Introduction to Medicaid Managed Care:

Enrollment and Eligibility, Introduction to Billing (Claim Submission) and specific billing tips for Public Health Departments

Presented to the Illinois Public Health Association

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Presented by

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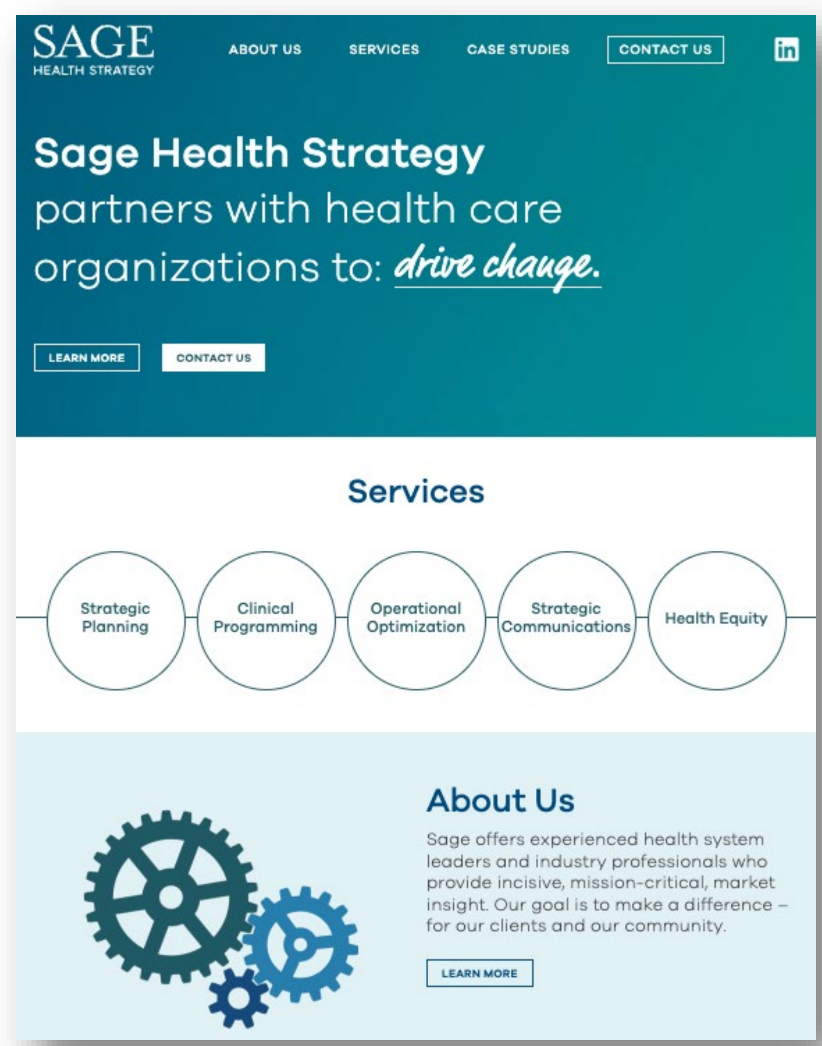
Who is Sage?



www.sagehealthstrategy.com

We are a boutique consulting firm focused on publicly-funded health care, offering experienced health system leaders and industry professionals who provide insights and action for client success.

Our goal is to make a difference – for our clients and our community.

Today's Learning Objectives

At the end of this webinar, participants will understand:

1. How Medicaid eligibility and enrollment works
2. The key steps to bill Medicaid Managed Care
3. Specific billing tips for Public Health Departments

Agenda

1. Medicaid Eligibility/Enrollment
2. Setting Up to Bill/Submit a Claim
3. Billing Tips for Public Health Departments
4. Questions and Answers

A Quick Note…

HealthChoice Illinois

- Aetna Better Health of Illinois
- Blue Cross Blue Shield
- CountyCare
- Meridian
- Molina

MMAI

- Aetna
- Blue Cross Blue Shield
- Humana
- Meridian
- Molina

YouthCare

- Meridian (Name displays as YouthCare)

Medicaid Eligibility and Enrollment

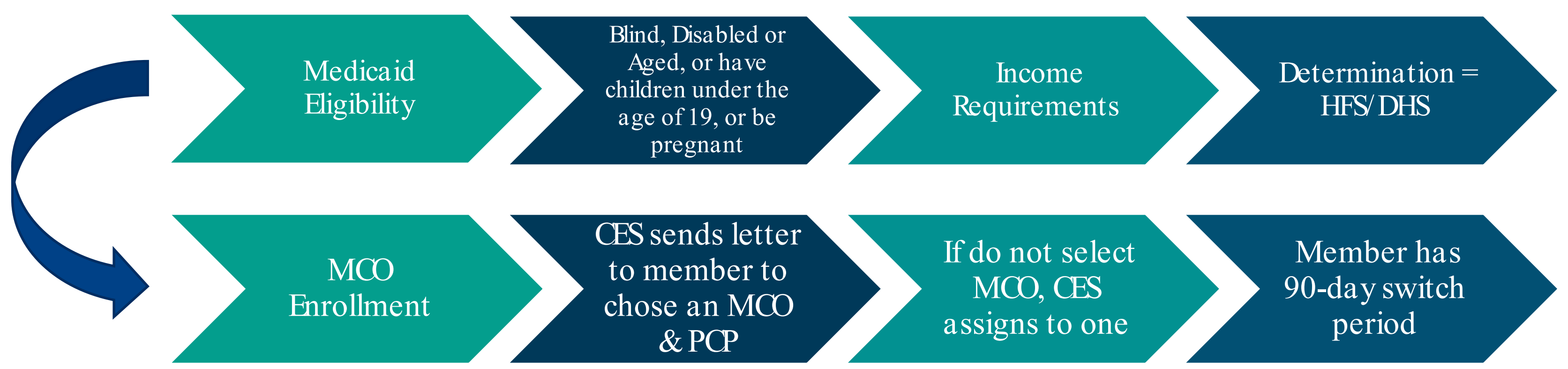
Medicaid Eligibility / Enrollment

- How are patients/clients assigned to an MCO?
- What do I need to understand about redetermination and open enrollment?
- What processes are necessary internally to manage member eligibility?

Medicaid Eligibility vs. MCO Enrollment

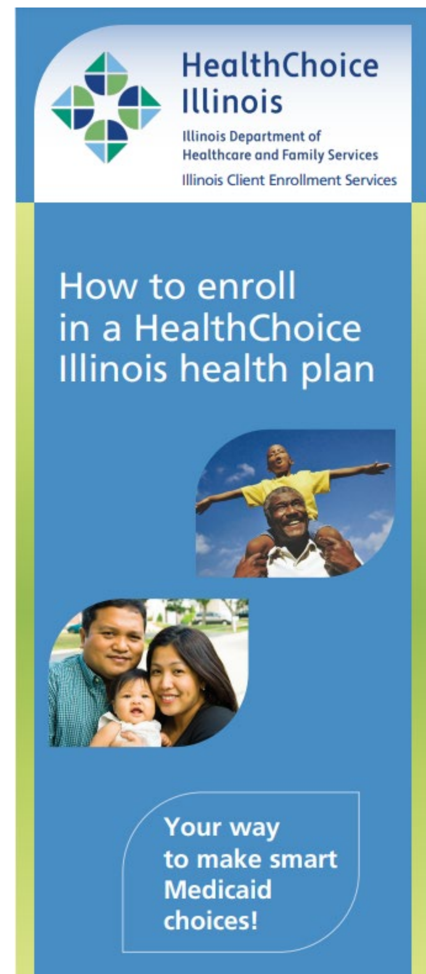
The MCO's are **not** responsible for determining Medicaid eligibility or enrolling members into a health plan (MCO).

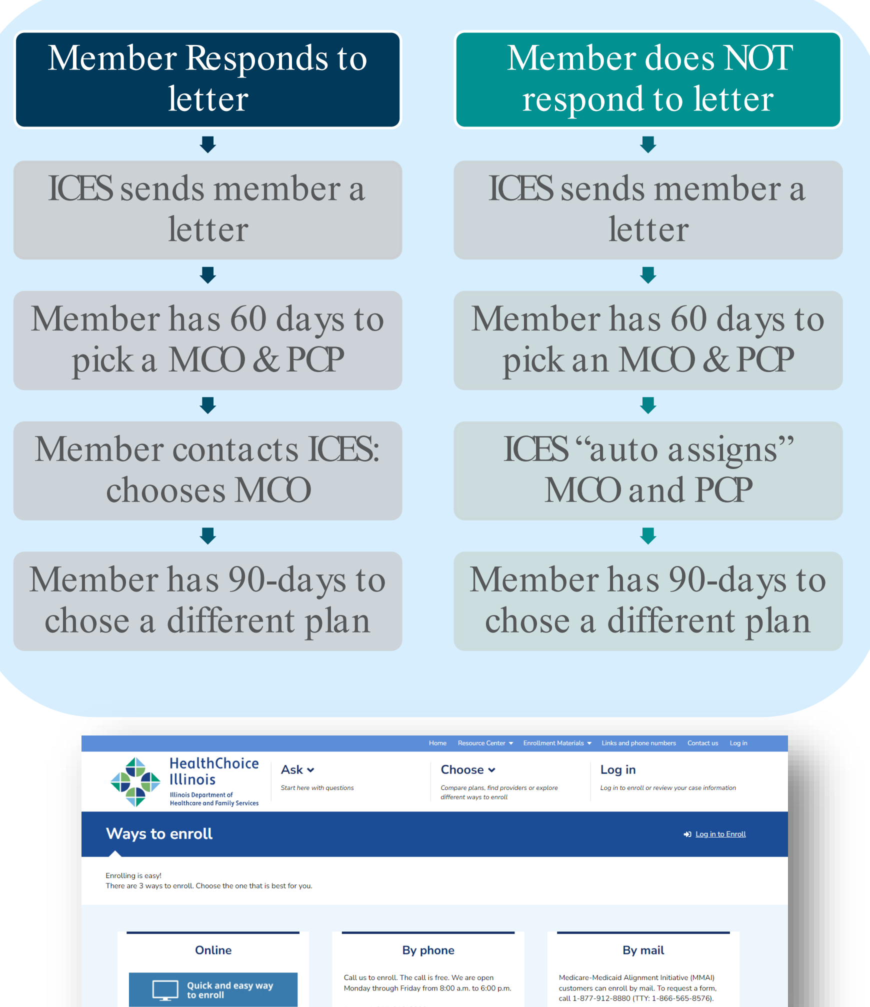
- Medicaid Eligibility = HFS/DHS
- Medicaid Enrollment into MCO = IL Client Enrollment Services (ICES) HFS contracts with the broker.



Medicaid MCO Initial Enrollment – How it Works

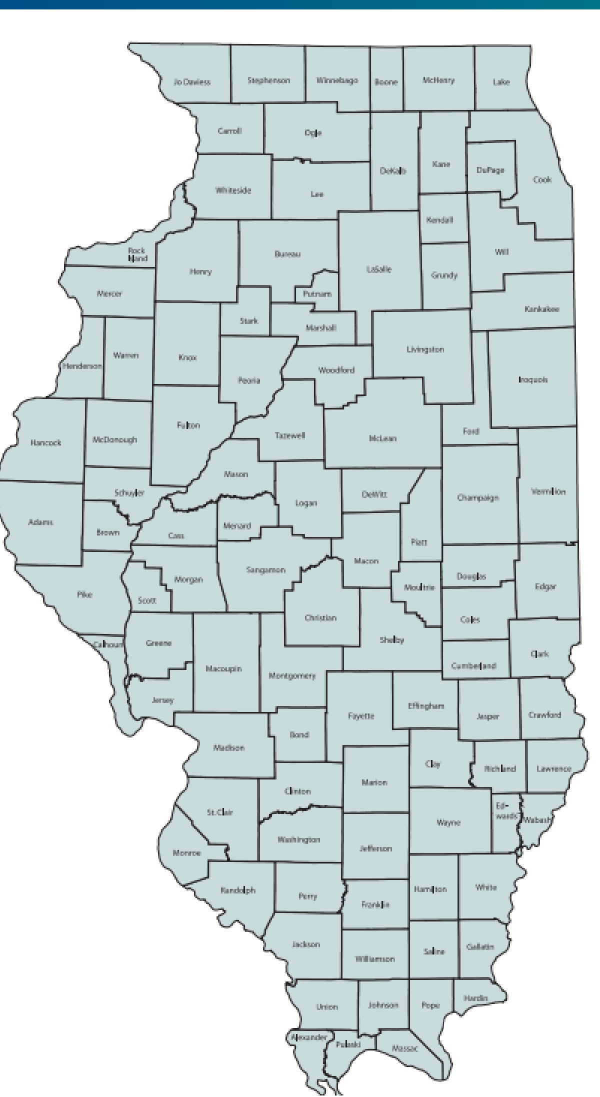
- HealthChoice IL Medicaid recipients can either choose a MCO (& PCP) or one will be assigned through the auto-assignment process.





Medicaid Membership

Meridian	815,560
Blue Cross Blue Shield	753,742
CountyCare	434,516
Aetna Better Health	391,594
Molina	327,137
YouthCare	36,259
Total	**2,758,808**



HealthChoice Illinois Plans

STATEWIDE

These health plans serve all counties in the state, including Cook County.

Aetna Better Health

Blue Cross Community Health Plans

MeridianHealth

Molina HealthCare

YouthCare[1]

COOK COUNTY

This plan only serves Cook County

CountyCare Health Plan

The HealthChoice Illinois Program includes Managed Long Term Supports and Services (MLTSS) membership.

[1] YouthCare serves Illinois Department of Children & Family Services (DCFS) Youth in Care (YIC) and Former Youth In Care (FYIC) enrollees only.

Enrollment by County:
https://hfs.illinois.gov/medicalproviders/cc/totalccenrollmentforallprograms.html

Eligibility Redetermination vs. MCO Open Enrollment

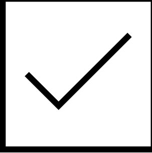
- **Eligibility Redetermination (Medicaid Renewal or REDE)**
  - Annual process to confirm **Medicaid Eligibility** (date = when member became eligible for Medicaid).
  - Members **must** complete required paperwork with HFS/DHS to maintain coverage. Do nothing = lose coverage

VS.

- **MCO Open Enrollment (Health Plan Renewal)**
  - Annual process for members to select a new **Health Plan** if they so choose (date = when member was "locked" into their 1 year with MCO, also called their "anniversary date").
  - Member will remain with current Health Plan if they do not respond. Do nothing = stay with current MCO.
  - Enrollees may not change MCOs at any time other than their annual MCO Open Enrollment period

Note: Dates are often different

Is Medicaid Eligibility Redetermination different than MCO Open Enrollment?



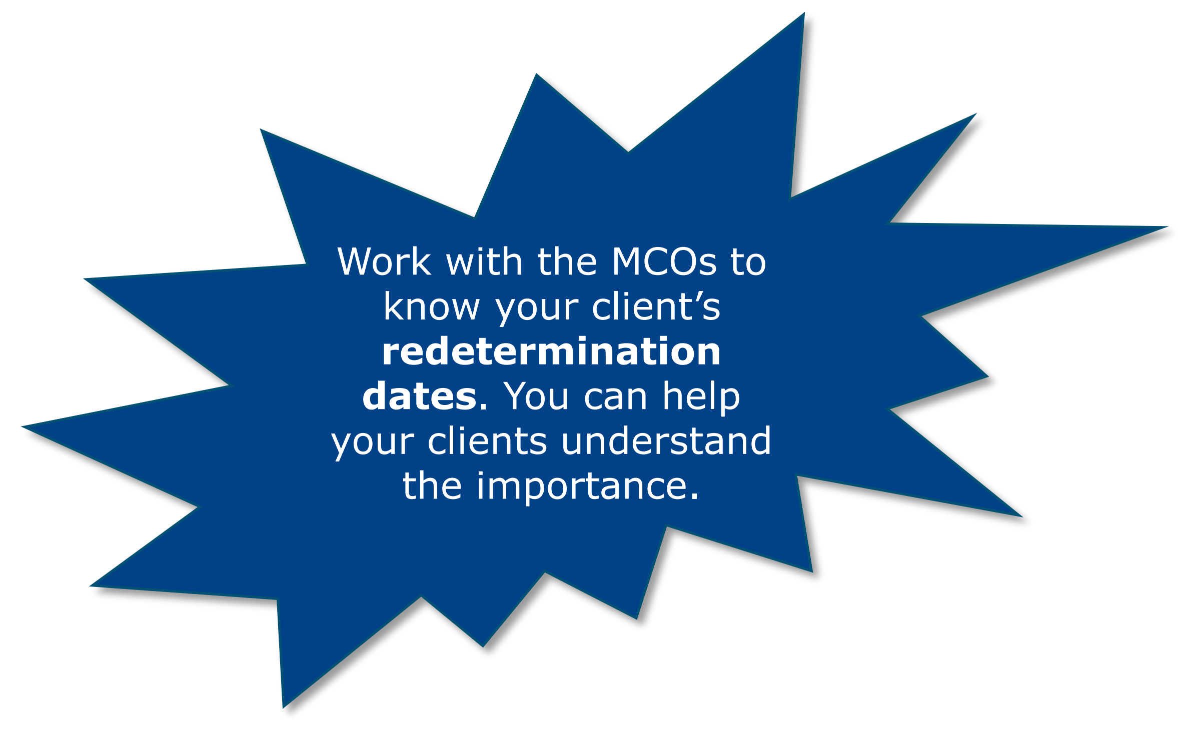
There are 2 separate annual processes for each member
(can occur at different timeframes)

Medicaid Redetermination – Annual process of determining if a member remains **eligible for Medicaid**

MCO Open Enrollment – Annual choice to stay with current MCO or switch.

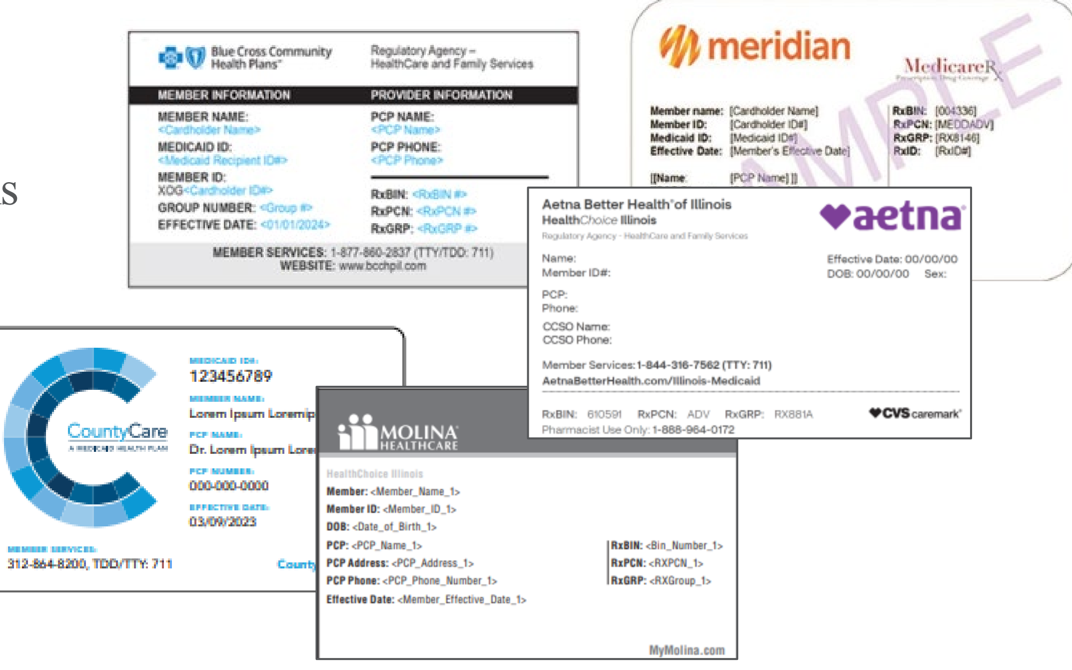
Eligibility Redetermination vs. MCO Open Enrollment – Provider Role?

- **Eligibility Redetermination (Medicaid Renewal) & MCO Open Enrollment (He Plan Renewal)**
  - Both processes can impact continuity of care:
    - Medical Coverage
    - Provider Network
    - PCP Assignment



Necessity of an Eligibility Workflow

- Top reason for claim denials = *Member not eligible*
- Patient / Client intake process needs to be **established and required every time.**
  - Check Member ID Card
  - Check HFS MEDI System
  - Document! Document!
  - Monitor eligibility claim denials



The MEDI System Basics

- Ensure the right members of your team have access.
  - In order to gain access, an organization and appropriate employees **must register** in the MEDI System and receive authorization.
  - The first step in MEDI registration is to obtain an Illinois Digital ID.
  - The MEDI Authorization System is available 24-hours a day, 7 days a week.

- HFS MEDI Home Page and Manual:
  - https://www.illinois.gov/hfs/MedicalProviders/EDI/medi/Pages/default.aspx
  - https://www.illinois.gov/hfs/MedicalProviders/EDI/medi/MediHelp/MEDIManual.pdf

- How are patients/clients assigned to an MCO?
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Setting up to Bill Medicaid Managed Care

Setting Up to Bill

- What do I need to include on a claim?

- How long do I have to file a claim?

- What are my options for filing claims?

Applicable Providers & Members

- Applies to contracted providers for HealthChoice Illinois only.
  - May differ from traditional commercial billing
  - Billing for MMAI services may follow different guidance

Claim Submission: All Claims Must…

✓Have valid Diagnosis, Procedure, Modifier, and Location Codes

- Ensure all Diagnosis Codes are to their highest number of digits available (4th, 5th, and 6th character requirements and 7th character extension requirements)

✓Ensure all other insurance resources have been exhausted before submission.

Medicaid is always the payer of last resort.

✓Be certified by the provider that the claim:

- is true, accurate, prepared with knowledge and consent of provider,
- does not contain untrue, misleading, or deceptive information
- identifies each attending, referring, or prescribing physician, dentist or other practitioner

✓Identify the name and appropriate TIN number of the health professional or facili that provided service, with matching NPI number based on the IMPACT provider type.

✓Identify the patient (RIN and/or MCO-specific Plan ID, address and date of birth).

✓List the date (mm/dd/yyyy) and place of service.

✓If necessary, include any applicable prior authorization numbers provided by the MCO.

Coding Guidelines: General

This is not intended as an exhaustive list of requirements that can cause claim rejection or denial.

- Providers must submit claims using the most current version of ICD-10 CM, CPT4, and HCPCS Level II for the date of service was rendered, in accordance with federal and state guidelines.
- It is important that providers bill with codes applicable to the date of service on the claim. Billing with obsolete codes will result in a potential denial of the claim and a consequent delay in payment.
- Claims will be rejected or denied if billed with:
  - Missing, invalid, or deleted codes
  - Codes inappropriate for the age or sex of the member
  - An ICD-10 CM code missing any 4th, 5th, and 6th character requirements and 7th character extension requirements.

Coding Guidelines: Modifiers

- Pricing modifiers are added to procedures listed in the Medicaid fee schedule:
  - to affect a procedure codes pricing,
  - to indicate that a service has been altered in some way by a specific circumstance, or
  - to identify or distinguish a service.

All Illinois MCOs generally follow National Correct Coding Initiative (NCCI) guidelines **unless otherwise specified by HFS**. Ensure that all appropriate modifiers are included on submitted claims.

- There are two types of modifiers:
  - Level 1 modifiers are those included with CPT codes and updated annually by the American Medical Association (AMA). CPT information and resources can be found at https://www.ama-assn.org/amaone/cpt-current-procedural-terminology
  - Level 2 modifiers are used with HCPCS codes and are recognized nationally. They are updated annually by CMS. Level 2 modifiers are found in the annual edition of the HCPCS procedure manual.

IMPORTANT NOTE: *Modifiers are specific for different provider types and fee schedules. Follow National Correct Coding Initiative guidelines,* ***unless otherwise specified by HFS.*** *More information and resources can be found at* https://www.medicaid.gov/medicaid/program-integrity/ncci/index.html

Coding Guidelines: Code Editing & Auditing

- MCOs use code-auditing software to assist in improving accuracy and efficiency in claims processing, payment and reporting, as well as meeting HIPAA compliance regulations.
- The software will detect and document coding errors on provider claims prior to payment by analyzing CPT, HCPCS, modifiers, and place of service codes against established rules *Claims billed in a manner that does not adhere to these standard coding conventions will be denied.*
- Code editing software contains a comprehensive set of rules, addressing coding inaccuracies such as unbundling, fragmentation, upcoding, duplication, invalid codes, and mutually exclusive procedures.

How Do I File a Claim?

- 3 Options:
  - Paper
  - Electronic Submission (through a clearinghouse)
  - Submission through MCO Portal (functionality and process will vary by MCO)

- Decision on which method to use will vary by organization:
  - Volume of claims
  - Revenue cycle systems capabilities
  - Contract language
  - Other payor relationships

Claim Submission: Paper Claim

DO:

- Only use the original billing forms (e.g., CMS 1500 red and white form).
- Ensure claim is computer generated or typed out in a 12-point Time New Roman font (recommended).
- Ensure claims information remains within the outlines of the data fields. Information that extends beyond the box may cause the claim to be rejected.
- Submit all claims in a 9"x 12" or larger envelope.
- Include all other insurance information (policy holder, carrier name, ID number and address) when applicable.
- Make sure the claim is legibly signed and dated in black ink by the provider or his or her authorized representative. Such representative must be designated specifically and must sign the provider's name and his or her own initials on each certification statement.

DON'T:

- Submit black and white, photocopied or other facsimiles of the original red and white form.
- Submit a claim with multiple members on a single claim. Each member requires a separate claim.
- Handwrite the billing form.
- Use colored ink, highlights, italics, bold or script text.
- Use font smaller than 10 font
- Use rubber signature stamp
- Use any staples.
- Circle any data or add any extraneous information to any claim form field.
- Submit forms by fax.
- Delegate the authorized signature to a billing service.

Claim Submission: Electronic Data Interchange (EDI)

IMPORTANT STEPS TO SUCCESSFUL EDI SUBMISSION

1. Select clearinghouse to utilize

2. Contact the clearinghouse to inform them you wish to submit electronic claims to which MCOs.

3. Inquire with the clearinghouse what data records are required.

4. You will receive two (2) reports from the clearinghouse. ALWAYS review these reports daily. The first report will be a report showing the claims that were accepted by the clearinghouse and are being transmitted to the MCO, and also those claims not meeting the clearinghouse requirements. The second report will be a claims status report showing claims submitted to, but rejected by, the MCO. These claims need to be corrected and resubmitted. ALWAYS review the acceptance and claims status reports for any rejected claims.

5. MOST importantly, all claims must be submitted with providers' identifying numbers. See the CMS 1500 and UB-04 claim form instructions in the Appendix.

Claim Submission: EDI Exclusions

The following are EDI **exclusions** and claim records must be submitted on paper:

- Claim records requiring supportive documentation or attachments
- Claim records billing with miscellaneous codes
- Claim records for medical, administrative or claim reconsideration or dispute requests
- Claim requiring documentation of the receipt of an informed consent form
- Claim for services that are reimbursed based on purchase price (e.g., custom DME, prosthetics). Provider is required to submit the invoice with the claim.
- Claim for services requiring clinical review (e.g., complicated or unusual procedure). Provider is required to submit medical records with the claim.
- Claim for services needing documentation and requiring Certificate of Medical Necessity - oxygen, motorized wheelchairs.

Claim Submission: Provider Portal

Aetna Better Health® of Illinois	Click here (https://medicaid.aetna.com/MWP/login.fcc)
Blue Cross Community Health Plan (BCCHP)	To register with Availity or learn more about services available to BCBSIL providers, please visit the Availity website, or call Availity Client Services at 1-800-AVAILITY (282-4548).
County Care Health Plan	Click here (https://countycare.valence.care/) or email ProviderServices@countycare.com and ask to have a PR Rep assist you with set up. Providers can review and check claims, but online submission is not yet available.
Meridian	Click here to access the Secure Provider Portal
Molina HealthCare	Click here (https://provider.molinahealthcare.com/provider/login)

Claim Submission: Timely Filing

tomorrow

(noun)

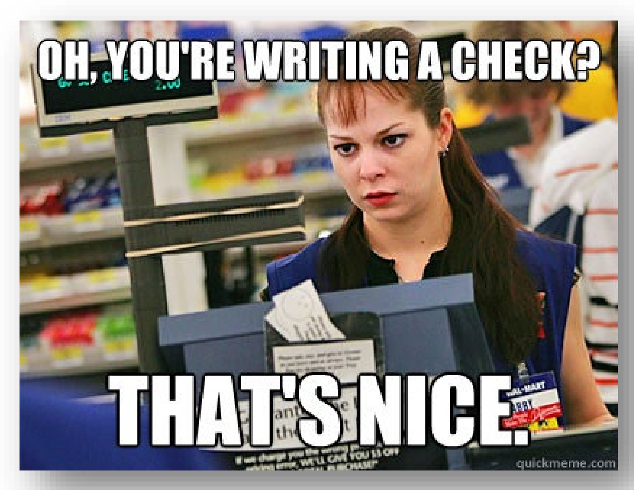
a mystical land where 99% of all human productivity, motivation and achievement is stored

- Providers are required to submit all claims eligible for reimbursement within **180 days** from the date of service or date of discharge which ever is greater.

- This is a standard requirement across the HealthChoice MCOs.

- This requirement applies to initial *and* corrected claims.

Electronic Fund Transfer (EFT)



- EFT is a convenient, paperless and secure way to receive claim payments. Funds are deposited directly into your designated bank account and you receive Electronic Remittance Advices (ERAs) for easier tracking. Additional benefits include:
  - Accelerated access to funds with direct deposit into your existing bank account
  - Reduced administrative costs by eliminating paper checks and remittances
  - No disruption to your current workflow – there is an option to have ERAs routed to your existing clearinghouse.
  - *Registration can be done quickly and easily on line.*

- What do I need to include on a claim?
- How long do I have to file a claim?
- What are my options for filing claims?

Billing Tips for Public Health Departments

Registering a Public Health Department

Public Health Departments can be registered in IMPACT with one or more of following provider types:

- Community Health Agency
- Certified Health Department
- FQHC or RHC
- CMHC – community mental health center
- SUPR – substance use prevention and recovery services

Each of these provider types can only bill for specific services associated with that type. For example:

If you are registered as a community health agency you can only bill for physical therapy, occupational therapy, or speech therapy.

Provider Types and Associated Services

Each Provider Type will be associated with a specific NPI/Taxonomy combination as registered in IMPACT.

Provider Type	Taxonomy	Services	Link to Fee Schedule
Community Health Agency	251K00000X	PT, OT, and Speech Therapy	HFS Therapy Fee Schedule
Certified Health Department	261QH0100X	Physician/Nursing services, PT, OT, Speech, Audiology, and Healthy Kids Services	HFS Practitioner Fee Schedule HFS Therapy Fee Schedule HFS Audiology Fee Schedule
FQHC or RHC	261QF0400X (FQHC) 261QR1300X (RHC)	Medical, Behavioral and Dental services	FQHC Encounter Rate Sheet Rural Health Encounter Rate Sheet
CMHC	261QM0801X	All Behavioral Health Services on the HFS Community Mental Health Fee Schedule	HFS Community Mental Health Fee Schedule
SUPR	261QR0405X* 276400000X*	Substance Use Prevention and Recovery Services	HFS SUPR Fee Schedule

*Check the Taxonomy used in your IMPACT registration and review SUPR section of the IAMHP Comprehensive Billing Guide.

Let’s talk.

Q&A

Appendix

MCO Key Plan Contacts

KEY PLAN CONTACTS

Aetna Better Health® of Illinois	Call Provider Services at **866-329-4701** or email ABHILProviderRelations@Aetna.com. To find your Aetna Better Health of Illinois Representative, please refer to PR Assignment Listing
Blue Cross Community Health Plan (BCCHP)	To find your designated point of contact, please refer to the **Government Provider Network Consultant List**. For more detailed information, you can contact Provider Services at **govproviders@bcbsil.com** or call **855-653-8126**.
County Care Health Plan	Call Provider Customer Service at **312-864-8200**, **Option 6** or email **ProviderServices@countycare.com**.
Meridian	Call Meridian Customer Service at **866-606-3700** or email ilproviderrelations@mhplan.com
Molina Healthcare	To find your Molina Provider Relations Manager click here or call Provider Services at **855-866-5462**.

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