**ROPA – MCO Breakout Workgroup**

**2/4/2021**

Topic 1 – Out of State Provider Options/Need to evaluate these allowances, if they are worth the lift and if so how to operationalize.

Related language reviewed – Outlines limited, difficult to administer exception allowances.

c. Services Ordered or Referred by Out-of-State Professional

Under federal regulations, State Medicaid agencies (SMAs) must require all ordering or referring physicians or other professionals (ORPs) to be enrolled as participating providers (see section 1.5.1.B.). In addition, all claims for payment for items and services that were ordered or referred must contain the National Provider Identifier (NPI) of the physician or other professional who ordered or referred the item or service (see section 1.6.A.). The requirements to enroll ORPs and deny *(not pay)* claims that do not have the NPI of an enrolled ORP applies equally to in-state and to out-of-state ORPs.

However, for claims representing care or items (including, but not limited to, prescription drugs) provided to a participant pursuant to the order or referral made by an out-of-state ORP, the SMA may pay such claims where the ORP is not enrolled in the reimbursing state’s Medicaid plan, in limited circumstances. Such claims qualify for FFP only to the extent that they are otherwise payable and meet all of the following criteria:

Based upon an order or referral, an item or service is furnished by:

·         An institutional provider at an out-of-state practice location– i.e., located outside the geographical boundaries of the reimbursing state’s Medicaid plan, or

·         An individual practitioner in an institutional setting at an out-of-state practice location– i.e., located outside the geographical boundaries of the reimbursing state’s Medicaid plan, or

·         A pharmacy, pursuant to an order (i.e., prescription) written by an individual practitioner in an institutional setting at an out-of-state practice location– i.e., located outside the geographical boundaries of the reimbursing state’s Medicaid plan

·         The NPI of the ORP is represented on the claim;

·         The ORP is enrolled and in an “approved” status in Medicare or in another state’s Medicaid plan; **and**

·         The claim represents services provided

·         The claim represents services covered under the state plan

·         The claim represents either - A single instance of care or order over a 180 day period, or multiple instances of care provided to a single participant, over a 180 day period. *(Follow-up Question to be sent by AHCCCS to our internal team regarding period of consideration, i.e. in a calendar year, ever, etc.)*

For any instances of care that exceed the thresholds above, the SMA must enroll the ORP in the state Medicaid plan for subsequent claims to be FFP-eligible.

EXAMPLE: A beneficiary receives services from an out-of-state emergency room or hospital, and a physician or other professional at the emergency room or hospital writes a prescription upon discharge. That physician/professional must be enrolled (either as a rendering provider or as an ordering or referring one) in the Medicaid Program in which the beneficiary is enrolled in order for the beneficiary’s State Medicaid Plan to cover the ordered/referred service/item. Otherwise, the claim is eligible for FFP only to the extent the following conditions are met: the NPI of the ORP is listed on the prescription; the ORP, if they were to enroll in the reimbursing state Medicaid Plan, would enroll with an out of state practice location; the ORP is enrolled in Medicare or another state’s Medicaid plan in an “approved” status; and there has not been more than one instance of payment made (irrespective of eligibility of payments for FFP) representing a claim for services ordered or referred by that provider’s NPI over a 180 day period, or, if there are multiple instances of payment made for benefits ordered or referred by that provider’s NPI over a 180 day period, that the payment is for a single beneficiary over a 180 day period.

Noted for the group that Out of State Providers are the largest volume of providers remaining in the gap assessments, and that this group will continue to be an issue/need in the future.

The workgroup members agreed that the steps and level of effort required to pend/verify/add exceptions for a limited timeframe would be difficult. Therefore these options will not be pursued at this time.

As an alternative the workgroup proposed that in limited situations which meet the criteria or for Encounters processed under appeal, that we develop a process to support attestation/documentation of the exception and override. AHCCCS supports this proposal.

Topic 2 – Other Open Items/Questions

1. The Team asked if AHCCCS could pursue looking at exceptions for Part B or Part D drugs for up to 6 months and will be submitting a formal question after running some member impacts. Members of the workgroup indicated that in other States with whom they work are allowing this exception (specific mention of IL).
2. The workgroup also asked where AHCCCS is with exception allowances for life saving drugs and how this would be indicated to support these as an exception, and would like a further review of Q&A13. It would appear based on the current answer that they should not deny but allow payment, but that those payments would be a plan responsibly



1. The workgroup also agreed to look at specific types of Taxonomy we are seeing in the remaining gaps to ensure that there are no other types of providers who are not registerable and should be included as exceptions (i.e. there are a number of BH providers who we may or may not register).