State of Wisconsin - Department of Health Services - Division of Long Term Care
Family Care/Partnership Technical Assistance Series
Issued: November 2, 2015
P-01048-15-02

LTC MCO Enrollment and Payment Discrepancy Resolution

Purpose: This technical assistance document is intended to provide instructions to be used by MCOs to efficiently identify enrollment discrepancies and determine the appropriate action for resolution.

Long-Term Care (LTC) Managed Care Organizations (MCOs) are responsible for monitoring regular enrollment and capitation payment reports for discrepancies in members the MCO considers enrolled. Monitoring for discrepancies and reconciling the discrepancies ensures that members are correctly enrolled and the MCO is appropriately paid.

MCOs should use reports from the ForwardHealth interChange (FHiC) Medicaid Management Information System (MMIS) to monitor and resolve discrepancies. These reports provide monthly membership information and changes, and weekly capitation payment information. The reports and their frequencies are:

- MMIS Enrollment Report – Bimonthly – two times a month
- MMIS Capitation Payment Report – Weekly (each weekend)
- MMIS Cost Share Report – Monthly

The FHiC system captures member Medicaid (MA) eligibility and managed care program enrollment from several sources including the Social Security Administration, CARES, and the HMO/SSI HMO Enrollment Broker. Due to the multiple sources of information and daily FHiC updates, the Department of Health Services requires LTC MCOs to use these reports to identify discrepancies related to member enrollment and capitation payments on a regular basis.

LTC MCO discrepancies generally fall into the five categories listed below. This document will step through each type of discrepancy and identify the action that the MCO should take based on the type of the discrepancy and the date the discrepancy occurred.

Information LTC MCOs can use to help determine a member's Medicaid eligibility status and cost share is included in this document, as a reference only.

Types of Discrepancies

1. Enrollment date: the member's enrollment or disenrollment date is not correct
2. Level of care: the member's level of care (LOC) information is incorrect
3. MCO ID: the member is enrolled into the incorrect MCO ID
4. Cost share: the member's monthly cost share responsibility is incorrect
5. MA eligibility

I. MCO, ADRC and IM Roles and Responsibilities

A. MCO - Identify discrepancies, by type, for members that are Medicaid eligible but do not have the correct enrollment, LOC, or MCO ID in FHiC.
   1. Identify and report discrepancies on the ADRC tab of the Discrepancy Report template (see attached Excel spreadsheet) when the date the discrepancy begins is in the report month or the month prior.
   2. Identify and report discrepancies on the Bureau of Managed Care (BMC) tab of the Discrepancy Report template when the discrepancy effective date is more than two calendar months in the past.
   3. Report Medicaid eligibility and cost share discrepancies on the Income Maintenance (IM) tab of the Discrepancy Report template. MCOs should collaborate with IM Consortia regarding the discrepancy resolution process and the preferred method to communicate discrepancies.

B. ADRC
   1. Enroll new members into LTC MCOs.
   2. Correct member enrollment, LOC, and MCO ID information when the MCO reports a discrepancy that occurred during the report month or the month prior.

C. Income Maintenance (IM)
   1. Complete a Medicaid eligibility determination for members that are not eligible for Medicaid from another source (e.g., SSI Medicaid, Foster Care Medicaid) within 30 days of the member's Medicaid application date.
   2. Complete annual Medicaid redeterminations.
   3. Calculate member cost share amounts.

Discrepancy Reporting Examples

Month Discrepancy Reported by MCO	Effective Date of Discrepancy	Discrepancy Type	MCO Report Discrepancy to:	Correct Member Information
March 2015	03/25/15	Enrollment	ADRC	03/16/15 – Enrollment Date
March 2015	01/31/15	Enrollment	BMC	02/01/15 – Reenroll Date
March 2015	02/28/15	Enrollment	Systematic[1]	03/01/15 – Reenroll Date
March 2015	01/15/15	MCO ID	BMC	01/15/15 – New MCO
February 2015	02/19/15	Enrollment	ADRC	01/31/15 – Disenrollment Date
February 2015	01/02/15	Level of Care	ADRC	02/04/15 – Non-Nursing Home LOC
February 2015	11/12/14	Enrollment	BMC	12/12/14 – Enrollment Date
January 2015	01/10/15	MCO ID	ADRC	02/01/15 – New MCO
January 2015	09/14/14	Level of Care	BMC	09/30/14 – Nursing Home LOC

[1] See page 3 for more information about systematic reenrollment.

II. Medicaid Eligibility

If a member does not have full Medicaid eligibility for the enrollment period, then the member cannot be enrolled in a LTC MCO. LTC MCOs should first use FHiC to determine the member's Medicaid eligibility status for the month(s) of the discrepancy. (A listing of full Medicaid Benefit Plans that are valid for MCO enrollment are included in Appendix E for LTC MCO reference.) If a member is not Medicaid eligible, then the MCO should take the following action:

MCO Action Needed

A. Check CARES to determine if IM is in the process of determining Medicaid eligibility.
   1. If so, the MCO should work with IM to ensure that Medicaid eligibility is confirmed for the month(s) of the discrepancy.
   2. Two business days after Medicaid eligibility is confirmed in CARES, it will update in FHiC.
B. Check CARES to determine if Medicaid eligibility for the month(s) of discrepancy has been denied. MCO enrollment cannot be added unless the member is Medicaid eligible.

MCOs should not report members that are not eligible for Medicaid on the ADRC or BMC tabs of the Discrepancy Report template. Only IM staff can update member Medicaid eligibility in FHiC. Once the member is Medicaid eligible, as verified in FHiC, for the month(s) of the discrepancy, the MCO can determine if there is a discrepancy and report the information on the ADRC or BMC tab in the Discrepancy Report template.

III. MCO Enrollment Date Discrepancy

Enrollment date discrepancies include:

- Member was enrolled into the correct MCO ID on the wrong day
- Member was disenrolled from the MCO on the wrong day
- Member should never have been enrolled in the MCO

If a member does not have the correct LTC MCO enrollment dates, it will result in a capitation payment discrepancy. LTC MCOs should first use FHiC to identify the enrollment and disenrollment information and compare it to the information in their system. If FHiC and the MCO system do not match, and the information in FHiC is incorrect, then the MCO should take the following action:

MCO Action Needed

A. If Medicaid eligibility is reestablished within one calendar month of the MCO disenrollment date, then FHiC will automatically reenroll the member if the following criteria are met:

   Conditions for Automatic Reenrollment/Systematic Reenrollment:

   1. A stop reason code was not updated in FHiC with the disenrollment date. Valid stop codes are:
      - 69 – LTC Disenroll – Member Request
      - 70 – LTC Disenroll – Member Moved Out of Service Area
      - 72 – LTC Disenroll – No Reason Provided

2. The disenrollment date is the last day of the month
3. The member is not enrolled in another MCO, HMO, or SSI HMO (not including Transportation manager).

B. If Medicaid eligibility is reestablished more than one calendar month after the MCO disenrollment date, then the member will not be systematically reenrolled.
C. If the member is not systematically reenrolled, the discrepancy should be reported on the BMC tab of the Discrepancy Report template as an "Enrollment" type discrepancy.

If Medicaid eligibility is not reestablished within one calendar month, the member may be automatically enrolled in an HMO or SSI HMO. HMO enrollment always begins on the first day of the month and disenrollment is always the last day of the month. ADRCs cannot add enrollment to FHiC during the month in which the member is enrolled in an HMO. In most cases, BMC cannot retroactively remove HMO enrollment.

The MCO will need to monitor whether the member has been enrolled in an HMO once Medicaid is reestablished. If the member has been enrolled in an HMO, the MCO should assist the member with contacting the HMO Enrollment Specialist. The HMO Enrollment Specialist is available toll free at 1-800-291-2002 from 7:00 a.m. to 6:00 p.m., Monday through Friday. If contacted timely, the HMO Enrollment Specialist can stop the HMO enrollment to allow managed long-term care enrollment without interruption.

For more information on Wisconsin Medicaid and SSI HMO enrollment, please refer to the following sources:

- Medicaid SSI HMO Choice Booklet
  https://www.dhs.wisconsin.gov/library/p-12770a.htm
- Wisconsin Medicaid SSI HMO Program Guide
  https://www.dhs.wisconsin.gov/library/p-12770.htm

IV. Member Level of Care Discrepancy

If a member does not have the correct LOC effective dates, it will result in a capitation payment discrepancy. LTC MCOs should first use FHiC to identify the member LOC information and compare it to the information in the Functional Screen Information Access (FSIA) application and in their system. If FHiC and the MCO system do not match, the MCO should verify the member's LOC in FSIA. If the FHiC information is not correct, then the MCO should take the following action:

MCO Action Needed – see chart on page two

A. Identify and report LOC discrepancies on the ADRC tab of the Discrepancy Report template when the discrepancy effective date is in the report month or the month prior. The type of discrepancy should be "level of care."
B. Identify and report discrepancies on the BMC tab of the Discrepancy Report template when the discrepancy effective date is more than two calendar months in the past. The type of discrepancy should be "level of care."

V. Member MCO ID Discrepancy

If a member is enrolled in an incorrect MCO ID, it will result in a capitation payment discrepancy. LTC MCOs should first use FHiC to identify the MCO ID and effective date for the member and compare it to the information in their system. If FHiC and the MCO system do not match, and FHiC information is not correct, then the MCO should take the following action:

MCO Action Needed – see chart on page two

A. Identify and report MCO ID discrepancies on the ADRC tab of the Discrepancy Report template when the discrepancy effective date is in the report month or the month prior. The type of discrepancy should be "MCO ID."
B. Identify and report discrepancies on the BMC tab of the Discrepancy Report template when the discrepancy effective date is more than two calendar months in the past. The type of discrepancy should be "MCO ID."

VI. Member Cost Share Discrepancy

If a member does not have the correct cost share amount in FHiC for a month(s), it will result in a capitation payment discrepancy, so LTC MCOs should first use FHiC to identify the member cost share amount for the month(s) in question.

If the FHiC member cost share amount does not match the amount that the MCO has for that month, then the MCO should take the following action:

MCO Action Needed

Check the CARES system to determine the member cost share amount for the month in question:

A. If the member is eligible for a Medicaid Waiver, then the cost share type in FHiC should be Waiver Cost Share type with effective and end dates that are consistent with the information in CARES.
B. If the member is eligible for Nursing Home/Institutional Medicaid, then the cost share type in FHiC should be the Medicaid Cost Share type with effective and end dates that are consistent with the information in CARES.
    1. FHiC uses an MCO capitation payment cost share offset hierarchy. Refer to appendix D for more information.
    2. If a member has both amounts, Waiver Cost Share amounts will offset capitation payments first.
C. If the member cost share information in CARES matches the information in FHiC and the MCO thinks that the amount is incorrect for a month(s), contact the IM worker.

IM workers need to correct the member cost share amounts as they are a condition of Medicaid eligibility. Do not report cost share discrepancies to the ADRC or BMC. The MCO should work with IM to get the information updated in FHiC, either using CARES or manually, as appropriate. Once the Medicaid cost share amount is corrected in FHiC the capitation payment will automatically adjust using the corrected cost share amount.

If you have questions regarding this memo, please email DHSBMCdiscrepancy@wisconsin.gov.

Contract reference

2015 annual DHS-MCO contract (Article IV. Enrollment and Disenrollment)

Attachments

- Appendix A: List of ForwardHealth interChange Reports
- Appendix B: Guidelines for Submitting Enrollment Discrepancies to DHS
- Appendix C: Screen Shots
- Appendix D: Member Cost Share Information and MCO Capitation Payment Offset for Family Care, PACE, and Partnership Members
- Appendix E: Full Benefit Medicaid Plans
- Appendix F: Enrollment Discrepancy Examples
- F-01655 Discrepancy Report Template (Excel)

Appendix A: List of ForwardHealth interChange (FHiC) Reports

- Enrollment – Paper and 834 HIPAA Transaction
  - **The INITIAL CMO Enrollment Report** is produced 12-13 days before the upcoming capitation month. This report contains a listing of all members and their enrollment status for the next month in FHiC. This report also includes members who are "pending" or do not have Medicaid eligibility on file for the next month, and, therefore, will not be enrolled unless Medicaid is updated for that month before the Final CMO Enrollment Report.
  - **The FINAL CMO Enrollment Report** is produced on the last business day before the first of the enrollment month. This report includes the final status of either enrolled or disenrolled members identified as "PENDING" on the initial enrollment report as well as any other changes that have occurred since the initial report was created.

- Capitation Payments – Text file and 820 HIPAA Transaction – This report provides a detailed listing of the members for which managed care programs are receiving capitation payments. Regular capitation payments are created once a month while capitation adjustments are created weekly.

- Coordination of Benefits Report – A monthly report that provides managed care programs with one year of private insurance and Medicare (Part A, Part B, both, and Medicare Part D) information for all of their newly enrolled members.

- Cost Share Report – This is a monthly report that contains three months of member cost share information.

- LTC Recertification Report – This report informs MCOs of the members that are due for a Medicaid review the following month.

Note: This is not a comprehensive listing of MCO reports. It is a subset of reports related to member eligibility and MCO enrollment.

Appendix B: Guidelines for Submitting Enrollment Discrepancies to the DHS-BMC

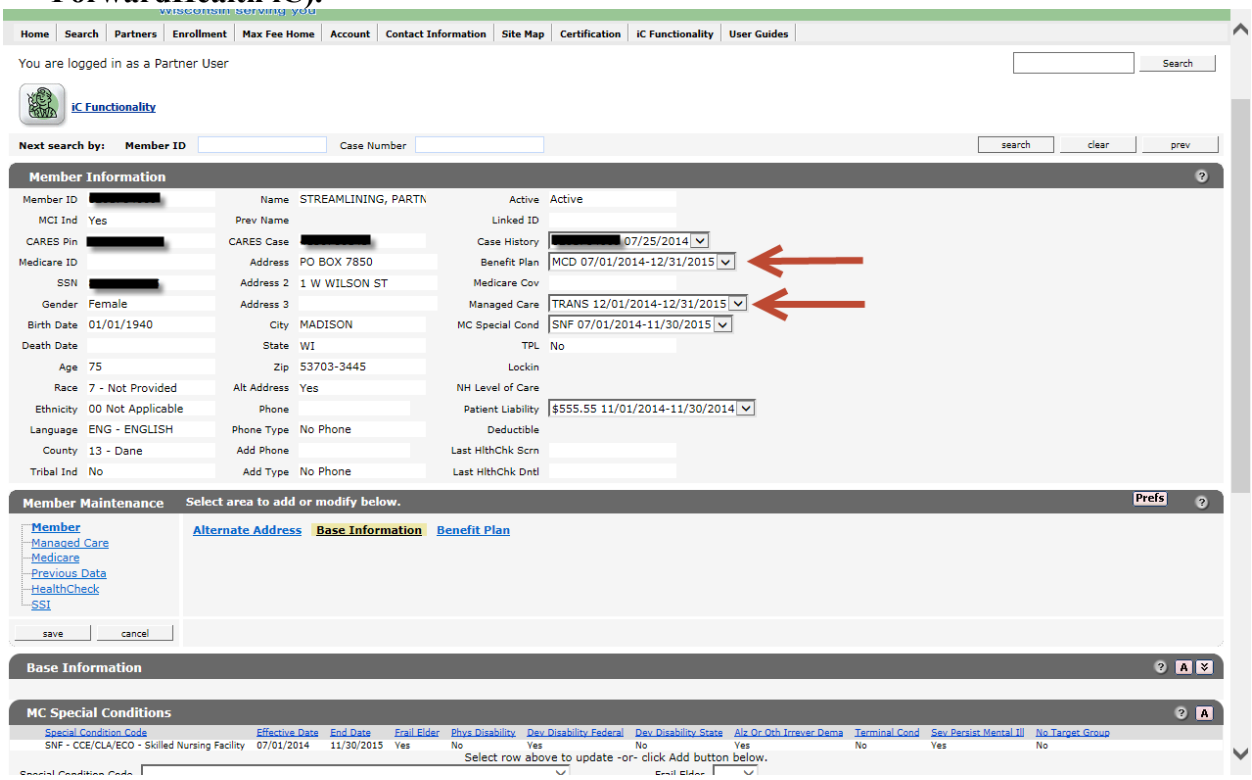
MCOs should use the following guidelines to report discrepancies on the BMC tab of the Discrepancy Report template:

- No more than twice per month, submit enrollment, LOC, and MCO ID discrepancies on the Discrepancy Report template, in accordance with the reporting examples chart on page two.
- Prior to submission to BMC, confirm Medicaid eligibility is in place in FHiC.
- Submit only discrepancies that were not previously reported to BMC, or clearly indicate on the report which discrepancies are new submissions since the prior report.
- Provide adequate notes on the Discrepancy Report template to indicate the incorrect information that appears in FHiC and the information the MCO believes should appear in FHiC.
- Provide evidence, upon BMC's request, that the MCO was providing services to the member during the time in question, or that the member was disenrolled on a certain date.
- Only submit individual requests for correction if there is an immediate need. The MCO's request should include sufficient information to indicate the reason for urgency (e.g., member needs durable medical equipment, but provider refuses to deliver services without enrollment in FHiC).
- Capitation payment adjustments are made automatically if the date of discrepancy is within 365 days. The actual capitation payment, or recoupment, will appear on the next payment cycle. MCOs should allow sufficient time for the payment/recoupment to occur before re-submitting the discrepancy to BMC.
- Do not submit requests to:
  - Adjust discrepancies that exceed 18 months previous to the report submission or correction request date. BMC will not process discrepancies that are over 18 months old.
  - Remove retroactive HMO or SSI HMO enrollment. Refer to pages three and four for more information.
  - Adjust the type or amount of cost share in FHiC. The only time an MCO should submit a cost share discrepancy is if a capitation payment was incorrect due to cost share, **and** the date of discrepancy was over 365 days. The MCO should submit this on the BMC tab of the template. The type of discrepancy should be "Other."
- Email submission guidelines:
  - Send requests to DHSBMCdiscrepancy@wisconsin.gov.
  - Do not copy or send requests to individual BMC staff.
  - Do not submit requests directly to HP.

Appendix C: Screen Shots

1. ForwardHealth Portal – member search

2. Benefit Plan and LOC information (eligibility and level of care information in ForwardHealth iC).

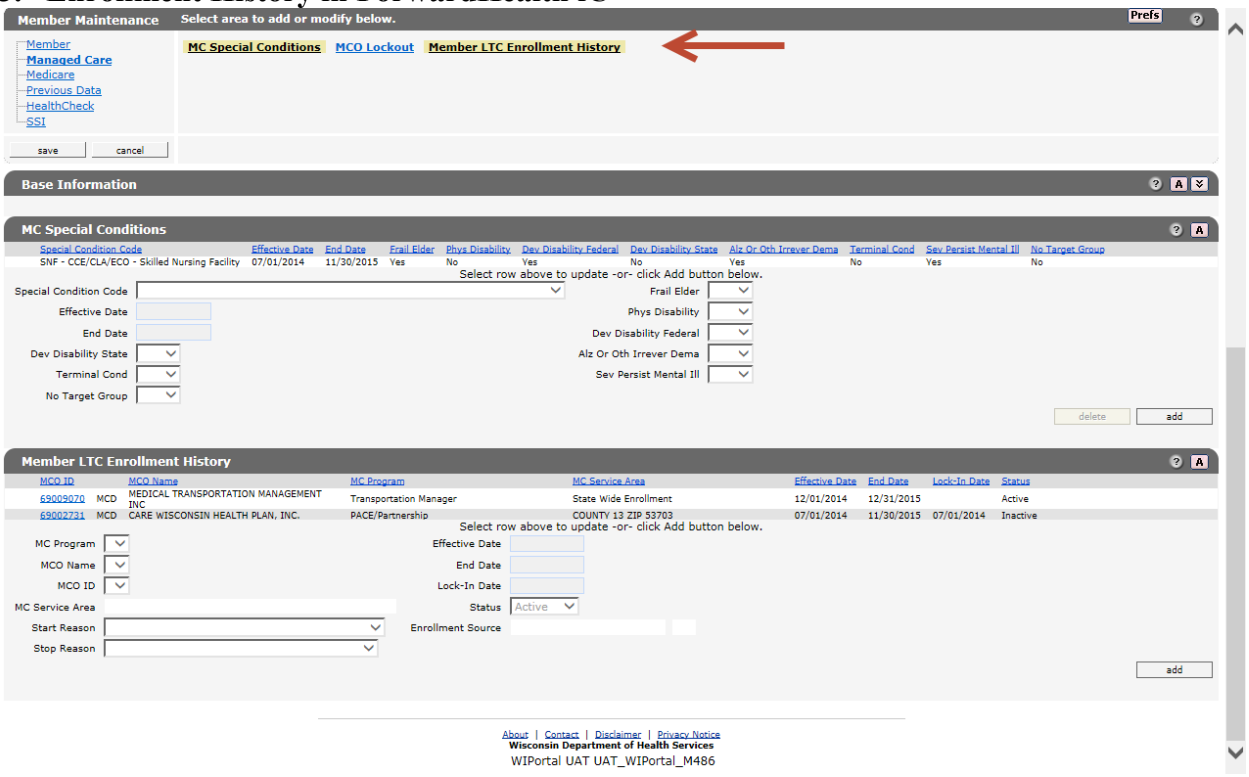


- **Benefit Plan** – This is the high-level member Medicaid, SSI MA, SSI payment, or limited benefit plan eligibility information. This is the same Benefit Plan information provided via the Enrollment Tab.
- **Managed Care** – This is the managed care program enrollment information for a member. Valid values are: FAMCR (Family Care), PACPB (PACE and Partnership),

HMOM_ (HMO enrollment), SSIM_ (SSI HMO enrollment), WAMMM (Wraparound Milwaukee), and CCFMM (Children Come First).

- **MC Special Conditions** – This is either the LOC for members enrolled in LTC MCOs or an exemption from HMO or SSI HMO enrollment.
  Exemptions are E01-E99 and they do not prevent LTC MCO enrollment.
  - Family Care levels of care are: L04 – Non Nursing Home and L06 – Nursing Home
  - PACE and Partnership levels of care are: ICF/IC1, SNF/SN1, and ISN/IS1
  - Target Group is populated from the Functional Screen Information Access (FSIA) via a web service or nightly batch. Includes: Frail Elder, Physical Disability, Developmental Disability Federal and State, Alzheimer's or Other Irreversible Dementia, Terminal Condition, Severe and Persistent Mental Illness, No Target Group

3. Enrollment History in ForwardHealth iC



Appendix D: Member Cost Share Information and MCO Capitation Payment Offset for Family Care, PACE, and Partnership Members

Cost Share Types
There are two types of cost share amounts identified in the Nursing Home (NH) Liability field in interChange. Both of these Cost Share types are monthly amounts sent from CARES to interChange. These monthly amounts are not prorated by CARES or by interChange.

- Medicaid Cost Share - NH liability cost share amount for a member residing in a medical facility.
- Waiver Cost Share - For waiver members not enrolled in Family Care, this is the cost share amount associated with the member's Waiver Medicaid eligibility from CARES. For members enrolled in Family Care, PACE, or Partnership, this is the member cost share amount.

Cost Share Capitation Payment Offset
An FHiC hierarchy has been established for the LTC MCO capitation payment offset process. The hierarchy below will use member cost share information that is effective the first of the capitation month.

1. Waiver Cost Share Type with Amount greater than $0.
2. Medicaid Cost Share Type with Amount greater than $0.
3. If for some reason, both a Waiver and a Medicaid cost share type exist (greater than $0), the Waiver Cost Share Type (and amount) will offset the capitation payment amount.

CARES Member Cost Share Information sent to FHiC			
LTC Program	**Medicaid Eligibility Type**	**FHiC Cost Share Type prior to 2/1/2015**	**FHiC Cost Share Type effective 2/1/2015**
Family Care	Medicaid Waiver	Waiver Cost Share	Waiver Cost Share
Family Care	Nursing Home Medicaid	Waiver Cost Share	Medicaid Cost Share
PACE and Partnership	Medicaid Waiver	Waiver Cost Share	Waiver Cost Share
PACE and Partnership	Nursing Home Medicaid	Waiver Cost Share	Medicaid Cost Share
No LTC MCO enrollment	Medicaid Waiver	Waiver Cost Share	Waiver Cost Share
No LTC MCO enrollment	Nursing Home Medicaid	Medicaid Cost Share	Medicaid Cost share

Appendix E: Full Benefit Medicaid Plans

Full Benefit Medicaid Benefit Plans

The following Benefit Plans are considered to be full benefit Medicaid. Therefore, members that want to enroll into Family Care, PACE, or Partnership would have to be eligible for one of the Benefit Plans below on or before the member's managed care enrollment date.

Benefit Plan	Description
MCDW	Medicaid Waiver
SSIMA	Medicaid for SSI
MCD	Medicaid
FSTMA	FosterCare Medicaid (IV-E)
MAPW	Medicaid Purchase Plan Waiver Medicaid
MAP	Medicaid Purchase Plan
WWMA	Well Woman Medicaid
BCSP	BadgerCare Standard Plan

Appendix F: Enrollment Discrepancy Examples

Example of MCO Discrepancy Report to Income Maintenance – Eligibility/Cost Share

MCI#	**MEMBER NAME**	**DATE(S) OF DISCREPANCY From**	**DATE(S) OF DISCREPANCY Thru**	COST SHARE	MEDICAID ELIGI-BILITY	OTH ER	**MCO ACTION REQUEST TO IM**	**IM RESPONSE** (IM use only)	**RESOLVED (MCO USE ONLY)**
3759103363	Doe, John	12/1/2015	12/31/2015	X			Member discharged from NH on 12/18/15 however FH still shows PL of 361.00. Liability should be zero for Dec.	IM Completed	
2453786239	Smith, Emma	4/1/2015	4/8/2015	X			FH is still showing CS of 288.23 for 04/01/15-04/08/15.		
5673002144	Moore, William	9/1/2014	10/31/2014	X			CARES budgets for Sept and Oct have incorrect spec housing. Member should not have cost share.	Amount needs to be submitted.	
1326001505	Johnson, Michael	4/1/2015	4/30/2015		X		FH shows a gap in Medicaid for April. Please determine Medicaid eligibility for April 2015.		

Example of MCO Discrepancy Report to ADRC

MCI#	**MEMBER NAME**	**MCO ID#**	**LOC**	**DATE(S) OF DISCREPANCY From**	**DATE(S) OF DISCREPANCY Thru**	ENROLLMENT DATE	DISENROLLMENT DATE	LOC	MCO ID	OTHER	**MCO ACTION REQUEST TO ADRC**	**ADRC RESPONSE** (ADRC use only)	**RESOLVED** (MCO use only)
4627760599	Smith, John	69004200	ICF	4/1/2015	12/31/2299	X					MA Review completed late. Medicaid now backdated, please add the enrollment for 4/1/2015-ongoing.	ADRC Completed	Resolved
7637525072	Henry, Sarah	69001234	NH	5/1/2015	5/1/2015		X				Date of disenrollment needs to be changed to 5/1/2015	ADRC Completed	Resolved
1997155561	Trepp, June	69003500	NNH	3/31/2015	12/31/2299	X					FH shows managed care ending 3/31/15	Need more info re: reason.	Resend to ADRC. Attach Change Routing from.
1800561234	Harris, Michael	69004848	NH	4/1/2015	12/31/2299			X			LOC date is effective starting 5/15/2015, needs to be changed to 4/1/15 when enrolled. LTC FS determined on 3/15/15.		

Example of MCO Discrepancy Report to BMC

MCI#	MEMBER NAME	MCO ID#	LOC	DATE(S) OF DISCREPANCY From	DATE(S) OF DISCREPANCY Thru	ENROLLMENT DATE	DISENROLLMENT DATE	LOC	MCO ID	OTHER	MCO ACTION REQUEST TO BMC	BMC DIRECTIONS TO HP (State use only)	BMC NOTES TO MCO (State use only)
4627760567	Brown, James	69004200	NH	10/1/2014	10/31/2014					X	Enrollment and LOC is correct in FH, but no payment received for October 2014		
1997155920	Davis, Lois	69003500	NNH	9/14/2014	12/31/2299				X		Wrong MCO-as of 09/15/14 member is MCO 69003500; Payment to wrong MCO. MCO ID 6900123 should end on 09/14/14		
3852696234	Garcia, Olivia	69004789	ICF	1/12/2015	12/31/2299			X			Member's LOC is showing as LO6 in FH, needs to be changed to ICF starting 1/12/15.		
1800565148	Wilson, Laura	69004848	ISN	12/15/2014	12/31/2299	X	X				Disenrollment/Enrollment - member disenrolled on 12/15/14 and re-enrolled on 12/23/14; FH has no gaps in enrollment.		