial/for profit insurance plans. Should any current Medicaid provider decide to no longer treat Medicaid recipients, that provider must work with each recipient to assure that appropiate referrals and transition plans are aranged, based on medical necessity for continuatin of services.	
394	Do patients have a set number of visits for behavioral/ mental health? Or is it included in the annual visits that Medicaid assigns for the year?	Medicaid-covered state plan services have no set limits, and are based on medical necessity. Adequate documentaiotn must be provided to justify authorizations over and above those initially allowed/offered by each health plan. Appeals and Fair Hering processes are in place for member and/or provider disputes relative to amount of services authorized.	
403	Who will authorize non-Medicaid clients for treatment? If the client gets Medicaid approved during treatment will the chosen plan honor the previous authorization?	The Office of Behavioral Health has set up its LaCAMS process for ASAM Levels III.5, III.7, III.7D, and IV, as well as for Inpatient Psychitric Hospitals admissions, and ACT. Lower level community -based services will be managed by local districts and authorities. Please access the OBH link for more informatin: http://dhh.louisiana.gov/index.cfm/subhome/10	
406	Split claims: Will the health plans require a separate claim for covered days and a separate claim for non covered days if there are non authorized days that are part of the same hospitalization?	Please see Informational Bulletins 15-18 and 15-19 for details on split billing.	
409	Are adjustment codes for all of the Bayou Health Plans?	Except for diagnostic evaluations, V-Codes are not generally considered sufficient for purposes of reimbursement for Medicaid-covered services. Consult with the member's specific Bayou Health Plan for more.	
412	What happens to the inpatient patients that are in the hospital prior to Dec + remain inpatient after Dec. Do we have to pre cert both or does it stay with the 1st one?	Please see Informational Bulletins 15-18 and 15-19 for details.	
416	If I am not a current provider, can I bill insurance companies?	In order to bill and be reimbursed by Bayou Helath Plans, providers must be credentialled and contracted with the member's Bayou Health Plan company/MCO. For those Medicaid-eligible members already receiving behavioral health services, claims will not be denied soley based on being a non-network provider until after 2/29/16.	
417	What about clients who had an authorization that expired prior to 11/30 but were awaiting decision from Magellan?	Magellan turn around time on such auth requests are 21-28 days, but Magellan feels it will be able to process all pending requests on or before 12/14/15. Magellan will back date auths to the date on the FOC or assessment, depending on the specific type of auth requested.	
419	Who in Medicaid is best resource for Behavioral/Mental Health services questions for children & adolescents?	Rapid Response Line: (225) 219-4195	
420	What is an "ACT" provider?	Assertive Community Treatmen. An evidence-based practice with established fidelity standards, which is avaiable to adults 18 years of age and older.	
423	What about LCSW Group sessions mental/behavioral health allowable for children + adolescent and/or parents?	There have been no changes to group psychotherapy codes, service defineitns or rates related to this integration.	
424	I have several clients that have overlapping PA's what will happen to these? Ex: 5/17 - 2/29, 12/1 - 1/1	Please contact your Magellan PRL for clarification.	
425	Can we bill for unlicensed mental health providers?	No changes in this from pre-12/1/15 LBHP/Magellan. Medicaid covered behavioral health services provided by non-licensed practitioners must be provided under the supervison of a Licensed Mental Heatlth Practitioner (Physician, Psychologist, LCSW, LPC, LMFT, LAC, or APRN-CNS.)	

Bayou Health--Behavioral Health Noon Provider Calls Q&A

Question #	Questions	Answer	UPDATED
429	When a patient arrives in the custody of the police, who is responsible for these services? And can the police entity release them during hospital stay?	Police do not have admission privilidges to any behavioral health facility, and cannot admit or release anyone to or from such settings without Judicial Order. Mental Health Services Law requires that any/every patient admitted to a inpateint facilty be on a recognized Legal Status. PECs, CECs, Judicial Committments, Formal Voluntary or Non-contested Admissions status must be established at or before admission. Under Mental Helath Law, all pateints must be considered for and offered Formal Volunatary admisson. Those on Formal Voluntary or Non-Contested Admisison status may leave or be discharged home at thier request, unless a PEC, CEC or Judicial Committment order is in place.	
431	As an MHR provider, we have a few members also enrolled in CSOC, but we only provide MHR services, (CPST/PSR). Will we continue to bill Magellan for those members for MHR services or will we bill one of the plans?	Magellan should still be billed for all behavioral health services EXCEPT PRTF, TGH and Residential Substance Abuse services.	
432	How will the role of Registered Nurse play in integration of these health plans, if there is a role?	No changes from pre-12/1/15 services under LBHP/Magellan.	
434	1. Will all the Bayou Plans still require a Certificate Of Need for inpatient treatment for patients under age 21? 2. Will the CON be required to be sent in at time of admission?	Yes. The Certificate of Need is a federal requirement for those 21 or younger and are admitted to a psychiatric facility. Certification under § 441.152 must be made by terms specified as follows: (a) For an individual who is a recipient when admitted to a facility or program, certification must be made by an independent team that— (1) Includes a physician; (2) Has competence in diagnosis and treatment of mental illness, preferably in child psychiatry; and (3) Has knowledge of the individual's situation. (b) For an individual who applies for Medicaid while in the facility of program, the certification must be— (1) Made by the team responsible for the plan of care as specified in § 441.156; and (2) Cover any period before application for which claims are made. (c) For emergency admissions, the certification must be made by the team responsible for the plan of care	
439	Will new companies be required to become credentialed through Magellan to provide services to children & youth?	No. Except for CSOC and Applied Behavior Analysis services, Bayou Health Plans will manage all behavioral health serivces for youth in addition to their medical/physical health service needs.	
440	Will there have a certain number of pass-throughs for inpatient services?	This will vary by Bayou Health Plan. Medicaid has not prescribed or required anything related to pass throughs.	
443	Are all 5 Bayou Health Plans and Magellan For CSOC going to be using the same Billing codes and modifiers? Ex Billing code, modifier clinician, modifier for client age degree level	All Plans should be using the same CPT and HCPCS codes for Medicaid-covered behavioral health and medical services. If Plans offer expanded services, which are not otherwise covered in state plan or waiver, such codes may differ among Plans.	
448	What if you have an outstanding auth request with Magellan as of November 30th that has not been approved?	Magellan has indicated that they plan to complete all such reviews on or before December 15th, 22015. Magellan wil backdate authorizatn to date on assessemt or FOC form.	
449	How will this transition affect MHSD? We currently provide medication management services, as well as complete Independent Assessment (1915), Plans of Care with Referrals for CPST/ACT/FACT/PSR. Do we continue assessments and Plans of Care? We also are referral conduct for the uninsured and underinsured for Home and Community based services. What will that look like now for (MHSD) Metropolitan Human Services District?	Beginning 12/1/15, Independent Assesmsents, independnet LOCUS and independent POC's will no longer be required, and serviceing providers wil be alowed to submit their own assessments, locus schore sheets and treatment plans. MHSD may complete such docuemnts for thier own clients/members in order to gain authorization for services. Behavioral Health services niinsured clients will be managed by OBH and/or the districts, depending on the level of care. The Office of Behavioral health has set up its LaCAMS process for ASAM Levels III.5, III.7, III.7D, and IV, as well as for Inpatient Psychitric Hospitals admissions, and ACT. Lower level community -based services will be managed by local districts and authorities. Please access the OBH link for more informatin: http://dhh.louisiana.gov/index.cfm/subhome/10	
452	I had Locus training in 2012. Is that training still valid? Would I have to complete it again to complete assessments and the Locus for Bayou Health Plans?	Yes. There is no requirement to renew such trainng. If documentaton for past treining is unavaiable, Obh and Bayou Helath Plans will be offering new LOCUS trainings. A listing of LOCUS-trained providers is being managed by OBH and availbe to all Bayou Health Plans.	
453	Do all authorizations have to go through BHP? For example, we have about 250 members in our program who have PA through Magellan well into 2016. Am I correct that all clients will have to have new authorizations through the respective Bayou Health Plan no later than 12/31/2015?	Please see Informational Bulliten 15-18 and 15-19 for details on this.	
456	What are the reasonable traveling distances-rural and urban?	According to Health Plan contract requirements, Travel distance to behavioral health specialists (i.e., psychologists, medical psychologists, APRN CNS in mental health, or LCSW's) and to psychiatrists for members living in rural parishes shall not exceed 30 miles for 90% of such members. Travel distance to behavioral health specialists (i.e., psychologists, medical psychologists, APRN CNS in mental health, or LCSW's) and to psychiatrists for members living in urban parishes shall not exceed 15 miles for 90% of such members. Travel distance to Level III.3/5 Clinically Managed High Intensity Residential shall not exceed 30 miles for 90% of adult members, and shall not exceed 60 miles for adolescent members. Travel distance to Level III.7 Medically Monitored Intensive Residential co-occurring treatment shall not exceed 60 miles for 90% of adult members. Travel distance to Level III.7D Medically Monitored Residential Detoxification shall not exceed 60 miles for 90% of adult members. Travel distance to Psychiatric Residential Treatment Facilities (PRTF) shall not exceed 200 miles for 90% of members.	
457	Do patients presenting to ED require notification and authorization prior to placement in a psychiatric facility?	For all Medicaid-eligible and Medicaid-pending youth Certificates of Need are require prior to admission to residential behavioral health facilities. All plans require precertificaton/prior authorization for inpatient and residential psyciatric servcies.	
461	Will we be able to continue to submit authorization to Magellan up to Nov. 30th?	Yes.	
465	I need some clarification on CSOC. So all children or youth under 18 will be considered? So claims go to Magellan?	All covered behavioral health services claims for Medicaid-eligible youth served by CSOC go to Magellan, EXCEPT for TGH, PRTF and Residential Substance Use Disorder treatment, which go the the member's Bayou Health Plan.	

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Question #	Questions	Answer	UPDATED
467	Is "Adult" defined as 18 and older, or 21 and up?	For EPSDT state plan services, adults are 21 years old and up. Individuals 18 years and older may be considered for Assertive Community Treatment Services.	
471	How are the medication that need authorizations decided - By whom?	Each Bayou Health Plan works with a Pharmacy Benefit manger organization/company, which established its own criteria, prioar auth, fail first and step therapy requirements for behavioral health meds.	
473	Are the 1915i's valid from Magellan transferable to bayou Health Plans?	Yes. Assessments, LOCUS, TX Plans, POC's and FOC's are valid for 365 days from original date performed.	
475	If a patient has a current Bayou Health Plan, is that the plan they will have their BH services with? I.e.. Louisiana Health Connections	Yes, unless member choses to switch plans.	
476	What should providers do regarding 1915i? Especially with Adult Admits. Pathways stop doing them and Magellan not giving a clear answer. We presently have adults semi on hold.	1915(i) has been retired as of 12/1/15. LMHP services like Assesment, individual family and group psychotherapy will no longer require assessments, LOCUS or POC's. However, adults 21 and over seeking rehab srvices like CPST, PSR, Crisis Interventinon and ACT wil require assemsents, treatment plans, and locus scores annually. Bayou Helath Plans wil be responsible for POCs.	
482	How are we to obtain authorizations on a member, if the authorization expires in December 2015?	Please see Informational Bulletins 15-18 and 15-19 for details. By level of service.	
483	If a patient is admitted medically with final dx as Psych who is responsible for payment?	Member's Bayou Health Plan wil be responsible for all services incurred for a given member's episode of care,if seervices provided are Medicaid-covered services, and provider is in network.	
486	Most of the children I see on Medicaid (Magellan) don't require prior authorization for outpatient psychotherapy. Do I have to stop seeing them on Dec. 1st until I complete credentialing?	No. See Informational Bulletins 15-18 and 15-19 for details. Grace periods are in effect depending on level of service.	
487	Will bachelor level or lower professionals be able to provide both CPST and PSR to clients?	No changes from pre-12/1/15 services under LBHP/Magellan.	
502	Will licensed mental health professionals be able to provide CPST and PSR?	They should, but may prefer to provide services under professinal level CPT codes for individual,famil and group psychotherapy.	
638	What constitutes a billing unit? Are there guidelines in place to determine the number of units to be billed based on the amount of time spent performing a service? For services that are billed in a 15 minute unit, does the provider have to provide the full 15 minutes before billing? If not, what are the rules?	CMS guidance indicates that---When only one service is provided in a day, providers should not bill for services performed for less than 8 minutes. For any single timed CPT code in the same day measured in 15 minute units, providers bill a single 15-minute unit for treatment greater than or equal to 8 minutes through and including 22 minutes. If the duration of a single modality or procedure in a day is greater than or equal to 23 minutes, through and including 37 minutes, then 2 units should be billed. Time intervals for 1 through 8 units are as follows: Units Number of Minutes 1 unit: ≥ 8 minutes through 22 minutes 2 units:≥ 23 minutes through 37 minutes 3 units:≥ 38 minutes through 52 minutes 4 units:≥ 53 minutes through 67 minutes 5 units:≥ 68 minutes through 82 minutes 6 units:≥ 83 minutes through 97 minutes 7 units:≥ 98 minutes through 112 minutes	