ADVANCING STATES

Leadership, innovation, collaboration
for state Aging and Disability agencies

MLTSS Claims Payment

November 9, 2022

Agenda For Meeting

WELCOME AND INTRODUCTION

TODAY'S SPEAKER

MCE CLAIM PROCESSES

QUESTIONS

FUTURE EDUCATION TOPICS

ADVANCING STATES

Today's Speaker – Camille Dobson

Camille Dobson
Deputy Executive Director

- Currently provide intensive TA to states operating MLTSS programs
  - Develop and manage semi-annual full day conferences on MLTSS
  - Co-author of eight MLTSS Institute papers
- Senior Policy Advisor on Medicaid Managed Care at CMS
  - Primary author of CMS MLTSS guidance and MLTSS sections of Medicaid managed care regulations
- 20 years experience in Medicaid managed care policy and operations

Delivery System Changes for Older Hoosiers

Why Reform Indiana's LTSS System?

From 2010 to 2030 the proportion of Hoosiers over 65 will grow from 13% to 20%.

Choice: Hoosiers want to age at home

- 75% of people over 50 prefer to age in their own home – but only 45% of Hoosiers who qualify for Medicaid are aging at home*
- The risk of contracting COVID and impact of potential isolation drives an even increased desire to avoid institutional settings

Cost: Developing long-term sustainability

- Indiana has about 2% of the U.S. population, but over 3% of nursing facilities
- LTSS members are 4% of Medicaid enrollment, yet 28% of spend. ONLY ~ 19% of LTSS spend goes to home and community-based services (HCBS)
- For next ten years, population projections show 28% increase in Hoosiers age 65+ and 45% increase in Hoosiers age 75+

Quality: Hoosiers deserve the best care

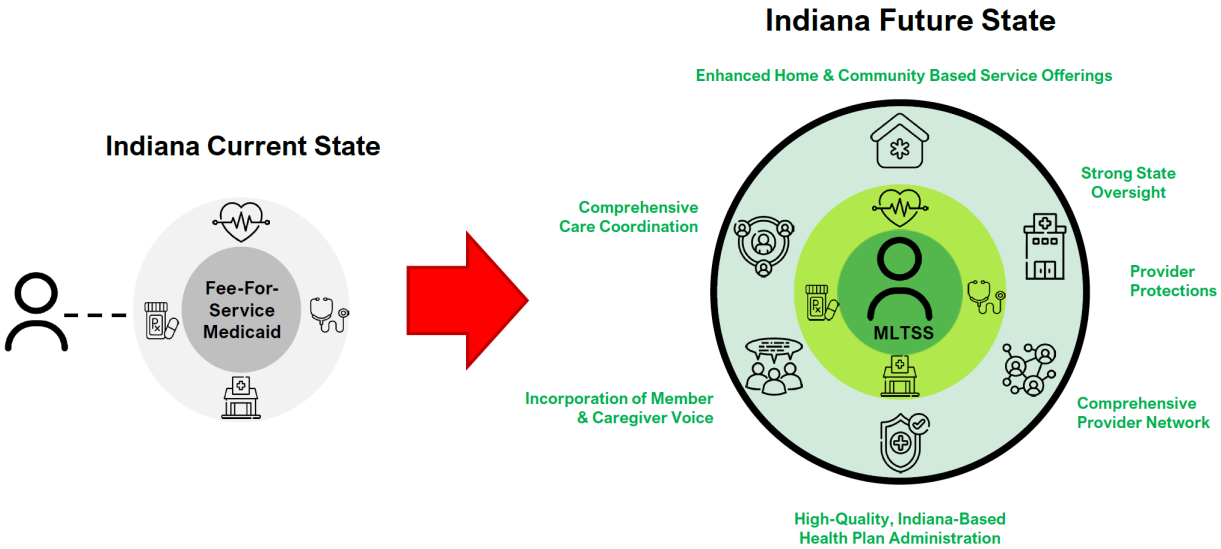
- AARP's LTSS Scorecard ranked Indiana 44th in the nation
- LTSS is uncoordinated and lacks cultural competency
- Payment for LTSS services is poorly linked to quality measures and not linked to outcomes

*Accurate as of January 2020

Indiana's Path to Long-term Services and Supports Reform

Our Objective

1) 75% of new LTSS members will live and receive services in a home and community-based setting
2) 50% of LTSS spend will be on home- and community-based services



The Basics

Hoosiers aged 60 and over who are eligible for Medicaid will be enrolled in new MLTSS program

Some are already in managed care

- About 10% will be Hoosiers between 60 and 65 who are not getting LTSS now and are enrolled in MCEs under Hoosier Care Connect

Most are in FFS

- About 40% are in NFs or on the A&D waiver
- About half (50%) are Hoosiers over 65 who are on Medicare

The Basics

- Current A&D waiver providers and NFs will have to join the network of each managed care entity (MCE) selected by the state in order to continue serving Hoosiers over the age of 60
- Each MCE will pay providers for services rendered to their enrollees, rather than FSSA

Claims Provisions in MLTSS SOW

Claims Provisions in SOW *

- MCE shall ensure that provider submission requirements are not burdensome and align with standard billing practices and IHCP guidance.
- MCE shall employ a local Provider Claims Educator to work collaboratively to educate LTSS providers transitioning from fee-for-service reimbursement to managed care.
- MCE shall offer provider participation in testing and auditing for accurate payment to LTSS providers.
  - MCE shall report to FSSA on their collaborative effort at least ninety (90) days prior to initial contract implementation

* https://www.in.gov/fssa/long-term-services-and-supports-reform/files/RFP-23-72118-Att-N-Exhibit-1-Scope-of-Work.pdf, Section 9.7, page 238

Claims Provisions in SOW *

- HCBS providers shall be reimbursed at no less than Fee for Service rates for the first five years of the program (current FSSA/MCE contract term).
- In-network providers must submit claims to the MCE within ninety (90) calendar days from the date of service.
- MCE must permit the submission of diagnosis code R69 (illness, unspecified) for members receiving HCBS.
  - Used to permit reimbursement on claims where diagnosis code is required but provider does not know the member's medical condition

* https://www.in.gov/fssa/long-term-services-and-supports-reform/files/RFP-23-72118-Att-N-Exhibit-1-Scope-of-Work.pdf, Section 9.7, page 238

Claims Provisions in SOW *

- MCE must pay or deny "clean" electronically filed claims within twenty-one (21) calendar days of receipt.
- MCE must pay or deny clean paper claims within thirty (30) calendar days of receipt.
  - A "clean claim" is a claim for covered services that can be processed without obtaining additional information from the provider of the service.

* https://www.in.gov/fssa/long-term-services-and-supports-reform/files/RFP-23-72118-Att-N-Exhibit-1-Scope-of-Work.pdf, Section 9.7, page 238

Claims Provisions in SOW *

- MCE must utilize the records from FSSA's EVV aggregator to verify that EVV requirements have been met.
- MCE may only utilize EVV for claims payments on services determined by FSSA to require EVV and only enforce claims denials for missing or inaccurate EVV records based upon the timeframe established by FSSA.
- Claims disputes must follow provisions in 405 IAC 1-1.6 (https://www.law.cornell.edu/regulations/indiana/405-IAC-1-1.6)

* https://www.in.gov/fssa/long-term-services-and-supports-reform/files/RFP-23-72118-Att-N-Exhibit-1-Scope-of-Work.pdf, Section 9.7, page 238

Claims Provisions in SOW *

- 405 IAC 1-1.6 (Managed Care Provider Reimbursement Dispute Resolution) lays out process for provider redress of claims denial:
  - Provider to send written informal appeal to MCE within 60 days of getting claim denial
  - If unsatisfied with MCE decision, provider may request a formal appeal with 60 days of getting informal appeal decision
  - MCE must hold appeal panel review with provider attending in person (or virtually if needed)
  - If provider unsatisfied with result of appeal panel review, may request binding arbitration

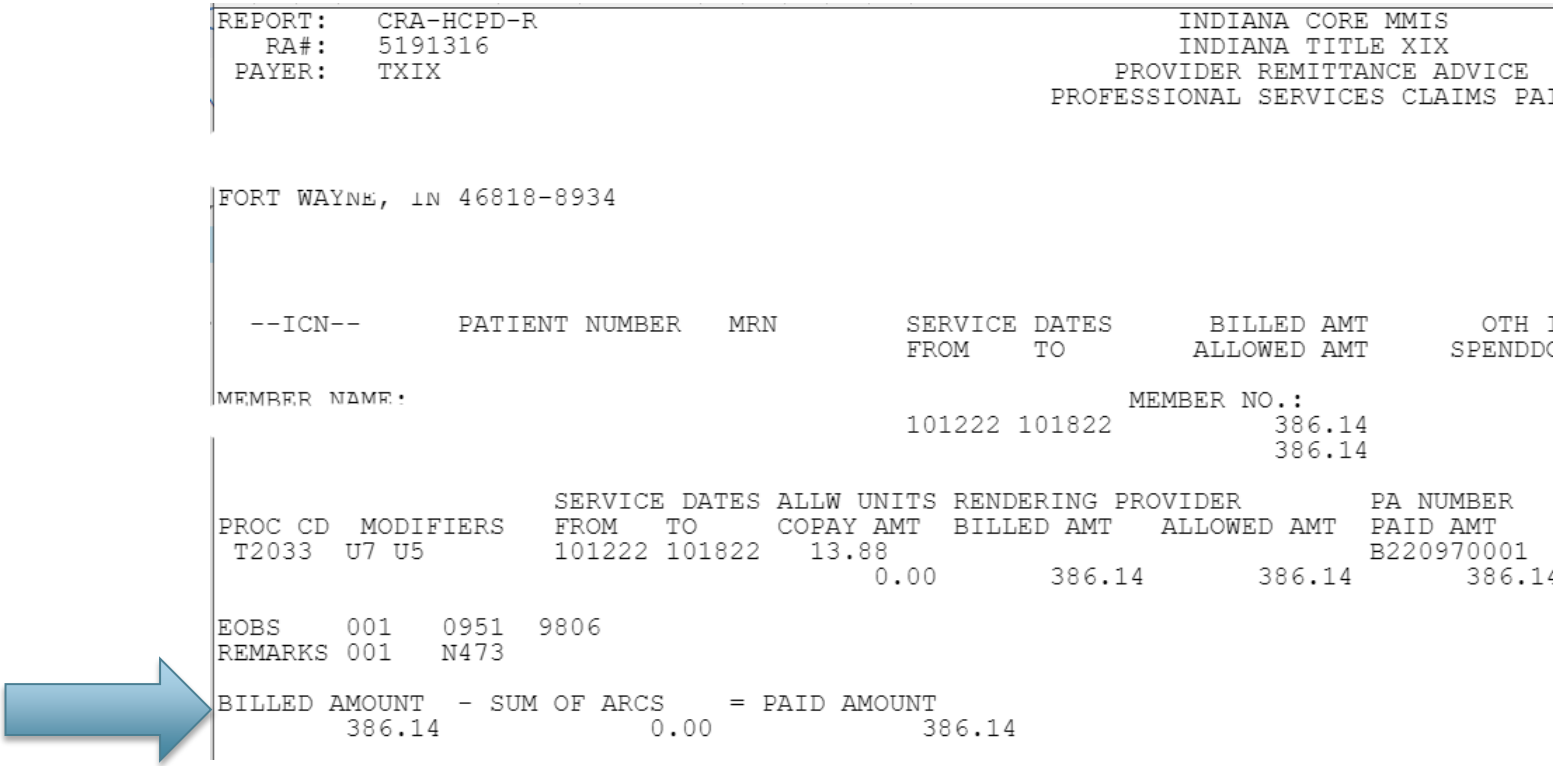
* https://www.in.gov/fssa/long-term-services-and-supports-reform/files/RFP-23-72118-Att-N-Exhibit-1-Scope-of-Work.pdf, Section 9.7, page 238

Today's HCBS Claims/Billing System vs. Tomorrow's MCE Claims/Billing System

Today: HCBS Claims Payment Requirements

- One payer (FSSA)
- One set of requirements – IHCP HCBS Provider Billing Guidelines (https://www.in.gov/medicaid/providers/files/hcbs-billing-guidelines.pdf)
- Receipt of remittance advice

Current IHCP Remittance Advice



```
REPORT:   CRA-HCPD-R                                    INDIANA CORE MMIS
   RA#:   5191316                                       INDIANA TITLE XIX
 PAYER:   TXIX                                       PROVIDER REMITTANCE ADVICE
                                                   PROFESSIONAL SERVICES CLAIMS PAI


FORT WAYNE, IN 46818-8934



  --ICN--      PATIENT NUMBER   MRN        SERVICE DATES      BILLED AMT       OTH I
                                           FROM    TO        ALLOWED AMT     SPENDDO

MEMBER NAME:                                              MEMBER NO.:
                                           101222 101822          386.14
                                                                  386.14

                      SERVICE DATES ALLW UNITS RENDERING PROVIDER        PA NUMBER
PROC CD  MODIFIERS    FROM    TO     COPAY AMT  BILLED AMT   ALLOWED AMT  PAID AMT
 T2033   U7 U5        101222 101822   13.88                               B220970001
                                         0.00       386.14       386.14       386.14

EOBS     001   0951  9806
REMARKS  001   N473

BILLED AMOUNT  - SUM OF ARCS    = PAID AMOUNT
       386.14            0.00            386.14
```


ADVANCING STATES

Tomorrow: MCE Claims Payment Requirements

MCE #1 will maintain its own claims processing system

MCE #1 will provide its own training

MCE #1 remittance advice might include additional/different information (i.e reason codes)

MCE #2 will maintain its own claims processing system

MCE #2 will provide its own training

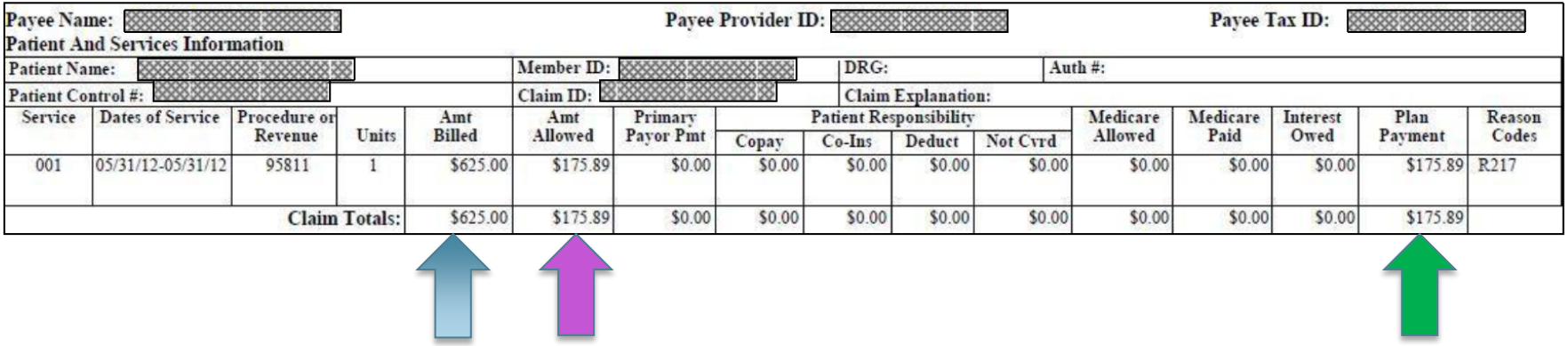
MCE #2 remittance advice might include additional/different information (i.e reason codes)

MCE #3 will maintain its own claims processing system

MCE #3 will provide its own training

MCE #3 remittance advice might include additional/different information (i.e reason codes)

Sample MCE Remittance Advice



Payee Name: [redacted] **Payee Provider ID:** [redacted] **Payee Tax ID:** [redacted]

Patient And Services Information

Patient Name: [redacted]	**Member ID:** [redacted]	**DRG:**	**Auth #:**
Patient Control #: [redacted]	**Claim ID:** [redacted]	**Claim Explanation:**	

Service	Dates of Service	Procedure or Revenue	Units	Amt Billed	Amt Allowed	Primary Payor Pmt	Patient Responsibility				Medicare Allowed	Medicare Paid	Interest Owed	Plan Payment	Reason Codes
							Copay	Co-Ins	Deduct	Not Cvrd					
001	05/31/12-05/31/12	95811	1	$625.00	$175.89	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$175.89	R217
Claim Totals:				$625.00	$175.89	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$175.89	

ADVANCING STATES

Common Claims Problems

Common reasons for claims denial

- Claim was sent to the wrong MCE
  - Verify member's enrollment in the MCE on the date of service
- The claim is a duplicate of one previously submitted
  - Be sure to wait for decision on original claim before submitting a new one
- Claim has wrong provider ID number
  - Make sure to use the provider number that is associated with you in the MCE's system

Common reasons for claims denial

- The # of service unit(s) billed does not match the service authorization from the MCE
- Claim has the incorrect CPT code and/or modifiers for the service rendered
- Claim was submitted beyond the timely filing limit
- Claim was for a service that is covered (in part) by both Medicaid AND Medicare (ie. home health) and the Medicare denial was not submitted with the claim

Lessons Learned

Lessons Learned from Other Transitions

- Will likely need administrative support to manage three or four MCE submissions/resubmissions/trouble-shooting
- Educate MCEs about payment problems under FFS model
- Identify ‘pain points’ as early as possible
- Understand your own claim volume and frequency to anticipate revenue cycle

Lessons Learned from Other Transitions

- Become familiar with MCE resources (provider network or claims specialists)
- Check MCE provider websites regularly (as you do with IHCP)
- Participate in claims testing opportunities with MCEs directly or through your trade association (if applicable)
- Train, train, train
  - Really understand each MCE's claims portal
  - Make sure EVV data is accurate

Last but not least….

READ the MLTSS SOW
(the contract between FSSA and the MCE)

https://www.in.gov/fssa/long-term-services-and-supports-reform/files/RFP-23-72118-Att-N-Exhibit-1-Scope-of-Work.pdf

OBTAIN a copy of the MCE's provider manual

Last but not least….

- The provider manual typically has the operational information you will need but that is not included or incorporated by reference into the contract
  - Definitions for claims payments (e.g. timeliness of filing; what is considered a ‘clean claim’) and instructions for filing
  - Claims appeal processes
- The online provider portal will be a key reference!

Questions

Future Education Topics

HCBS Provider Virtual Sessions

November 16	Care and Service Coordination
November 30	Quality and Managed Care Oversight

The presentation materials and recordings from earlier sessions on MLTSS 101, MLTSS Contracting, and Provider Success Stories are available here: http://www.advancingstates.org/long-term-services-and-supports-provider-training

Resources/Contacts

Website	www.informindiana.com
FSSA Provider Bulletins	https://www.in.gov/medicaid/providers/provider-references/news-bulletins-and-banner-pages/bulletins/
Email	informIN@advancingstates.org

ADVANCING STATES

Leadership, innovation, collaboration
for state Aging and Disability agencies

Camille Dobson
cdobson@advancingstates.org