Medicaid Nursing Facility Services and Statewide Medicaid Managed Care

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Learning Objectives

Understand:

- Current status of SMMC program
- What types of plans your residents are enrolled in and when they can change plans
- Which plan to bill for what services
- Patient responsibility and personal needs allowance
- Performance measures for facilities
- New DCF forms for admission/discharge

Long-term Care and Managed Medical Assistance: Putting the Pieces Together

Two Components of Statewide Medicaid Managed Care (SMMC)

- Long-term Care (LTC) program
  - Implemented August 2013 – March 2014
  - 83,000* enrollees in seven plans
- Managed Medical Assistance (MMA) program
  - Implemented May – August 2014
  - 2.6* million enrollees in 20 plans

*Numbers are approximate

LTC Program

- The LTC program provides long-term care services, including nursing facility and home and community based services, to recipients eligible for enrollment.
- Recipients are mandatory for enrollment if they are:
  - 65 years of age or older AND need nursing facility level of care.
  - 18 years of age or older AND are eligible for Medicaid by reason of a disability, AND need nursing facility level of care.

MMA Program

- The MMA program provides primary care, acute care, dental, and behavioral health care services.
- Most Medicaid recipients are required to enroll in an MMA plan.
- Some recipients are eligible to enroll in BOTH LTC and MMA.

Comprehensive Plans

What is a Comprehensive Plan?

- Medicaid managed care plans that offer both LTC and MMA services.
- Cover all LTC and MMA services.
- Plan care coordinator(s) coordinates with all of the recipient's medical and long-term care providers.
- All regions except 1 & 2 have at least one comprehensive plan.

Are recipients eligible for both LTC and MMA required to enroll in a comprehensive plan if one is available?

- No, a recipient can choose any MMA plan in the region.
- 25,000 recipients are enrolled in a comprehensive plan for both LTC and MMA services.

Can a recipient choose to enroll in a comprehensive plan for LTC services and another plan for MMA services? (and vice versa)

- Yes, recipients can enroll in an LTC plan that is part of a comprehensive plan, but then select a different MMA plan offered by another vendor.
- Recipients can also choose to enroll in a comprehensive plan for their MMA services, but then select a different plan for their LTC services.

Open Enrollment

Open Enrollment

- Open enrollment is the 60-day period before the end of enrollees' enrollment year, during which the enrollee may choose to change plans for the following enrollment year.
- Some LTC enrollees are now in their annual open enrollment for LTC.

Why aren't all my residents receiving open enrollment information?

Enrollment periods are based on the first date of enrollment in a LTC plan, an MMA plan, or a comprehensive plan.

- If the resident is enrolled with a LTC plan that is different from their MMA plan, the annual open enrollment date for:
  1. LTC is the month they enrolled in the LTC plan; and
  2. MMA is the month they enrolled in the MMA plan.
- If the resident is enrolled in a comprehensive plan, annual open enrollment is the month they enrolled in the MMA portion of the comprehensive plan.

Why didn't my resident enroll in MMA?

Possible reasons:

- In a group that is excluded from MMA
- In a group that can choose whether to be in MMA ("voluntary")
- Enrolled in a Medicare Advantage plan
  - Starting in October 2014 recipients enrolled in Medicare Advantage plans can choose a comprehensive Medicaid plan where the recipients' Medicare and Medicaid plans are the same entity.
  - Medicaid recipients currently enrolled in a Medicare Advantage plan that offers the full set of MMA benefits will not be required to enroll in a Medicaid MMA plan.
  - Please see the Agency's guidance statement at: http://ahca.myflorida.com/MEDICAID/statewide_mc/pdf/Guidance_Statements/SMMC_Guidance_Statement_enrollment_in_Medicare_Advantage_Plans.pdf

Mixed Services
and
Who Pays for Them

What are mixed services?

- Services available under both LTC and MMA
- These services are:
  - Assistive care services
  - Case management
  - Home health
  - Hospice
  - Durable medical equipment and supplies
  - Therapy services (physical, occupational, respiratory, and speech-language pathology)
  - Non-emergency transportation

Which plan pays for mixed services?

- If an enrollee has other insurance coverage, such as Medicare, the provider must bill the primary insurer prior to billing Medicaid.
  - For dually eligible Medicare and Medicaid recipients, Medicare is the primary payor.
  - The MMA and LTC plans are responsible for services not covered by Medicare (including any Medicare co-insurance and co-payments).
- If the enrollee only has Medicaid coverage and is enrolled in an MMA and an LTC plan, the LTC plan is responsible for paying for the mixed services.

Mixed Services Reimbursement

Recipient Coverage	Who Pays for Mixed Services
Medicare and Medicaid	Medicare (if a covered service)
Medicaid LTC and Fee-for-Service	Medicaid LTC Plan
Medicaid LTC and MMA Plan	Medicaid LTC Plan
Medicaid MMA Plan only (not enrolled in LTC)	Medicaid MMA Plan
Medicaid Fee-for-Service	Medicaid Fee-for-Service

Hospice Services:

LTC plan always pays if the recipient is enrolled in both LTC and MMA

LTC Program	MMA Program
Payment	
LTC plans must pay hospice providers through a prospective system for each enrollee an amount equal to the rate set by the Agency	MMA plans must pay institutional hospice providers through a prospective system for each enrollee an amount equal to the rate set by the Agency*
Provider Network	
LTC plans must offer all hospices in the region a network contract for the first twelve months of operation	MMA plans must meet network adequacy requirements, but do not have to have offer a network contract to all hospices in the region

Non-Emergency Transportation Services:

LTC plan pays for NET to LTC care services.
MMA plan pays for NET to MMA services.

LTC Program	MMA Program
Services	
LTC plans must provide non-emergency transportation services to all long-term care covered services	MMA plans must provider non-emergency transportation services to all MMA covered services
Payment	
Plans and providers will negotiate transportation services rates.	

Why aren't nursing facility services a mixed service?

- LTC plans cover long-term nursing facility services.
- MMA plans cover nursing facility services as a downward substitution for inpatient hospital care.

Which plan pays the nursing facility for long-term care?

Recipient Coverage	Who Pays
Medicaid LTC Plan	Medicaid LTC Plan
Medicaid LTC and MMA Plan	Medicaid LTC Plan
Medicaid MMA Plan only (not enrolled in LTC)	Medicaid Fee-for-Service (until enrolled in LTC)
Medicaid Fee-for-Service	Medicaid Fee-for-Service

Which plan pays the nursing facility if services are a downward substitution for inpatient hospital care?

Services Prior Authorized by MMA Plan

Recipient Coverage	Who Pays
Medicaid LTC and MMA Plan	Medicaid MMA Plan
Medicaid MMA Plan only (not enrolled in LTC)	Medicaid MMA Plan

Medicare Coinsurance, Deductibles, and Crossover Claims and Who Pays for Them

Medicare Crossover Claims: Plan Responsibilities

- The plan is responsible for Medicare co-insurance and deductibles for covered services.
- The plan must reimburse providers or enrollees for Medicare deductibles and co-insurance payments made by the providers or enrollees, according to guidelines in the Florida Medicaid Provider General Handbook.
- The plan must not deny Medicare crossover claims solely based on the period between the date of service and the date of clean claim submission, unless that period exceeds three years.

Medicare Crossover Claims: Plan Responsibilities

- Plans must pay all Medicare Part A and B coinsurance crossover claims for dates of service while the individual was enrolled in the plan.
- Fee-for-service Medicaid will continue to pay Medicare Part A and B (level of care X) crossover coinsurance claims for dates of service from the date of eligibility until the date of enrollment in a plan.

Medicare Crossover Claims: Plan Responsibilities

- LTC plans are responsible for paying crossovers (if any) for the following services:
  - nursing facility
  - durable medical equipment
  - home health, and
  - therapies (occupational, physical, speech or respiratory)
- MMA plans are responsible for paying crossovers (if any) for all covered services, including:
  - nursing facility (if recipient is not enrolled in a LTC plan)

Medicare Crossover Claims: Provider Responsibilities

- Medicare crossover claims are not automatically submitted to the LTC or MMA plans.
- Providers bill the LTC plans for co-payments due after receiving the Medicare Explanation of Benefits (EOB) for the copayments.
- Providers bill the MMA plan for co-insurance or deductibles.

Medicare Crossover Claims: Recipient Responsibilities

- Except for patient responsibility for long-term care services, the plan members should have no costs to pay or be reimbursed.

Who pays the nursing facility for Medicare coinsurance?

Recipient Coverage	Who Pays
Medicaid LTC Plan	Medicaid LTC Plan
Medicaid LTC and MMA Plan	Medicaid LTC Plan
Medicaid MMA Plan only (not enrolled in LTC)	Medicaid MMA Plan
Medicaid Fee-for-Service	Medicaid Fee-for-Service

	Long-term Care	Managed Medical Assistance
Are the plans responsible for payment of Part A coinsurance and deductible?	**Yes**	**Yes***
Are the plans responsible for payment of Part B coinsurance and deductibles?	**Yes**	**Yes***

*Note: If member is also enrolled in an LTC plan, the LTC plan must pay any coinsurance and deductibles on mixed services listed in slide #16.

	Long-term Care	Managed Medical Assistance
Do providers submit crossover claims to the plan for payment?	Yes	Yes
Should the provider wait to receive the EOB before submitting the crossover to the plan?	Yes	Yes

Patient Responsibility & Personal Needs Allowance

Patient Responsibility for Nursing Facility Services

- Patient responsibility is the portion of the recipient's income DCF determines the recipient must pay towards the cost of nursing facility services.
- Medicaid must reduce payments to nursing facilities by the amount of the recipient's patient responsibility.

Do Hospice and SSI recipients have nursing facility patient responsibility?

Yes:

- DCF may determine the nursing facility patient responsibility to be zero.
- DCF must determine the amount of nursing facility patient responsibility prior to Medicaid reimbursement of nursing facility services.

When does DCF calculate nursing facility patient responsibility?

DCF calculates a monthly amount of patient responsibility for nursing facility services during the process of determining eligibility for the:

- Institutional Care Program (ICP); and
- Hospice benefit.

Exceptions to Nursing Facility Patient Responsibility

1. Medicare deductibles and co-insurance claims when the enrollee receives SSI or is a Qualified Medicare Beneficiary (QMB);
2. MMA plan reimbursement of less than 31 consecutive days of nursing facility services as a downward substitution of inpatient hospital care;
3. LTC plan reimbursement of less than 31 consecutive days of nursing facility services for respite; and
4. Nursing facility Medicare Part B claims

Can the amount of nursing facility patient responsibility change?

Yes. DCF can change the amount of nursing facility patient responsibility for one or more months. For instance, DCF may determine:

- An increase in the amount of the recipient's nursing facility patient responsibility due to an increase in the recipient's income; or
- A decrease in the amount of the recipient's nursing facility patient responsibility due to due an uncovered medical expense.

Does DCF notify recipients about changes in patient responsibility?

DCF mails a Notice of Case Action (NOCA) to the recipient when the amount of patient responsibility is increased or decreased.

- If DCF has a record of the recipient's representative or case manager, DCF also mails a copy of the NOCA to those entities.

What is a recipient's nursing facility personal needs allowance?

- A recipient can keep $105 of their monthly income for personal needs such as:
  - Toiletries not provided by the facility
  - Newspaper subscription
  - Haircuts
  - Clothing
- Effective July 1, the monthly amount of the PNA for nursing facility recipients increased from $35 to $105.

What is the nursing facility personal needs allowance for SSI recipients?

- Each month an SSI recipient resides in a nursing facility, the amount of the SSI check is reduced to $30.
- To supplement the $30 and ensure the SSI recipient has $105 for their nursing facility personal needs allowance, DCF issues a monthly payment for $75.
- Prior to the July 1, DCF issued a payment for $5.

Long-term Care Program Network Performance Measures for Nursing Facilities

SMMC LTC Network Performance Measures for Nursing Facility Providers

- LTC plans must monitor the quality and performance of each participating provider using measures that are adopted by the Agency as well as additional measures agreed upon by the provider and the LTC plan.
- The Agency has adopted the following measures for LTC plans to use to monitor participating nursing facilities.

Data Source

Centers for Medicare and Medicaid Services Nursing Home Compare website http://www.medicare.gov/nursinghomecompare/

Step #1

Does the nursing facility have an *overall rating* of two or more stars?

- If the answer is *yes*, the analysis is complete and the nursing facility *has met* this measure.
- If the answer is *no*, proceed with the analysis.

Step #2

- Within the section for Long-Stay Residents, does the nursing facility have a rating of two or more stars for the *Quality Measures*?
- If the answer is *no*, the analysis is complete and the nursing facility *has not met* this measure.
- If the answer is *yes*, proceed with the analysis.

Step #3

- Within the section for Long-Stay Residents, under the sub-section for Quality Measures, is the percentage of long-stay residents who received an *antipsychotic medication* at the nursing facility equal to or less than less than the statewide average percentage?
- If the answer is *no*, the analysis is complete and the nursing facility *has not met* this measure.
- If the answer is *yes*, the analysis is complete and the nursing facility *has met* this measure.

SMMC LTC Network Performance Measures

- At a minimum, LTC plans must use these performance measures when re-credentialing a nursing facility provider.
- After 12 months of active participation in the network, a LTC plan *may* exclude a qualified nursing facility from its network if the qualified nursing facility does not meet this measure.
- LTC plans are not required to exclude a nursing facility that does not meet this performance measure.
  - Plans must consider network adequacy requirements when making the decision to exclude a nursing facility from its network of providers.
  - LTC plans may also limit providers in their network based on credentials and price.

New Procedures to Notify DCF of Nursing Facility Admissions and Discharges

Notifying DCF of Nursing Facility Admissions and Discharges

Department of Children and Families (DCF) must be notified of a Medicaid recipient's admission to or discharge from a nursing facility, when Medicaid fee-for-service or managed care plans are expected to pay for:

1. Long-term care;
2. More than 30 days of nursing facility services as a downward substitution of in-patient hospital care; or
3. Medicare Part A coinsurance if the recipient does not receive Supplemental Security Income (SSI) or is not a Qualified Medicare Beneficiary (QMB).

DCF Responsibilities

Upon notification of a nursing facility admission or discharge, DCF:

- Updates the recipient's demographic information in the DCF computer system.
- Makes any necessary changes in the recipient's Medicaid eligibility aid category and patient responsibility.

Who Notifies DCF of Admissions/Discharges

Nursing Facility	• When the recipient is not enrolled in LTC or MMA • When the recipient is enrolled in the MMA program but is not enrolled in the LTC program
LTC Plan	• When the recipient is enrolled in the LTC program

Revised Forms to Notify DCF of Nursing Facility Admission

- Within 10 working days of the Medicaid recipient's admission to a nursing facility, DCF must receive a completed DCF #2506A Form (Client Referral/ Change).
- When the recipient is enrolled in SMMC, the SMMC plans may delegate submission of the DCF #2506A Form to the nursing facility.
- SMMC plans must retain a copy of the completed form in the plan member's file.

Forms to Notify DCF of Nursing Facility Discharge

Resident Not Enrolled in LTC Plan	Resident Enrolled in LTC Plan
When residents are **not enrolled in a LTC plan,** the nursing facility submits a completed **DCF Form #2506** (Client Discharge/Change Notice) to DCF, within 10 working days of discharge.	When residents are **enrolled in a LTC plan**, LTC plans submit a completed **DCF #2515 Form** (Certification of Enrollment Status, Home and Community Based Services) to DCF, within 10 working days of the recipient's discharge. *Note: *When the Medicaid recipient being discharged is enrolled in the LTC program, the LTC plan may not delegate submission of the DCF Form #2515 to the nursing facility.*

Forms Are Online

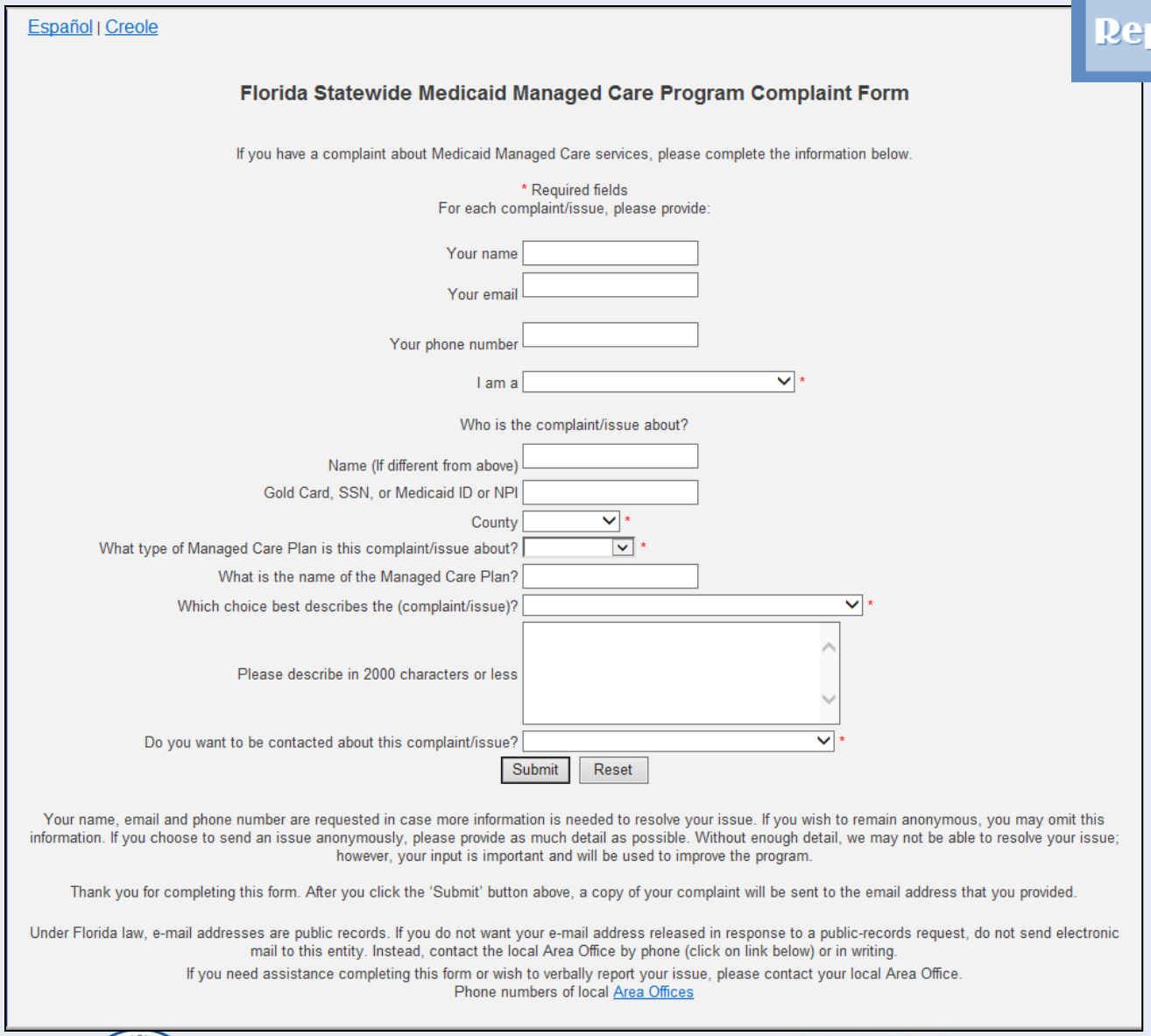
http://ahca.myflorida.com/Medicaid/nursing_fac/index.shtml

Concluding Thoughts

Our Work is Not Yet Done

- Goals:
  - Continual improvement
  - Increased quality
  - Appropriate enrollee placement

Report a Complaint



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Florida Statewide Medicaid Managed Care Program Complaint Form

If you have a complaint about Medicaid Managed Care services, please complete the information below.

* Required fields
For each complaint/issue, please provide:

Your name
Your email
Your phone number
I am a *

Who is the complaint/issue about?

Name (If different from above)
Gold Card, SSN, or Medicaid ID or NPI
County *
What type of Managed Care Plan is this complaint/issue about? *
What is the name of the Managed Care Plan?
Which choice best describes the (complaint/issue)? *
Please describe in 2000 characters or less
Do you want to be contacted about this complaint/issue? *

Submit Reset

Your name, email and phone number are requested in case more information is needed to resolve your issue. If you wish to remain anonymous, you may omit this information. If you choose to send an issue anonymously, please provide as much detail as possible. Without enough detail, we may not be able to resolve your issue; however, your input is important and will be used to improve the program.

Thank you for completing this form. After you click the 'Submit' button above, a copy of your complaint will be sent to the email address that you provided.

Under Florida law, e-mail addresses are public records. If you do not want your e-mail address released in response to a public-records request, do not send electronic mail to this entity. Instead, contact the local Area Office by phone (click on link below) or in writing.

If you need assistance completing this form or wish to verbally report your issue, please contact your local Area Office.
Phone numbers of local Area Offices

- If you have a complaint or issue about Medicaid Managed Care, please complete the online form: http://ahca.myflorida.com/smmc
- Click on the blue "Report a Complaint" button.
- If you need help completing this form or prefer to verbally report your issue, please call (877) 254-1055.

THANK YOU!

- FHCA has been a tremendous partner!
- Rollout could not have succeeded without your help and cooperation.