COLORADO
Department of Health Care Policy & Financing

08/23/2024

Dear Home and Community-Based Services (HCBS) Providers,

Resolving the billing issues for services to Long-Term Services and Supports (LTSS) members continues to be a top priority for the Department of Health Care Policy & Financing (the Department).

The Department hosted a webinar on April 25, 2024, to discuss the issues impacting LTSS members and providers. The recording and the slide deck for that webinar are available on the Stabilizing LTSS web page. This message includes the updates covered in the webinar and outlines the Department's guidance to providers.

Provider Actions:

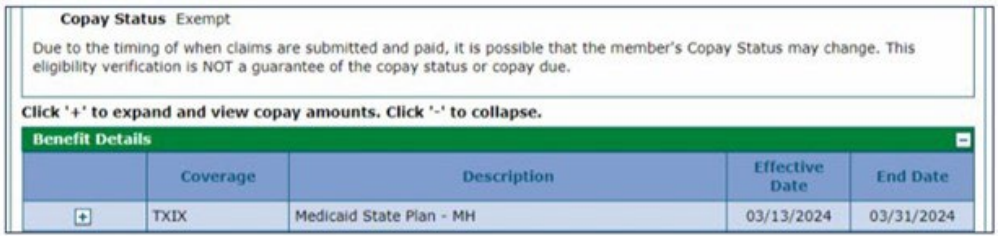
1. **Continue to render previously authorized services to members** even if the HCBS Benefit Plan or Prior Authorization Request (PAR) is no longer there. Providers should bill timely for all services rendered. The Department will manually create the Benefit Plan and add it to the member's eligibility and the claim will be reprocessed.
2. **Continue to resubmit previously denied or suspended claims monthly**. Claims will be reprocessed as new system fixes are implemented. As a reminder, there are additional issues related to a member's eligibility determination or a missing Benefit Plan that may cause a claim to be denied or suspended. System fixes are being implemented to mitigate these payment impediments.
3. **Providers should not contact a county or Case Management Agency** to resolve claims processing issues. Contact the Provider Services Call Center.

A process is in place to review provider billing for accuracy, request additional documentation on questionable claims and recoup payments if they were paid incorrectly.

Member Eligibility Verification: Waiver Benefit Plan

Providers can see when a member has the HCBS Aid Code and Level of Care (LOC) for HCBS services in the Provider Web Portal.

In this screenshot from the Provider Portal Eligibility Verification screen, providers can see the member has the 'MH' aid code for HCBS LOC and the Medicaid Benefit Plan, but that there is no HCBS Benefit Plan (e.g., EBD).



Copay Status Exempt

Due to the timing of when claims are submitted and paid, it is possible that the member's Copay Status may change. This eligibility verification is NOT a guarantee of the copay status or copay due.

Click '+' to expand and view copay amounts. Click '-' to collapse.

Benefit Details

	Coverage	Description	Effective Date	End Date
⊞	TXIX	Medicaid State Plan - MH	03/13/2024	03/31/2024

This means the member is eligible for HCBS but the specific waiver has not yet been received by the Colorado interChange.

Refer to the Verify Member Eligibility and Co-Pay Quick Guide for additional guidance.

Previously reported and implemented strategies:

1. Claims may be processed for previously approved services for a specific member, even if there is not an active Prior Authorization (PAR) in the system.
2. Member HCBS Benefit Plans are being extended if an existing HCBS Benefit Plan or an existing HCBS PAR is not found. Providers should verify eligibility to identify the member's current HCBS Benefit Plan and check for a PAR to determine what services are authorized for the member, however, if the HCBS Benefit Plan (for example, the Benefit Plan only shows 'MH') or PAR is not found, the provider should continue to provide and bill for the services that were previously authorized for the member.

Current implemented strategy:

3. As of March 20, 2024, all currently active cases for LTSS members that were placed in a 'pend status' in CBMS to mitigate a termination from occurring. This means that there has been, and continues to be, a significant decrease in members who receive a termination and therefore have a disruption in coverage. This pend status allows eligibility workers to continue to process cases, but guidance has been given to place the case back into a pend status after working the case. There is also a system backup to add the pend status if an eligibility worker is not able to do so and reinstate a member's eligibility at the end of the month if necessary.
4. Effective April 13, 2024, the Department implemented another strategy to mitigate terminations for missing LOC determinations. When eligibility is determined, a 12-month extension will be applied to the current LOC end date and will not terminate eligibility with that extension. This will help resolve provider payment issues associated with lapses in LOC determinations.

What will appear in the Provider Web Portal:
Providers may see adjusted claims on remittance advice (RA) statements.

- **If a claim is paid** without a PAR on file, the claim will be automatically reprocessed once there is an applicable PAR. Providers will see that the claim was adjusted and paid on the RA but **no additional payment will be issued**.
- All billed services are expected to align with an approved PAR. The Department has not yet determined a date for when PAR edits will be set back to Deny when a service is not matched to a PAR.
- **If a claim is suspended or denied** because of a missing HCBS Benefit Plan or PAR, it will be reprocessed based on the new HCBS Benefit Plan or PAR when those become available.
- **If a claim is suspended** with a service that will only pay if the rate is on the PAR, the service will either be manually priced or will be reprocessed based on the new Benefit Plan or PAR when those become available.

Denied or suspended claims:
Claims may deny for other reasons. If a service was previously paid, the service will be denied for duplicate service edits.

Providers may anticipate larger remittance statements which include adjusted claims. This is necessary to get timely payments to providers.

Impact to providers:
A net increase in reimbursements should result as stabilization efforts continue.

The Department is committed to overcoming these challenges through focused actions, partnership, transparency, and communication.

Refer to the new Stabilizing Eligibility & Case Management for Long- Term Services & Support (LTSS) Members web page to learn more.

Use the Health First Colorado and Child Health Plan *Plus* Grievance Form to notify the Department of members who are experiencing difficulty with the eligibility renewal process.

The Department sincerely appreciates providers' continued engagement and service to Health First Colorado LTSS members.

Thank you for your partnership,

Department of Health Care Policy & Financing