# Medica CCP Reports

September 23, 2020

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# AGENDA

## Overview of Care Coordinated Product (CCP) Reports

- Review CCP Report Grid

## EW Ineligibility Report

- Navigating, identifying and resolving issues and providing responses

# CCP Reports Grid

## Presenters

- Clinical Liaison – Shelley Lano
- Supervisor Care Coordination Support – Tammy Nutt
- Clinical Review Analyst /Benefit Managers – Threasa Orion and Deb Santana
- Clinical Program Manger – Joy Boser

## CCP Reports Grid Overview

- Medica created this new reference document in a response to request to provide general information about reporting
- It does not represent everything you may receive from Medica
- The CCP Reports grid lists reports that are sent from the CCP team
- Not every delegate receives every report at the frequency listed on the grid.
- The CCP Reports grid is a high level overview of the report including purpose, frequency, where to find the report, and whether responses are needed

## CCP Report Grid Overview - Continued

- Messaging in the email notification of the report will provide more details
- The grid is subject to change. It may be updated when any Information changes such as an email address or when a report is updated or added
- When sending report responses back to Medica, we ask that staff trained in the reports review responses prior to sending to Medica
- Please complete attendance log and send to MedicaCCSupport@Medica.com with any questions or comments regarding this training

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# EW Ineligible

SPP Clinical Review Analysts – Government Programs

Deb Santana, MSW, LGSW & Threasa Orion, MSN, RN

September 23,2020

# Agenda

EW Ineligible report:  Purpose, Report, and Resolution

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# Objectives

At the completion of the training you:

1. will be able to communicate the purpose of the EW Ineligible report.
2. will be able to locate report.
3. will identify and be able to resolve issues on report.
4. will be able to verbalize tips and tricks to reduce ineligible members.

# Purpose

## Purpose of Report

# Purpose of the Elderly Waiver (EW) Report

- Identifies members receiving Elderly Waiver (EW) services but not open to EW in the month noted on the report

- The EW Ineligible report is based on claims submitted by provider (**claims could be submitted up to a year later)**

# Difference between EW Ineligible report and EW drop report

## EW Ineligible

Identifies members receiving Elderly waiver (EW) services but not open to EW in the month or months on report

Report ***is not*** in “real time”. This report is based on information received from DHS and then compared to claims submitted to Medica.

## EW Drop

Identifies members whose Rate Cell changed from a B to an A.

Important to review and reinstate as quickly as possible as this will eliminate the same member showing up on the EW Ineligible report

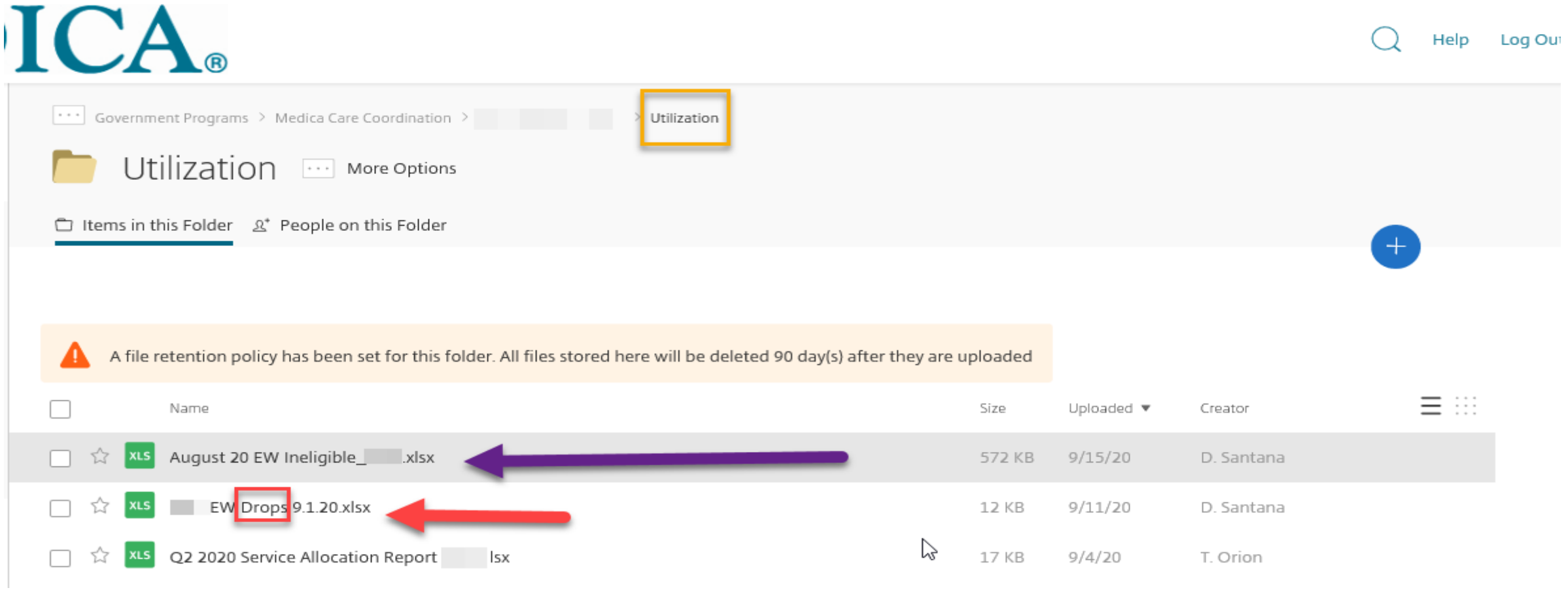
Report ***is*** in “real time”

# Report

## Report review

# Sharefile/Response

The report is dropped in Sharefile folder under utilization tab monthly;  if you do not have members on report for the month nothing will be dropped in the folder.



# What triggers the report

- Each month Medica is informed by Department of Human Services (DHS) what members are and are not open to EW.
- Medica then runs a report showing submitted claims from providers and these lists are compared to each other.
- People who were not open to EW yet had a claim for an EW service submitted to Medica will be on the Ineligible Report we send out for your review.
- Ex: Member received Personal Emergency Response System (PERS) in September but per DHS, September EW was inactive.  Because Medica received a claim and because EW was inactive the member is now on the report

# Cut off dates (also known as capitation date/CAP)

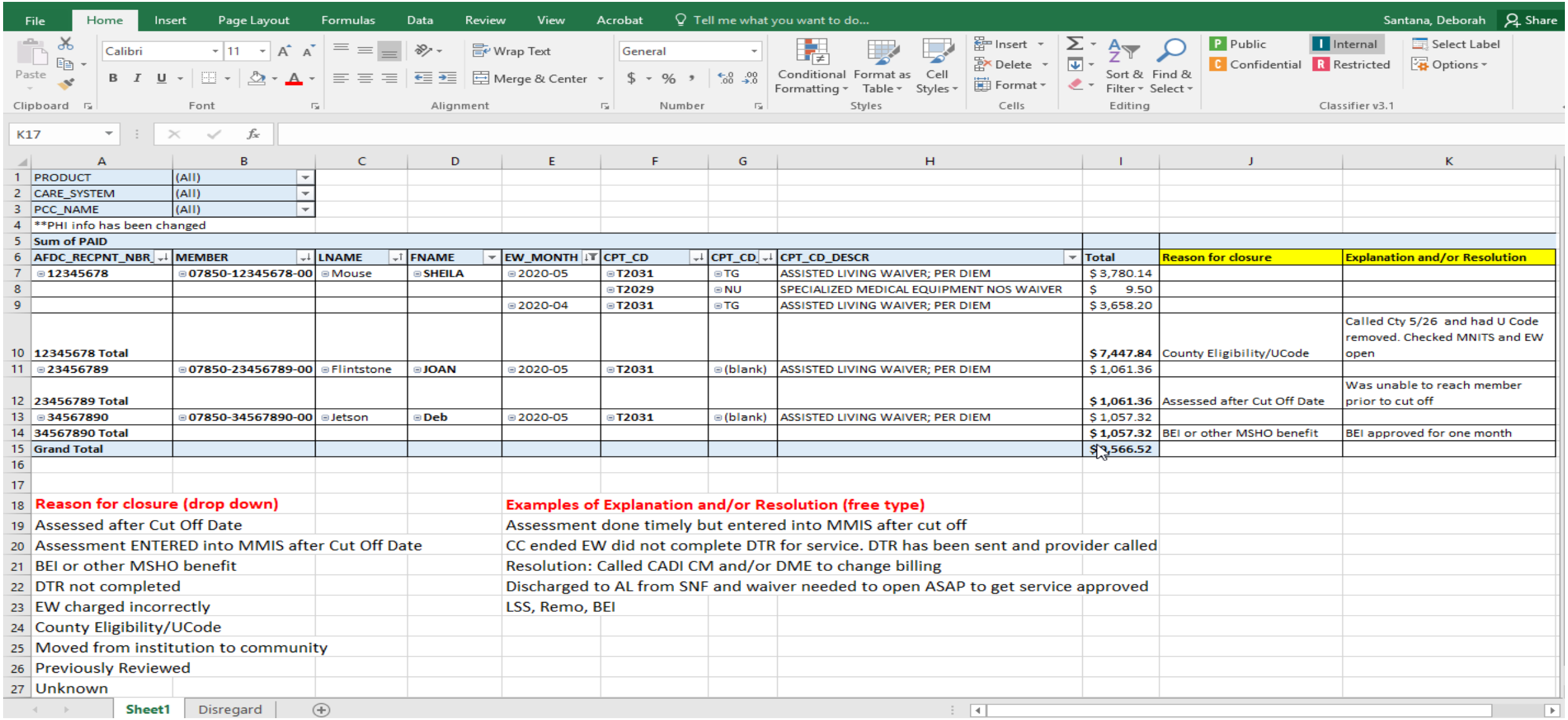
Cut off dates are determined by DHS. Once these dates are published by DHS, Medica will send out the dates and will then expect that EW assessments are entered on or before that date in Medicaid Management Information System (MMIS). This means, not only does the assessment need to be completed on or before the date but the assessment MUST be submitted into MMIS on or before the date.

***Ex:*** Member's EW span ends Sept 30th. Care Coordinator (CC) must reassess by the due date (within 365 days) and enter assessment results into MMIS on or before 9/21/2020. If the assessment is completed timely and MMIS entry happens after 9/21/2020:

- Member risk: If the waiver is allowed to close, there may be negative consequences to the member related to disruption of services, issues with waiver obligations, etc.
- Compliance/Audit risk: Care coordinator may not meet the assessment timeline of 365 days
- Financial risk: Medica will not receive proper capitation reimbursement for the month of October.

***Please note*** If the assessment is not completed/entered timely, the member may still receive services and the provider will be paid however it is an error and the member will show on the report.

# What do you find on the report?



| | A | B | C | D | E | F | G | H | I | J | K |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | PRODUCT | (All) | | | | | | | | | |
| 2 | CARE_SYSTEM | (All) | | | | | | | | | |
| 3 | PCC_NAME | (All) | | | | | | | | | |
| 4 | **PHI info has been changed | | | | | | | | | | |
| 5 | Sum of PAID | | | | | | | | | | |
| 6 | AFDC_RECPNT_NBR | MEMBER | LNAME | FNAME | EW_MONTH | CPT_CD | CPT_CD | CPT_CD_DESCR | Total | Reason for closure | Explanation and/or Resolution |
| 7 | 12345678 | 07850-12345678-00 | Mouse | SHEILA | 2020-05 | T2031 | TG | ASSISTED LIVING WAIVER; PER DIEM | $ 3,780.14 | | |
| 8 | | | | | | T2029 | NU | SPECIALIZED MEDICAL EQUIPMENT NOS WAIVER | $ 9.50 | | |
| 9 | | | | | 2020-04 | T2031 | TG | ASSISTED LIVING WAIVER; PER DIEM | $ 3,658.20 | | |
| 10 | 12345678 Total | | | | | | | | $ 7,447.84 | County Eligibility/UCode | Called Cty 5/26 and had U Code removed. Checked MNITS and EW open |
| 11 | 23456789 | 07850-23456789-00 | Flintstone | JOAN | 2020-05 | T2031 | (blank) | ASSISTED LIVING WAIVER; PER DIEM | $ 1,061.36 | | |
| 12 | 23456789 Total | | | | | | | | $ 1,061.36 | Assessed after Cut Off Date | Was unable to reach member prior to cut off |
| 13 | 34567890 | 07850-34567890-00 | Jetson | Deb | 2020-05 | T2031 | (blank) | ASSISTED LIVING WAIVER; PER DIEM | $ 1,057.32 | | |
| 14 | 34567890 Total | | | | | | | | $ 1,057.32 | BEI or other MSHO benefit | BEI approved for one month |
| 15 | Grand Total | | | | | | | | $ 13,566.52 | | |
| 16 | | | | | | | | | | | |
| 17 | | | | | | | | | | | |
| 18 | Reason for closure (drop down) | | | | Examples of Explanation and/or Resolution (free type) | | | | | | |
| 19 | Assessed after Cut Off Date | | | | Assessment done timely but entered into MMIS after cut off | | | | | | |
| 20 | Assessment ENTERED into MMIS after Cut Off Date | | | | CC ended EW did not complete DTR for service. DTR has been sent and provider called | | | | | | |
| 21 | BEI or other MSHO benefit | | | | Resolution: Called CADI CM and/or DME to change billing | | | | | | |
| 22 | DTR not completed | | | | Discharged to AL from SNF and waiver needed to open ASAP to get service approved | | | | | | |
| 23 | EW charged incorrectly | | | | LSS, Remo, BEI | | | | | | |
| 24 | County Eligibility/UCode | | | | | | | | | | |
| 25 | Moved from institution to community | | | | | | | | | | |
| 26 | Previously Reviewed | | | | | | | | | | |
| 27 | Unknown | | | | | | | | | | |

# Reasons for EW Closure

Column J on the report will provide a dropdown list of EW closure reasons. Once you have researched why the closure occurred you will select one dropdown reason for the closure. In general, the reasons for closure are as follows:

- Assessed after cut off date
- Assessment ENTERED into MMIS after cut off date
- Benefit Exception Inquiry (BEI) or other MSHO benefits
- Denial Termination Reduction (DTR) not completed
- EW charged incorrectly
- County Eligibility/Ucode
- Moved from institution to community
- Previously Reviewed
- Unknown (this should be used sparingly)

# Things to ask yourself to determine which drop down is needed on report

1. Did assessment/reassessment get entered into MMIS by cut off date?
2. Was member assessed annually? If so, was assessment completed after cut off date?
3. Is member on a waiver other than Elderly Waiver? If so, is the provider billing Medica incorrectly?
4. Did Elderly Waiver end but DTR not completed to end all services?
5. Did service show up on the report but should have been covered by BEI, MSHO added benefit, or Lutheran Social Services (LSS)?
6. Was EW closed due to member being in an institution Skilled Nursing Facility (SNF)/hospital) and then moved to community setting?
7. Did member have a Ucode assigned to their case by the County Financial Worker which prevented Elderly Waiver to open?
8. Did member have Medical Assistance (MA) renewal paperwork due?
9. Have you researched the EW closure reason and can't find where the error occurred? If so, chose the dropdown "Unknown". This should be used sparingly

# Explanation and/or Resolution to EW Closure

Once the reason for closure has been researched and selected in column J you will then need to provide the explanation and/or resolution for closure in **column K.**

Examples:

- EW billed incorrectly.  Member's Community Access for Disability Inclusion (CADI) should be covering Durable Medical Equipment (DME)
  - **CC called CADI CM and DME provider and informed them of incorrect billing**
- Member was assessed on time but assessment entered into MMIS after cut off date.
  - **CC has been educated on assessment entry timelines**
- Member was assessed late.
  - **CC was unable to get a hold of member prior to cut off date**
- Member EW closed and no DTR sent.
  - **Provided education to CC regarding closing EW and sending DTR for all services**
- Member's MA was inactive as county was processing benefits.
  - **Member was assessed after MA reinstated. Will remind member of MA reinstatement paperwork deadlines**

# Resolution

Resolving the issue

FIRST: **Check MN-ITS**

a) If not open to waiver in MN-ITS confirm they should be open to waiver and resolve issue ASAP

b) If open to waiver in MN-ITS identify the rationale for why member was not open in the month noted on the report

*A note about MN-ITS:* Waivers that are retro opened will show in MN-ITS as it if the Waiver was opened timely. If the member is on the report and you check MN-ITS and it says the Waiver was open for that service month it means the case was retro-opened.

# What to look for in MN-ITS

## Active/Open Elderly Waiver

**Prepaid Health Plan**

- This subscriber receives **MA02 - Minnesota Senior Health Options (MSHO)** delivered through **Medica**. The phone number is: **800-458-5512**.
- The health plan is responsible for paying for Nursing Facility Services.

**Other Eligibility Information**

- No Hospice.
- Refer to Health Care Programs and Services Overview of the MHCP Provider Manual for a list of covered services.

**Waivers**

- This subscriber is eligible for the **Elderly** Waiver.
  Elderly Waiver services are the responsibility of the Health Plan.

**Subscriber Responsibility Information**

None

## Inactive/Closed Elderly Waiver

**Prepaid Health Plan**

- This subscriber receives **MA02 - Minnesota Senior Health Options (MSHO)** delivered through **Medica**. The phone number is: **800-458-5512**.
- The health plan is responsible for paying for Nursing Facility Services.

**Other Eligibility Information**

- No Hospice.
- Refer to Health Care Programs and Services Overview of the MHCP Provider Manual for a list of covered services.

**Waivers**

None

**Subscriber Responsibility Information**

None

# How to avoid errors

## Tip and tricks to avoid errors:

- Check MN-ITS beginning of month-this method allows you to know the error before reporting
- Review your transferred members—what are Waiver Span Dates, What services are they receiving under EW
- Assist member with MA renewal paperwork to ensure eligibility does not lapse
- Send DTR's for **ALL** EW Services when closing EW or ending a service/update provider
- If member open to alternative waivers be sure to work closely with Case Manager to assure services are being billed appropriately
- Work with county financial worker if there is an U code
- Assess members timely and prior to cut off
- Working with facilities when member moving back to community, and complete DHS 5181 to inform financial worker of member move.

# RECAP

The purpose of the report to identify members receiving EW services that are not open to the waiver

The report allows you to see what services the member is receiving, the amount of months, the possible issue (see dropdown), and document the resolution/explanation.

The resolution assures the member is receiving services necessary and is identified by DHS to be open to the waiver as necessary.

Utilize tips and tricks to reduce member's on the ineligibility report.

# Questions or Concerns

Please reach out as needed; send questions or concerns to the Benefit Manager box (BenefitManagers@medica.com)

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## Mission

To be the trusted health plan of choice for customers, members, partners and our employees.

## Vision

To be trusted in the community for our unwavering commitment to high-quality, affordable health care.