PROVIDER BULLETIN

News and Updates on the Louisiana Medicaid Provider Portal

This Provider Bulletin was developed to answer questions and address concerns providers may have regarding Medicaid's new enrollment and eligibility system. Launched on November 13, 2018, the new system includes a new Provider Portal that replaces the former Facility Notification System (FNS) as ***the primary way providers manage documentation requirements****. The Self-Service Portal can be accessed at https://sspweb.lameds.ldh.la.gov/selfservice/.*

Optional State Supplement Payment Concerns

Medicaid is aware that a number of nursing facilities have reported missed payments for their optional state supplement (OSS) payments since the advent of the new eligibility and enrollment system.

Last year, Medicaid was required to have all facilities register with the Division of Administration in order to receive payments for their recipients. While Medicaid has encountered some issues when processing files, payments should only be temporarily delayed, with most processing within the month. January payments did encounter some extended delays due to an unforeseen error, but that has since been resolved.

Any facility that is experiencing extended delays or has not yet received their payment should reach out to Medicaid at OSS@la.gov for resolution.

Medicare Copayments

Delays in processing a backlog of long-term care facility notification (148) forms is impacting the full-benefit dual eligible enrollment of Medicaid/Medicare recipients. This has resulted in unnecessary Medicare Part D copayment charges for these Medicaid recipients.

For affected recipients, prescription and copayment bills sent to Medicaid will be denied because the recipient is enrolled in a limited benefit program. Even after the 148 form is processed, Medicare will continue to require a copayment charge until Medicaid is able to update the full benefit enrollment status within the Medicare system. Medicaid is currently working to resolve this issue with Medicare.

One additional point of clarity: Medicaid does not cover Part D copayments for dual eligibles.

Important Updates on Pregnancy and Newborn Issues

Eligibility and enrollment system updates made the first weekend of March have addressed several provider concerns, including an issue related to newborns of Medicaid mothers that resulted in denied claims.

The updates will correct several processing issues with newborn forms and resolve payment/coverage problems during the month of birth. Medicaid and the managed care organizations are working on a solution for providers who had claims previously denied due to the month of birth coverage issue.

Initial Applications for Newborns. Mothers who are not eligible for Medicaid must check the box for retroactive enrollment on their baby's initial application for coverage or the application will not process with retroactive coverage. Retroactive enrollment, however, can be requested after the initial application is submitted.

Medicaid continues to identify and work toward resolution on all newborn issues and processing delays. As solutions are determined and deployed, Medicaid will share the details in subsequent Provider Bulletins.

Medicaid Quarterly Eligibility Checks and Loss of Coverage

Starting in February, Louisiana Medicaid's new eligibility and enrollment system began conducting quarterly eligibility checks using wage data to verify that Medicaid recipients continue to meet requirements. Previously, income was verified annually or upon notification of a change in circumstances.

These more frequent checks will require some active Medicaid recipients to verify income to remain enrolled. They will be contacted **by mail only** if we need more information from them. This could include some of your patients. To help ensure your eligible patients do not lose out on coverage, please help us in encouraging them to:

- **Respond to Medicaid as soon as possible if they get a letter** from us asking for more information or asking them to verify their income. If they do not, their case may be closed and they may lose their Medicaid coverage, even if they are still eligible. Our call center has a high volume of calls, so we would suggest they submit the information we ask for using the contact information included in their letter. We've included that contact information below as well. ***Please note,*** **there is a unique email contact for long term care patients.** If you share the following contacts with your patients, please be sure to give them the proper contact information.

  Contacts for Submitting Requested Information to Medicaid:
  - **MAIL**: Louisiana Medicaid/LaCHIP, P.O. Box 91283, Baton Rouge, LA 70821-9278
  - **FAX**: 1-877-523-2987
  - **E-MAIL:**
    - ***For all Medicaid patients EXCEPT long term care****:* MyMedicaid@la.gov
    - ***For long term care patients ONLY:*** laltc.processingcenter@la.gov
- **Always keep their Medicaid information – especially their contact information – updated**. They can make changes to their address and other information online in the eligibility and enrollment system found here: https://sspweb.lameds.ldh.la.gov/selfservice/. They just need to create an account to make changes. They cannot submit verification documentation this way. That needs to be mailed, faxed or e-mailed.

LDH has heard the frustrations of providers about the confusion brought on by recipient notices. Therefore, we have created a dedicated task force to review and simplify notice language, and expect changes to be evident very soon.

If you have a patient that loses coverage, they do have options. Please let them know:

- If they are pregnant and they got a letter saying they were closed because of income, have them call Medicaid at 1-888-342-6207. Pregnant women have continuous eligibility in Medicaid until 60 days postpartum. They need to call Medicaid and let us know they are pregnant.
- If they are being treated for a serious illness like cancer that is expensive to treat, we do have special coverage designed especially for people with high cost illnesses (such as cancer or others) and who do not otherwise qualify for Medicaid because they earn too much. The program is called the Medically Needy program. This program will evaluate eligibility based on a person's net income after their medical expenses are subtracted. For people who find themselves in this situation, we urge them to call us at 1-888-342-6207 and speak to a representative to see if they qualify.
- If they lose their Medicaid coverage, they can contact the federal Health Insurance Marketplace. The loss of Medicaid coverage may be grounds for qualification for coverage through the Marketplace, even though the annual enrollment period has closed.

Important Updates Regarding Long Term Care

Intelligent scanning, an enhancement to the new eligibility and enrollment system, will automate some of the manual data entry previously required to reach an eligibility decision. These enhancements are planned to go live in April 2019.

Manually inputting supporting documentation, such as 148 status updates, was a primary reason for processing delays and payment issues for long term care providers, especially nursing homes and home and community based waiver providers. These delays have caused some out-of-date eligibility periods in the Medicaid system, resulting in improper claims payments and denials. As these delays are remedied, Medicaid will begin reprocessing both paid and denied claims during improper eligibility periods, resulting in recoupment of previous erroneous payments to certain providers in some circumstances. Medicaid will work diligently to ensure that debits and credits on same person are done in same payment cycle for ease of tracking. Plans are to pursue automation of additional provider forms by fall 2019, but we are working with Office of Technology Services to accelerate this timeline.

LDH is also seeking an alternate method to send decision notices other than postal mail. Decision notices are not going to Support Coordinators, partners and Office of Aging and Adult Services staff, causing delays in providing services to eligible recipients. This delayed notification may also cause providers to continue providing services to recipients who are no longer eligible for services.