Standardization Sub-group Report

November 24, 2014
MCO/HH Workgroup Report

Proposed Transition Timeline

- **August - October**

  - **Recommendation Period** – Address proposed recommendations and action items, *[model for billing, timelines, reports/data tracking/enrollment file, automated processes, dispute resolution, credentialing].*

- **November – January**

  - **Implementation** – Provide time for all CMAs, HHs and MCOs to implement recommendations and build systems to support the recommended processes.

- **February - March**

  - **Testing** – Test systems by exchanging "simulated" billing/claims data while continuing to send actual claims to Medicaid.
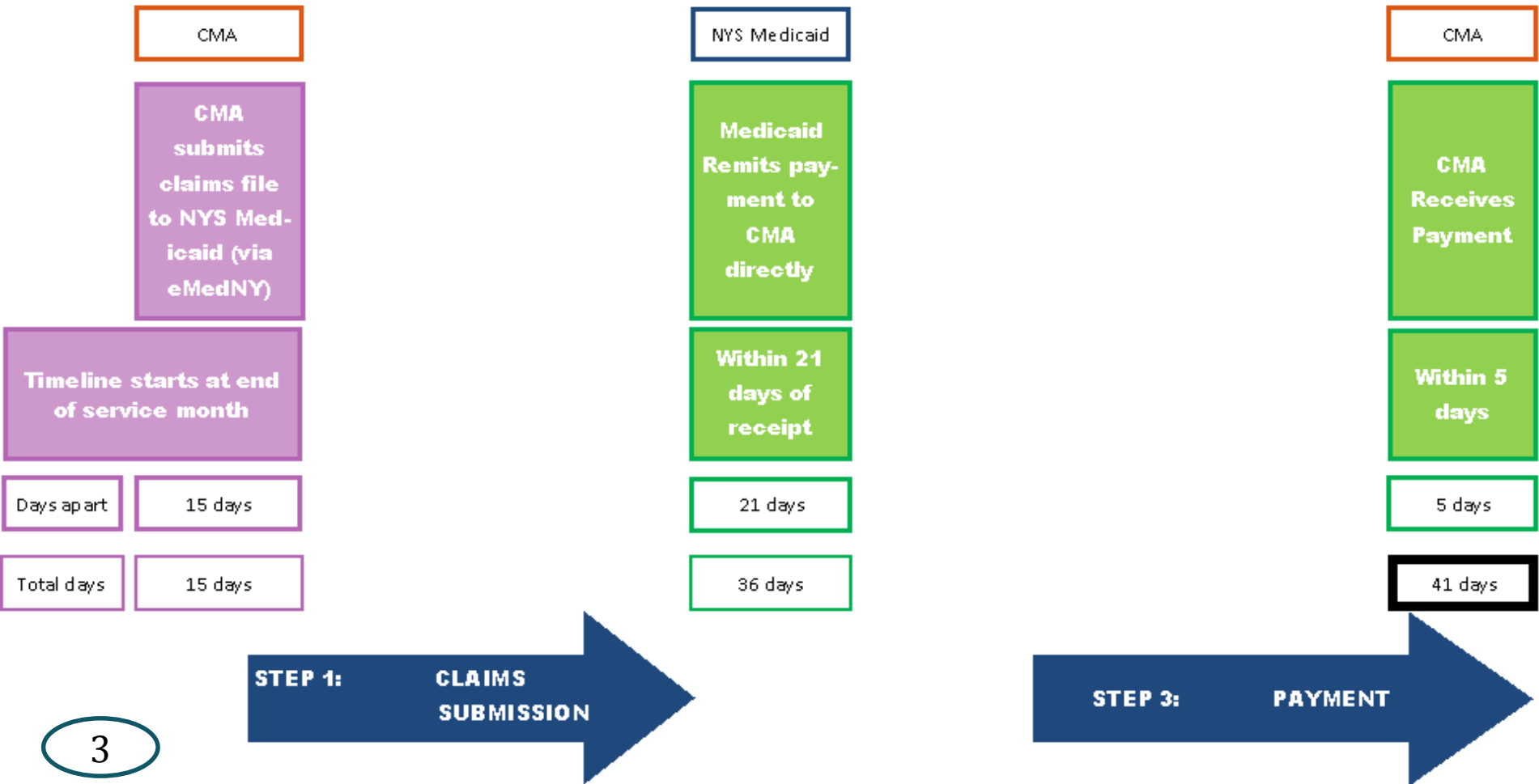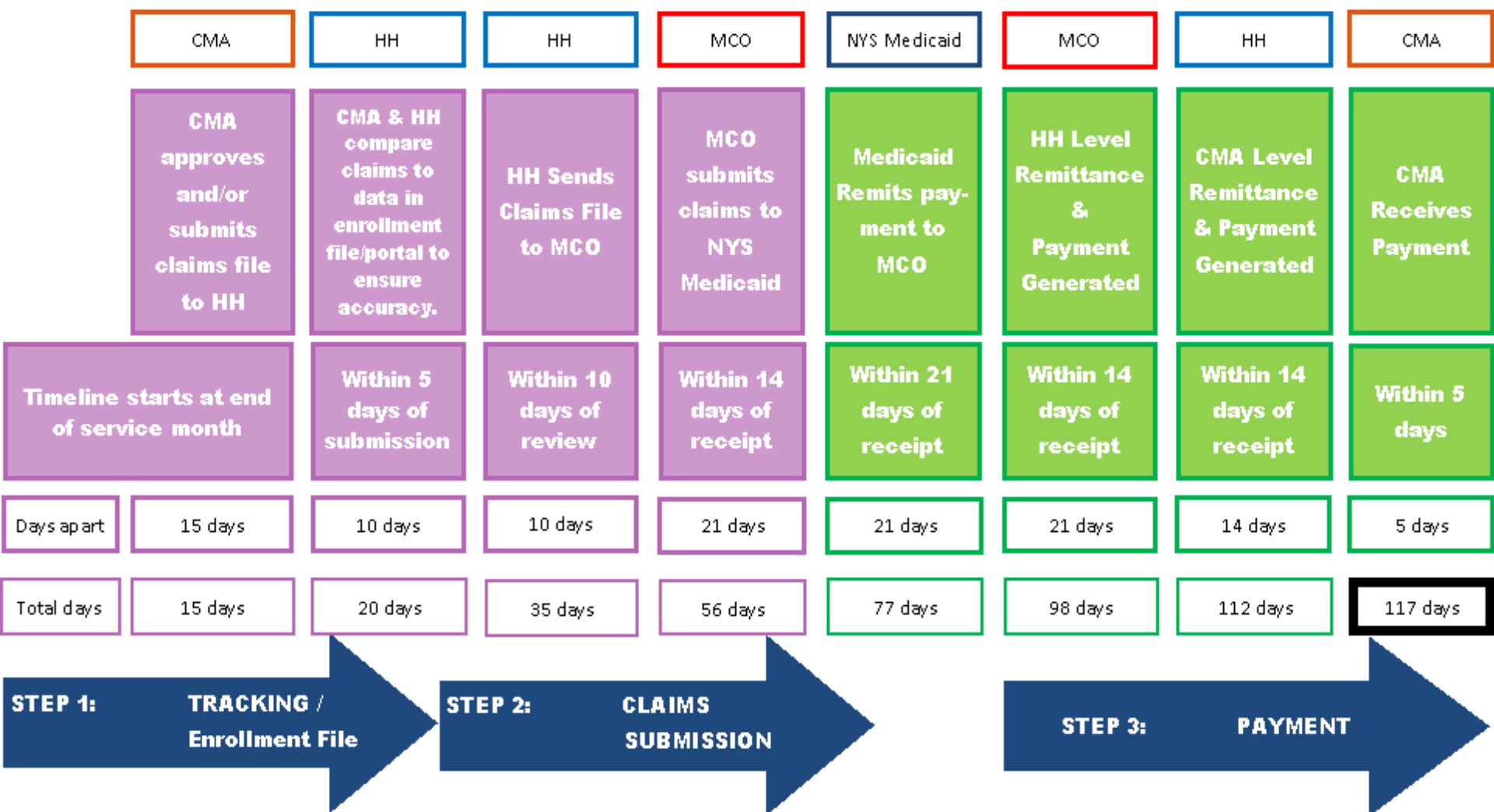
- **April, 2015**

  - **Go Live** – Services provided in January are billed through the new system and payments are generated as a result of these claims.

Areas of work

- ❑ Updates on Progress
    - ❑ Claims Process Workflow
        - o Timelines
        - o Claims and Remittance File (CARF)
    - ❑ Contracting
        - ❑ Developing automated process for reconciliation, rebills, voids, etc.
        - ❑ Reports and data exchange required
        - ❑ Dispute resolution
    - ❑ Surveys

Current Legacy Billing Process

CMA	HH	HH	MCO	NYS Medicaid	MCO	HH	CMA
CMA approves and/or submits claims file to HH	CMA & HH compare claims to data in enrollment file/portal to ensure accuracy.	HH Sends Claims File to MCO	MCO submits claims to NYS Medicaid	Medicaid Remits payment to MCO	HH Level Remittance & Payment Generated	CMA Level Remittance & Payment Generated	CMA Receives Payment

Timeline starts at end of service month	Within 5 days of submission	Within 10 days of review	Within 14 days of receipt	Within 21 days of receipt	Within 14 days of receipt	Within 14 days of receipt	Within 5 days

Days apart	15 days	10 days	10 days	21 days	21 days	21 days	14 days	5 days
Total days	15 days	20 days	35 days	56 days	77 days	98 days	112 days	117 days

STEP 1: TRACKING / Enrollment File

STEP 2: CLAIMS SUBMISSION

STEP 3: PAYMENT

All claims and payment files must include the following:

- Individual claim ID
- date of claim (if rebill, date of original claim)
- name of client

- DOB
- date of service
- acuity score
- level of acuity (high/medium/low)
- name of HH
- name of CMA
- Medicaid ID # (CIN)

- Verification of insurance status
- reimbursement rate (expected for pended)
- status of claims (denied, pended, paid)
- reason for status

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Claims and Remittance File (CARF)

Data Element	First Name of Client	Status of Claim Code (Denied, Pended)
Adjusted Amount	Gender	Functional/Clinical Rate Indicators
Amount due to CMA	Health Home Fee	Base Acuity (unadjusted)
Billed Amount	Health Home MMIS	Risk
CIN Number	Last Name of Client	
Claim ID Number	Locator Code	HIV Viral Load
		HIV T-cell Counts
CMA MMIS	MCO Fee	Homelessness
County Code	MCO MMIS	Rural
Date of Claim Submission	Paid Amount	Incarceration
	Rate Code	
Date of Original Claim (if rebill)		IP Stay for Mental Illness
Date of Service	Reason for Status (denied, pended)	IP Stay for SUD Treatment
	Reimbursement Rate (Expected for pended)	SUD Active Use/Functional Impairment
DOB	Reimbursement Rate (Expected for pended)	
Diagnosis Code		Literacy (reading level at or below 4th grade)