Financial Updates

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FY 2020-2021 DMC-ODS RATES

Michelle Gibson

FY 2020-2021 RATE CHANGES

DMC-ODS Base Rates			
Level of Care/Service	**Increment**	**FY 19-20**	**FY 20-21**
Outpatient 1.0-AR	15-Minute	$31.77	$32.69
Outpatient 1.0	15-Minute	$31.77	$32.69
Intensive Outpatient: 2.1	15-Minute	$34.32	$35.32
Withdrawal Management WM-1	Clinical Day Rate*	$222.96	$230.10
Withdrawal Management WM-2	Clinical Day Rate*	$261.77	$270.03
Withdrawal Management WM-3.2	Clinical Day Rate*	$300.57	$338.01
Withdrawal Management WM-3.7	Clinical Day Rate*	$437.78	$739.23
Withdrawal Management WM-4	Clinical Day Rate*	$507.78	$785.43
Residential 3.1	Clinical Day Rate*	$141.86	$174.69
Residential 3.3	Clinical Day Rate*	$185.15	$219.24
Residential 3.5	Clinical Day Rate*	$165.33	$198.84
Room and Board (Non-DMC)	Day Rate	$53.03	$25.00
Case Management	15-Minute	$34.74	$35.75
Recovery Support Services	15-Minute	$23.71	$24.40

* Excludes Room and Board

DMC RATES HIGHLIGHTS

- Increase DMC base rates by **2.9%,** which is the Medicare Market Basket Inflator for 2019.
- Continued **Staffing Modifiers** for certified counselors (+6%), licensed eligible (+15%) and licensed (+20%) staff.
- Continued **Population Modifiers** for youth (+2.14%) and perinatal (+7.81%).
- Modified **Room and Board** rate to $25.00 with the balance moved to the clinical day rate. *Note: Cost Report Implications.*
- Incorporated $19.03 **Documentation Supplement** into residential and WM rates due to minimum daily note requirement effective 7/1/20.
- State does not allow separate **Case Management** claims for **WM-3.7 and WM-4** at this time so codes suspended.

BUDGET & SERVICE CONSIDERATIONS

Staffing Modifiers:

- SAPC is examining if modifications to the current residential setting standards are needed to achieve desired outcomes. This may result in changes in eligibility.
- SAPC is examining if providers claiming enhanced rates are entering claims per service (not just day rate) as required.

Population Modifiers:

- SAPC is developing standards, in collaboration with providers, to ensure similar service expectations for the target population to support the enhanced rates.

COST RECONCILIATION VS. COST SETTLEMENT

Michelle Gibson

SETTLEMENT TYPES

COST RECONCILIATION: Settle up to, but not to exceed, the rate for services delivered to patients where allowable costs align with SAPC requirements including business and clinical capacity efforts outlined in the DHCS approved Fiscal and Rates Plan.

This process is in effect July 1, 2017 and moving forward (except March through June 2020 due to COVID-19)

COST SETTLEMENT: Settle up to the substantiated costs of delivering services to patients which may exceed the established rates.

This process ended for all contracts June 30, 2017 (except March through June 2020 due to COVID-19)

COST SETTLEMENT

Rates Paid for Services Delivered

Actual Provider Costs

SAPC Pays the Difference

If fee-for-service claims for patients served are below allowable expenditures, SAPC pays the difference.

COST RECONCILIATION

Rates Paid for Services Delivered

Actual Provider Costs

Provider Pays Back SAPC

If fee-for-service claims for patients served is above allowable expenditures, provider pays back SAPC the difference.

COST RECONCILIATION

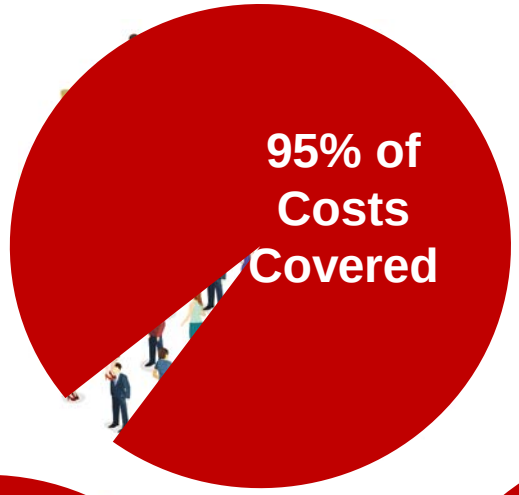
Rates Paid for Services Delivered

Actual Provider Costs

Additional Payment by SAPC

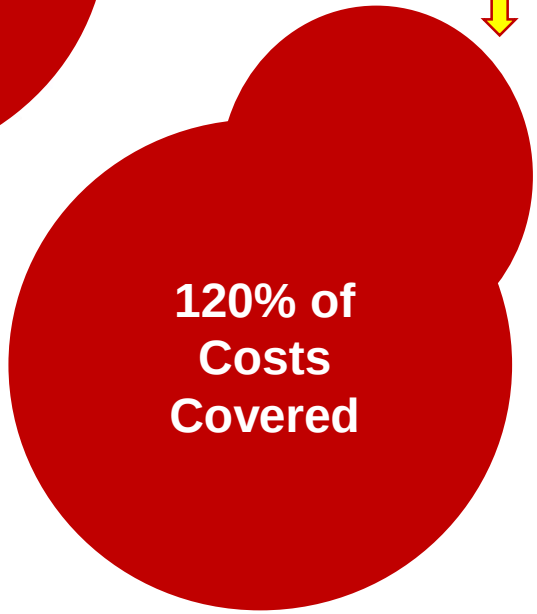
If fee-for-service claims for patients served is <u>below</u> allowable expenditures, SAPC <u>does not</u> pay the difference.

Does your agency deliver enough medically necessary services at the appropriate frequency to cover costs?
Which pie chart looks most like your financial situation?



Do you need to invest more?

Do you need to serve more people or lower your costs?



COST REPORTING

Babatunde Yates

COST REPORTING METHOD

- **FY 17-18**: Cost Reconciliation based on *provider approved* units of services due to State issues.
- **FY 18-19**: Cost Reconciliation based on *State* (DMC) and *County* (non-DMC) approved units of services.
- **FY 19-20**: Cost Reconciliation for July 2019-February 2020 **AND** Cost Settlement for March 2020-June 2020 based on *State* (DMC) and *County* (non-DMC) approved units of services.

COST REPORTING STRATEGY

- The County contract indicates cost reports are due no later than 60 days after the end of the fiscal year (August 30).

- The release of the State template has been delayed (beginning with FY 17-18) but it is expected to be back on track soon.

- SAPC is targeting completion of FY 17-18, 18-19, and 19-20 cost reporting by **June 2021**.

	STATE DENIALS*		COST REPORTING*
June 2020	Provider to correct errors and REPLACE claims if possible.	SAPC posting State 835s prioritizing files for FY 18-19 and then FY 19-20	SAPC & Providers finalize FY 17-18 DMC and non-DMC cost reports
July 2020			
August 2020			
September 2020			
October 2020			
November 2020		Providers finalize FY 18-19 claims	SAPC & Providers finalize FY 18-19 DMC and non-DMC cost reports
December 2020			
January 2021			
February 2021			
March 2021		Providers finalize FY 19-20 claims	
April 2021			
May 2021			
June 2021			SAPC & Providers finalize FY 19-20 DMC and non-DMC cost reports

*Dates are subject to change based on progress and DHCS due dates.

TIMELINE IMPLICATIONS

- SAPC needs to organize and post State denials (*in process*).
- SAPC needs to determine if limited number of State denials can be corrected on behalf of provider to reduce burden (*in process*).
- State or County may require a more aggressive timeline (*to be determined)*.

PROVIDER IMPLICATIONS

- Only approved claims can be considered on the cost report to justify the lesser of costs or charges.
- State denials that are not or cannot be replaced are included in the cost report, but not reimbursed representing a possible loss in revenue.
- Not all State denials can be replaced (e.g., duplicate, late, missing information). SAPC does not cover the cost of these claims, representing a possible loss in revenue.

STATE CLAIM DENIAL IDENTIFICATION AND RESOLUTION

Christopher Anwary

What are State Denials?

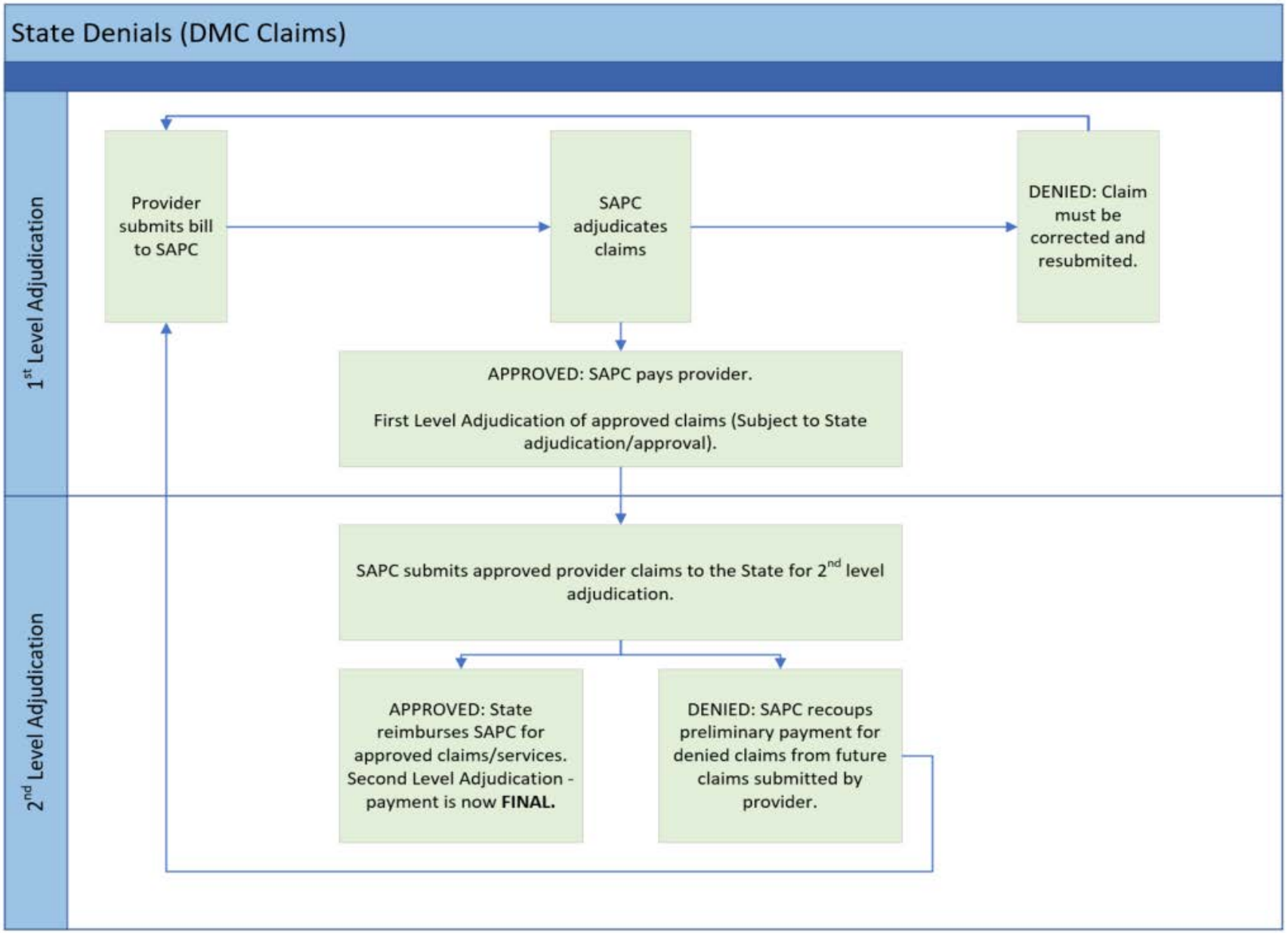
- State denials are claims that have been approved and **paid by SAPC** (1st level of adjudication) but **denied by the State** (2nd level adjudication).

- When the State rejects a claim submitted by SAPC, the County must **recoup** the payment **before** the provider to correct and **replace** the claim.

What are State Denials (Continued)?

- There are some State denials that SAPC recoups (e.g., eligibility standards) and other categories of denials that SAPC does not recoup (e.g., State administrative fees)

- Providers only have visibility on State denials in Sage once they are recouped by SAPC. Without recouping State denied claims, providers will not have visibility on State denials.


State Denials (DMC Claims)
1st Level Adjudication
Provider submits bill to SAPC
SAPC adjudicates claims
DENIED: Claim must be corrected and resubmited.
APPROVED: SAPC pays provider.
First Level Adjudication of approved claims (Subject to State adjudication/approval).
2nd Level Adjudication
SAPC submits approved provider claims to the State for 2nd level adjudication.
APPROVED: State reimburses SAPC for approved claims/services. Second Level Adjudication - payment is now FINAL.
DENIED: SAPC recoups preliminary payment for denied claims from future claims submitted by provider.

Current Status

- Since the inception of Sage, SAPC has only recouped a little over $600k in state denials across the provider network.
- SAPC is actively preparing for the recoupment process including determining the most appropriate timeline and strategy to minimize financial impact.
- SAPC will recoup denied claims for FY 18-19, 19-20, and all appropriate state denied claims moving forward.
- SAPC will not recoup additional denied FY 17-18 claims.

Importance of Working State Denials

Providers must correct State denied claims for the following reasons:

1. **Maximize revenue** for allowable services.
2. Appropriately **capture allowable services** as approved units for cost reporting purposes.
   - *This will ensure all allowable services provided are accounted for and ultimately reimbursed during cost reconciliation.*
   - *If denials are not or cannot be corrected, the State and County will consider these units denied and will settle at a lower amount.*
3. The State FY 18-19 cost reporting is **imminent**. As such, it is important that State denied claims from FY18-19 are corrected as soon as possible.
   - *County uses cost report information to determine rates for the following fiscal year. Denied units could affect rate settings.*

Why is SAPC Recouping State Denials?

- SAPC has paid providers and has not been reimbursed for State denials for FY 17-18, 18-19, and 19-20.
- This puts the County at financial risk by carrying the liability for state denials.
- In order for SAPC to sustain its operations, it must recoup state denials and have providers correct and replace these claims as appropriate.
- The majority of denied claims are able to be corrected, replaced, and reimbursed.

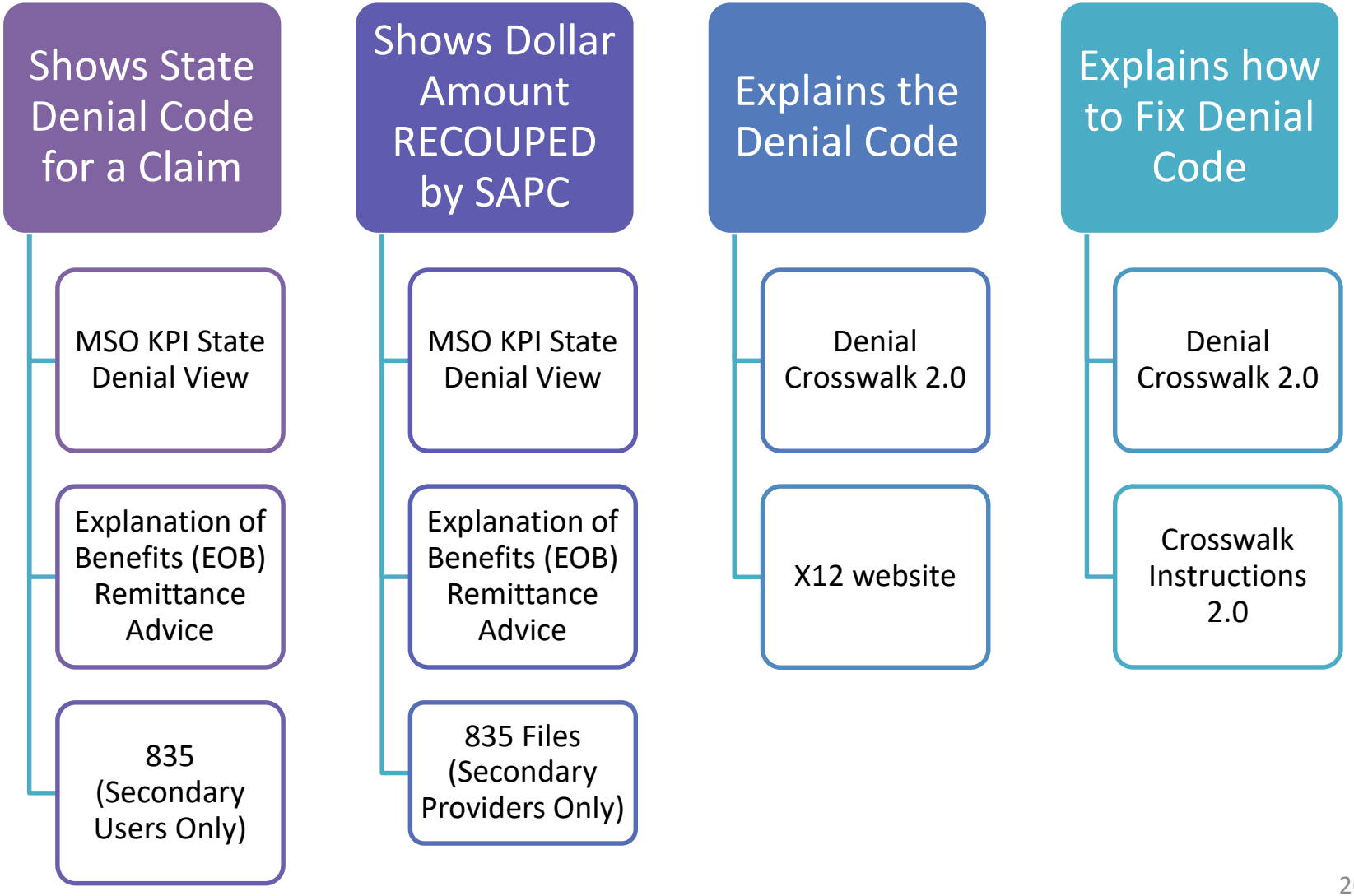
Working denials is an area where SAPC and its provider network really need to work together, and we really need our network to be correcting and replacing their denials. Otherwise, provider finances will be significantly and adversely impacted in the managed care environment we are operating under DMC-ODS.

Resources

- Providers have the following tools to utilize in order to correct claims denied by the State:
  1. State Denial View for KPI Dashboards (Available 5/7/2020)
  2. Claim Denial Reason and Resolution Crosswalk For Providers
  3. Denial Crosswalk Instruction Version 2.0
  4. Explanation of Benefits (EOBs) Remittance Advice
  5. Provider Connect - Treatment History Report
  6. 835 (Secondary Providers)
- SAPC will also host a State Denial Training Webinar on 6/25/20. Please ensure billing managers and staff attend.

Denial Resource	What does this resource do?	How can you find this resource?
Explanation of Benefits (EOBs) Remittance Advice	Gives you a breakdown of approved claims, denied claims with denial reasons, and adjusted claims.	EOBs are loaded to a Provider's SFTP on a daily basis. They are deleted after 7 days.
835 (Secondary Providers)	This will show the denied claim with the denial reason.	835s are loaded to a Provider's SFTP on a daily basis. They are deleted after 7 days.
State Denial View for KPI Dashboards	This will show you denied claims from the state along with denial reasons.	KPI (Available 5/7/2020)
Provider Connect - Treatment History Report	The Provider Connect Treatment History Report indicates that a claim was voided, but does not tell providers the reason it was taken back. For this info, providers need to go to the Denial View (for local level) and the State Denial View (for state denials). This report is listed by individual clients.	Sage/Provider Connect
Claim Denial Reason and Resolution Crosswalk for Providers	Listing of denial codes and resolution steps	SAPC Website under Provider Manual and Forms: http://publichealth.lacounty.gov/sapc/NetworkProviders/Forms.htm
Denial Crosswalk Instruction Version 2.0	Instructions on how to use the Claim Denial Reason and Resolution Crosswalk For Providers and how to resubmit/replace a claim.	SAPC Website under Provider Manual and Forms: http://publichealth.lacounty.gov/sapc/NetworkProviders/Forms.htm

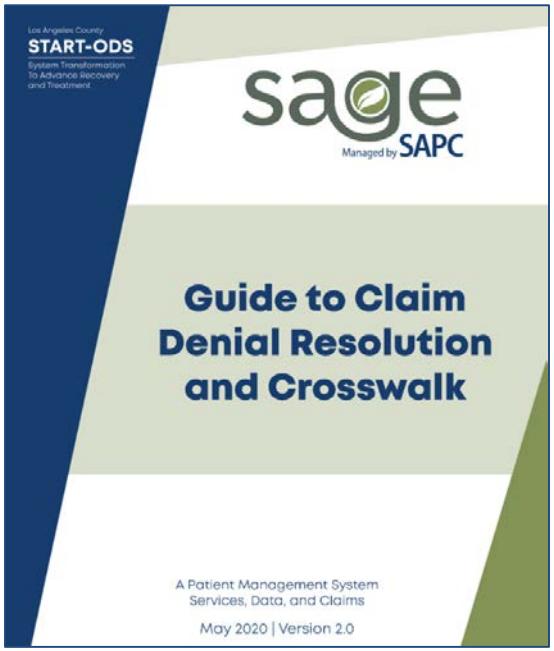
Resources


Shows State Denial Code for a Claim
MSO KPI State Denial View
Explanation of Benefits (EOB) Remittance Advice
835 (Secondary Users Only)
Shows Dollar Amount RECOUPED by SAPC
MSO KPI State Denial View
Explanation of Benefits (EOB) Remittance Advice
835 Files (Secondary Providers Only)
Explains the Denial Code
Denial Crosswalk 2.0
X12 website
Explains how to Fix Denial Code
Denial Crosswalk 2.0
Crosswalk Instructions 2.0

Denial Crosswalk and Instructions

Finance Related Forms and Documents

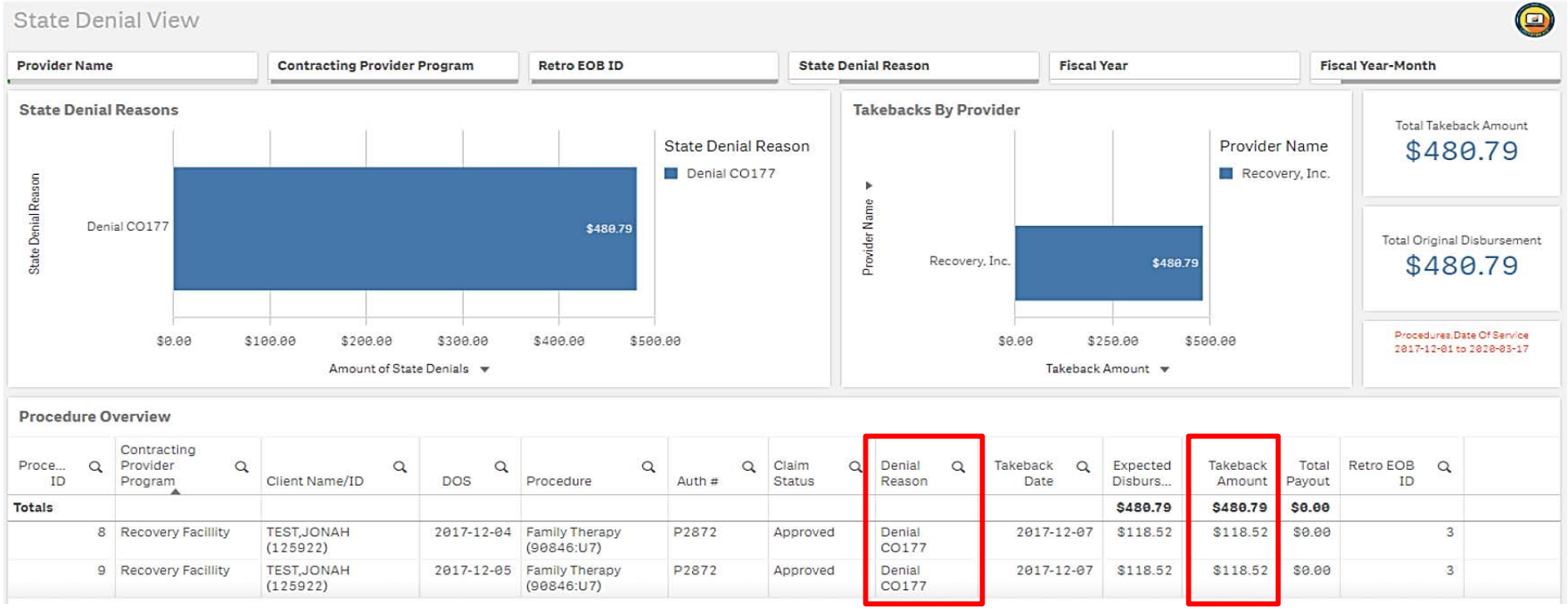
- Claim Denial Reason and Resolution Crosswalk for Providers *(Updated - May 2020)*
- Denial Crosswalk Instructions Version 2.0 *(Updated - May 2020)*
- Quick Guide to Identifying Denials *(New - May 2020)*



Click on images to be directed to the document

Sage Claim Denial Reason and Resolution Crosswalk (May 2020)						
Adjustment Reason Group Code	Claim Adjustment Reason Definition (CARC)	Explanation of Coverage Message/DMC Description	Original Claim Status	Denial Level Level 1= Local Level 2= State or SAPC Initiated Takeback	Adjudication Rule (Level 1 Denials Only)	Resolution

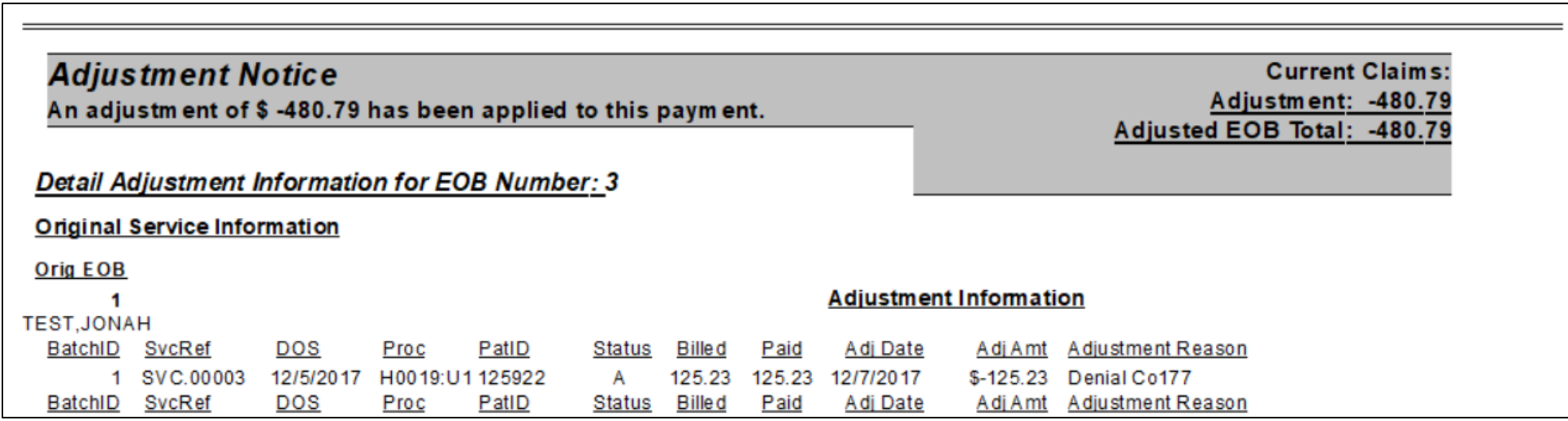
MSO KPI Dashboards 2.0- State Denial View



Proce... ID	Contracting Provider Program	Client Name/ID	DOS	Procedure	Auth #	Claim Status	Denial Reason	Takeback Date	Expected Disburs...	Takeback Amount	Total Payout	Retro EOB ID
Totals									**$480.79**	**$480.79**	**$0.00**	
8	Recovery Facility	TEST,JONAH (125922)	2017-12-04	Family Therapy (90846:U7)	P2872	Approved	Denial CO177	2017-12-07	$118.52	$118.52	$0.00	3
9	Recovery Facility	TEST,JONAH (125922)	2017-12-05	Family Therapy (90846:U7)	P2872	Approved	Denial CO177	2017-12-07	$118.52	$118.52	$0.00	3

- Shows State Denied claims that SAPC has recouped
- "Claim Status" will continue to show as "Approved" because the claim was initially approved by SAPC prior to being denied by the State.
- Use the Claim Denial Resolution Crosswalk to fix and **replace** these claims.

Explanation of Benefits (EOB) Remittance Advice



Adjustment Notice

An adjustment of $ -480.79 has been applied to this payment.

Current Claims:
Adjustment: -480.79
Adjusted EOB Total: -480.79

Detail Adjustment Information for EOB Number: 3

Original Service Information

Orig EOB
1
TEST,JONAH

Adjustment Information

BatchID	SvcRef	DOS	Proc	PatID	Status	Billed	Paid	Adj Date	Adj Amt	Adjustment Reason
1	SVC.00003	12/5/2017	H0019:U1	125922	A	125.23	125.23	12/7/2017	$-125.23	Denial Co177
BatchID	SvcRef	DOS	Proc	PatID	Status	Billed	Paid	Adj Date	Adj Amt	Adjustment Reason

- State denials resulting in a retro will be listed on the EOB Remittance Advice.
- The EOB will begin with an “Adjustment Notice,” the adjustment amount and adjusted EOB total on the first page of the EOB.
- This will only show State denied claims that were automatically retro’d by the system.
- Finance may also manually retro denials, which will then show on a subsequent retro EOB.

835 File- Secondary Providers Only

State Denial and Takeback

```
ISA*00*          *00*          *ZZ*680290013      *ZZ*951234567      *171019*2205*!*00501*000000055*0*P*:~
GS*HP*951234567*680290013*20171019*220515*1*X*005010X221A1~
ST*835*0137~
BPR*I*0*C*NON************20171019~
TRN*1*34_DENIED_137*1953893470~
REF*F2*AVATAR MSO 2017~
DTM*405*20171019~
N1*PR*COUNTY OF LOS ANGELES SAPC~
N3*1000 S FREMONT AVE~
N4*ALHAMBRA*CA*91803~
PER*CX*RICHARD LUGO*TE*8008751850*EM*RLUGO@PH.LACOUNTY.GOV~
PER*BL*LA SAPC EDI HELP DESK~
N1*PE*RECOVERING, INC..*XX*1751934005~
REF*TJ*951234567~
LX*1~
CLP*3048*22*-28*-28**HM*288*11*1~
NM1*QC*1*CLIENT*TREATMENT****MI*12~
REF*F8*288~
DTM*232*20170904~
DTM*233*20170904~
SVC*HC:90846:U8*-28*-28**1~
DTM*472*20170904~
REF*BB*P1136~
AMT*B6*-28~
CLP*3048*1*28*0**HM*288*11*1~
NM1*QC*1*CLIENT*TREATMENT****MI*12~
REF*F8*288~
DTM*232*20170904~
DTM*233*20170904~
SVC*HC:90846:U8*28*0**0**1~
DTM*472*20170904~
CAS*CO*177*28*1~
REF*BB*P1136~
PLB*1619008380*20180630*FB:34_DENIED_137*-28~
SE*33*0137~
GE*1*1~
IEA*1*000000055~
```

This 835 only contains a takeback due to a State Denial and is processed as a $0.00 payment with a future deduction listed in the PLB segment

The first loop of 2100 – 2110 segments contains a negative transaction to takeback funds previously paid for this claim.
The CLP and SVC segments contain a negative payment of -$28.00

The second loop of 2100 – 2110 segments contains the denial of the claim. The CAS segment contains the CARC from Drug Medi-Cal

PLB Segment shows the amount of a future takeback. This amount will be deducted from the next 835(s) until full amount has been consumed.

Best Practices in Denial Resolution

- Providers must monitor their State denials and ***replace*** them as soon as possible in order to maximize reimbursement and minimize financial impact of recoupments. The sooner a claim is corrected the sooner payment is issued.
- **State denials must be *REPLACED*, not *RESUBMITTED*.**
- Providers use the **State Denial View** in MSO KPI Dashboards 2.0 to identify their most common denial reasons and implement internal controls to avoid these errors on future claims.
- Primary providers use the **pre-adjudication tool** to lower denial rates.
- All providers run the **Real-Time 270 Eligibility Request** on a monthly basis to ensure patient has active Medi-Cal.