Welcome to the Agency for Health Care Administration Training Presentation for Potential Long-term Care Providers.

The presentation will begin momentarily.

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AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION
Better Health Care for All Floridians
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Statewide Medicaid Managed Care (SMMC)

Long-term Care Program

Medicaid Pending

May 9, 2013

1. Follow the link below to the SMMC Website

2. Select the “News and Events” tab under the header image.

Note: You can also use the red button to sign up for SMMC Program updates via e-mail.

http://ahca.myflorida.com/smmc

3. Select “Event Materials” to download today’s presentation.

Note: You may also view details regarding future SMMC events using the “Upcoming Events” tab.

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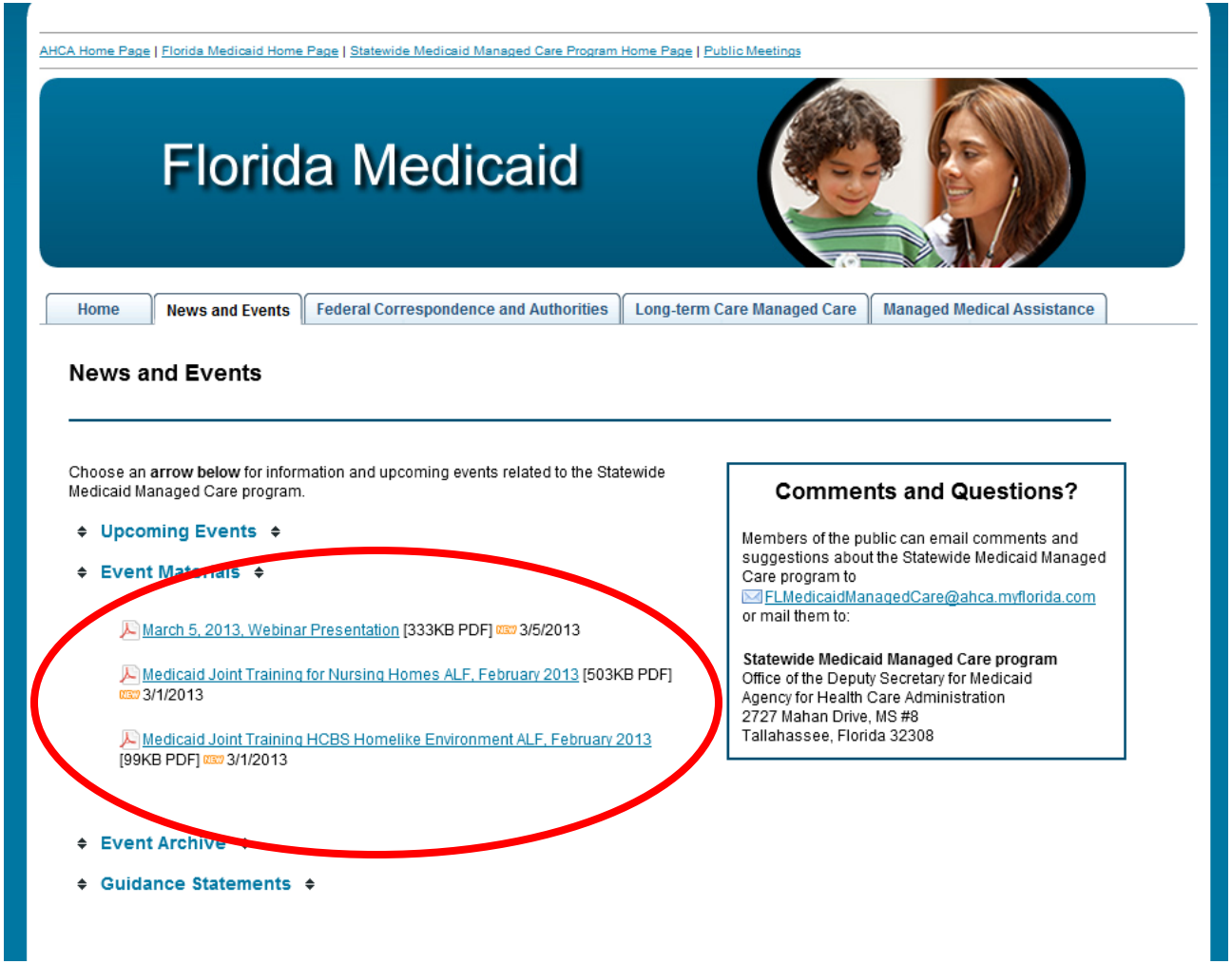
Note: You may also view files from past events and AHCA guidance statements or submit questions to be answered in future presentations.



Today's Presenters

- Cheryl Young
  - Bureau Chief of the Bureau of Long-Term Care & Support Services
  - Department of Elder Affairs
- Damon Rich
  - Choice Counseling with the Agency for Health Care Administration

Objectives

- Define/explain Medicaid Pending
- Explain how Medicaid Pending will affect SMMC long-term care applicants in nursing facilities vs. community settings
- Clarify the differences between Medicaid Pending under the Nursing Home Diversion waiver and the Long-term Care (LTC) program

Legislative and Technical Advisory Workgroup Direction

409.9841(e), Florida Statutes, directs the Agency for Health Care Administration (AHCA) to develop a process for the "enrollment of and payment for individuals pending determination of Medicaid eligibility."

Workgroup Recommendation

Nursing Facility Care

- The Agency shall ensure nursing facilities receive payment (the state will maintain a separate fee-for-service payment system for nursing facilities) for individuals whose Medicaid eligibility is determined retroactively prior to their enrollment with a managed care organization.

Home and Community Based Care

- The Agency shall develop and incorporate a retroactive eligibility and payment process that allows individuals access to home and community based care as quickly as possible even if their financial eligibility for Medicaid has not yet been determined.

What is Medicaid Pending?

Medicaid Pending is when recipients elect to enroll and receive services before their application for financial eligibility is approved.

Reasons for Medicaid Pending

- Individuals that qualify for a Long-term Care plan may be elders or disabled individuals that have chronic illnesses and require long-term care services right away.
- Individuals are given the option to either receive services without verified Medicaid financial eligibility or wait for Medicaid financial eligibility to be verified to start receiving services.

Medicaid Pending Process

- After the Medicaid application has been completed (no eligibility yet), the DCF application information will be sent to HealthTrack, a system that is used to complete enrollments.
- HealthTrack will store the information until the applicant's level of care from CARES is received stating the member is clinically eligible for the Long-term Care program.
- Therefore, HealthTrack will be receiving the Department of Children and Families (DCF) application information stating the individual has applied for Medicaid and the level of care from CARES indicating the individual is clinically eligible for long-term care services.
- In order to enroll with an SMMC Long-term Care managed care plan (MCP) as "Medicaid Pending," applicants must have completed the following steps:
  - Filed a Medicaid application with DCF
  - Received clinical eligibility (met "Level of Care" requirement).

Medicaid Pending Process

- Once an SMMC Long-term Care applicant has completed these two steps, they have two options:
  1. **Now:** Clients can choose to enroll with a managed care plan in a "Medicaid Pending" status. This will allow the recipient to receive services immediately, but puts them at risk for the cost of services received if their application for Medicaid is later denied.

     OR

  2. **Later:** Clients can choose a managed care plan, but have the Enrollment Broker hold the choice until their Medicaid application has been approved by DCF. They are **not** formally enrolled in a health plan and do **not** receive services until Medicaid is approved.
     - There is also the option to "Wait" when choosing to receive services "Later." Choosing to "Wait" means you opt to wait until you receive approval of eligibility to both choose a plan and receive services.

What does the choice “Now” mean?

- If the individual chooses to get LTC services “Now,” they will be enrolled into the plan of their choice for the next enrollment cycle.
- The plan choice will be sent to the managed care plan and the member will receive a confirmation letter stating the plan choice, effective date and another reminder about getting services “Now” without approved Medicaid eligibility.
- During this Medicaid Pending period, the managed care plan cannot deny or delay services based on the individuals pending Medicaid eligibility status.
- **There is a financial risk to the Medicaid recipient associated with receiving services prior to receiving verification of Medicaid eligibility.**

What does the choice “Later” mean?

- If the recipient decides to receive long-term care services “Later,” their services will not start until Medicaid eligibility has been approved.
- Although the recipient chooses to get services “Later,” they may still choose a managed care plan.
- The managed care plan choice will be saved in the system as a pending enrollment until Medicaid eligibility is approved.
- A confirmation letter with the managed care plan will be sent; however, since there is no eligibility yet, it will not indicate an effective date.

Enrollment Timeframe Examples

- **Example 1**

  If a recipient begins enrollment with the plan effective 9/1/13, but Medicaid eligibility is approved effective 10/1/13, then the recipient is responsible for paying the plan for services rendered for the month of September.

- **Example 2**

  If a recipient begins enrollment with the plan effective 9/1/13, Medicaid eligibility is approved effective 8/1/13, then the plan will only be paid for services rendered September forward.

What does the choice to "Wait" for eligibility to enroll mean?

- Recipients can also choose to get services later and wait to make their managed care selection when eligibility is verified.
- When eligibility is granted, these recipients will receive a letter that lets them know that they have 30 days to choose a plan and informs them of the health plan they will be automatically enrolled in if they do not make this choice within that timeframe.
- They will have 90 days from the initial effective date indicated in this letter to try out either their chosen or automatically-assigned plan and change it for any reason.

Managed Care Plan "Medicaid Pending" Protocol

- Managed care plans (MCPs) are not allowed to delay or limit services provided to Medicaid Pending members.
  - If a member is denied Medicaid eligibility (for some or all of the enrollment months spent in Medicaid Pending status), the MCP can seek reimbursement of the cost of services from the member for the ineligible time period.
  - If a member gains Medicaid eligibility, the MCP will be reimbursed for the months in which the enrollee received services in a Medicaid Pending status pursuant to the rates established in the Long-term Care program contract.

“Medicaid Pending” Recipient Protocol

- Medicaid Pending recipients are not allowed to change plans while in a Medicaid Pending status.
  - Members can choose to opt out of Medicaid Pending, and stop receiving services until Medicaid is approved.
  - Once a member receives Medicaid eligibility, he/she will have a 90 day change period to switch MCPs, if desired.
    - After the change period is over, members are locked in for the rest of the year and can only change MCPs with an approved “just cause” request.

LTC vs. Nursing Home Diversion

- Medicaid Pending under SMMC LTC differs from Nursing Home Diversion's version of Medicaid Pending in the following ways:
  - SMMC LTC applicants must file a Medicaid Application before they are enrolled with an MCP.
  - SMMC LTC MCPs will only receive Medicaid Pending members who wish to receive services, and have filed their application with DCF.
    - The "606" vs. "608" process under Nursing Home Diversion will end.
    - SMMC LTC MCPs will not assist with initial DCF applications. MCPs will only assist if they are providing services and also assist with financial eligibility completion as a part of case management.
  - Medicaid Pending members will show up as enrolled with their MCP in FMMIS while Medicaid Pending.

Medicaid Pending & Nursing Facilities

- LTC applicants who reside in nursing facilities will be subject to the same retroactive eligibility process under LTC that they were under Institutional Care Program (ICP) Medicaid.
  - This is technically different from the SMMC LTC Medicaid Pending process, which only applies to recipients in community settings.
  - Individuals in nursing homes will not have the option to enroll in a managed care plan until their eligibility for Medicaid has been approved by DCF.
- According to the Medicaid Nursing Facility Handbook, Medicaid eligibility can be granted retroactively by DCF for up to three months before the date of Medicaid application if the applicant meets all eligibility criteria, including level of care.

Resources

- Questions can be emailed to: FLMedicaidManagedCare@ahca.myflorida.com
- Updates about the Statewide Medicaid Managed Care program are posted at: http://ahca.myflorida.com/smmc
  - Upcoming events and news can be found on the “News and Events” tab.
  - You may sign up for our mailing list by clicking the red “Sign Up for Program Updates” box on the right hand side of the page.