Florida Association of Aging Service Provider Questions

Question:

In preparation, what should providers be doing, and what should they be expecting to hear from the MCOs & in what time frames prior to their Implementation date? Example: Say my PSA goes live January 1, 2014. Start with July & monthly, tell me what should be happening on my end & what should the MCOs be firming up with me?

Answer:

Providers for all regions should be working to contract with Long-term Care plans now, although providers can contract with a plan at any time. Recipients begin choosing LTC plans two months prior to the "go live" date for their region. Choice counselors use a list of contracted providers to help recipients choose a LTC plan. To be on the list used by the choice counselors, providers must have an executed contract and the contract must be verified by the state's automated Provider Network Verification System. It is important to start early so that you can finalize the contract in time for the LTC plan to get your contract verified by the state at least two months prior to your region's start date.

Question:

Clarify in great Detail: If I am an aging services provider, what happens with clients currently being served?

Answer:

LTC plans must continue enrollees' **current** services for up to 60 days until a new assessment and care plan are complete and services are in place. Current service providers should continue to provide services at the same levels until they are notified in writing by the LTC plan that services should terminate. During this time, the service providers will be paid by the LTC plan for services rendered according to the recipient's current care plan.

If you have a contract with the LTC plan, you will be paid at the rate negotiated in the contract. If you do not have a contract with the LTC plan, you will be paid the rate you are currently being paid for that recipient. The LTC plan may require documentation of the rate you are currently paid (e.g., referral agreement, paid claim, contract).

Question:

How will I know which MCO my client has chosen?

Answer:

There are two ways to know which LTC plan your client has chosen:

- Ask the client
  - Recipients will have a letter stating their plan choice over 60 days prior to go live date, unless they change plans during the choice period or 90 day election period.
  - If they change plans, they will receive a letter confirming their choice.
- Check the Medicaid Eligibility Verification System (MEVS)
  - LTC plan will be on file on the region's "go live" date.
  - Training on how to check eligibility is online at http://ahca.myflorida.com/smmc . Go to News and Events, then to Event and Training Materials to view the presentation.

Question:

Who is responsible for notifying me when the MCO has completed their assessments, their care plan & assumes services?

Answer:

The LTC plan will notify providers in writing when it is time to terminate services.

Question:

What is the minimum amount of notice I will I get to terminate services? (Providers have to cancel meals, re-arrange staff schedules, cancel subcontractor orders, etc)

Answer:

The LTC plan can give as little as one day's notice, although at most times more notice will be given.

Question:

I know the MCO is required to reimburse me for the services in that period even if we do not have a contract going forward, but how do I know who to bill?

Answer:

The LTC plan will provide instructions on how to bill for services. If you have any difficulty getting paid, contact your local Medicaid office. Contact information for the local offices is at: http://ahca.myflorida.com/Medicaid/index.shtml#areas . There is also an online complaint form to use if you prefer. It is online at http://ahca.myflorida.com/smmc .

Question:

Will I be paid at the current contractual Med waiver and/or Nursing Home Diversion rate?

Answer:

If you have a contract with the LTC plan, you will be paid at the rate negotiated in the contract. If you do not have a contract with the LTC plan, you will be paid the rate you are currently being paid for that recipient. The LTC plan may require documentation of the rate you are currently paid (e.g., referral agreement, paid claim, contract).

Question:

How long does the MCO have to pay the obligation? What if there is a delay in payment? (MCO's are notorious for this, and it will be particularly treacherous if we do not have a contract) What is the recourse if they refuse to pay? Who do I report them to? AHCA? DFS? How do providers and vendors appeal, and to whom, if they are not paid by an MCO in a timely fashion, or not paid the full amount billed for services provided during the transition?

Answer:

The LTC plan must pay providers within the timeframes specified in its contract with the Agency for Health Care Administration. For nursing facility and hospice providers, the LTC plan must pay within ten business days from receipt of an electronic claim that contains sufficient information for processing. For all other providers, LTC plans must pay a clean claim within 20 days if electronic or 40 days if paper. (For more details on prompt pay provisions, see s. 641.3155, Florida Statutes.)

Any failure to pays claims or to pay claims timely should be reported to your local Medicaid office. Contact information for the local offices is at:
http://ahca.myflorida.com/Medicaid/index.shtml#areas .
There is also an online complaint form to use if you prefer. It is online at
http://ahca.myflorida.com/smmc .

Question:

Do the ITN provisions about rates and payments apply to sub-contracted vendors, too?

Answer:

LTC plans must pay nursing facilities and hospices at the Agency-established rate. During the transition to the LTC plan, providers will be paid the rate established in their subcontract with the plan or, if not contracted with the plan, at their current rate for that recipient. LTC plans are required to follow the provisions of their contract with the Agency, which includes prompt pay provisions.

Question:

How does the provider know what services are in the new MCO care plan?

Answer:

The Long-term Care program has standard benefits that all LTC plans must provide. These are listed online at http://ahca.myflorida.com/smmc . On the Long-term Care tab there are summaries of the program, a link to the Agency's contract with the LTC plans, and many other program details.

In addition, LTC plans can provide expanded benefits to their members. These are available on the choice counseling website at http://www.flmedicaidmanagedcare.com/PlanChoice.aspx .

Question:

So, if a client has been receiving meals for 3 years, and the MCO does not elect to include meals in their care plan, what happens to the client & their need for meals?

Answer:

A recipient continues to have all rights that exist under the current Medicaid program. If the LTC plan intends to reduce, deny, suspend, or terminate a service, the LTC plan must give the recipient written notice of the right to a Medicaid Fair Hearing in advance of any such change to services. The recipient may choose to continue receiving services at the same level until the Fair Hearing process is complete.

In addition, all LTC plans must have a grievance and appeal process that allows the proposed service change to be reconsidered by the LTC plan. The recipient may choose to use the grievance and appeal process and then, if not satisfied with the outcome, file for a Fair Hearing, or skip the grievance and appeal process and go straight to the Fair Hearing.

Question:

What if the MCO moves to drop shipping a week's worth of frozen meals on the client's front steps and the client is unable to bring in the box, open the box and microwave the meal, what happens to the client then?

Answer:

There are two parts to this answer. First, the LTC plan must work with the recipient to create a person-centered care plan. This process ensures that the recipient's goals and needs are the drivers of what services are ordered for the recipient. The care manager is tasked with assessing the recipient's abilities and living environment to ensure that the services ordered will meet not only the recipient's needs, but preferences. Second, in the scenario described, the service is not meeting the recipient's needs, so the recipient would be able to use the LTC plan's grievance and appeal process and/or the Medicaid Fair Hearing process to appeal this service change.

Question:

Who does the client appeal to if they do not receive services, or receive service reductions, and cannot get the MCO to address the issue?

Answer:

A recipient continues to have all rights that exist under the current Medicaid program. If the LTC plan intends to reduce, deny, suspend, or terminate a service, the LTC plan must give the recipient written notice of the right to a Medicaid Fair Hearing in advance of any such change to services. The recipient may choose to continue receiving services at the same level until the Fair Hearing process is complete.

In addition, all LTC plans must have a grievance and appeal process that allows the service change to be reconsidered by the LTC plan. The recipient may choose to use the grievance and appeal process and then, if not satisfied with the outcome, file for a Fair Hearing, or skip the grievance and appeal process and go straight to the Fair Hearing.

Finally, there is a new protection for recipients, the Independent Consumer Support Program. The Department of Elder Affairs will ensure the resolution of enrollee complaints, in coordination with the Agency for Health Care Administration. Aging and Disability Resource Centers will help resolve issues by assisting enrollees with the information needed to contact their LTC plan, file a Medicaid Fair Hearing, or take whatever other action is necessary to resolve the complaint. Residents of assisted living facilities, nursing facility, or adult family care home may also contact the LTC Ombudsman for assistance in resolving complaints.

Question:

If providers have no authorization from the MCO, and choose to terminate services, what is the procedure for notifying clients? What is the procedure for notifying MCOs of termination of services by existing providers?

Answer:

The Agency is guaranteeing that you will be paid for services rendered according to an approved care plan from the "go live" date in your region until the LTC plan notifies you in writing that you should terminate services. If you decide to terminate services prior to receiving notice from the LTC plan, you must give notice to recipients that you are ending services:

- Aged Disabled Adult and Assisted Living Waivers: 10 days prior to last day of service.
- Review your current referral/service agreement or provider handbook for details.

Question:

During Transition how do existing providers direct seniors to their appropriate (selected) MCO for service questions?

Answer:

Contact information for the LTC plans is online at http://www.flmedicaidmanagedcare.com/PlanChoice.aspx .

Question:

During Transition who, other than the MCO, is responsible for knowing which MCO a client selected?

Answer:

Service providers must check eligibility prior to rendering services. Information on how to check LTC plan enrollment is available on the first date of services for each region. Training on how to check eligibility is online at http://ahca.myflorida.com/smmc . Go to News and Events, then to Event and Training Materials to view the presentation.

Question:

During Transition how can providers help educate clients about details of the transition? The dissemination of information thus far to clients has been confusing and incomplete.

Answer:

Providers can help best help recipients by continuing to provide services until informed by the LTC plan that the new care plan is complete and new services are in place. The LTC plan care manager will contact the recipient to orient him or her to the LTC plan, provide a member handbook with details about the program, and begin the assessment and care planning process.

Question:

Assisted Care Services $9.28/day going to ALFs for low income individuals, not Medicaid, just cash assistance. Now it is under LTC Managed Care and ALF's can no longer bill ACS for this amount; only adult family care homes can. What happens to those facilities that have Medicaid-only (not on waiver) clients but do not qualify for this program and now they cannot bill the extra $9.28/day? Is this supplement going away? The ALF, especially small ALF's, rely on this for operating expense. Can facilities serving these clients still bill the state for these clients?

Answer:

The Assistive Care Service is still in place.

- For individuals enrolled in the LTC program who reside in an assisted living facility, the assistive care service has been rolled up into the Assisted Living service.
- For individuals enrolled in the LTC program who reside in an adult family care home, the home can bill the LTC plan for the Assistive Care service.
- For Medicaid-eligible individuals residing in an assisted living facility or adult family care home who are NOT enrolled in the LTC program, the ALF or AFHC can continue to bill Medicaid fee-for-service for the Assistive Care service. Once the Managed Medical Assistance goes live in 2014, providers will bill the Managed Medical Assistance for the Assistive Care service for these recipients who are not enrolled in the LTC program.

Question:

Is Nursing Home transition still in place or is LTC Managed Care going to replace Nursing Home Transition? If it stays in place, will it still be a "work around" of the wait list?

Answer:

The nursing home transition provisions are still in place. If a Medicaid recipient has resided in a nursing facility for at least 60 consecutive days, he or she is eligible to transition to home and community based services without going on the waiting list. Home and community based services will be provided by the LTC plan, and the plan care manager will help the recipient with the transition out of the nursing facility. In addition, many of the LTC plans are offering additional nursing home transition assistance as an expanded benefit (e.g., help with paying for housing or utility deposits, home furnishings, or moving expenses).

Question:

Once a client is in a Nursing Facility and Medicare days run out (or they no longer qualify and can't transition to the community) and the client transitions to Medicaid, according to the AAA, those individuals will have to go through the entire eligibility process through the AAA. Will they have to be on the wait list once their 60 days run out? Who alerts the AAA that they are going to need to have the application completed?

Answer:

The nursing home transition provisions are still in place. If a Medicaid recipient has resided in a nursing facility for at least 60 consecutive days, he or she is eligible to transition to home and community based services without going on the waiting list. Home and community based services will be provided by the LTC plan, and the care manager will help the recipient with the transition out of the nursing facility.