District of Columbia Department of Health **Ryan White HIV/AIDS Program Policies and Procedures** **Retroactive Medicaid Billing**		**Policies and Procedures** Implementing Office: HAHSTA Care and Treatment Division Ryan White HIV/AIDS Program (RWHAP) Training Required: Yes Originally Issued: ***December 13, 2023*** Revised/Reviewed:
Program Approval: Ebony Fortune Ryan White Program Manager	**Recipient Authorization:** Avemaria Smith Ryan White Recipient	**Effective Date:** ***December 13, 2023*** **Valid Through Date:** ***December 31, 2024***

I. SUBJECT

Retroactive Medicaid Billing

II. PURPOSE

The purpose of this policy document is to provide sub-recipients with guidance on how to bill Medicaid for services delivered to eligible persons during the retroactive Medicaid eligibility period defined under Title XIX of the Social Security Act, Section 1902 (a)(34).

III. Definitions and Acronyms	**Adjustment** – a transaction that changes any information on a claim that has been paid. An adjustment transaction credits a credit record, which reversed the original claim payment, and a debit record that replaces the original payment with a corrected amount, usually due to a billing or processing error. **Back-billing** – a billing made to collect an expense incurred in a previous billing period. **Billing entity** – a business whose only significant activity is invoicing and collecting payments for professional medical services on behalf of an Affiliated Medical Group or a Subsidiary and transfers all revenue on a regular basis to such. **Claim** – a submission requesting payment for specific services rendered to a recipient by the Billing provider. **Eligibility** – process of collecting information based on multiple criteria in order to determine if an individual qualifies for available benefits and services. **Medicaid** – the District of Columbia's medical assistance program, provided under a state plan which has been approved by the U.S. Department of Health and Human Services under Title XIX of the Social Security Act.

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	Payor of Last Resort – an entity that pays for services or goods after all other programs have been pursued for enrollment and payment. **Provider** – a person, business, or facility currently licensed under the law of any state and enrolled in Medicaid to practice medicine, osteopathy, dentistry, podiatry, optometry, or to provide other Medicaid approved services and has entered into an agreement with the District of Columbia's Medicaid program to provide such services. **Retroactive Medicaid Eligibility Period** – three months prior to the Medicaid application date if the individual would have been eligible during that period had he or she applied.
IV. Procedures	An efficient and cost-effective Medicaid back-billing process is important to meeting the "payor of last resort" requirements. Pass-thru Entities, such as HAHSTA, and its sub-recipients are required to ensure that grant funds are not utilized to make payments for any item or service to the extent that payment has been made, or can reasonably be expected to be made, with respect to that item or service— (i) under any State compensation program, under an insurance policy, or under any Federal or State health benefits program; or (ii) by an entity that provides health services on a prepaid basis (except for a program administered by or providing the services of the Indian Health Service) HAHSTA monitoring staff must ensure that sub-recipients retroactively bill Medicaid. HAHSTA monitoring staff fulfill this requirement by requiring sub-recipients establish systems and policies and procedures for service eligibility determination and retroactive Medicaid billing for services delivered to eligible customers during their retroactive Medicaid eligibility period. *Identify Eligibility* The eligibility screening, which involves annual and semi-annual recertification, assesses if a customer qualifies for Medicaid retroactively. If eligible, the retroactive period covers three months before the application date. Medicaid claims in the District of Columbia can be submitted up to 365 days post-service. Successful reimbursement for sub-recipients requires coordinated efforts among the service provider, billing entity, and Medicaid. The eligibility screening process (including annual and semi-annual recertification) determines whether a customer is eligible for Medicaid retroactively. The retroactive Medicaid eligibility period includes the three months before the Medicaid application date should the customer be eligible during that period had he or she applied. Medicaid claims can be filed within 365 days after the service date in the District of Columbia. For sub-recipients to receive reimbursement efforts must be coordinated between the service provider, the billing entity, and Medicaid. *Methodology* There are several methods to back-bill Medicaid for services provided to customers during the retroactive Medicaid eligibility period. A well-established process to determine service

	eligibility for Medicaid is integral for retroactive Medicaid billing of eligible customers. Individuals identified as Medicaid eligible are informed that their (Medicaid) coverage will be billed for services that occurred three months prior to eligibility and all subsequent encounters. Once identified, HAHSTA, the sub-recipient, or the billing entity is required to bill Medicaid for claims processed during the retroactive Medicaid coverage period. The claims can be adjusted to ensure Medicaid is the payer, reversed, and/or the actual charges can be credited back to the service provider. It is the sub-recipient's or the billing entity's responsibility to ensure all systems are updated regularly to prevent the future payment of claims against non-Medicaid funding resources. *Annual Review* During the Annual Comprehensive Site Visit, HAHSTA's Grants Management Specialist is responsible for reviewing the sub-recipient's policies and procedures for service eligibility determination and retroactive Medicaid billing. The GMS will review sub-recipient's general ledger for adjustments made for all retroactive Medicaid billing that occurred during the review period. The sub-recipient is responsible for ensuring full implementation of their policies and procedures to provide documentation to support its actions and transactions.
VI. Key Contacts	Ebony Fortune, MPH, Ryan White HIV/AIDS Program Manager, (202) 671-4900 or ebony.fortune@dc.gov Janice Carroll, Grants Management Supervisor, (202) 671-4900 or Janice.carroll@dc.gov
VII. Related Documents, Forms and Tools	HIV/AIDS Bureau (HAB) Policy Clarification Notice (PCN) 13-01, "Clarifications Regarding Medicaid-Eligible Clients and Coverage of Services by the Ryan White HIV/AIDS Program" HIV/AIDS Bureau (HAB) Policy Clarification Notice (PCN) 21-02, "Clarifications on Ryan White HIV/AIDS Program Client Eligibility Determinations and Recertification Requirements" Title XIX of the Social Security Act, Section 1902 (a) (34).