

TCOW Tribal Compliance and Operations Workgroup

April 10, 2019

Agenda

- ▶ Medicaid Administrative Claiming (MAC) – Guest Speaker, Tyron Nixon
- ▶ Apple Health Billing Guides overview
- ▶ Apple Health Client Eligibility overview
- ▶ Updates
 - ▶ 100% FMAP and 638 FQHC
 - ▶ Dental Managed Care
 - ▶ IGT Conversion to CPE
- ▶ FAQ and Open Discussion

Medicaid Administrative Claiming (MAC)

Tyron Nixon
Program Manager, Tribal MAC
Medicaid Program Operations and Integrity
April 10, 2019

Presentation Objectives

- ▶ Have a high-level understanding of MAC
- ▶ Know the governance structure MAC follows
- ▶ How to participate in MAC
- ▶ The Random Moment Time Study (RMTS)
- ▶ RMTS Demonstration

What is MAC?

MAC is a voluntary program that reimburses governmental entities for the time their staff spend performing administrative activities on behalf the HCA's Medicaid program. These administrative activities include:

- ▶ Applying for and renewing Washington Apple Health (Medicaid) coverage.
- ▶ Explaining and linking individuals and their families to Medicaid services.
- ▶ Coordinating or Referring for Services
 - ▶ Assisting a client with access to medical home care services and medical equipment
 - ▶ Discharge planning activities to ensure continuity of care
 - ▶ Referring to medical, dental, vision, pharmacy, and specialty services
- ▶ Policy Development, program planning related to Medicaid.
 - ▶ American Indian Health Commission Meetings (AIHC)

Tribal Staff Eligible to Participate

- ▶ Examples of Approved tribal job positions include, but are not limited to:
 - ▶ Billings and Benefits Specialist
 - ▶ Case Manager/Caseworker/Clinic Coordinator
 - ▶ Chemical Dependency Professional
 - ▶ Medical Professionals
 - ▶ Program Manager/Coordinator
 - ▶ Family Support Specialist
 - ▶ Recovery Specialist
 - ▶ Contract Health Specialist
 - ▶ Health Directors

MAC Participant's Role

- ▶ Receive emails when selected to answer a moment.
- ▶ Moments consist of a series of questions followed by a brief narrative describing the activity.
- ▶ Participants notify Coordinator of schedule and work shift changes.

The Random Moment Time Study (RMTS)

- ▶ System collects data from “moments” to generate statistical daily activity average.
- ▶ Daily activity average identifies both MAC reimbursable and non-reimbursable activities.
- ▶ Participants answer random moments (1 minute interval of time) each quarter.
- ▶ 5 day grace period to answer moments.
- ▶ Participants, Coordinator, and supervisors receive reminder emails at 24, 48, and 72 hour marks.
 - If moments go unanswered, they are invalid and may jeopardize the statistical validity of the RMTS and reimbursement.
 - RMTS is ongoing and reoccurs every quarter.

RMTS Demonstration

<https://www.chcf.net/chcfweb/sbc/wa-rms/?userID=TnixonTy>

MAC Participation Elements

Entities may participate if they:

- ▶ Federally recognized.
- ▶ Contract with HCA.
- ▶ NO biannual administrative fee is required.
- ▶ Participate in an ongoing RMTS.
- ▶ Assign a Coordinator to manage the program and work closely with HCA.
- ▶ Comply with program rules and monitoring requirements.
- ▶ Provide local matching funds through the CPE process

University of Massachusetts Medical School (UMMS)

- ▶ UMMS operates the web-based application which includes the RMTS and claiming components
- ▶ Real time updates makes program management easier
- ▶ Wide variety of real time reports making program monitoring more effective
- ▶ Quarterly participant data rolls over to next quarter; Coordinator makes updates
- ▶ UMMS provides Technical Assistance (email and phone) through their help desk

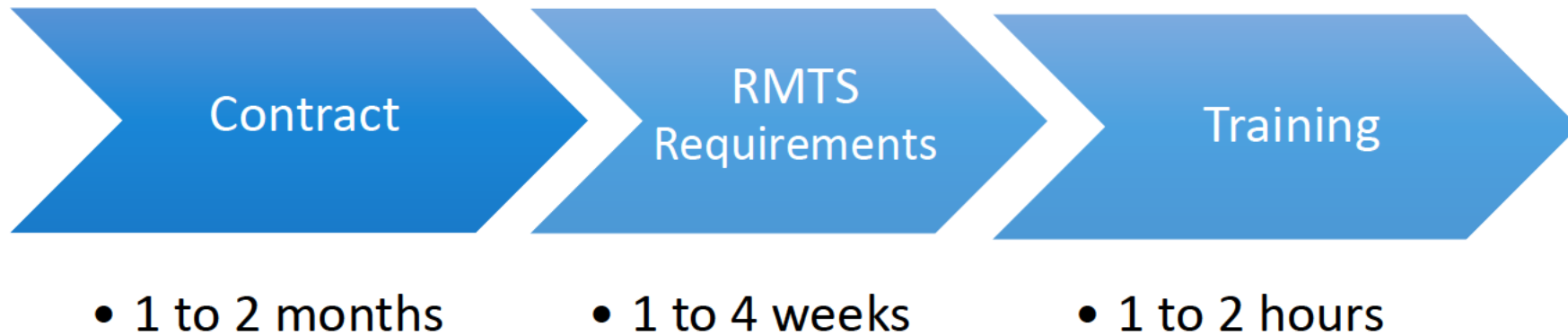
Reimbursement Process

Partial reimbursement is provided for expenses incurred while performing administrative activities related to Medicaid.

Federal Reimbursement Factors:

- ▶ Expenses after federal funds/grants are subtracted
- ▶ The time study results (percent of time documented as Medicaid)
- ▶ The Medicaid Eligibility Rate (MER - the percent of individuals served who are Medicaid eligible)
- ▶ The Federal Financial Participation (FFP) rate (50%)

MAC Participation Timeline



Resources

HCA MAC program website:

<https://www.hca.wa.gov/billers-providers/programs-and-services/medicaid-administrative-claiming-mac>

Follow Tribal MAC.

2003 CMS School-Based Administrative Claiming Guide:

<https://www.cms.gov/research-statistics-data-and-systems/computer-data-and-systems/medicaidbudgetexpendsystem/downloads/schoolhealthsvcs.pdf>

RMTS system website:

<https://www.chcf.net/>

Questions?

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Apple Health Billing Guides

- ▶ The [ProviderOne Billing and Resource Guide](#) is a step-by-step resource to help providers with technical processes in P1. There is a [medical webinar](#) and a [dental webinar](#) that work as companion tools to the ProviderOne Billing and Resource Guide
- ▶ The Tribal Health Program billing guide and Federally Qualified Health Center (FQHC) billing guide both address program specific policies regarding IHS/638 and FQHC clinics but neither billing guide is able to go into any detail regarding Medicaid-covered services
- ▶ In order to find out if a service is a Medicaid covered service we will look to see if the service is covered in a program-specific billing guide
- ▶ Refer to the [Provider billing guides and fee schedules page](#), there are 54 HCA Billing guides, most of the ITU services may be broken into 4 categories (Medical, Dental, Mental Health, Substance Use Disorder)
- ▶ Which billing guides do we use? The following slides will look at each category separately

Apple Health Billing Guides – Medical Services

The following Billing guides may be used for billing **medical** services to HCA

- ▶ Chiropractic services for children
- ▶ Diabetes education program
- ▶ Early and periodic screening, diagnosis and treatment (EPSDT)
- ▶ Family planning
- ▶ Habilitative services (ABP client with congenital, genetic or early-acquired conditions requiring *physical/speech/occupational therapy type services*)
- ▶ HIV/AIDS case management (case management is not encounter eligible)
- ▶ Maternity support services/infant case management (MSS/ICM)
- ▶ Medical nutrition therapy (clients age 20 and younger)
- ▶ Outpatient rehabilitation Program (physical, speech and occupational therapy)
- ▶ **Physician-related/professional services**
- ▶ Professional administered drugs (drugs are not encounter eligible)
- ▶ Sterilization
- ▶ Vision hardware for clients 20 years of age and younger (hardware is not encounter eligible)
- ▶ The various fee schedules may be used as a quick reference to see if a code is covered

Apple Health Billing Guides – Dental Services

The following Billing guides may be used for billing **dental** services to HCA

- ▶ Dental Program – This is the general dental billing guide and it covers most dental services
- ▶ Access to Baby and Child Dentistry (ABCD) – Program for ABCD certified dentists serving clients age 0 through 5. Family Oral Health Education and Interim therapeutic restoration are ABCD services available for trained dentists
- ▶ Orthodontic Services (clients age 20 and younger)
- ▶ Refer to the [dental fee schedule](#) for a quick reference of **all** billable codes

Apple Health Billing Guides – Mental Health Services

The following Billing guides may be used for billing **mental health** services to HCA

- ▶ Mental health services (all billable codes are on the table on page 31-37)
- ▶ There are some mental health services that are not covered through ProviderOne (*Crisis services, Day Support, Medication Monitoring, Peer Support, Stabilization Services and Therapeutic psychoeducation*), these services are normally rendered by BHO-level providers. AI/AN clients receiving care at an IHS/638 clinic may practice their elective exemption rights ([42 U.S.C. 1396u-2](#)) and receive culturally competent care at their tribal clinic, refer to the Tribal Health Program billing guide, page 36-38 for more information)

Apple Health Billing Guides – Substance Use Disorder Services

The following Billing guides may be used for billing **Substance Use Disorder** services to HCA

- ▶ Substance use disorder program (all billable codes are on the table on page 21-23)

HCA Tribal Affairs office has a quick reference sheet for outpatient billing and for residential billing

Apple Health Billing Guides – Other Services

Other billing guides that may be used but are not as common

- ▶ Durable Medical Equipment (DME)
- ▶ Nondurable medical supplies and equipment
- ▶ Hearing hardware
- ▶ Nursing facilities
- ▶ Prescription drug program

Apple Health Billing Guides – Other References

- ▶ When is it acceptable to bill a client? Refer to the [bill-a-client webinar](#) and [FAQ](#)
- ▶ HCA launched a new prior authorization process last year – prior authorization requests may now be directly entered in the P1 portal. [Medical](#), [dental](#), [DME](#), and [pharmacy](#) authorizations may be submitted

Apple Health Client Eligibility

Apple Health Client Eligibility is a three-step approach

1. Is the P1 client ID for the correct client
2. Is the client eligible for Apple Health?
3. If the client is eligible for Apple Health, who do you bill? (Managed Care, commercial insurance, Medicare, P1?)

Apple Health Client Eligibility

- ▶ A client benefit inquiry may be done via a HIPAA 270/271 or a magnetic reader or most often - directly in the ProviderOne portal as a *Client Benefit Inquiry*
- ▶ To perform a Client Benefit Inquiry, log in to P1 using one of the following profiles *EXT Provider Eligibility Checker* or *EXT Provider Super User*
- ▶ The next few slides will outline an eligibility check and the three-steps

Apple Health Client Eligibility

From the P1 home page,
select *Benefit Inquiry*

The screenshot displays the ProviderOne web application interface. At the top, the header includes the 'ProviderOne' logo, 'My Inbox', and a navigation bar with 'Relations, Provider' and 'Profile: EXT Provider Super User'. Below the header, the 'Provider Portal' is visible, showing a search field for 'ProviderOne Id/NPI'. The main content area is a list of services categorized into several sections: 'Online Services', 'Claims', 'Client', 'Payments', 'Managed Care', 'Prior Authorization', 'Provider', and 'HIPAA'. A red arrow points to the 'Benefit Inquiry' link under the 'Client' section.

- Online Services
- Claims
 - Claim Inquiry
 - Claim Adjustment/Void
 - On-line Claims Entry
 - On-line Batch Claims Submission (837)
 - Resubmit Denied/Voided Claim
 - Retrieve Saved Claims
 - Manage Templates
 - Create Claims from Saved Templates
 - Manage Batch Claim Submission
- Client
 - Client Limit Inquiry
 - Benefit Inquiry**
- Payments
 - View Payment
 - View Capitation Payment
- Managed Care
 - View Enrollment Roster
 - View ETRR
- Prior Authorization
 - On-line Prior Authorization Submission
 - Prior Authorization Inquiry
- Provider
 - Provider Inquiry
 - Manage Provider Information
 - Initiate New Enrollment
 - Track Application
- HIPAA
 - Submit HIPAA Batch Transaction
 - Retrieve HIPAA Batch Responses

Apple Health Client Eligibility

Enter the client's P1 ID. If you do not have the client's P1 ID you may search using the other criteria listed.

The inquiry start and end dates must include the claim date of service (mike always 'goes back' at least 1 year).

The Service Type Code is always 30

The screenshot shows the 'Client Eligibility Inquiry' form in the ProviderOne system. The form is titled 'Client Eligibility Inquiry' and includes a 'Close' button and a 'Submit' button. Below the buttons, there is a list of criteria to complete for an inquiry:

- ProviderOne Client ID(Client Identification Code) or
- Last Name, First Name AND Date of Birth or
- Last Name, First Name AND SSN or
- SSN AND Date of Birth
- ProviderOne Client ID(Client Identification Code), Last Name, First Name AND Date of Birth or
- ProviderOne Client ID(Client Identification Code), Last Name AND Date of Birth or
- ProviderOne Client ID(Client Identification Code) AND Last Name

Below the list, there is a note: 'Please contact Customer Service Center at (800) 562-3022'.

The form fields are as follows:

- ProviderOne Client ID: #####WA X
- Last Name: [Text Field]
- Date of Birth: [Date Picker]
- Inquiry Start Date: 01/01/2018 [Date Picker]
- SSN: [Text Field]
- First Name: [Text Field]
- Inquiry End Date: 04/08/2019 [Date Picker]

Below the form, there is a 'Service Type Code' section with a dropdown menu set to '30-Health Benefit Plan Coverage'.

Apple Health Client Eligibility

The Client Benefit Inquiry page may be split into 3 sections (3 steps)

1. Verify that the client is the correct client - **Selection Criteria Entered and Demographic and Response Information**
2. Verify that the client has Apple Health - **Client Eligibility Spans**
3. Verify whether or not the client has other insurance that is primary over P1 or if the client is in FFS -- **Other Insurance** (Managed Care information, Medicare Eligibility Information, Health Home Eligibility, and Coordination of Benefits)

Apple Health Client Eligibility

1. Selection Criteria Entered and Demographic and Response Information

- ▶ Double check the from and to dates to make sure that the date of service is captured
- ▶ Double check the client info to make sure that you are looking at the right client
- ▶ If you see “Active Coverage” then we proceed to the next step

Provider 76 My Inbox

Relations, Provider Profile: EXT Provider Super User

Provider Portal > Client Eligibility Inquiry > Client Benefit Level

Client ID: [REDACTED] Name: [REDACTED]

Printer Friendly Version

Close Submit Another Inquiry Exit

Selection Criteria Entered

Date of Request: 04/08/2019
Time in Request: 01:49:33 PM PDT
Provider ID: [REDACTED]
From Date of Service: 01/01/2018
To Date of Service: 04/08/2019

ProviderOne Client ID: [REDACTED]
Client Date of Birth:
Client SSN:
Client Last Name:
Client First Name:

Demographic and Response Information

Client Demographic Information:

ProviderOne Client ID: [REDACTED]
Client First,Middle,Last Name: [REDACTED]
CSQHCS: 183-HCA SOUTHWEST
County Code: 025-Pacific
CSOR: 025-SOUTH BEND BRANCH
Date of Birth: [REDACTED]
Gender: [REDACTED]
Language: ENG-English
Placement:
ACES Client ID: [REDACTED]
MBI:

System Response Information:

Valid Request Indicator: Y
Reject Reason Code:
Eligibility or Benefit information Code: 1-Active Coverage
Follow-Up Action Code:

Apple Health Client Eligibility

2. Client Eligibility Spans

Refer to the [Scope of Coverage website](#) to see what services are offered for the client's *Benefit Service Package*

Refer to the [Tribal Health Billing Guide](#) (p.21) or the [FQHC billing guide](#) (p.27) for the list of RACs that **do not** qualify for the encounter rate RAC 8000 and 8500 – **ignore**. RAC 8000/8500 are not there for P1 eligibility reasons, **always ignore RAC 8000/8500**

“Suspended” in the *Benefit Service Package* section indicates that the client has been reported as incarcerated during those dates and medicaid covered services are suspended while the client is incarcerated

Sort by the End date (click the down-caret), if your date of service is not on the screen, push the ‘next’ button

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	[REDACTED]		
MC: Medicaid	1201	ABP	02/27/2018	08/31/2018	N05	[REDACTED]		
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	[REDACTED]		

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

Apple Health Client Eligibility

3. Other Insurance

Managed Care information,

Medicare Eligibility Information,

Coordination of Benefits

Each section will be reviewed on the following slides

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	AMG Behavioral Health Services Only	201599811	(800) 600-4441		01/01/2019	12/31/2999
HM: Health Maintenance Organization	MC: Capitated	Community Choice - Health Hemo Only	203030501	(888) 509-0563		08/01/2018	12/31/2009
HM: Health Maintenance Organization	MC: Capitated	Spokane Behavioral Health Organization	105021302	(509) 477-5722		08/01/2018	12/31/2018
HM: Health Maintenance Organization	MC: Capitated	Spokane Behavioral Health Organization	105021302	(509) 477-5722		01/01/2017	07/31/2018

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Message(s):

Medicare Eligibility Information			
Service Type Code	Insurance Type Code	Eligibility Start Date	Eligibility End Date
30: Health Benefit Plan Coverage	MA: Medicare Part A	04/01/2016	12/31/2999
30: Health Benefit Plan Coverage	MB: Medicare Part B	04/01/2016	12/31/2999

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Message(s): We believe this information to be correct, but you must verify eligibility and coverage with specified payor

Health Home Eligibility	
Start Date	End Date
07/01/2018	12/31/2000

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Coordination of Benefits Information									
Service Type Code	Insurance Type Code	Insurance Co. Name & Contact	Carrier Code	Policy Holder Name	Policy Number	Group Number	Plan Sponsor	Start Date	End Date
30: Health Benefit Plan Coverage	C1: Commercial	AETNA MEDICARE (800) [REDACTED]	35810		Med Part D			04/01/2016	12/31/2999

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Apple Health Client Eligibility

3. Other Insurance - Managed Care information

If you are providing physical health care or *low acuity* mental health – if the client is enrolled in any of these managed care plans the managed care plan is primary over P1* If the client is not enrolled in any of the plans listed then the client is in the “fee for service” program for the service

AMG Apple Health adult Coverag
AMG Fully Integrated Managed Care
AMG Healthy Options Blind/Disabled
AMG State Children's Health Insurance Program

MHC Fully Integrated Managed Care
MHC Apple Health Adult Coverag
MHC Healthy Options Blind/Disabled
MHC State Childrens Health Insurance Program
MHC Healthy Options

CHPW Fully Integrated Managed Care
CHPW Apple Health Adult Coverag
CHPW Healthy Options Blind/Disabled
CHPW State Childrens Health Insurance Program
CHPW Healthy Options

Coordinated Care Apple Health Adult Coverag
CCW Fully Integrated Managed Care
Coordinated Care Healthy Options Foster Care
Coordinated Care Healthy Options Blind/Disabled
Coordinated Care State Childrens Health Insurance
Coordinated Care Healthy Options

UHC Apple Health Adult Coverag
UHC Healthy Options Blind/Disabled
UHC State Childrens Health Insurance Program
UHC Healthy Options

* IHS/638 clinics currently have a choice in regards to mental health services - either bill managed care (then P1 for the balance of the encounter rate) or bill P1 directly

If you are providing Substance Use Disorder services or *high acuity* mental health – if the client is enrolled in any of these managed care plans the managed care plan is primary over P1* If the client is not enrolled in any of the plans listed then the client is in the “fee for service” program for the service

North Sound Behavioral Health Org
Thurston-Mason Behavioral Health Organizations
Great Rivers Behavioral Health Organization
King County Behavioral Health Organization
Optum Pierce BHO
North Central Washington Behavioral Health
Salish Behavior Health Organization
Spokane Behavioral Health Organization
Greater Columbia Behavioral Health

AMG Fully Integrated Managed Care
AMG Behavioral Health Services Only
CCW Fully Integrated Managed Care
CCW Behavioral Health Services Only
Coordinated Care Healthy Options Foster Care
CHPW Fully Integrated Managed Care
CHPW Behavioral Health Services Only
MHC Fully Integrated Managed Care
MHC Behavioral Health Services Only

* IHS/638 clinics currently have a choice to either bill managed care primary (then P1 for the balance of the encounter rate) or bill P1 directly

If you are providing services to any client enrolled in a PCCM listed below – call the client's PCCM to request a referral. PCCM is not a payer, clients in the PCCM program are in FFS (bill P1 directly, PCCM is not 'insurance')

Colville Confederated Tribes
Lower Elwha Health Clinic
Puyallup Tribal Health
Seattle Indian Health Board
Lummi Indian Health Center
Quinault Indian Nation
Native Health of Spokane
Nooksack Community Clinic
Tulalip Health Clinic
Yakama Health Center
David C Wynecoop Memorial Clinic
Colville Indian Health Clinic

DENTAL MANAGED CARE - pending

Apple Health Client Eligibility

3. Other insurance - **Medicare Eligibility**

Medicare-enrolled clients may have up to 4 different types of Medicare

- Part A for hospital insurance
- Part B for medical (professional) insurance
- Part C is a *Managed Medicare* plan that covers hospital and medical insurance
- Part D is prescription drug coverage (this too is in the Coordination of Benefits section)

NOTE: HCA opted to list Medicare Part C and D in the *Coordination of Benefits* section instead of the Medicare Eligibility section

Claims for clients who have part B or C are billed identically to P1, the only difference is that there is no trading partner agreement with the part C plans unlike Part B, which often forwards claims to P1 as *medicare cross-overs*

Generally, if a client has Part B or C then P1 will be secondary to Medicare (exceptions, dental & SUD are currently not covered by Medicare - Dental/SUD services may billed directly to P1 if the client does not also have managed care or commercial insurance that covers the service)

Apple Health Client Eligibility

3. Other insurance – **Coordination of Benefits**

If you see Medicare part C or D in the Coordination of Benefits section, refer to the previous slide for Medicare Eligibility

If the client has a commercial insurance plan then it should be listed in the Coordination of Benefits section. HCA is almost always the payer of last resort (other than IHS/PRC, which is truly the payer of last resort)

- If a client has commercial insurance but it is not reflected in the Coordination of Benefits section, P1 will need to be updated before services are payable in P1
- If a client does not have commercial insurance but commercial insurance is in the Coordination of Benefits section, P1 will need to be updated before services are payable in P1 (refer to page 29 of the [ProviderOne Billing and Resource Guide](#))
- HMA (and Shasta and WebTPA) insurance may be primary or secondary to P1, depending on the source of funding of the client's insurance
 - If the AI/AN client has insurance coverage that was purchased using IHS Purchased and Referred Care (PRC) funds, that insurance is a payer of last resort – no different from when PRC funds are being used to pay for services.
 - If the AI/AN client has insurance coverage that was not purchased using PRC funds, then that insurance should be treated as commercial insurance.

Apple Health Client Eligibility

- ▶ In most situations where a client has other insurance, a secondary claim may be billed to P1

Billing P1 secondary to other insurance			
I/T/U	Apple Health Managed Care client	Medicare B or C client	Commercial insurance client
IHS/638	Bill managed care then P1 for balance of encounter rate	Bill Medicare then bill P1 for the balance of the encounter rate on HCFA format	Bill primary insurance then P1 for the balance of the encounter rate (HCFA or dental format)
FQHC	Bill managed care. There is a reconciliation process for FQHCs	Bill Medicare then bill P1 for the coinsurance on a UB format	Bill primary insurance then P1 for the balance of the encounter rate (HCFA or dental format)

Apple Health Client Eligibility

If a client is on spenddown there will be a spenddown amount listed in the Client Benefit Inquiry

Client Eligibility Spans							
Spenddown Information							
RAC Code - 1101		Base Period - Start: 11/01/2018 End: 04/30/2019					
Total Spenddown ▲▼	Spenddown Liability ▲▼	Remaining Spenddown ▲▼	EMER Liability ▲▼	Remaining EMER ▲▼	Spenddown Status ▲▼	Update Date ▲▼	Spenddown Start Date ▲▼
21187.98	21187.98	21187.98	0.00	0.00	Pending	11/02/2018	11/01/2018

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Refer to the [Spenddown step-by-step instructions](#) for the full information on spenddown.

Spenddown is like an insurance deductible and is used to determine a client's liability for the cost of medical care. Clients must incur medical expenses equal to their excess income (spenddown or liability) before medical benefits are covered.

If a provider is assisting a client to have bills applied to the client's spenddown, the provider can fax paid or unpaid bills incurred during the client's base period to the Spenddown Fax Line at 1-888-338-7410

Apple Health Client Eligibility

- ▶ During a Client Benefit Inquiry if you notice that P1 has an incorrect birthday or gender (e.g., mike is a girl in P1) – rather than bill with incorrect data in order to have the claim paid it is better to update P1
- ▶ Corrections may be requested via the [contact us portal](#) or contacting mike directly

- ▶ NOTE: Transgender client issues are different from the birthday/gender mismatches mentioned above.
 - ▶ If a client indicates that they are male when signing up for healthcare then services must be billed as male (if client is enrolled as female then services must be billed as female)
 - ▶ If there are procedure to gender mismatches (e.g. female needs prostate exam) a specific transgender diagnosis may be added to the claim
 - ▶ More information on transgender billing issues is in the [physician related billing guide](#), page 351

100% FMAP for Services *Received Through a Tribal Facility*

[SHO 16-002](#) (02/26/2016) – 100% FMAP (Federal Medical Assistance Percentages) is available for services *received through a 638/IHS facility*

Refer to the SHO (State Health Official) letter and the [FAQ for SHO 16-002](#) for more information. Summary:
IHS/Tribal facilities¹ may enter into care coordination agreements with non-IHS/Tribal providers to furnish certain services for their patients who are AI/AN Medicaid beneficiaries, and the amounts paid by the state for services requested by facility practitioners in accordance with those agreements would be eligible for the enhanced federal matching authorized under section 1905(b) of the Social Security Act at a rate of 100 percent. Upon execution of a written care coordination agreement, this will be effective immediately for states for the expenditures for services furnished by non-IHS/Tribal providers to AI/AN Medicaid beneficiaries who are patients of an IHS/Tribal facility acting under such agreement, as described below

There are specific requirements listed in the SHO 16-002 notice, refer to the notice for complete information on the care coordination requirements

Q. How does HCA/P1 know to claim 100% FMAP for the service?

A. The non-tribal provider will need to add a data element to the claim (possibly an EPA, Expedited Prior Authorization)

Q. Now that HCA is claiming 100% FMAP, what happens with the money that HCA is saving?

A. Stay tuned, there is a bill in the legislature that would reinvest any new Medicaid savings from the 100% FMAP savings back into the ITU system of care

638-FQHC

As per the CMS suggestion as outlined in the [FAQ for SHO#16-002](#), HCA has submitted a State Plan Amendment (#19-0009; 638-FQHC). If the SPA is approved **as written**, these are the only changes to expect

1. 638-FQHC encounter payments will not be restricted to services rendered *inside the 4-walls*
 - Medicaid covered FQHC services in elder homes, schools, alternative living facilities and other locations are payable at the encounter rate (sites of service must continue to be clinically appropriate)
 - 638-FQHC can enter into a contract (recently labeled an *FQHC Affiliate Agreement*) with an outside specialist/provider and thereby make the outside specialist/provider part of the 638-FQHC group. FQHC Services rendered by the outside specialist/provider may be billed to P1 at the 638-FQHC encounter rate
2. FQHCs have a *one-facility - one-rate* rule
 - Services for nonAI/AN clients who are enrolled in managed care are eligible for the 638-FQHC rate. Medical/Dental/Mental Health services are eligible for the full encounter rate, SUD services will continue to pay at the federal share because the Tribe is responsible for local matching funds.
 - FQHCs have a one facility, one rate rule (see Social Security Act § 1902(bb))
 - Compare to Indian enrollee rate rule (see Social Security Act § 1932(h)(2)(C)), this provides the encounter rate for AI/AN clients in managed care but there is no provision for nonAI/AN clients in managed care

Q. What is the 638-FQHC rate?

A. The CMS FAQ suggested an APM (Alternative Payment Model) for the 638-FQHCs which will be at least equal to the IHS rate

Dental Managed Care

- ▶ Apple Health is scheduled to move to managed care in July, 2019
- ▶ The Apple Health [Dental Managed care website](#) will have current information
- ▶ AI/AN clients will not be automatically enrolled in a dental managed care plan (following same process for Physical and behavioral health – no automatic enrollment for AI/AN clients)

IGT to CPE (for non-AI/AN SUD services)

- ▶ Tribes who render Substance Use Disorder (SUD) services for nonAI/AN clients are switching from Intergovernmental Transfer (IGT, mailing checks back and forth) to Certified Public Expenditure (CPE, certifying that funds were allocated)
- ▶ The final steps on P1 testing are occurring and the first “invoices” should be sent out shortly for the third and fourth quarters of CY2018

FAQ and Open Discussion

Q. If a client wants to enroll in or change their Apple Health Managed Care plan – who do they contact?

A. There are several ways that any Apple Health client can enroll/disenroll or change plans.

- HealthPlanFinder (except for dental)
- Call 800 562 3022 (MACSC call center)
- Use the [Contact Us Portal](#)
- The [ProviderOne client portal](#)
- HCA [Change my Health Plan website](#)

FAQ and Open Discussion

Q. Can an MD or ARNP apply fluoride? Is a dental or HCFA claim? Are there any modifier requirements?

A.

- Dentists (and hygienists) bill for the fluoride on a dental claim form and we just follow the dental billing guide
- MDs (and ARNPs and PAs) bill for the fluoride on a HCFA claim form and we follow the physician-related billing guide (page 276)

NOTE:

- Dental claims do not need a diagnosis code on the claim but if a diagnosis is added it must be valid and appropriate for the service
- HCFA claims always need diagnosis and the Physician-related billing guide indicates to use Z00129 for fluoride (and we always need the UA or SE modifier but otherwise there really aren't any modifier requirements)
- The fluoride code for HCFA claims (MD/ARNP) *may* be changing in July (probably changing to CPT 99188 but we need to wait for the billing guide update)

FAQ and Open Discussion

Q. Does the SPA that allows up to 5 encounters per day conflict with NCCI?

A. The State Plan allows up to 5 encounters per day for medicaid-covered services. Medicaid is mandated to follow NCCI and if NCCI indicates that a service is not payable then it isn't a medicaid covered service (even though the fee schedule has a rate, etc)

FAQ and Open Discussion

Q. Can you share the contact information for the Provider Enrollment teams?

- HCA - contact the Provider Enrollment team at 800 562 3022 ext 16137 (M-F, except Wednesdays) or providerenrollment@hca.wa.gov
- Amerigroup -
- Community Health Plan of WA -
- Coordinated Care - To get IHCP providers credentialed with Coordinated Care, please email us at CONTRACTING@coordinatedcarehealth.com
- Molina -
- United HealthCare –

FAQ and Open Discussion

Q. Can we have more information on CGM (Continuous Glucose Monitor) training?

A. Stay tuned

FAQ and Open Discussion

Q. The list of diagnosis codes that are generally not payable includes Z0131, Encounter for examination of blood pressure with abnormal findings. Why isn't this payable?

A. Another great example of why it is OK to question the policy – Z0131 has been updated and is now a payable diagnosis. Mike will reprocess rejected claims soon

Also asking about some noncovered TMJ diagnoses (stay tuned)

M26601 RIGHT TEMPOROMANDIBULAR JOINT DISORDER UNSPEC

M26602 same thing but for LEFT

M26603 same thing but for bilateral

FAQ and Open Discussion – Open Questions

Q. Any update on the SUD Match going quarterly?

A. Stay tuned, this is in reference to the switch to the CPE process (Spring/Summer, 2019?)

FAQ and Open Discussion – Open Questions

Q. Dental assistants are not licensed, however some are certified and some are *registered*. If a dental service was performed by a *registered* dental assistant would that qualify for an encounter?

A. Certified Dental Assistants and Licensed Dental Hygienist are consider a 'Health Care Professional' Per current SPA and Tribal Billing guides. if the service was rendered by a *registered* dental assistant – HCA has not completed the analysis on this question yet, stay tuned

FAQ and Open Discussion

Q. Does HCA cover paramedicine?

A. Not yet. House Bill 1358 has not been implemented yet.

Paramedicine is an emerging profession, it allows EMTs/Paramedics to provide some healthcare services to underserved populations.

A scenario explains why the question was asked

Over the years, paramedics have routinely been called out to various sites and, when they get there, they find that the client is not “sick” enough to need to go to the hospital.

For example – client calls because he has chest pain. The EMT’s get there and determine that there is no need to go to the hospital, they see he has elevated BP and suggest a primary care visit. The EMTs do not have a billable service, even after driving to the site

Stay tuned

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- The bottom-left corner of each slide will contain either I/T (impacts IHS and Tribal) or I/T/U (impacts IHS, Tribal and Urbans) or U (only impacts Urban)
- If there is a difference between any information in this webinar and current agency documents (e.g. provider guides, WAC, RCW, etc), the agency documents will apply.

Thank you!