Managed Care Onboarding Resources

For services provided by ALF, AFH, and ESFs

Information About Contracting with the MCOs

Washington State Health Care Authority

Content

In this learning session, we will be covering:

- The differences between a CPA and MCO credentialing/ contracting
- The MCO credentialing/ contracting process and what to expect
- The anticipated timeline for MCOs to reach out for contracting
- Monthly enrollment and understanding why, when, and how to check eligibility
- Important information about billing
- How to bill
- Payment timeframes and options
- Helpful Resources

The Differences Between a CPA and MCO Credentialing/Contracting

CPA vs. MCO Credentialing/Contracting

Core Provider Agreement (CPA):

- The CPA is how providers gets recognized with the State of Washington as being a Medicaid Provider.
- The CPA also serves as a contract between the provider and HCA, when the client is in a fee-for-services program.
- The CPA needs to be in place for MCOs to contract with providers, based on federal rules.

MCO Contracting and Credentialing:

- Providers have the choice to contract with any/all MCOs. The terms you set up with an MCO can vary.
- For this program, however, providers not already under contract with the MCOs, we have streamlined contracts, forms, and billing as much as possible.
- Credentialing is part of a MCO's process for contracting.

The Credentialing/Contracting Process and what to Expect

Credentialing

Credentialing is the first step in the contracting process.

Credentialing is a method of verifying that healthcare professionals and facilities are certified and licensed. This process requires multiple steps and can take up to *90-days* to complete.

- **How to start the Credentialing process:**
  - Complete the MCO credentialing application and provide requested documentation such as:
    - Current license(s) (must be licensed in WA state)
    - Current liability insurance
    - Most recent survey
    - W-9 form
    - Roster/list of locations.
  - Following the receipt of your application, a MCO credentialing specialist will reach out if anything is missing, or if additional information is needed.
  - Upon successful completion of credentialing, a MCO credentialing representative will reach out to move forward with contracting.

Credentialing – Continued

Important 'Good to knows' for Credentialing:

- **Time sensitive**: Credentialing is a CRITICAL step to ensure go-live readiness and is initiated by Providers.
  - Failure to complete credentialing early, may result in downstream delays to portal access, provider loading into MCO systems, and claims testing and payments.
- **Multiple Locations**: Credentialing applications must include EACH licensed location.
- **New locations**: New locations must be credentialed with MCOs in a timely manner.
  - MCOs should also be notified of location closures.

Credentialing Process and Inquiries

- Facility credentialing applications vary by EACH MCO.
- Credentialing materials and inquiries may be submitted to each MCO, as follows:

MCO	Email
Community Health Plan of WA	Provider.Contracting@CHPW.org
Coordinated Care	JoinOurNetwork@CoordinatedCareHealth.com
Molina Healthcare	MHWProviderContracting@MolinaHealthcare.com
UnitedHealthcare Community Plan	wabhcontracts@uhc.com
Wellpoint	https://www.provider.wellpoint.com/washington-provider/home

MCO Contracting

Contracting

- Upon completion of credentialing, the MCO will draft a provider contract and release for provider review and approval.
- Once the contract is complete/signed, the provider will be loaded into the MCO's system, which will allow the provider to continue onboarding activities including
  - New Provider Orientation
  - Register for portal access
  - Register for EFT and ERA

MCO Contracting – Continued

To become a participating provider with an MCO you must have a fully executed contract

- Your contract defines the relationship between you, as a provider and an MCO, the payer of your provider services
- The contract outlines obligations, compensation and references to policies, procedures and more
- A contract specialist will walk you through the contracting process from initiation to full execution
  - Contracting can take time – contracts can be reviewed and signed by a provider as quickly as 30 days or can take much longer
    - Once a contract is signed by the provider, an MCO will route for counter-signature internally
    - Once complete – a fully executed contract will be sent back to the provider and a provider profile will be built with the MCO system

The Anticipated Timeline for MCOs to Reach Out for Contracting

Transition to CBHS

- Transitioning from the BHPC to align with when the individual's annual CARE assessment is due.
- This will reduce burden on providers, case managers, and HCA.
- Focus for the July 1, 2024, start date will be on clients with a CARE assessment end date between June-August.
- MCOs will be focusing on contracting with providers who have members with CARE assessments due in that time-frame.
- Additionally, there are a few areas of the state where MCOs may reach out even if they don't have a current client. This is because federal rules require MCOs to be able to provide this service statewide.
- Every quarter, the MCOs will work on contracting with another group of providers, based on CARE assessment dates.
- Having a contract in place allows you to also be ready to serve new clients that are ready to discharge from other settings.

Transition to CBHS

IMPORTANT: Contracts need to be in place before a MCO can approve a CBHS authorization for clients transitioning from BHPC.

MCOs will focus contract outreach efforts on providers serving clients who are due for CARE reassessments using the following schedule:

Start the Contracting Process	Provider Group 1: Reassessment due 06/30/2024-08/31/2024	Provider Group 2: Reassessment due 09/30/2024-11/30/2024	Provider Group 3: Reassessment due 12/31/2024-02/28/2025	Provider Group 4 Reassessment due 03/31/2025-05/31/2025
	April 2024	**July 2024**	**October 2024**	**January 2025**

New clients on or after 07/01/2024 are referred for services will also need to be served within contracted residential settings, so additional outreach may occur outside these timelines, as necessary, to serve new clients.

Pause For Questions

Important Information about Billing

Home and Community Services

- Beginning 7/1/2024, Home and Community Services (HCS) will no longer have authority to authorize or pay for Behavioral Health Personal Care (BHPC) (*SA389, U1*) in a residential facility for:
  - Any new residents, and
  - Current residents during the implementation year (July 2024-June 2025) once the residents' annual CARE assessment is completed.
    - This means if a current resident is receiving BHPC, and their CARE assessment is due in November 2024, the provider will continue to have BHPC authorized and paid through HCS until November 2024. If eligible for CBHS service authorization and payment will transition to HCA/MCO on December 1, 2024
- The way personal care is authorized and paid is not changing. You will continue to claim through ProviderOne.
- Providers can continue to reach out to their assigned HCS case manager for questions related to HCS authorized services, including but not limited to RSW.

Key Billing Information

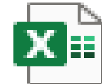
- Bill the MCO referenced in the 'Plan/PCCM Name' column if it lists one of the names in the textbox to the right.
- If the 'Plan/PCCM Name' column has something other than the MCO list on the right, or is blank, this client is Fee-for-service. These clients are billed to HCA directly.
- For clients receiving CBHS Supportive Supervision, providers will use the CBHS Billing Guide. For clients receiving IBSS/ILOS services, providers will use the following ILOS Policy Guide.
- **Depending on the facility license type, providers will bill differently!**

Managed Care Plan Names

- CCW Fully Integrated Managed Care
- CCW Behavioral Health Services Only
- CHPW Fully Integrated Managed Care
- CHPW Behavioral Health Services Only
- Coordinated Care Healthy Options Foster Care
- MHC Fully Integrated Managed Care
- MHC Behavioral Health Services Only
- UHC Fully Integrated Managed Care
- UHC Behavioral Health Services Only
- WLP Fully Integrated Managed Care
- WLP Behavioral Health Services Only

Billing Process for Adult Family Homes

- Adult Family Homes (AFHs) will bill for services using a spreadsheet that contains the following:
  - Data Dictionary Tab - Directory of Fields
  - “Tier” Tabs – Specific to Supportive Supervision (1915i/CBHS)
  - “ILOS” Tabs – Specific for In Lieu of Services – Intensive Behavioral Supportive Supervision (ILOS IBSS)



Supportive
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- MCOs will convert the information submitted via the spreadsheet into claims/encounters.
- **<u>Spreadsheet billing is a temporary solution.</u>**

Note: HCA is in the process of setting up a single clearinghouse option for Adult Family Homes to use in the future. When this clearinghouse is up and running, Adult Family Homes will be able to submit claims directly, and the spreadsheet process will be retired.

Billing Process for **Assisted Living Facilities (ALFs)** and **Enhanced Service Facilities (ESFs)**

- ALFs and ESFs that utilize a clearinghouse will use the clearinghouse to submit claims to the MCOs.
- ALFs and ESFs that bill HCA, or don't currently use a clearinghouse, will submit claims using the spreadsheet or submit claims via the MCO portal.

Definition of a Clearinghouse: A trading partner securely transmitting claims (837 file) electronically from the provider to the MCO.

Benefits of a Clearinghouse

- Submits multiple claims to specified payer
- Provides Electronic Remittance Advice (ERA) for automatic updates for payments and adjustments by MCO
- Meets HIPAA compliance standards
- Stand-alone entity
- Scrubs claims for errors prior to submission to MCO to improve accuracy
- The most common Electronic Data Information (EDI) transmissions are known as, files: 837, 277, 999 and 835.
- Allows providers to manage claim status in one place

Rules for MCOs to Follow Around Claims

- **MCOs, by federal law, are only allowed to pay "clean claims"**
  - **Clean Claim** means a claim containing all required data elements and can be processed without obtaining additional information from the provider of the service, or from a third party (see each MCO's provider manual for requirements for claim form submission).
  - **Non-Clean Claim** means a claim where not all of the necessary information is provided or there are errors. For example, claims rejected for missing data elements, submitted on incorrect forms, contain incorrect data (e.g. wrong member ID, invalid CPT/ICD code, etc.).
- MCOs are **NOT allowed to alter any information** on the claim.
  - The Spreadsheet for Adult Family Homes will serve as a "claim like" submission for services rendered.

Rejected vs Denied Claims

There are two reasons that an MCO or HCA would not pay a claim.

- **A Rejected Claim** This is a non-clean claim. It does not get sent forward for processing of the claim due to missing or incorrect information.
- **Denied Claim** This claim has all the correct information but is denied for payment. An example of a reason for denial could be changes in the person's eligibility.

When this happens:

- For providers using the spreadsheet template to bill:
  - MCO: the provider will receive an email notification explaining the reason for the rejection/denial.
  - Notification of denial may be received via email or letter, depending on the MCO.
  - HCA: the provider will receive a notification explaining the reason for the rejection/denial.
- For those using a clearinghouse:
  - Clearinghouses can send rejected claims reports. (You may need to request these reports!). The provider will need to work through these reports regularly to resolve issues and resubmit claims.

Timely Filing of Claims

Timely filing: the number of days between when the MCO receives a 'clean claim' from you and the date of service.

- The amount of time you have to file a 'clean claim' is dependent on your specific contract terms with each Managed Care Organization.
  - For CBHS Services, new provider contracts will use a standard contract template that all Managed Care plans will be using, which has 365 days.
- Claims not received within the required timeframes <u>will be denied and not be paid</u>, unless there are extenuating circumstances which is very rare.
- Contracted providers have 24 months from date of an explanation of payment (EOP) to appeal a claim decision.

Reminders:

1. Verify a client's eligibility for the dates of service will help ensure timely billing.
2. A claim that rejects (not assigned a claim number) is <u>not</u> a clean claim. These claim do not count towards timely filing calculations.

Monthly Enrollment and Understanding Why, When, and How to Check Eligibility

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Why Confirm Client Eligibility/MCO? to CBHS

- Not frequently, but at times, a client may change MCOs. This can happen if the individual or their authorized representative requests a change.
  - Sometimes clients will change plans because of a specific medical provider they want to see. If your client doesn't tell you they changed plans, you may accidently bill the incorrect MCO.
  - Prior authorizations from a previous MCO are only required to be honored for 60 days by a new MCO.
- Billing the correct MCO will ensure prompt payment.
- Sending information to the wrong MCO would be a HIPPA violation.

When to Check Member Eligibility

- HCA updates eligibility daily.
- Providers should, at a minimum, check eligibility before billing.
- This is true for both Community Behavioral Health Support (CBHS) and In-Lieu of Services/Intensive Behavioral Support Supervision (ILOS/IBSS) services.

How to Check Member Eligibility

To confirm eligibility:

- HCA ProviderOne: https://www.waproviderone.org/
  - For help, refer to HCA Eligibility Manual: https://www.hca.wa.gov/assets/billers-and-providers/manual_verifyclienteligibility.pdf

Checking Eligibility Using ProviderOne

To determine Medicaid coverage in ProviderOne, there are 2 steps to determine:

1. Is the client enrolled in Apple Health (Medicaid)?
2. If yes, does the client have an Apple Health (Medicaid) managed care plan?

Note: Apple Health (Medicaid) fee-for-service coverage is also known as 'coverage without a managed care plan'. This means that Apple Health (Medicaid) fee-for-service coverage is shown by:

- Yes, to Question 1; and
- No to Question 2

Checking for Medicaid Coverage

To determine if the client is currently in Apple Health (Medicaid):

Step 1: Log in to ProviderOne and go to the "Benefit Inquiry" screen

Step 2: Enter in the client's P1 ID.

Step 3: In the "**Client Eligibility Spans**" area of the Apple Health Client Eligibility ProviderOne webpage, you need to confirm that there is active coverage.

Step 4: Sort by the Eligibility End Date (click the down-caret) with highest value at the top.

Step 5: The client is eligible if: Eligibility End Date = 12/31/2999 or the Eligibility End Date = current month's end (this means coverage may end).

Client Eligibility Spans

Insurance Type Code	Recipient Aid Category (RAC)	Benefit Service Package	Eligibility Start Date	Eligibility End Date	ACES Coverage Group	ACES Case Number	Retro Eligibility	Delayed Certification
MC: Medicaid	1217	ABP	09/01/2018	12/31/2999	N05			
MC: Medicaid	1201	ABP	02/27/2018	08/31/2018	N05			
MC: Medicaid	8500	SBP - Institutionalized Dates	02/23/2018	02/27/2018				
MC: Medicaid	8500	SBP - Institutionalized Dates	02/27/2018	02/27/2018				
MC: Medicaid	1201	Suspended - Inpatient Hospital Services Only	02/24/2018	02/26/2018	N05			

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Message(s): Suspended Medical, Inpatient Hospital Service Only

Determining MCO in ProviderOne

Once you determine Medicaid eligibility, you will need to check to see if the client has a Managed Care Plan.

Step 1: Go down to the "Managed Care Information" Section.

Step 2: Sort by the 'End Date' (click the down-caret).

Step 3: If one of the names in the box to the right is listed under the column "Plan/PCCM Name", the client has Managed Care with that Plan.

- Note: If none of the MCOs are listed under "Plan/PCCM Name" or it lists "PCCM" or "HH", that means the **client has does not have a managed care plan. You will need to work with HCA for these clients.**

Managed Care Plan Names

- CCW Fully Integrated Managed Care
- CCW Behavioral Health Services Only
- CHPW Fully Integrated Managed Care
- CHPW Behavioral Health Services Only
- Coordinated Care Healthy Options Foster Care
- MHC Fully Integrated Managed Care
- MHC Behavioral Health Services Only
- UHC Fully Integrated Managed Care
- UHC Behavioral Health Services Only
- WLP Fully Integrated Managed Care
- WLP Behavioral Health Services Only

Managed Care Information

Insurance Type Code	PCCM Code	Plan/PCCM Name	Plan/PCCM ID	Plan/PCCM Phone Number	PCP Clinic Name	Start Date	End Date
HM: Health Maintenance Organization	MC: Capitated	WLP Behavioral Health Services Only	201599811	(833) 731-2167		06/01/2021	12/31/2999

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What Does it Show for an Ineligible Client

If you enter an individual's P1 number into the "benefit inquiry" and see a screen like the example below, it means the individual is ineligible.

Demographic and Response Information

Client Demographic Information:

ProviderOne Client ID:
Client First,Middle,Last Name:
CSO/HCS:
County Code: 017-King
CSOR: 040-KING EAST CSO
Date of Birth: 05/22/1981
Gender: Male
Language: ENG-English
Placement:
ACES Client ID:
HIC:

System Response Information:

Valid Request Indicator: Y
Reject Reason Code:
Eligibility or Benefit information Code: 6–Inactive
Follow-Up Action Code: C - Please correct data and resubmit

How to Bill

Information Needed to Bill and Spreadsheet Walk-through

In general, the following categories of information will be needed to complete a claim/bill:

- Provider information
- Client information
- Diagnosis
- Service Date
- Service Provided
- Amount of services

The same type of information will be needed for Clearinghouse billing as well.

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Where to Submit Spreadsheets

MCO/HCA	Email Address
Community Health Plan of WA	FIMC.invoice@chpw.org
Coordinated Care	WaClaimsLiaison@centene.com
Molina Healthcare	CBHSBilling@MolinaHealthcare.com
UnitedHealthcare Community Plan	mpc_etr@uhc.com
Wellpoint	WACBHS@Wellpoint.com
HCA	HCA1915iservices@hca.wa.gov

How to Submit Electronic Claims/Encounters

MCO	Payer ID(s)	Contact Number	Address
Wellpoint	Availity: WLPNT	Availity: (877) 334-8446	Washington Claims Wellpoint Washington, Inc. PO Box 61010 Virginia Beach, VA 23466-1010
Coordinated Care	68069	(877) 644-4613	Claim Processing Department PO Box 4030 Farmington MO 63640-4197
Molina Healthcare	Claims: 38336 Encounter: 43174	(866) 409-2935 EDI.claims@MolinaHealthcare.com	Molina Healthcare of Washington P.O Box 22612 Long Beach, CA 90801
United Healthcare Community Plan	Electronic: 87726 ERA: 04567	(866) 556-8166 Fax (855) 312-1470	UnitedHealthcare PO Box 31365 Salt Lake City UT 84131-0365
Community Health Plan of WA	CHPWA	1-800-AVAILITY (282-4548)	CHP Claims PO Box 269002 Plano, TX 75026-9002

Payment Timeframes and Options

Provider Payments and Balance Billing

- There are no restrictions on how often providers can bill the MCO. The cadence of claim submission is up to the provider (i.e. weekly, monthly).
- Most clean claims are paid within 30 days of receipt.
- Providers may be paid via:
  1. Electronic Fund Transfer (EFT)
  2. Paper Checks (mail)- **No additional steps needed.**
- Providers must accept payment by MCOs as payment in full.
  - Balance billing is not permitted unless the provider and member fully complete and sign an HCA 13-879 form--*Agreement to Pay for Healthcare Services*. *For additional information, refer to:* WAC 182-502-0160, 42 CFR 447.15, and HCA Memo #10-25.

Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA)

Benefits of registering for Electronic Fund Transfer and/or Electronic Remittance Advice:

- EFT:
  - Receive payments through direct deposit to bank account – **FASTEST WAY TO GET PAID!**
  - More timely and secure payments
  - Receive notification upon payment

For clearinghouse submissions only:

- ERA:
  - Download an 835 file – This is the electronic transaction that provides claim payment information and documents for you EFT
  - Download other available reports to use for auto-posting
  - Historical Explanation of Payment (EOP)
    - Search by various methods (i.e. claim number, member name)
  - Create custom reports

How to register for EFT and ERA

Providers must register with each MCO separately.

MCO	Website	Contact Number	Email
Community Health Plan of WA	www.Availity.com	(800) 440-1561	edi.support@chpw.org
Coordinated Care	www.payspanhealth.com	(877) 331-7154	ProviderSupport@payspanhealth.com
Molina Healthcare	https://enrollments.echohealthinc.com/efteradirect/molinaHealthcare.	(888) 834-3511	edi@echohealthinc.com
UnitedHealthcare Community Plan	https://www.uhcprovider.com/en/claims-payments-billing/electronic-payment-statements.html	(877) 620-6194	n/a
Wellpoint	EFT: EnrollSafe (payeehub.org) ERA: www.Availity.com	(877) 882-0384 1-800-AVAILITY (282-4548)	EFT help: support@payeehub.org For ERA, submit email/ticket: https://www.availity.com/about-us/contact-us

EFT and ERA Registration – Continued

You'll need:

- Bank account information for direct deposit
- Either a voided check or a bank letter to verify bank account information
- A copy of your practice's W-9 form

Helpful Resources

Helpful Resources

- HCA CBHS Webpage
- HCA Contact:
  - Inbox - hca1915iservices@hca.wa.gov
- MCO Contracts
  - Community Health Plan of WA (CHPW) - Provider.Contracting@CHPW.org
  - Coordinated Care (CCW) - JoinOurNetwork@CoordinatedCareHealth.com
  - Molina Healthcare (MHC) - MHW_BH_IMC@MolinaHealthcare.com
  - United Healthcare Community Plan (UHC) - jennifer_emery-morelli@uhc.com
  - Wellpoint (WLP) - WACBHS@wellpoint.com

Questions and Answers