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Special Bulletin

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INTERNET SITE

The Internet site containing the Medicaid Provider and Electronic Billing Manuals will soon undergo a change. The manual information has not changed, but users will notice a different layout.

CHANGES TO MEDICAID SPENDDOWN PROGRAM

Spenddown is a process by which the elderly and people with disabilities become Medicaid eligible based on their incurred medical expenses when they would not otherwise be eligible. A person's spenddown requirement, (the amount of medical expenses one must incur to qualify for Medicaid) is the difference between their countable income and the income level for Medicaid eligibility. Currently, spenddown is calculated on a quarterly basis, so that the monthly difference between countable income and Medicaid income level is multiplied by 3. The monthly income level for Medicaid eligibility is $545 for a single person, and $817 for a couple. The income level changes each January with the Social Security Administration's Cost of Living Adjustment (COLA).

Today, people participating in Medicaid through the spenddown option provide the local Division of Family Services (DFS) office with documentation of their incurred medical expenses.

Eligibility begins on the first date that a person's cumulative medical expenses equal or exceed the quarterly spenddown amount.

Beginning October 1, 2002, Medicaid edits will not allow reimbursement for covered services that do not exceed the individual's spenddown amount. Claims for services provided to a spenddown recipient on the first date of eligibility will suspend and be considered for payment. One of three actions will occur:

- The claim will reimburse at zero, but billed charges will accrue toward the spenddown amount.
- The claim will be partially paid and part of the expense accrues toward spenddown.
- The claim will be paid up to the Medicaid allowable if spenddown has been met.

In order to mitigate the impact of the changes to spenddown recipients, the program will change as follows:

- Recipients will meet spenddown on a monthly basis, rather than quarterly.

- The re-application process will be automated so that recipients do not have to file a new application for each new spenddown period.

- Recipients will have the option to pay their monthly spenddown requirement to the Division of Medical Services (DMS), much like a premium payment, in order to have continuous Medicaid coverage. Recipients may also arrange to make the monthly spenddown payment through electronic funds transfer (EFT) from a bank account.

QUESTIONS AND ANSWERS ABOUT SPENDDOWN

Question 1: Does the recipient have to pay a bill in full before Medicaid coverage can begin?

Answer 1: No, spenddown recipients are only required to *incur* medical expenses, as before. The change is that Medicaid will not pay for medical expenses that are incurred prior to the point where spenddown is met. Arrangements for payment of the amount for which the recipient is responsible are strictly between the provider and the recipient.

Question 2: Are providers allowed to deny services to persons before they have met spenddown?

Answer 2: Prior to meeting spenddown, individuals are not considered Medicaid eligible and should be treated like any other private pay patient. Providers may not discriminate against any individual regardless of whether or not they may become Medicaid eligible.

Question 3: May someone other than the recipient make arrangements for paying the monthly spenddown to the state to ensure continuous eligibility?

Answer 3: Yes. Recipients will receive information about how to make the monthly payment or how to set up an automatic payment through EFT. The payment does not have to come from the recipient.

Question 4: What charges are the responsibility of the spenddown recipient?

Answer 4: The spenddown recipient is responsible for payment of medical services prior to the date of Medicaid eligibility. The recipient is also responsible for payment of medical services for any amounts used to meet spenddown on the first date of eligibility each month. When billed, DMS is responsible for payment of covered medical services, up to the Medicaid allowable, less any spenddown amount.

Question 5: What if the spenddown recipient has private insurance in addition to Medicaid? How will this work?

Answer 5: A third party payment will be deducted from the provider billed amount prior to any deduction of a spenddown balance. In the claims system, the spenddown balance will compare to the billed amount net of any third party payment. If the billed amount is less then the spenddown balance, the claim will “0" pay and the spenddown balance will be reduced by the billed amount.

When the billed amount, net of any third party payment is equal to or greater than the remaining spenddown balance, it becomes a split claim. On the split claim, the Medicaid allowed amount will be reduced by the remaining spenddown amount to determine the payment. Example 1: Recipient spenddown balance is $400. The provider billed amount of $500, net of a $100 third party payment is $400. This $400 is applied to the $400 remaining spenddown balance and the claim “0" pays. Example 2: Recipient spenddown balance is $300. The provider billed amount of $600, net of a $200 third

party payment, is $400. Three hundred of that amount is applied to the remaining spenddown balance, the Medicaid allowable for the service is $600, so the provider is reimbursed $100. Example 3: Recipient spenddown balance is $300. The provider billed amount of $600, net of a $200 third party payment, is $400. Three hundred of that amount is applied to the remaining spenddown balance, the Medicaid allowable for that service is $500, the claim will pay zero.

Question 6: How much can the provider collect from the spenddown recipient?

Answer 6: On split claims billed to DMS, the provider can collect only up to the Medicaid allowable, less the remaining spenddown balance. If the spenddown balance is greater than the Medicaid allowable, the provider may collect that amount. If the claim is not billed to DMS and eligibility is retroactive (recipient not eligible on date of service, but was later backdated), the provider has the option to bill Medicaid or bill the recipient.

Question 7: How will the provider be able to tell when a patient is a potential spenddown recipient?

Answer 7: The provider will know only if the patient informs them. A patient is not Medicaid eligible until the spenddown amount is met. Until then, the patient may be considered a private pay patient.

Question 8: How will a provider bill services that continue past the end of the month?

Answer 8: Providers should only bill services through the end of the month for any Medicaid recipient. For example, when a hospital stay extends beyond the end of the month, hospitals may bill interim claims through the end of the month. Eligibility should be verified at the beginning of the next month, and the provider should only bill those days where the patient was eligible. Some recipients may elect to pay in their spenddown amount on a monthly basis, and will thus have continuous eligibility from month to month.

Question 9: At what point will the pharmacy POS show the recipient eligible?

Answer 9: If the recipient selects the pay-in option, they will show as having continuous eligibility in the POS at all times. If the recipient submits receipts to the DFS office their eligibility will show on the POS only after the recipient has given copies of incurred medical expenses to the DFS and the caseworker has entered their eligibility into the system. Example: Recipient brings bills into the DFS office. On November 10, 2002, caseworker reviews bills and notes that the recipient met spenddown on November 5, 2002. Caseworker updates eligibility file on November 10, 2002, with a November 5, 2002 start date. POS will begin showing November 5, 2002, eligibility date on November 11, 2002.

Question 10: If the pharmacy submits a claim on the date of eligibility and a remaining spendown balance exists, how does the POS system respond?

Answer 10: If the pharmacy claim is submitted the same day the recipient meets eligibility then the eligibility file will not yet be updated and the claim will deny. If the pharmacy is billing the claim retroactively and there is a spenddown amount remaining, the claim will capture. The provider's remittance advice will indicate the spenddown amount deducted and the final payment by Medicaid.

Question 11: If the claim is submitted retroactively after eligibility is established on the POS system is there a time when pharmacies will

receive a payment with the remaining spenddown balance deducted? If so how are they notified via the POS system?

Answer 11: Yes, see answer 10.

Question 12: If the pharmacies are working with a recipient and have agreed to accept partial payment from the recipient and partial payment from Medicaid how is that accomplished?

Answer 12: See answer 10.

Question 13: Will spenddown recipients still be eligible for a 90-day supply of medication?

Answer 13: No, spenddown recipients will be subject to the same pharmacy benefits and limitations requirements as other Medicaid recipients including the limit on 31 day supply of medications.

Question 14: Which pricing determines the amount applied to meet a recipients spenddown, the pharmacy Usual and Customary Rate (UCR) or the Medicaid reimbursement?

Answer 14: Since the claim would be made as a private transaction the pharmacy UCR should be submitted and used. If the pharmacy is attempting to accept a partial payment for a qualifying expense after the spenddown is met, the lower of logic of the submitted claim will be the basis for recipient reimbursement.

Question 15: How is the recipient copay or cost-sharing amount collected on a split claim? Does the recipient pay the copay for the total amount of the claim, or just on the amount payable by Medicaid? How will the provider know what Medicaid allowable is so he/she does not over collect from the recipient?

Answer 15: The patient would be responsible for the cost-sharing amount based on the cost of the product in the total claim. The provider would need to assess that on a prescription-by-prescription basis.

Question 16: If a claim for the first date of eligibility is not paid in full because a recipient has a spenddown liability but the recipient later provides verification of another bill for that date of service, will the claim be adjusted?

Answer 16: If the recipient provides DMS with proof of another medical expense that meets or partially meets the spenddown liability for the first date of eligibility the expense will be reviewed. If approved, a manual payout may be made to the provider whose claim was reduced by the spenddown liability. If the medical expense has a date of service that is prior to the date of eligibility, the recipient should report the medical expense to the DFS caseworker.

CHANGES TO RA

We have made changes to the format of the electronic Remittance Advice. To view these changes please visit our website: www.medicaid.state.mo.us/ Click on Missouri Medicaid Electronic Billing Layout Manuals, then click on Updated Billing Manuals. Choose the Remittance Advice. This will contain revisions made approximately in the last 6 months. Once you are in the manual, click on the double-arrow button next to the HOME button (at the bottom of your screen) to find the next update made to that manual during the latest revision period. Please note, if an update has not occurred to a manual in the las t 6 months, a link to that manual will not exist. If you have any questions please call the Verizon Help Desk at 573-635-3559. Please continue to check for revisions as there are many changes ahead.

HIPAA MODEL COMPLIANCE EXTENSION PLAN

In 1996, the Health Insurance Portability and Accountability Act (HIPAA) became law. It requires, among other things, that the Department of Health and Human Services establish national standards for electronic health care transactions and code sets. October 16, 2002, is the deadline for covered entities such as health plans, clearinghouses, and providers (such as physicians, dentists, hospitals, nursing homes and others) to comply with these new standards. However, in December 2001, the Administrative Simplification Compliance Act (ASCA, Public Law 107-105) gave covered entities not compliant by October 16, 2002, the opportunity to extend their compliance deadline by one year to October 16, 2003. This extension opportunity is applicable to all HIPAA covered entities other than small health plans (those with less than $5 million in annual receipts whose compliance date is already set for October 16, 2003). In order to qualify for this extension, covered entities must submit a comprehensive model compliance plan to the Centers for Medicare & Medicaid Services (CMS) by October 15, 2002.

A model compliance plan and instructions on how to complete and submit it are available on the CMS website at http://www.cms.hhs.gov/hipaa/ The on-line model plan can be submitted electronically through the website or printed and mailed. A paper version of the plan may be submitted as long as it provides equivalent information (covered entity and contact information; reasons for filing for the extension; HIPAA implementation budget information; and status of implementation and testing including whether or not use of a vendor is planned). CMS strongly encourages electronic filing but if a paper version must be filed, send the form to Attention: Model Compliance Plans, Centers for Medicare & Medicaid Services (CMS), P.O. Box 8040, Baltimore, MD 21244-8040. The deadline for both electronic and paper submissions is October 15, 2002.

If an extension is filed electronically through the CMS website, an electronic confirmation number acknowledging and granting the extension will be returned to the covered entity. If a paper version is filed, no confirmation will be received. However, if the paper plan consists of the required equivalent information, the covered entity may consider the extension granted.

The instructions give more details for completing the form; who should file for an extension; what data is needed; and where to get more information on definitions, frequently asked questions, etc. For more information, submit questions to askhipaa@cms.hhs.gov.

For additional information on HIPAA, the Administrative Simplification provision, and HIPAA reference guides, refer to Missouri Medicaid Special Bulletin, Vol. 24, No. 4, dated December 10, 2001.

PROGRAM INTEGRITY SOFTWARE UPDATE

The Missouri Department of Social Services, Division of Medical Services (DMS) has signed a multi-year agreement with The Medstat Group, Inc. to implement an enhanced software system designed for the purpose of the detection of overpayment and waste of Medicaid dollars. This new information technology system will further assist with procedures already in place to identify, prevent and deter incorrect or improper payments to providers. The process to install this system has already begun and will be ongoing over the next several months.

Federal and state law requires DMS to monitor Medicaid program integrity. Providers can reference Section 2, Provider Conditions of

Participation, of their provider manuals, www.dss.state.mo.us/dms/, for more information regarding current overpayment detection procedures.

MEDICAL ASSISTANCE FOR WORKER'S WITH DISABILITIES (MA-WD)

The Medical Assistance for Workers with Disabilities (MA-WD) eligibility groups were implemented July 1, 2002. These two optional groups, Basic Coverage and Medically Improved, are authorized by the federal Ticket to Work - Work Incentives Improvement Act and Missouri Senate Bill 236 (2001). Recipients have the same Medicaid fee-for-service benefits package and cost sharing as the Medical Assistance for the Permanently and Totally Disabled (ME Code 13). An age limitation, 16 through 64, applies. The gross income ceiling for this program is 250% Federal Poverty Level (FPL) for an individual. Premiums are charged on a sliding scale based on gross income between 150% - 250% FPL. Additional income and asset disregards apply for MA-WD, including spousal income and assets up to $100,000, children's income, one-half marital assets, and certain special asset accounts funded with the worker's earnings. Proof of employment/self employment is required. Eligible recipients will be temporarily enrolled under ME Code 13. Once systems work is completed, eligible recipients will be converted from ME Code 13 to ME codes 85 (premium) and 86 (non-premium). Eligibility for Medical Assistance for Workers with Disabilities is determined by the Division of Family Services.

DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION (DESE), FIRST STEPS PROGRAM REDESIGN

During the last several months, the DESE along with the Department of Social Services/Division of Medical Services (DSS/DMS), Department of Health and Senior Services (DHSS), and the Department of Mental Health (DMH) have been cooperatively working on the First Steps program redesign. The DESE is the state lead agency responsible for ensuring the provision of early intervention services to eligible infants and toddlers with disabilities and their families consistent with the requirements of Part C of the Individuals with Disabilities Education Act (IDEA).

Phase I of the First Steps Redesign began on April 1, 2002 for St. Louis City and County, St. Charles County and Northwest Missouri counties. Phase II implementation for the remainder of the state is January 1, 2003. The DESE website is http://www.dese.state.mo.us/ Click on Special Education for information regarding First Steps program.

The State has received approval from the Centers for Medicaid and Medicare Services to enroll DESE as an Organized Health Care Delivery System for the provision of physical, occupational and speech therapy, and for targeted care management for children in First Steps.

MC+ Fee-For-Service providers of physical therapy, occupational therapy, and speech/language pathology will enroll through the Central Finance Office (CFO) which is DESE's contractor for enrolling, authorizing services, and reimbursing providers for First Steps services when included in the child's Individualized Family Services Plan (IFSP). DMS also implemented a new Targeted Case Management/Service Coordination (TCM/SC) program for First Steps effective April 1, 2002, with the CFO doing the Medicaid provider enrollment for this provider group. MC+ Fee-For-Service reimburses TCM/SC Monthly Specialist Level and TCM/SC Monthly Associate Level. MC+

Managed Care enrollees may receive physical therapy, occupational therapy, speech/language pathology, and targeted case management/service coordination services that are identified in an IFSP on a fee-for-service basis outside of the MC+ benefit package.

DESE, Division of Special Education, has a central operator who directs calls to the appropriate section for a response. Calls relating to Part C regulations, child complaints, due process, Educational Surrogates, contract matters, finance and related issues, software and forms, data requests, data collection/reporting and related issues, training, research-based early intervention practices, and general provider enrollment issues should be directed to the following First Steps phone number at DESE: 573-522-8762. Provider questions concerning billing, service authorizations, and provider enrollment status need to be directed to the CFO at: 866-711-2573. Referrals to the First Steps program should be directed to DESE's System Point of Entry (SPOE) at 866-583-2392.