DS HCBS Interim Payment Method – Effective 7/01/2020

Effective with date of service 07/01/2020, the Medicaid billing code DS providers are to use when submitting Medicaid claims for the DS HCBS program is **99199 with modifier code HW**. This is replacing the use of code H2022 HW. The unit of service is changing from a daily unit with a daily billing rate to a monthly unit with a monthly billing rate. Providers need to use the same billing provider number as before when billing for DS HCBS.

Waiver Spreadsheet – No changes in this process. Waiver spreadsheets must be submitted monthly with regular updates to individual recipient information. The waiver spreadsheet itself will have some minor updates removing daily rate calculations. DAIL will update the spreadsheets and HCBS spreadsheet instructions.

Respread - Because the FY21 budget is not yet finalized, agencies may choose to delay the completion of their respread process until the FY21 budget is approved and instructions provided to agencies. This will prevent having to make adjustments twice during this FY.

Per Member Per Month (PMPM) Rate Setting - The initial PMPM billing rate will be set by DAIL prior to each provider submitting their first set of FY21 claims at the beginning of August. This is NOT a prospective payment thus the monthly claims must be submitted after the prior month's dates of service have passed. Each provider will have a unique monthly per person rate set based on their individual DS HCBS allocations and caseload counts at that time (per the latest DAIL approved waiver spreadsheet). DAIL will continue to set provider specific monthly rates each month for the rest of the fiscal year with a final reconciliation done after the close of the fiscal year. Each subsequent monthly rate will be set accounting for Medicaid revenue collected to-date, the revised allocation, new client count, and number of remaining months in the fiscal year. Example of how the new monthly billing rate is calculated:

August 1st rate calculation for July billing –

FY21 estimated beginning allocation = $10,000,000

Clients served = 200

July rate = $10M/200 = $50K/ 12 months = $4,166 PMPM

Sept 1st rate calculation for August billing –

FY21 revised allocation (per waiver spreadsheet changes) = $10,250,000

Clients served = 205

August rate = $10.25M minus $833,200 (200 x 4,166) of prior month Medicaid revenue = $9,416,800/205 clients = $45,936/ 11 months = $4,176 PMPM

This process would continue each month. It is important to note that Medicaid claims reports will be run by DAIL to gather the Medicaid paid to date amounts and will not be provided to DAIL by each provider.

Cash Advance – DAIL will approve the cash advance (if requested by an agency) in mid-July in an amount equal to that agency's average bi-weekly DS HCBS Medicaid receipt. The advance will be automatically recouped, evenly, in a provider's next twelve monthly DXC payments for DS HCBS.

Date Range on Claims – Providers should submit claims for the authorized PMPM after the month in which the service was delivered. A claim may be submitted as long as the person received one unit of service during that month. In most circumstances the date range should be the first of the month to the last day of the month. The unit is "1". In some circumstances a person may have only received services for part of the month because they were exiting or entering HCBS services with your agency. In these circumstances, you should reflect the actual days of service. This will prevent denials if the person transitions to another service within your agency or transfers to another agency. A few examples:

1) A person was receiving targeted case management for the first 10 days of a month and then starts receiving HCBS on the 11th day. You would use the 11 to the last day of the month as the date range.
2) A person received HCBS services from provider A from the 1-15th and provider B from the 16 to the end of the month. Each provider can submit a claim for that month, but must reflect the actual dates of service in order to prevent a denial.
3) Billing for Bridge Care Coordination and HCBS is not allowed in the same month because they are both monthly billing codes. Agencies will need to monitor transfers between these programs to prevent billing both in the same month.