



North Carolina Department of Health and Human Services
Division of Mental Health, Developmental Disabilities and Substance Abuse Services
 3001 Mail Service Center • Raleigh, North Carolina 27699-3001
 Tel 919-733-7011 • Fax 919-508-0951

Michael F. Easley, Governor
 Dempsey Benton, Secretary

Michael Moseley, Director

October 24, 2007

MEMORANDUM

To: Legislative Oversight Committee Members
 Commission for MH/DD/SAS
 Consumer/Family Advisory Committee Chairs
 State Consumer Family Advisory Committee Chairs
 Advocacy Organizations and Groups
 North Carolina Association of County Commissioners
 County Managers
 County Board Chairs
 North Carolina Council of Community Programs
 NC Association of Directors of DSS

State Facility Directors
 Area Program Directors
 Area Program Board Chairs
 DHHS Division Directors
 Provider Organizations
 MH/DD/SAS Professional Organizations and Groups
 MH/DD/SAS Stakeholder Organizations and Groups
 Other MH/DD/SAS Stakeholders

From: Mike Moseley 



**Re: Communication Bulletin #082
 Draft Provider Action Agenda Committee
 Recommendations for Public Comment**

Attached please find for your review and comment a *draft* document entitled *Recommendations to the Provider Action Agenda Committee (PAAC) Related to the Standardization of Claims Processing for State-Funded Services and Implications for Implementation*. This document was developed by the Technical Assistance Collaborative (TAC) through a contract with the Division. The recommendations contained in this report have been reviewed and endorsed by the PAAC.

The Division created the PAAC, a group comprised of representatives from provider agencies and Local Management Entities, a year ago and charged the group with identifying areas of standardization that will help to achieve the goal outlined in the State's Strategic Plan to achieve more integrated and standardized processes and procedures in the delivery of publicly funded mental health, developmental disabilities, and substance abuse services. The Committee has been working diligently, as evidenced by this set of draft recommendations.

Please provide any suggestions or feedback regarding this document to Dick Oliver, dick.oliver@ncmail.net, by November 30, 2007.

Cc: Secretary Dempsey Benton
 Dan Stewart
 DMH/DD/SAS Executive Leadership Team
 DMH/DD/SAS Staff
 Sharnese Ransome
 Rich Slipsky
 Kaye Holder
 Wayne Williams

Kory Goldsmith
 Andrea Poole
 Mark Van Sciver
 Brad Deen
 Walker Wilson



Memorandum

To: PAAC Members

From: Steve Day and Dan Gerber

Date: July 30, 2007

Re: Revised Recommendations to the PAAC Related to the Standardization of Claims Processing for State-Funded Services and Implications for Implementation

CC: Dick Oliver

The following is the draft final summary of TAC's recommendations for the standardization of claims processing for state funded services, including a discussion of options for implementation of these recommendations. These recommendations have been derived from: (a) review of current DMH/DD/SAS and LME requirements and practices related to the claims payment system; (b) discussions with DMH/DD/SAS and LME staff about issues related to service authorization, claims processing, data reporting and provider contracting; and (c) three meetings with a sub-committee of the PAAC. Unless there are further edits, these are the recommendations which TAC will submit to DMH.

Guiding Principles

- The experience of providers with regard to the receipt of service authorizations, submission of claims, receipt of payment of claims, and other related business practices should be consistent and standard in all parts of North Carolina and across all LMEs.
- The authorization of services and processing of claims should be as consistent as possible across Medicaid, state funded services (IPRS) and, when applicable, county-funded services.
- The service authorization and claims payment process should include only the requirements, practices, data elements, etc. that are specifically associated with claims payment. Legitimate provider claims for payment for services should not be encumbered with other requirements.

Initial Service Authorization

- The initial service authorization should be for diagnostic or other approved assessment, initial service plan development and initial service delivery up to X units of specified services. The time frame for the initial authorization should not

exceed the required time frame for PCP development and approval for enrolled consumers.

- There should be no variation among LMEs in the data elements required by LMEs as a basis for issuing the initial service authorization.
- The time frame between a complete initial service request and issuance or denial of the initial service authorization should not exceed five business days.
- The amount, duration and scope of an initial authorization might vary among LMEs based on contract specifications between an LME and specific providers. For example, an LME might designate certain core service providers with the authority to make decisions about the level of service need for certain consumers within the first month of services or number of service encounters. However, the exchange of information between an LME and a provider with regard to intake, enrollment, target population category, etc. should be consistent among all LMEs.
- LMEs should give providers an authorization number that will be entered by the provider on its invoice(s) against the specific authorization. If the provider does not include the authorization number on the claim, it would not be a clean claim. However, it should not be necessary for an LME to enter its own authorization number on a claim before it can be processed. LMEs should not pend a claim from a provider for the purposes of entering its own unique information onto the claim form.
- Under most circumstances, an initial authorization represents a “promise to pay” the provider for the authorized types and amounts of services, upon submission of a clean claim. The authorization should have the same standing, in a business sense, as a purchase order for supplies and equipment. Exceptions to this promise to pay standard might include court orders, retroactive changes in state or federal payment policies, the availability of other payer sources, etc. It should be noted that if IPRS denies a claim at the state level, there will be no obligation of the LME to pay the provider, at least until the reasons for denial are resolved. For example, IPRS may deny a claim based on an assessment that an individual is not part of a defined target population. If the provider was the source of unaccepted target population information, then the provider would not automatically get paid for services for that particular consumer. In those cases where the LME arranges to pay a provider in advance of receiving IPRS reimbursement, an IPRS denial will result in the appropriate adjustment.
- Because the service authorization represents a promise to pay, the LME must enter and encumber sufficient funds to support all initial (and on-going) service authorizations. The LME will need data management capacity to manage service encumbrances from a budget and accounting perspective; clean out un-used service encumbrances, analyze the standard variation between encumbrances and actual expenditures, etc. This is a key management tool for LMEs to manage the total sum of service authorizations against their respective budget authority for each age-disability group. For example, to expend all funds on services, LMEs may need to “over-authorize”, knowing that less than 100% of all service authorizations will result in claims. The process of cleaning out un-used service authorizations also allows the LME to continue authorizing new services at a level consistent with current funds allocations.

On-Going Service Authorization

- On-going service authorization should be based on LME approval of the fully completed Person Centered Plan for each consumer. Documented communication of each authorization needs to be sent to the company providing each service within five working days of submission of a complete authorization request. If not complete, the LME will ask the provider to submit the missing information. The provider will have five days to resubmit a complete authorization request. The LME will, in turn, have five days to re-evaluate the request and respond to the provider with the determination. If the PCP specifies different service types within a given provider, or services from multiple providers, the LME should take responsibility for entering and encumbering all requisite service authorizations.
- Any changes in the amount, duration or scope of service authorizations after the PCP is developed should be based on specific changes to the PCP approved by the LME.
- Providers will need to submit requests for on-going service authorization(s) [accompanied by the completed PCP] 30 calendar days before the expiration of the initial authorization for services to be authorized for three months. However, for services authorized for shorter durations, requests should be submitted no less than two weeks prior to the expiration of the current authorization.
- In special circumstances, the LME might issue on-going service authorizations in the absence of an approved PCP, but these should be treated in the same manner and within the same time frames as an initial service authorization.
- LMEs may vary the type of service authorizations issued to a provider based on LME/provider contract specifications. For example, a provider could be approved to provide bundles of best practice services within certain cost limits, while other LMEs might continue to authorize specific numbers of units of service for each specific service type. However, the steps providers must go through to obtain on-going service authorizations, and the time frames for that process, should be consistent among all LMEs.
- As with initial service authorizations, each LME must have the capacity to encumber and manage all service authorizations.
- On-going service authorizations represent the same promise to pay as do initial service authorizations. Providers may limit their financial liability by using “hard cap” contracts with fixed maximum obligation limits. In these cases, the promise to pay extends only to the financial cap on the contract. In the event of a hard cap, provider and the LME should jointly plan how to use those funds to benefit consumers through the course of the fiscal year.

Claims submission

- The claim information submitted by providers to LMEs for payment should be consistent among all LMEs. A clean claim includes all applicable data including the LMEs authorization number. No additional data submission requirements may be added to the claims format by individual LMEs.

- The standards claim format and data should be consistent with the HIPAA 837 plus the national provider identifier number.
- An LME that is not able to accept an electronic 837 claim will accept the provider's invoice on the format generated from the provider's billing system as long as the invoice contains all of the required data.
- If providers submit paper invoices, the LME will be responsible for data entry into their own billing system from the provider's invoice. Providers will not be required to do data entry into the LME's billing systems. However, providers may be required to directly enter data into a web-based billing and reporting system implemented by an LME.
- To the extent possible, DMH/DD/SAS should make every effort to keep the claims submission requirements for IPRS (a) as consistent as possible over time, at least until the system is stabilized; and (b) as consistent as possible with DMA requirements and practices for providers delivering the same types of services for the same types of consumers.
- Providers should submit all claims within 30 days of the delivery of state funded services and must submit within 60 days in order for the claim to be paid. In the event the provider does not receive the service authorization by the billing deadline, the provider must submit the related claim within 60 days of receiving the authorization. An incomplete claim must be resubmitted within 30 days. Providers are limited to two opportunities to repair an incomplete claim.

Claims processing and payment

- LMEs must pay complete and clean claims within 90 calendar days of receipt. 95% of clean claims must be paid within 30 calendar days of receipt. This implies that LMEs log and date stamp (electronically or manually) all claims upon receipt. It also implies that there has been no delay at the state level in processing IPRS reimbursement based on clean claims submitted to IPRS by the LME.¹
- LMEs must notify providers that their claims have been denied or pended within 15 calendar days of receipt.
- LMEs must provide a remittance advice (RA) to each provider for each payment. The RA should provide detail as to claims paid for each consumer for each time period. Aggregate data is not sufficient for the RA.
- LMEs may not deny, pend or otherwise fail to process a clean claim based on provider non-compliance with non-claims related information submission requirements.
- LMEs should conduct periodic retrospective reviews of claims submitted for state funded services (in the same manner as Medicaid claims and associated documentation are reviewed). The LME may be entitled to make retrospective adjustments to provider claims based on these reviews.

¹ Once the Division has sufficient confidence that the service authorization/claims processing system is running smoothly and effectively at the LME level, consideration should be given to making prospective payments to qualifying LMEs followed up with retrospective claims reviews and reconciliations of monthly payments. This would be more efficient and less time consuming at the state level, and also would support LME efforts to speed up payments for providers at their level.

Implications for LME/provider contracting

- Contracts or MOUs with providers should specify data submission requirements in addition to claims data (e.g., NC-TOPPS, CDW, NCI) and should include provisions to sanction any provider that fails to submit such data. Any financial sanctions would have to be based on a standard state-wide policy related to enforcement of provider compliance with contract requirements.² Financial sanctions may be subtracted from future claims payments.
- The use of hard cap or maximum obligation contracts does not relieve either the LME or the provider from meeting all requirements for claims submission and processing.

Implications for data systems

- The Division and LMEs should be working towards assuring that all claims submission, processing, payment, RA, etc. can be accomplished electronically. This may entail establishing standards for web-based capability for claims submission and payment.
- Each LME must have an information system capable of entering, encumbering and tracking service authorizations. Each LME should have the necessary systems and financial analysis capacity to clean out unused authorizations and track the ratio between authorizations and actual claims submitted and paid.

Implications for implementation

TAC envisions that the Division will monitor and enforce implementation of any policy it adopts related to service authorization and claims processing in the same manner as it will for any other standard LME function. That is, TAC assumes that the Division will develop operational criteria and performance indicators consistent with the policy framework, and will monitor LME performance against these criteria and indicators. If an LME is found to not be performing well, the Division and the LME will jointly engage in a six month plan of correction and technical assistance process. If the LME is still not able to carry out the function properly, the Division will then consider other options and could remove the function from the LME. It should be noted that service authorization and claims processing cut across several of the defined LME functions (access, service management, provider relations, and financial management) and thus TAC assumes that monitoring of these functions will incorporate the applicable indicators. As noted below, LMEs may find it preferable or cost effective to contract with another LME or with an independent third party administrator rather than operating the claims processing directly.

² Note: financial sanctions might be implemented only after efforts to provide technical assistance and to have a provider develop and implement a plan of correction have not resulted in compliance.

As part of the LME monitoring process, TAC may suggest that DMH/DD/SAS develop a process through which providers may request the Division to step in and assess whether a given LME is properly paying bona fide claims for state funded services. This could help to identify issues when claims are submitted but not put into the queue for payment for some reason other than denial or return for correct information.

1. Provider Contracting

These recommendations will be easier to implement if LMEs develop relatively small provider networks for state funded services. This means that over time LMEs would develop close working relationships with a limited number of providers (consistent with consumer choice of provider and reasonable amounts of marketplace competition). LMEs could have hard cap or maximum obligation contracts with these providers, which would assist with the overall management of state funds in a fixed budget environment.³ LMEs could work with these providers to simplify and streamline the initial intake, referral, and service authorization process. They could also move towards a variety of service authorization and payment mechanisms, such as authorizing packets of services, authorizing whole PCPs, using a “speedy payments” mechanism, etc. which would be more efficient for both providers and the LMEs. Several LMEs are already using or moving towards this approach to contracting for state-funded services.

Regardless of the provider contracting and service authorization process, LMEs will always need to have capacity for managing authorizations and claims at the individual provider, consumer and encounter levels. LMEs receiving single stream funding will have to be able to maintain shadow claims data for all sources of funds and payment mechanisms.

2. Claims processing capacity

The claims processing capabilities and capacities for state funded services implied by the above recommendations can be attained by LMEs in a number of ways. These include:

- Some LMEs already have all the necessary capacities to meet the recommended standards, and are already issuing service authorizations and paying claims in a manner that needs no substantial changes. These LMEs should continue doing so, and may also offer their capabilities to other LMEs that may not currently have all the necessary capacities.
- LMEs that do not have current capacity to meet all the recommended standards should have the option of contracting with another LME to perform all or part of the service authorization and claims payment functions. LMEs in North Carolina have a tradition of using this approach, and there are several successful models

³ LMEs could still have open-ended fee for service relationships with other providers, particularly those that are endorsed by the LME for Medicaid services. Services could be authorized and paid to these providers on an as needed basis and consistent with consumer choice. However, the expectation over time would be that these open ended relationships would represent a small portion of overall LME payments for state funded services.

that could be emulated. This approach also gives incentives for LMEs that already have expertise and capacity to extend that expertise and capacity to others in the system, with attendant economies of scale.

- If an LME does not have sufficient capacity, and does not want to contract with another LME for assistance with one or more functions, then the LME could contract with any number of different types of entities. For claims adjudication and processing, one option is to contract with a third party administrator (TPA). TPAs typically perform the “back-room” activities necessary to receive and process a claim, issue remittance advice (RA) and /or explanation of benefits (EOB), etc. TPAs are usually paid on a per-claim basis. If DMH/DD/SAS wants to make this option available to LMEs, it might be advisable to identify and pre-qualify a number of existing TPAs that are capable and willing to do this type of business in North Carolina.