**Health Plan Questions:**

**6/15/2021**

* When is a referring provider required?  Request clarification on the coverage categories outlined in the FFS manual. – FFS Manual represents FFS billing policy and MCO “default” policy in lieu of contract or policy language to the contrary. There are technically no changes to when a referring provider is required as a result of ROPA.

However, to clarify, ROPA states that whenever a referring, ordering, attending or prescribing provider is reported (regardless of if it was required or not) it must be a known provider.

Per discussion with the workgroup there are many instances (especially in BH) in the data analyzed to date, where referring or ordering providers are being submitted when not required by billing policy. Therefore, there is a potential for provider education in the area in terms of whereby policy this information is required or not required on the claim, that would result in a decrease of ROPA gaps/potential failures.

* What is the state of the exception file and what ongoing updates are expected as new providers are identified? – We are continuing to get updates/additions almost daily, directly from Pharmacy systems, Hospital systems and licensing boards. It is anticipated this will be an ongoing effort. We are currently updating ASAP as received and posting a current version of the Exception listing to the webpage as well as to the ShareInfo weekly.

Q15 on the ROPA webpage outlines how Exception Providers may be identified and what information is required.

Future consideration to automate the updates from the various boards may be evaluated.

* Can larger groups, such as Sonora Quest, outreach providers?  - Upon agreement in messaging, etc. this type of communication mechanism should be utilized/encouraged.

Would need to establish a unified MCO review process for this messaging, determine the definition of “large” groups (i.e. based on level of ROPA impact not necessarily the size of the provider) you would want to engage in these efforts and identify consistently; Suggestion to leverage the Health Plan Association communications subgroup to evaluate and determine next steps.

* Will AHCCCS allow for Lab/Imaging/DME providers to not accept an order from an un-registered provider? – As stated in the FAQ #16, yes.

Discussed the understandable reluctance of providers to do this, the touchiness of turning away covered services, and the capacity of these providers to really track and put handling in place for this.

Need to consider policy/compliance implications for timely provision of needed/medically necessary services (i.e. DME, therapies, etc.)

* Request AHCCCS guidance on expectations/criteria for member communication – Workgroup discussion included pros/cons, how to focus on impacted members only; identification of whether this is really needed, how to message, etc.

Suggestion to leverage the Health Plan Association communications subgroup to evaluate and determine next steps.

* Can a transition period be agreed upon, allowing plans to implement an overridable edit for a set time frame, prior to implementing hard edits? – Yes, this should be happening now with the soft editing that should currently be in place.

Workgroup discussion clarified that the MCO’s would like if possible, to receive a report for Encounters when fail the soft ROPA editing as a validation and checkpoint for their claims processing, etc. AHCCCS agreed that we will evaluate the provision of this reporting and update the MCO’s shortly.

* How is AHCCCS going to define/adjudicate emergency exceptions? – Workgroup discussion focused on this are and exception in general. Unless exceptions can be easily and concretely defined, they will be difficult to operationalize especially at the Pharmacy/PBM level. I.e. at the PBM level any “override” processes would result in inability to encounter and gaps in encounter submissions.

Reference was made to potential impacts of 310-V and scenarios where the member cannot pay cash.

Need clarity around what is and what is not emergency for purposes of this exception.

How are Part B requirements to be handled? Any option to treat all Medicare secondary as an exception?

OTHER ITEMS:

Confirmed that we should proceed with the understanding that hard editing will be Date of Service 1/1/2022 based and noted that we may want to be clear about this as that time approaches on the ROPA webpage.

Out of State – Discussed whether or not the address data in NPPES is current and how many of these “re-occurring” or influx of new providers each gap run are really not out of state. Discussed ongoing (noted) challenges that the out of state provides are inconsistent each time the gap is run and that there is a new group of providers each time (moving target). Discussed the current volume of remaining “unknown” providers that appear to be out of state. Noted that we are making efforts to identified ‘exception’ out of state providers based on NPPES taxonomy data.

Should we consider some sort of exception for COVID testing which should not require a ordering provider?

Noted that the Attending Provider inclusion was an AHCCCS decision and not noted as a requirement, therefore we may have some flexibility around it if needed.

Discussed the noted UHC best practice and the feasibility of others to adopt. “UHC PBM is providing a file of “unknown” prescriber NPI’s that UHC then validates against the NPPES data set to identify and request addition of exception providers.”