FY11CQ- Questions and Answers

Residential and TFC Contracting for FY2011

Permanency Contracts

1. With the permanency cases, most of those are either in another agency’s TFC program, Moderate residential or intensive residential, will we be able to bill basic living services for the target client? **It seems that you would be billing family support.**

2. We have served kids on Medicaid waiver slots in the past. Will these kids be covered by the full contract rate? **You would bill them as a non-medicaid child and you would receive the stated rate in the meeting, based on whether you chose the Medicaid or non-medicaid rate. If you choose the Medicaid rate you would submit your itemized listings or services provided to the family in accordance with the ISP and we would reimburse you accordingly.**

3. A large portion of the worker’s time involves searching for relatives or searching through the case files to assist with development of the permanency plan; can we be reimbursed for this time? **The time involved in this effort is not eligible for reimbursement through Medicaid Rehab billing.**

4. When the identified client is in TFC or Moderate, we can only bill Medicaid related to the child’s diagnosis but often times we are working with the parents on housing, employment and other parent issues getting ready for reunification, how can we bill for these services? **If services are provided to parents for reunification, Family Support Services are eligible for Medicaid Rehab reimbursement if they meet the definition of the service and are authorized in the ISP and Treatment Plan. They have to relate to the treatment needs of the child and how to help the parent understand and maintain the child based on those treatment needs.**

5. Because children are in TFC or Moderate placements outside of the Permanency contract, we are dependent on the placement provider or DHR to get the EPSDT’s done and a copy to us. We have had cases where we did not get them, how will we bill in this situation? **The EPSDT Screening is required for services provided over the Medicaid limits. If the TFC or Moderate Providers have not exceeded the yearly Medicaid limits, your claims should not be denied when billed. Please consider making the EPSDT Screening apart of your checklist during admission to ensure the Screening is received at the time of admission or soon thereafter. You may contact SDHR for assistance when all efforts have been exhausted in trying to obtain the EPSDT Screening form.**

6. Under the current contract there is an add on rate for siblings, will this remain in place for the new contract? **Yes**

7. When children are in intensive residential programs, no Medicaid is billed, how will we be paid for those children? **See answer to question 2**

8. Is it possible to bill for services in one area (Birmingham) at the higher, non-Medicaid rate and then bill at the Medicaid rate in a different area (Huntsville)? Perhaps breaking the contract out
under a separate contract number? If they are currently under the same contract they would need to use the same methodology. To use separate contract numbers would mean that the new contract number would have to go back to the Legislative oversight Committee and to the Governor for signature and we do not have the time to complete all of the necessary paperwork before August 23rd when the document would be do to be filed with the Legislative Oversight Committee.

Continuum Contracts

1. 90% of our cases in one county has clients that are 6 and under and do not have a diagnosis, how will we be paid for these clients? **You would bill the children through Medicaid using the V629 code as outlined in Chapter 105 of the Medicaid manual.**
2. What about target children who are in home and do not have a diagnosis, how do we bill for these children? **See answer to question 1 above**
3. With some of our cases, the parents have private insurance, will that present a problem with billing if the child is in the parent’s custody? **Bill as a non-medicaid child with itemized services if Medicaid billing option chosen.**
4. What happens when Medicaid is expired and we have to wait on the county worker to re-activate, sometimes that can be months at a time. How will this be tracked? **The child would be billed as non-medicaid eligible with the itemized h code services attached to the invoice. If the child later became Medicaid eligible, back to the time of billing the child as non-medicaid eligible, it will be an expectation that the provider will complete the Medicaid billing on the child for that time period.**
5. There is currently an in home rate and an out of home rate, will there still be two rates under the new contract? **yes**
6. Under the current contract there is an add on rate for siblings, will this still be in place under the new contract? **yes**
7. How will we be compensated for non-Medicaid eligible families? **See answer to question 2 under permanency.**

ILP Contracts

1. I recognize that the department is discussing options on ILP related to the reimbursement rate. I would caution you in any such discussion to consider the locations and the set up of the ILP model when comparing program’s Medicaid billing rates. In an apartment based model in the city (remote from any campus) where youth approved for service must be both in school and working, the available opportunity for Medicaid billing will be substantially less than programs near to campus where youth might not be working and be readily available and convenient to staff for billing to caps. Our reality has been that availability of youth, or lack thereof has resulted in Medicaid billings averaging $6 - $8/per day. This is nowhere near the present split
rate. Program costs are being subsidized by United Way and agency donations. Ilp will be reimburse as follows: if your current fy10 rate is $70 with a 80% DHR rate and 20% net Medicaid then DHR would pay $6 and you received 14 from Medicaid billing. For FY11 you will receive 35% of your $56(19.60) rate for room and board and you must bill Medicaid to receive the other portion of the $70 rate.

TFC Contracts

2. How do we bill for TFC children who are on extended home visits, away at camp for a week, in the hospital? Face-to-face services that require a child’s signature cannot be billed when the child is not present to receive the service or is in a hospital. Family Support, Mental Health Consultation and Treatment Plan Review are the only services that can be provided and billed without the child being present or in a hospital.

3. Is the clause going to remain in the contract that addresses clients that are Medicaid ineligible for 30 days or more can be billed to state DHR? (If the client is Medicaid ineligible who will pay for the placement?) Yes, the clause will remain in the contract. See answer to question 2 under permanency regarding payment for non-medicaid eligible child.

4. How will children who are in specialized foster care be paid for? These are children who have IQ’s that do not meet the TFC guide. Bill as non-medicaid

Additional questions

1. Would it be possible to extend our current contract through the end of December while we work through the changes that are being requested in the contracts? No, Medicaid’s expectation is that changes will be implemented on October 1, 2010.

2. Would the State’s position on Mental Health Consultation be negotiable if the provider accepts full responsibility for any charge backs to Medicaid? We certainly would not bill emails, but monthly reports and court reports are time consuming activities by the social workers and would be allowable by Medicaid? SDHR Internal Policy that Mental Health Consultation would only be billed face to face or by telephone remains in effect.

3. Family counseling was not listed on any of the B2, it only addresses individual and group, we do a lot of family work toward reunification will you be adding it to the list? Only on b2 for continuums and permanency.

4. Because of these changes, if agencies give up slots how will these be redistributed or will you decrease the total number of slots in counties that have not been utilized? That will be an issue for Procurement officer.

5. Both Continuum and Permanency contracts were designed to find permanency for children and families. In order to bill Medicaid, treatment plans have to be developed to address the target child’s diagnosis, how do we get paid for all the family work if it doesn’t relate to the child’s diagnosis? All work should relate to the child’s diagnosis.

6. Several of the contracts being extended lend themselves to Medicaid funding (TFC, Mother and Infants, Residential). Others attempt to use a funding mechanism that is designed for individual,
target-child services but has no mechanism for services that are primarily related to non-target family members (continuum, permanency). In these type services, meeting contract billing expectations, if not impossible, is very unlikely. Can you revisit the amount of Medicaid that must be billed for continuum and permanency cases? **No, because the options given were the only ones that would meet the cost neutral criteria.**

7. In all the meetings reference was made to an “average Medicaid billings” of 28%. Was this average based on each contract type individually (i.e., continuum, residential, TFC, etc) or were all services pooled to determine this rate? I am asking as 28% Medicaid billing rate for continuum or permanency seems extremely high. The 28% figure was based the average figure **from the Continuum and Permanency contracts.**

8. Given the uncertainties of a contract that has both occupancy and Medicaid billing in its funding language, can providers extend their contracts in the hope of hitting occupancy/billing targets and then if failing to do so, exit the contract without subsequent RFP penalties on other proposal responses? **Contracts cannot be extended under the current methodology. If the provider chooses to terminate their contract there would not be any penalties on other proposal responses as long as the termination complies with the terms of the contract.**

9. Under Section V of the Addendum B, it states that Blanket Permission slips cannot be used by the provider for off-campus trips that involve boating, swimming, camping, hiking, etc. An individual permission slip should be signed by the DHR Social Worker/Supervisor for each trip. Please elaborate on what would constitute an et cetera activity? **This is not new policy. This was part of the contract document last year. This policy centers around outdoor activities that occur away from campus or activities on campus it the campus has a pool, lake or hiking/sport area. It is very important, that the DHR Social Worker, acting as the parent for the child, gives permission for each specific trip because of the safety factor and skill level required for these activities. Some examples of these activities would be water activities, camping, hiking, rock climbing, and amusement park rides. Et Cetera means any activity where there is a risk of harm.**

10. Since we are now billing Medicaid directly, will we use our own provider number or continue to use SDHR’s provider number? **The Billing Procedure for Medicaid Rehab providers has not changed. You will continue to use your NPI as the Rending ID and SHDR’s NPI as the Payee ID.** Will the funding still be funneled through SDHR or will we receive our funds directly from Medicaid? **The process remains the same as previous Fiscal years. Your agency will receive a check from SDHR each checkwrite based on services billed through your software. Your agency will now be paid 100% of what was billed and paid by the Medicaid Agency.**

11. If we are to be paid directly by Medicaid and any monies recouped by an audit would be 100% legally and financially, for any charge backs or incorrect/fraudulent billing, is totally the responsibility of the provider, will we be allowed to utilize different forms of documentation for services as approved by Medicaid, i.e. check lists, instead of the bulky and very time consuming method of documentation now required? **The Basic Living Skills Progress Report continue to be a requirement as per your state held contract. All other documentation must be completed as described in Chapter 105 of the Medicaid Provider Manual Section 105.2.3**
Requirements for Client Intake, Treatment planning and Service Documentation (July 2010 update).

12. Since DHR is no longer capping services and is no longer responsible for recoups, why can we not utilize Medicaid standards when billing for ALL services that have been allowed over the past several years by both DHR and Medicaid (i.e. written Mental Health Consults)? Many programs have been billing this way for quite a long time and the number of mental health consults billed should not rise significantly enough to raise red flags and will severely limit our current billing. DHR internal policy for billing Mental Health Consultation was developed because “Red Flags have already been raised”. The limitation should reduce the amount of recoupment because of errors currently being found. Appropriate methods of billing Mental Health consultation are:
   a. Consultation face-to-face or by phone with the county DHR worker regarding the treatment needs of the child.
   b. Consulting face-to-face or by phone with a doctor, therapist, school teacher, school counselor and/or other professional that is working with the child external to your agency regarding the treatment needs of the child.
   c. The time spent testifying in court regarding the treatment needs of the child.

13. While this billing system seems beneficial to both providers and SDHR for higher levels of care, there is a great concern as to recoupment for lower levels of service such as Basic, and TLP/ILP programs. Many services are not billable at those levels and meeting daily rate will be difficult if not close to impossible. How are we to recoup at the least our daily rate in Medicaid monies at lower levels of care? The services that you currently bill to Medicaid for your Basic and TLP/ILP programs should yield you more Medicaid monies than before with the increase in rates. Currently around 70% of the ILP providers exceed the level of required billing to meet their daily rate.

14. With the current system of payment for services already in place SDHR pays both room and board and monies for core services as set forward by SDHR. Is it correct in thinking that under the new system of payment, SDHR will no longer pay for Core Services? These are services supposedly not billable to Medicaid. Are we expected to provide these services without reimbursement by SDHR or Medicaid? Or will SDHR pay room and board and core services? This is a concern for all levels of treatment but again more specific to lower levels of care i.e. Basic, TLP/ILP. SDHR did not pay for core services before as was explained in the vendor meeting on July 30th. SDHR will be paying for room and board and SDHR will reimburse the providers 100% of the billed services paid to SDHR by Medicaid.

15. TFC Core Services per grid limited to 18 hours(72 units per week). If child needs more than 72 units providers need to request an 1878 during ISP from county DHR- is this correct? The DHR caps on services have been lifted. Check your BLS grid and your core services attached to your contract document for fy11 and there should be no mention of 18 hours or 72 units. There would be no need to obtain an 1878 unless the ISP team wanted Medicaid Rehab services not covered in the core service document.

16. Have county DHR offices been informed about changes for new contracts and new Medicaid rates? Yes
17. For TFC providers-whereby a child is being released from a treatment program and several pre-placement visits must occur prior to discharge, meaning more than 3 day, should providers continue to an 1878 from county DHR for these days? Yes. Are there other changes in protocol? No.

18. DHR ISP – it is my understanding that ISP as of Oct. 1 must specify number of units per BLS and other services. Will the counties be instructed on this new procedure? This is current policy.

19. In the meeting with providers, you mentioned no caps, could you clarify what this means? It means that the caps imposed by DHR are no longer applicable but the Medicaid caps established in chapter 105 are still applicable.

20. In the meeting with providers you mentioned that core services for programs will remain the same. For example, on Medicaid grid for TFC it states 18 hours or 72 units per week of BLS. IS this correct? Your current fy11 contract document should contain a core service attachment that does not have any caps for any services other than Medicaid caps and you should also have a BLS grid that does not have 18 hours or 72 units.

21. In the past MHC/Crisis interventions did not have to be authorized in the ISP. Will this change? No, unless changes are made to Chapter 105 of the Medicaid Provider Manual.

22. As of October 1, TFC providers will receive only Medicaid Revenue, what about situations whereby TFC child is being reunified with family, adoption resource other than TFC parent, placed short-term (2 weeks) in hospital for medication adjustments, camps, ILP trips, etc. whereby provider is not able to bill Medicaid. Is there any consideration for compensation since we are holding placement for the child’s return? State DHR will continue to send the board payment for the child. No other reimbursement will be made because the child is not receiving any Medicaid services during the absence.

23. In regard to the BLS Daily Progress Report Form, the instructions state that sign-in sheets for client services must be completed at the time of service delivery. Therapeutic Foster Parents will be delivering services multiple times throughout the day and will document each service separately, including the start and end times that each service is provided. The BLS Daily Progress Report Form only provides one place per day for client signature. Can this be interpreted to mean that the only time a client is required to sign at the time of each service delivery is when a sign-on log is used? Yes that is true. The BLS Daily Progress Report Form needs only to signed once by the client to cover the entire day of services from the Therapeutic Parent.

24. 60% of our families are not on Medicaid. Will we bill as we do now? See answer to question 2 under permanency.

25. 60% of our families have all children under the age of 6. Medicaid billing is not an option – how do we deal with this? Medicaid billing is not prohibited on a child under the age of 6 – you have to use the v629 code.

26. Would you consider a contract extension through December 2010 so we can work through these issue? See answer to question 1 under Additional questions.

27. We are concerned about the cases where youth are placed out of the home in a residential facility or other Medicaid funded placement. It is our understanding that we can’t bill Medicaid for family support, mental health consult, etc. for these youth if they are enrolled in our in-
home program while placed in these types of settings. As you are well aware, we often do extensive transition work with families to get youth back home and as a result, the amount of time that we might be serving a family with a youth in another placement can potentially be rather long. Is our understanding about not being able to bill in these instances accurate? **If the child is in a Medicaid funded out of home placement you should be able to bill for your services with the family and the child when he is not at the facility. If the child is placed in an intensive placement or MR waiver placement- these programs are not Medicaid rehab and therefore you cannot bill for services through the Medicaid rehab option. You would submit the family under your contract rate and if you chose the Medicaid option, you would submit an itemized listing of the services provided to the child and the state will reimburse. If the child is not Medicaid eligible you would do the same thing for billing purposes. For children that do not have an axis I diagnosis but are Medicaid eligible you would bill Medicaid using the v629 code.**