FOOTHOLD TECHNOLOGY

TRANSFORM THE WAY YOU PROVIDE CARE

Billing in FCM

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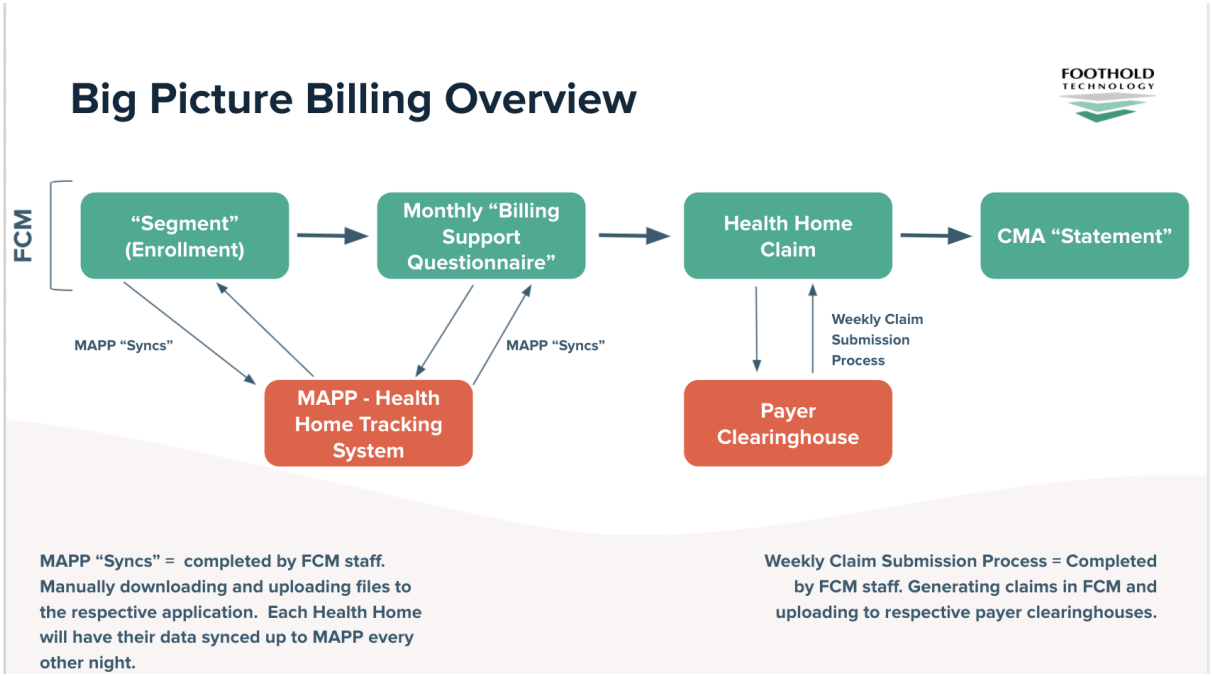
Revenue Cycle Overview



Step 1: Segment

The ability to bill for a member begins with a segment. Segments are what DOH uses to track a member's status (ie, Enrolled) in the Health Home Program. It's critical to address any tracking errors to ensure successful reporting of the segment to MAPP. Without a reported segment, you will be unable to bill for a member.

Here is more information on how to create and update segments in FCM!

Step 2: Billing Support Questionnaire (BSQ)

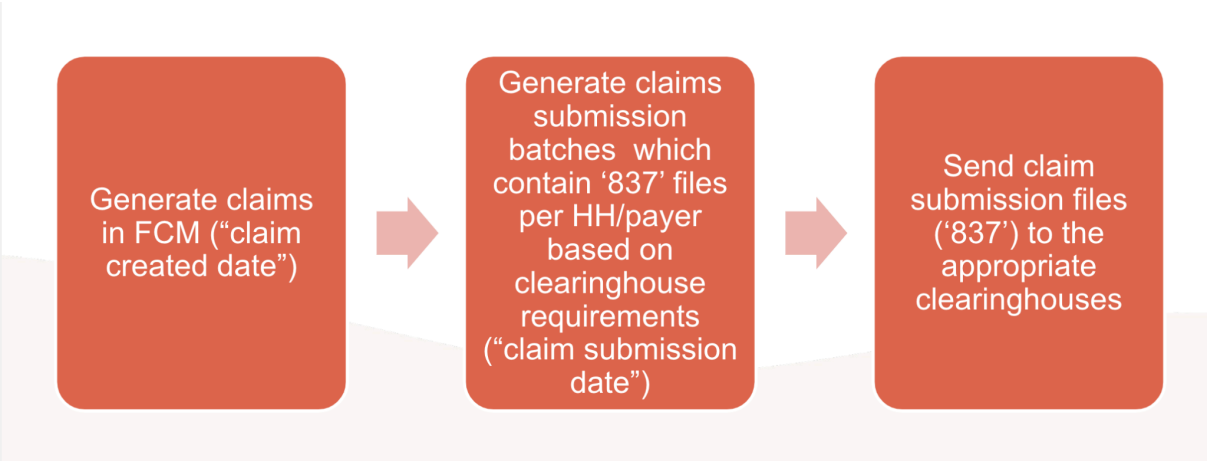
If there is a billing potential for the month of service (i.e. encounter documentation of a core service), a BSQ will be made available for completion. These "Potential" BSQs are available for Enrolled segments and Pended due to Diligent Search segments that have been successfully reported up to MAPP.

To comply with timely filing, please ensure the BSQ is completed as soon as possible.

*A note for Health Homes Serving Children, if you are completing a CANS assessment within the UAS in a given month, you would want to complete that month's BSQ at the end of that month so that MAPP will have the updated rate (determined by the CANS) for that member on file.

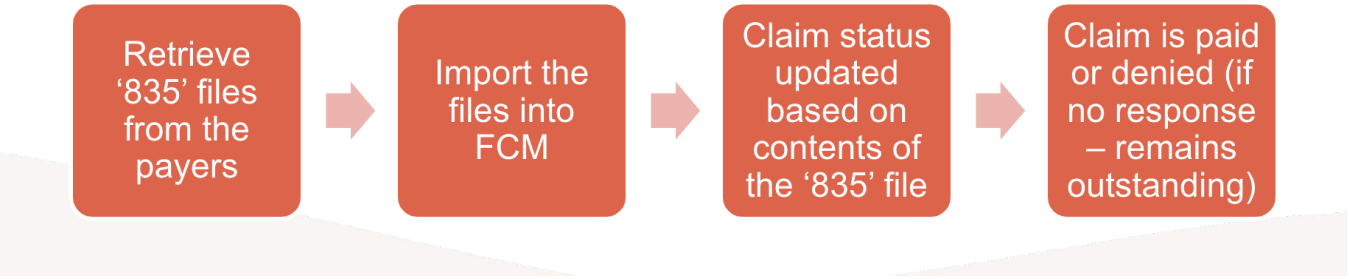
You can learn more about BSQs on our Support Page here!

Step 3: Claim Generation & Submission



- HH core service claims
  - includes replacement and voids when applicable
- HCBS EA claims

Step 4: Claim Response (from Payer)



Weekly remittance retrieval: FCM obtains payer responses electronically in an 835 format, as per CMS Guidelines, from the payers (eMedNY and the MCOs) on a weekly basis. These files may be referred to as remits, 835 files, ERAs, etc. Those 835 files are imported to FCM also on a weekly basis. If a claim is included in a file, its status is updated (i.e. goes from outstanding to paid or denied).

Manual adjustments and manual postings: Manual posting of remittances not received directly from payers is not recommended by FCM due to the risks involved. HHs must agree to the risks of potential human error and duplicate postings (i.e. HH asks FCM to manually post a handful of paid claim responses from a few months ago. The payer, next month, includes those claims on a large electronic remit). If the HH

wishes to still have manual adjustments or claims posted, they can fill out a template with the fields required by our system and provide it to FCM.

Step 5: Statements

Statements can be created for health homes at most weekly. FCM can offer an accompanying report of remits posted for during the statement time frame. That information, however, is available at all times to users with billing functionality via the claims screen.

Statements include all claim transactions for the CMA for the indicated timeframe (usually 1 or 2 weeks), along with any statement adjustments and a net payable amount to the CMA.

Step 6: Disbursement of funds (handled by HH)

Health Homes are responsible for reviewing the receipt of funds and disbursing funds to the CMAs. FCM provides statements to assist with the disbursement and reconciliation.

Outstanding Claims

Once a claim is submitted to the payer, that claim will show as Outstanding within FCM until we receive a response back from the payer (paid or denied). The amount of time it takes to receive a response varies by payer. Please allow 60 days for a response to come in.

How to best identify which claims are truly outstanding:

Navigate to the Claims screen, and select the appropriate HH/CMA. If there is a desired DOS timeframe, the DOS filters should also be used. The *last submitted date (ends)* filter is the key piece here. The date in that field should be at minimum one month ago. Some payers, such as AmidaCare, take up to 8 weeks to generate a response on a claim once it is submitted.

As an example, you may be interested in reviewing claims with DOS from 3 months ago. If the BSQ was completed just 2 weeks ago and the claim went out the following week, it would be too soon to expect to see a claim response. The *last submitted date (ends)* filter helps account for the lag.

Users making changes to the members' address are encouraged to review the claims for those members. If there are outstanding claims (older than 6-8 weeks), we recommend reaching out to the FCM support inbox. It is possible that the incorrect address on file was causing a claim to be rejected. FCM can edit the already-submitted claim with the new address information on file in an attempt to obtain payment.

FCM will regularly review Outstanding Claims for each Health Home in order to identify possible missing remits. This review would include checking provider portals for sampling of outstanding claims based on submission date (as that correlates to expected remit received date).

Denials

How FCM handles denials:

FCM looks for trends amongst payers when it comes to denials. FCM reviews those denial codes associated with a large number of denials.

FCM meets with most payers on a monthly basis to discuss any trends and identify ways to work with the payer to resolve inappropriate denials. For information on widespread issues already under review, please check here (TBD).

FFS Medicaid/eMedNY supplies clear reasons when claims are denied due to mismatched demographic information (i.e. DOB, gender) and what needs to be changed on a claim in order for it to be processed. FCM will make these updates to the claims and resubmit them. FCM reviews these on a monthly basis.

FCM does not automatically resubmit denied claims that have not been edited as it will be denied for duplicate claims, unless requested to do so by the payer.

FCM will review denial inquiries on claims up to one year from DOS.

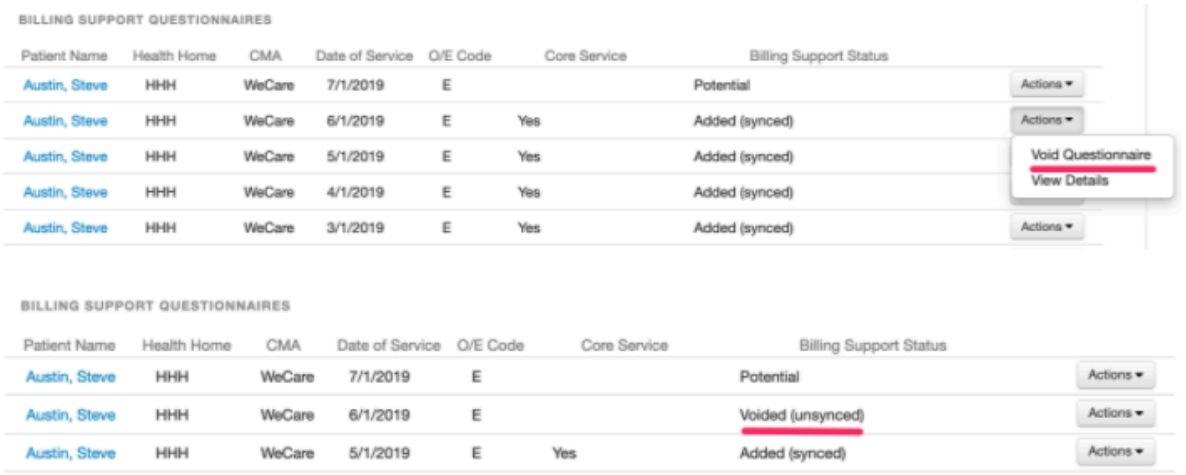
How can you address denials:

Sometimes there are issues with the members' demographics. HH/CMAs should alert FCM via support inbox if any changes to demographics are made, and the member has denials or outstanding claims - that could be a reason, and FCM can edit and resubmit those claims on behalf of the HH/CMA.

For denial inquiries on claims <1 yr old and not covered in the "payer claim overview", please feel free to reach out to us at fcm-support@footholdtechnology.com.

Voids

In order to request that a previously paid claim be voided, CMA and Health Home users can simply void the associated billing support questionnaire for the month in question. Foothold Care Management will use that voided questionnaire as an indication that there should be no claim for that patient that month and void any previously paid or submitted claims.



BILLING SUPPORT QUESTIONNAIRES

Patient Name	Health Home	CMA	Date of Service	O/E Code	Core Service	Billing Support Status	
Austin, Steve	HHH	WeCare	7/1/2019	E		Potential	Actions
Austin, Steve	HHH	WeCare	6/1/2019	E	Yes	Added (synced)	Actions
Austin, Steve	HHH	WeCare	5/1/2019	E	Yes	Added (synced)	
Austin, Steve	HHH	WeCare	4/1/2019	E	Yes	Added (synced)	
Austin, Steve	HHH	WeCare	3/1/2019	E	Yes	Added (synced)	Actions

Void Questionnaire
View Details

BILLING SUPPORT QUESTIONNAIRES

Patient Name	Health Home	CMA	Date of Service	O/E Code	Core Service	Billing Support Status	
Austin, Steve	HHH	WeCare	7/1/2019	E		Potential	Actions
Austin, Steve	HHH	WeCare	6/1/2019	E		Voided (unsynced)	Actions
Austin, Steve	HHH	WeCare	5/1/2019	E	Yes	Added (synced)	Actions

Deletion of segments or some adjustments to segments (ie, you edit the end date to an earlier date), will result in MAPP automatically voiding those associated BSQs within MAPP. For example, you have a segment that has an end date of 6/30/2021 and edit the end date to 2/28/2021, MAPP will then void any completed BSQs for the months of March-June. Similarly, if you delete a segment (even if you later re-create it), MAPP will void any BSQs for months during that segment period. To be safe, we recommend checking any previously completed BSQs in FCM after deleting or fixing an old segment error to ensure that there are not any BSQs voided unintentionally that would need to be re-completed **within that 30 day window**.

When a BSQ gets voided in FCM (or in MAPP), that will trigger a void to be sent out to the payer. For those BSQs that MAPP voids due to segment changes, the FCM system waits 30 days before sending a void out to the payer to allow time for the HH/CMA to re-complete those BSQs in case they ended up being voided in error.

Reconciliation

FCM does not have access to Health Home bank information and, as such, Health Homes are responsible for their own reconciliation of what is posted in FCM versus the actual payments received to the Health Home by the Payer.

Payer Updates

FCM will maintain a living document of any payer issues or updates. Health Homes should review this document as it may answer questions as to what is going on with claims with specific payers.
Link to doc to be posted.

Statement Adjustments

MCO Incentive Payments

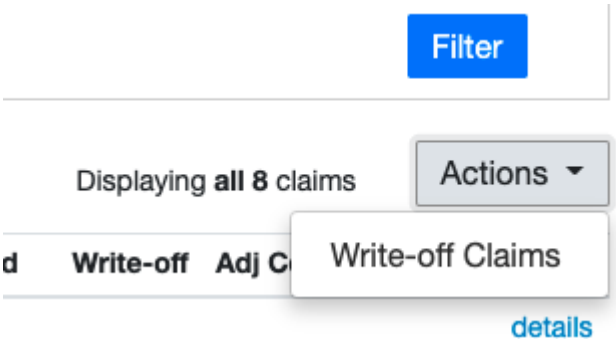
Some MCOs choose to incentivize HHs and CMAs for certain activities. Those payments are sent outside of the usual electronic remittance cycle. If a HH is in receipt of an incentive payment from an MCO, the HH can provide a breakdown by CMA with the dollar amount and accompanying note and FCM will reflect those via statement adjustments. HHs should provide this information to FCM at least two business days prior to their designated statement generation date in order to be included in that statement cycle.

Write Offs

FCM has a write-off functionality that allows designated users to indicate that payment is no longer expected for a claim. That functionality requires a specific user permission - for access, please contact the FCM support desk.

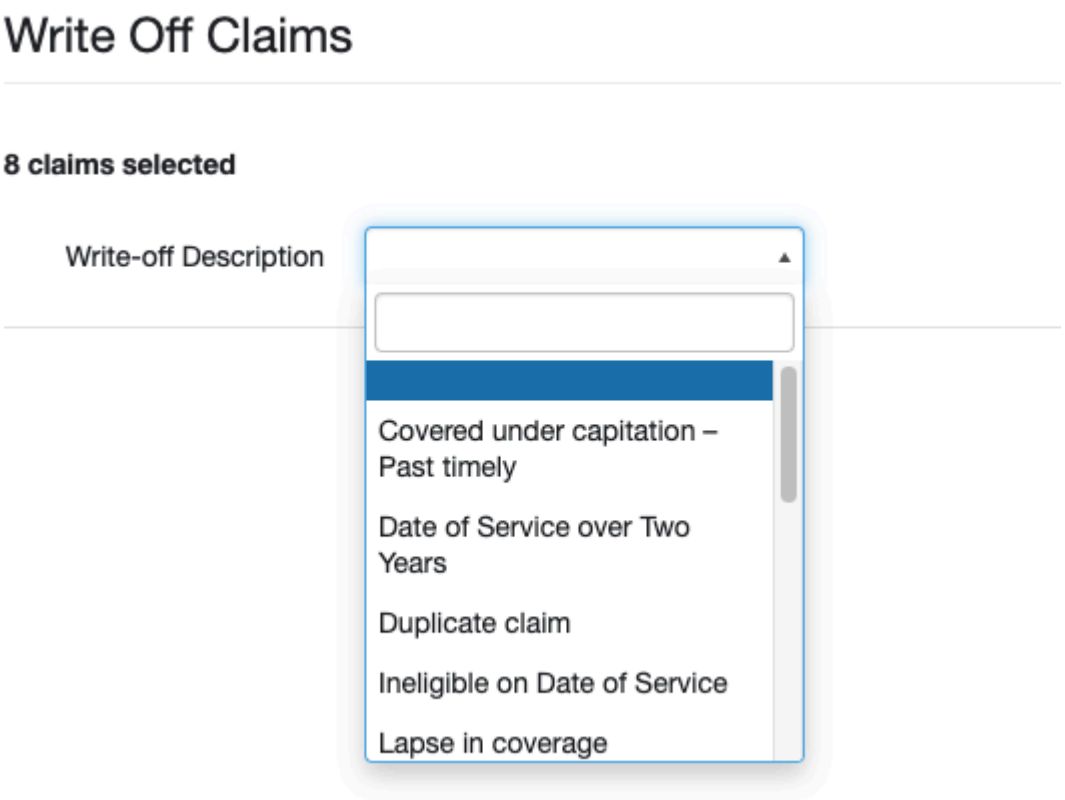
Marking a claim as a write-off does not change the claim status (i.e a claim that is outstanding or denied will remain as such). Instead it adds an extra layer of filtering that can be combined with other filters to ensure that those claims are not included in the search results (on the claims screen or on the associated csv downloads).

Steps:
Navigate to the claims screen and apply any filters to see search results. Once the feature is enabled within permissions, the user will see that there is now an Actions button with a Write-off Claims dropdown:



If users click on that, they'll be prompted to select a write-off reason. The same reason needs to be used for the amount of claims selected (helpful for bulk write offs for the same reason of course, but if users want to do different reason codes, they can select each individual claim separately by clicking into claim detail first or by bucketing the desired write-offs into different lists to search).

Select reason, and hit save.



Once back on the claims screen, those claims will now appear with a “write-off” indicated in that write-off column.

Admin Fee Models

We can support 3 different Health Home Admin Fee models within FCM:

- Per Member Per Month flat rate
- Percentage of paid claim
- Combination of a PMPM with a % of paid claims on top

PMPM Flat Rate

- All members with an active segment in FCM will be assessed a flat rate (ex, $10) Per Member Per Month admin fee
- This PMPM applies to all members who are actively enrolled or Pended Diligent Search.
- Health Homes are able to assess different PMPMs for CMAs within their network (CMA1 gets charged $10PMPM, CMA2 gets charged $12)
- Admin Fees are assessed in the beginning of the following month for the previous month’s DOS
- If a segment is deleted or edited in FCM so that it does not cover that DOS, the admin fee is recouped from the Health Home

Percentage of Paid Claim

- All members who had a paid claim for a given Date of Service are assessed a percentage (ex, 5%) of the amount paid for an admin fee

- This only applies to members for which the CMA received payment. It excludes any members where there was not a paid claim
- Reasons why a member with an active segment may not have a paid claim for a DOS:
    - Segment type (outreach or pended-other)
    - Segment did not successfully report to MAPP
    - Member did not receive a core service
    - BSQ not completed
    - BSQ not successfully reported to MAPP
    - Member's coverage
    - Claim denied or outstanding
- Admin Fees are assessed in the beginning of the following month for the previous month's DOS
- If a claim is voided, the admin fee is recouped from the Health Home
- If there is a rate adjustment on the claim, the admin fee is recalculated accordingly. The previous admin fee will be recouped and a new admin fee will be assessed based upon the new amount paid.
- Health Homes are able to assess different percentages for CMAs within their network (CMA1 gets charged 4%, CMA2 gets charged 5%)

Combination of PMPM & Percentage of Paid Claim

- This combination would apply the rules of the above options, but they would sit on top of each other. For example, an $8 PMPM with 3% of paid claims.
- On the statements, these would show as 2 separate lines for each member. This provides clarity on the amounts being assessed.
- If a claim is voided, the percentage portion of the admin fee will be recouped, but the flat rate will remain.

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