Welcome to the Agency for Health Care Administration (AHCA) Training Presentation for Recipient Eligibility Verification.

The presentation will begin momentarily.

Please dial in ahead of time to:
1-888-670-3525
Passcode: 771-963-1696

Statewide Medicaid Managed Care Long-Term Care Program (SMMC LTC)

Recipient Eligibility Verification

October 22, 2013

Today's Presentation

Follow the link below to the SMMC Website and select the "News and Events" tab under the header image.

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

http://ahca.myflorida.com/smmc

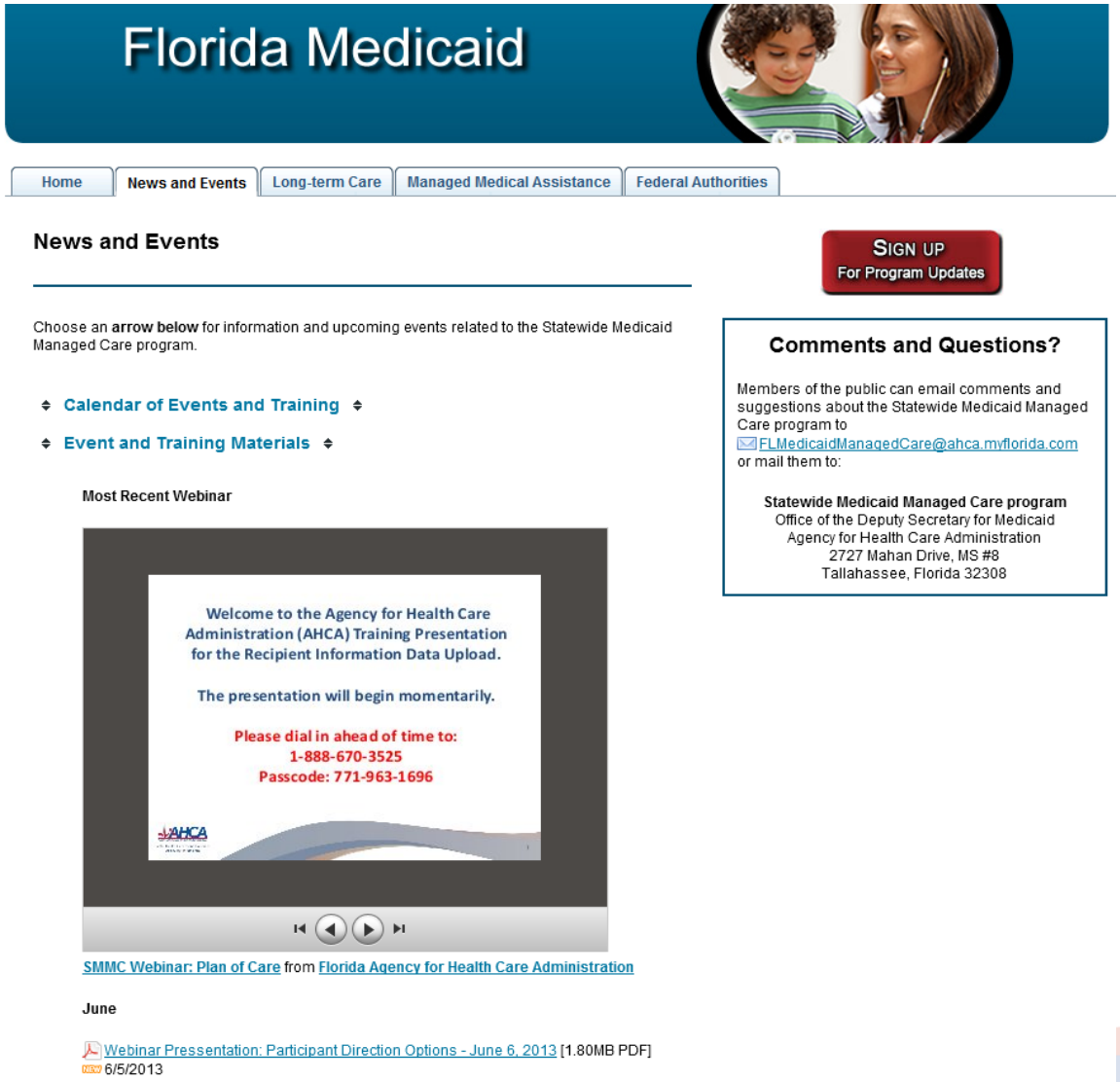
Today's Presentation, cont.

Select "Event and Training Materials" to download today's presentation.

Today's Presentation, cont.

Choose the file(s) you would like to save.

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



Today's Presenter

- Melissa Vergeson
  - Agency for Health Care Administration

A New Long-term Care Program

- Florida Medicaid is implementing a new program for Medicaid enrollees.
- Statewide Medicaid Managed Care has two components:
  - Long-term Care (LTC) program
  - Managed Medical Assistance (MMA) program
- The LTC program began implementation August 1, 2013, and continues to roll out through March 2014.
- LTC services for most Medicaid eligible individuals in nursing facilities and many receiving home and community based Long-term Care services will be provided by six Health Maintenance Organizations (HMOs) and one Provider Service Network (PSN).

What Services are Covered?

Adult companion care	Hospice
Adult day health care	Intermittent and skilled nursing
Assisted living services	Medical equipment and supplies
Assistive care services	Medication administration
Attendant care	Medication management
Behavioral management	Nursing facility
Care coordination/Case management	Nutritional assessment/Risk reduction
Caregiver training	Personal care
Home accessibility adaptation	Personal emergency response system (PERS)
Home-delivered meals	Respite care
Homemaker	Therapies, occupational, physical, respiratory, and speech
Transportation, non-emergency	

Each recipient will not receive all services listed. Recipients will work with a case manager to determine the services they need based on their condition.

Multiple Benefit Plans

- The Long-term Care benefit plan requires full Medicaid eligibility.
- Recipients must be eligible for one of the LTC program codes in order to be eligible for services.
- Please keep in mind that the recipient can be in multiple benefit plans that must be checked.

If a person is in a LTC plan the provider must ensure that they have authorization from the plan **before** rendering services.

SMMC LTC Populations

- **Mandatory**
- **Voluntary**
- **Excluded**

Mandatory Populations

Eligible recipients age 18 or older in any of the following programs or eligibility categories are required to enroll in a LTC Plan if they have been determined by CARES to meet the nursing facility level of care:

Temporary Assistance to Needy Families (TANF)	SSI (Aged, Blind and Disabled)	Institutional Care	Hospice	Aged/Disabled Adult waiver

Individuals who age out of Children's Medical Services and meet the following criteria for the Aged/Disabled Adult waiver:

- Received care from CMS prior to turning age 21
- Age 21 and older
- Cognitively intact
- Medically complex
- Technologically dependent

Mandatory Populations

Eligible recipients age 18 or older in any of the following programs or eligibility categories are required to enroll in a LTC Plan if they have been determined by CARES to meet the nursing facility level of care:

Assisted Living waiver	Nursing Home Diversion waiver	Channeling waiver	Low Income Families and Children	MEDS (SOBRA) for children born after 9/30/83 (age 18 — 20)
MEDS AD (SOBRA) for aged and disabled	Protected Medicaid (aged and disabled)	Dual eligibles (Medicare and Medicaid)	Individuals enrolled in the Frail/Elderly Program component of United Healthcare HMO	Medicaid Pending for Long-Term Care Managed Care HCBS waiver services

Voluntary Populations

Traumatic Brain and Spinal Cord Injury waiver	Project AIDS Care (PAC) waiver	Adult Cystic Fibrosis waiver	Program of All-Inclusive Care for the Elderly (PACE) plan members	Familial Dysautonomia waiver
Model waiver (age 18 — 20)	Developmental Disabilities iBudget waiver	Aged and Disabled (MEDS AD) — Sixth Omnibus Budget Reconciliation Act (SOBRA) for aged and disabled — enrolled in DD waiver	Recipients with other creditable coverage excluding Medicare	

Excluded Populations

SSI enrolled in a DD waiver	Model waiver (under age 18)	Presumptive Newborns (PEN)	Foster Care	Institutional Care — Transfer of Assets
MediKids	MEDS (SOBRA) for children born after 9/30/83 (under age 18)	MEDS (SOBRA) for pregnant women	Presumptively eligible pregnant women	Medically needy
Refugee assistance	Family planning waiver	Women enrolled through the Breast and Cervical Cancer Program	Emergency shelter/ Department of Juvenile Justice (DJJ) residential	Emergency assistance for aliens

Excluded Populations

Qualified Individual (QI) 1	Qualified Medicare beneficiary (QMB)	Special low-income beneficiaries (SLMB)	Working disabled

Regardless of eligibility category, the following recipients are excluded from enrollment in an LTC Managed Care Plan:

- Recipients residing in residential commitment facilities operated through DJJ or mental health facilities
- Recipients residing in DD centers including Sunland and Tacachale
- Children receiving services in a prescribed pediatric extended care center (PPEC)
- Children with chronic conditions enrolled in CMS
- Recipients in the Health Insurance Premium Payment (HIPP) program

Ways to Access Recipient Information

Remember:

It is the provider's responsibility to verify a recipient's Medicaid eligibility prior to providing any Medicaid reimbursable services

Card Not Proof of Eligibility

- Possession of a Medicaid ID card does **not** mean a recipient is eligible for Medicaid services.
- A provider should **verify a recipient's eligibility each time the recipient receives services**.
- Medicaid will not reimburse a provider for any service rendered on a day on which the recipient of that service was ineligible.

Ways to Access Recipient Information

Eligibility and benefit information is available to providers via the following:

- Calling (800) 239-7560 for self-service automated voice response system (AVRS) to verify eligibility and other automated options.
- Online, real time verification through the secure Web Portal.
- Batch transactions supporting standard X12 270/271 eligibility verification through the secure Web Portal.
- A Point-of-Sale (POS) device/connection through an approved Florida Medicaid MEVS vendor.

Information Available

The following recipient eligibility information is available through all the listed Ways to Access Recipient Information for dates of service within the past 12 months:

- Medicaid program code/aid category
- Hospital and other service limitations
- Managed care membership
- Third party insurance coverage and policy number
- Medicare number
- Medicare Part A & B coverage
- Nursing home status

The provider should record the recipient's Medicaid ID number and other relevant information obtained from the eligibility verification for billing and compliance purposes.

There are two new eligibility aid categories for the Long-term Care program.

New Aid Categories

- Providers may notice the following new aid categories when verifying eligibility:
  - **MEDP** for Medicaid Pending
  - **SIXT** for sixty-days loss of eligibility

What is the "MEDP" Aid Category?

- The "MEDP" aid category applies to individuals who apply for the Long-term Care program to receive home and community based services and who meet medical eligibility requirements.
- These individuals can choose to receive services ***before*** being determined financially eligible for Medicaid by the Florida Department of Children and Families (DCF).
- This option is not available to individuals in nursing facilities.

What is the “SIXT” aid category?

- Long-term Care plans are required to cover recipients who have lost Medicaid eligibility for sixty days from the date of ineligibility.

- The SIXT aid category allows recipient eligibility to continue during loss of eligibility.

LTC Plan Responsibility

- The Long-term Care plan is responsible for reimbursing subcontracted providers for the provision of home and community based services during the Medicaid Pending period, **whether or not** the enrollee is determined financially eligible for Medicaid by DCF.

- The Long-term Care plan must assist Medicaid Pending enrollees with completing the DCF financial eligibility process.

Provider Payment When Recipient has MEDP or SIXT (HMO)

- **How will providers of service get paid if the recipient is in an HMO and they are Medicaid pending or in loss of Medicaid eligibility for 60 days?**
  - The HMO will be responsible for paying the provider in both situations.

Provider Payment When Recipient has MEDP or SIXT (PSN)

- **How will providers of service get paid if the recipient is in a Provider Service Network (PSN) and they are Medicaid pending or in loss of eligibility for 60 days?**
  - The provider of service will submit claims to the PSN.
  - If the recipient is MEDP or SIXT, the PSN will hold the claims and submit them to the Medicaid fiscal agent for processing and payment once the recipient becomes eligible and the eligibility is retroactive covering the time period the service was rendered.
  - If a recipient does not become eligible, the claim will not pay. The vast majority of recipients in these categories, however, become eligible.

Recipient Responsibility During MEDP

- If DCF determines the recipient is not financially eligible for Medicaid, the Long-term Care plan may terminate services and seek reimbursement from the enrollee.

- In this instance only, the Long-term Care plan may seek reimbursement only from the individual for documented services, claims, copayments and deductibles paid on behalf of the Medicaid Pending enrollee for services covered under the Long-term Care program during the period in which the Long-term Care plan should have received a capitation payment for the enrollee in a Medicaid Pending status.

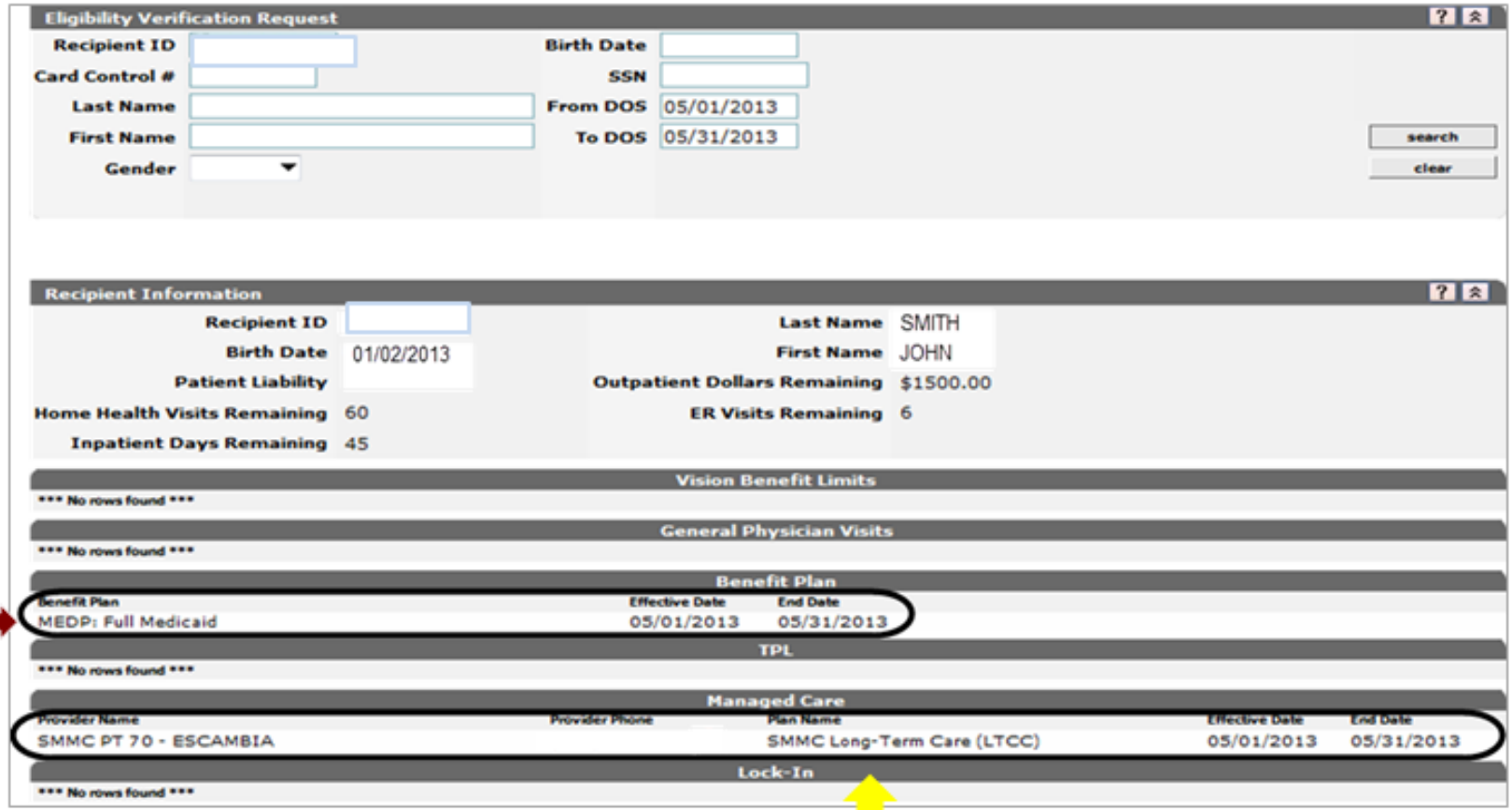
- The Long-term Care plan sends the affected enrollee an itemized bill for services. The itemized bill and related documentation shall be included in the enrollee's case notes.

How will providers be able to tell if a recipient has

MEDP or SIXT on file?

- Providers should always verify recipient eligibility.
- When a recipient has an aid category of MEDP or SIXT and is also enrolled in a Long-term Care plan, the recipient has full Medicaid.
- When verifying eligibility, a returned response will include the MEDP or SIXT and the Long-term Care plan information including the name and phone number of the LTC plan.

Example illustrating a Web Portal verification in which the recipient is fully eligible:



Eligibility Verification Request

Recipient ID		Birth Date	
Card Control #		SSN	
Last Name		From DOS	05/01/2013
First Name		To DOS	05/31/2013
Gender			

search clear

Recipient Information

Recipient ID		Last Name	SMITH
Birth Date	01/02/2013	First Name	JOHN
Patient Liability		Outpatient Dollars Remaining	$1500.00
Home Health Visits Remaining	60	ER Visits Remaining	6
Inpatient Days Remaining	45		

Vision Benefit Limits

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General Physician Visits

*** No rows found ***

Benefit Plan

Benefit Plan	Effective Date	End Date
MEDP: Full Medicaid	05/01/2013	05/31/2013

TPL

*** No rows found ***

Managed Care

Provider Name	Provider Phone	Plan Name	Effective Date	End Date
SMMC PT 70 - ESCAMBIA		SMMC Long-Term Care (LTCC)	05/01/2013	05/31/2013

Lock-In

*** No rows found ***

Recipient Enrolled in LTC Plan

- If a recipient is enrolled in a LTC plan, a fee-for-service claim for LTC program-covered services cannot be submitted directly to Florida Medicaid for payment by the provider.
- The provider needs to contact the recipient's LTC plan for claim submission and payment.
- This process is the same as it is currently for recipients enrolled in managed care plans.

How will Claims be Impacted with Only MEDP or SIXT?

- If a professional provider submits a fee-for-service claim directly to the Medicaid fiscal agent for a recipient with MEDP or SIXT, the provider's claim will be denied with Explanation of Benefit (EOB) code 0260 "Service Not Covered for Recipient Plan."

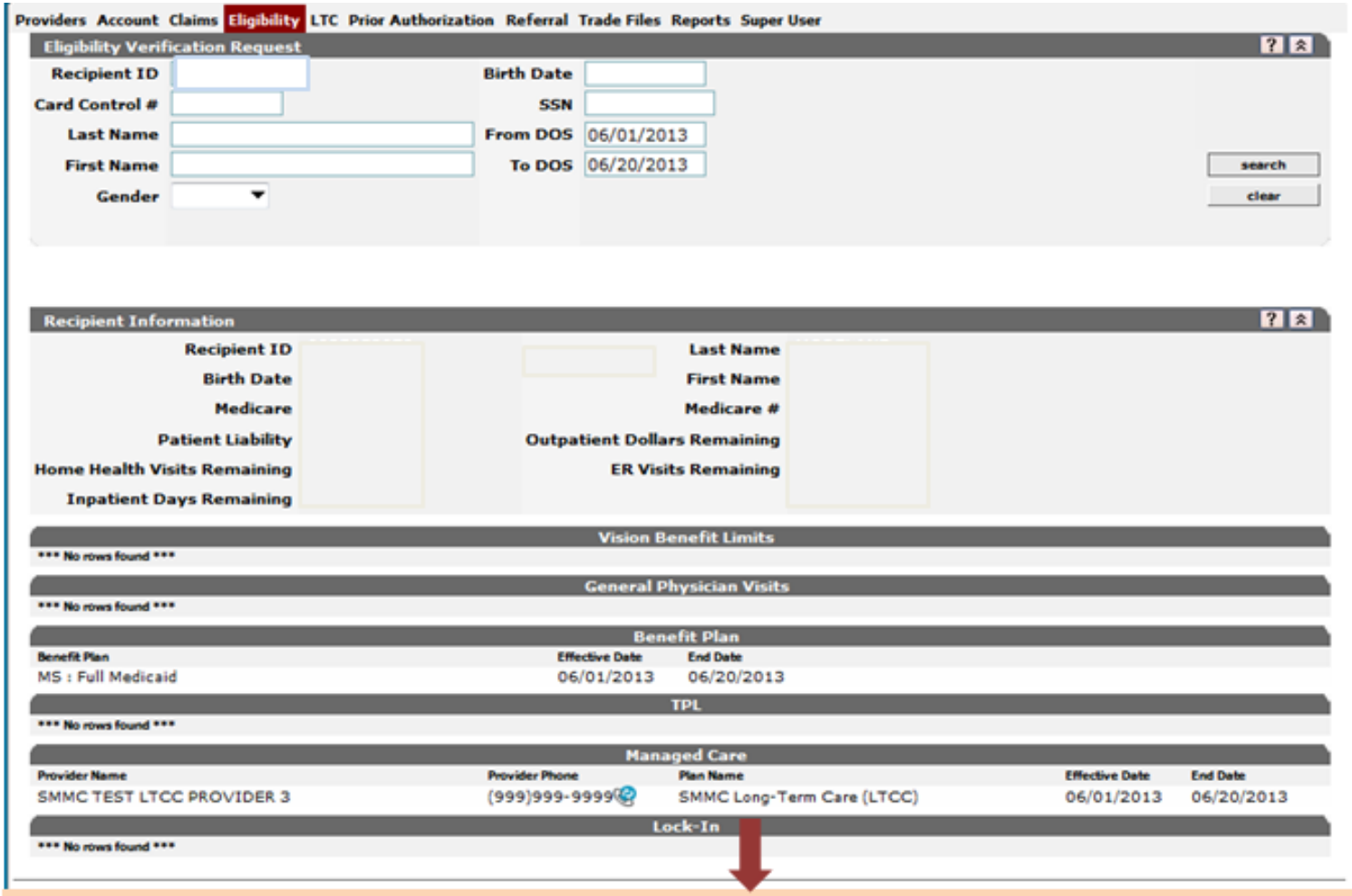
How will Claims be Impacted with Only MEDP or SIXT?

- If an institutional provider submits a fee-for-service claim directly to the Medicaid fiscal agent for a recipient with MEDP or SIXT, the provider's claim will be denied with EOB code 4227 "This Revenue Is Not Covered for This Member."

How will Claims be Impacted when the Recipient has MEDP or SIXT?

- If a provider receives either EOB code 0260 or 4227, the provider should verify eligibility and contact the LTC plan noted in the verification response for claim submission and payment.

Important Tip when you Verify Recipient Eligibility for the Long-term Care program

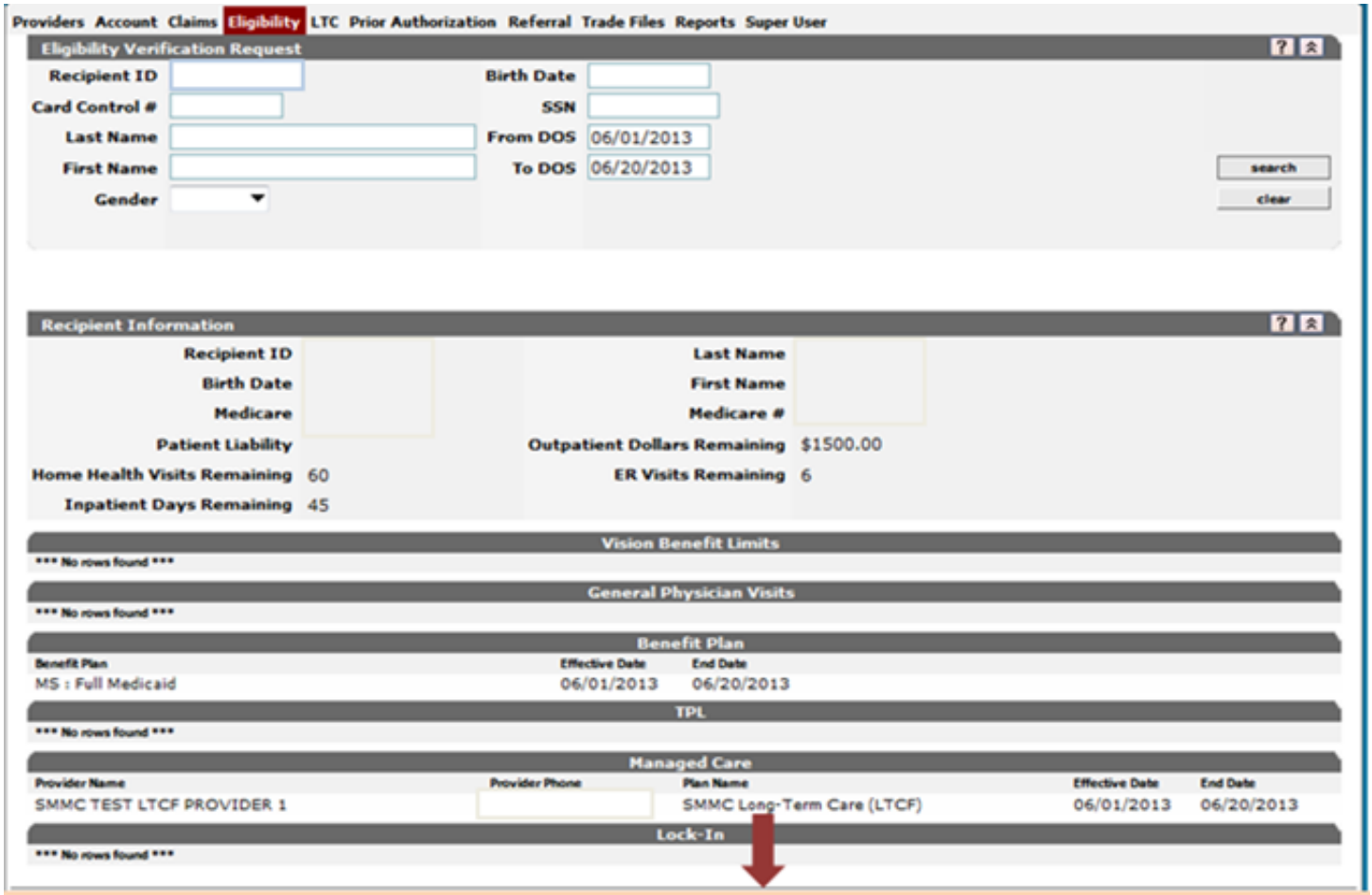


Check the bottom of the screen under MANAGED CARE, PLAN NAME for:

SMMC Long-Term Care (LTCC)

This indicates that recipient is enrolled in a capitated Long-term Care plan

Health Maintenance Organization (HMO)



Check the bottom of the screen under MANAGED CARE, PLAN NAME for:

SMMC Long-Term Care (LTCF)

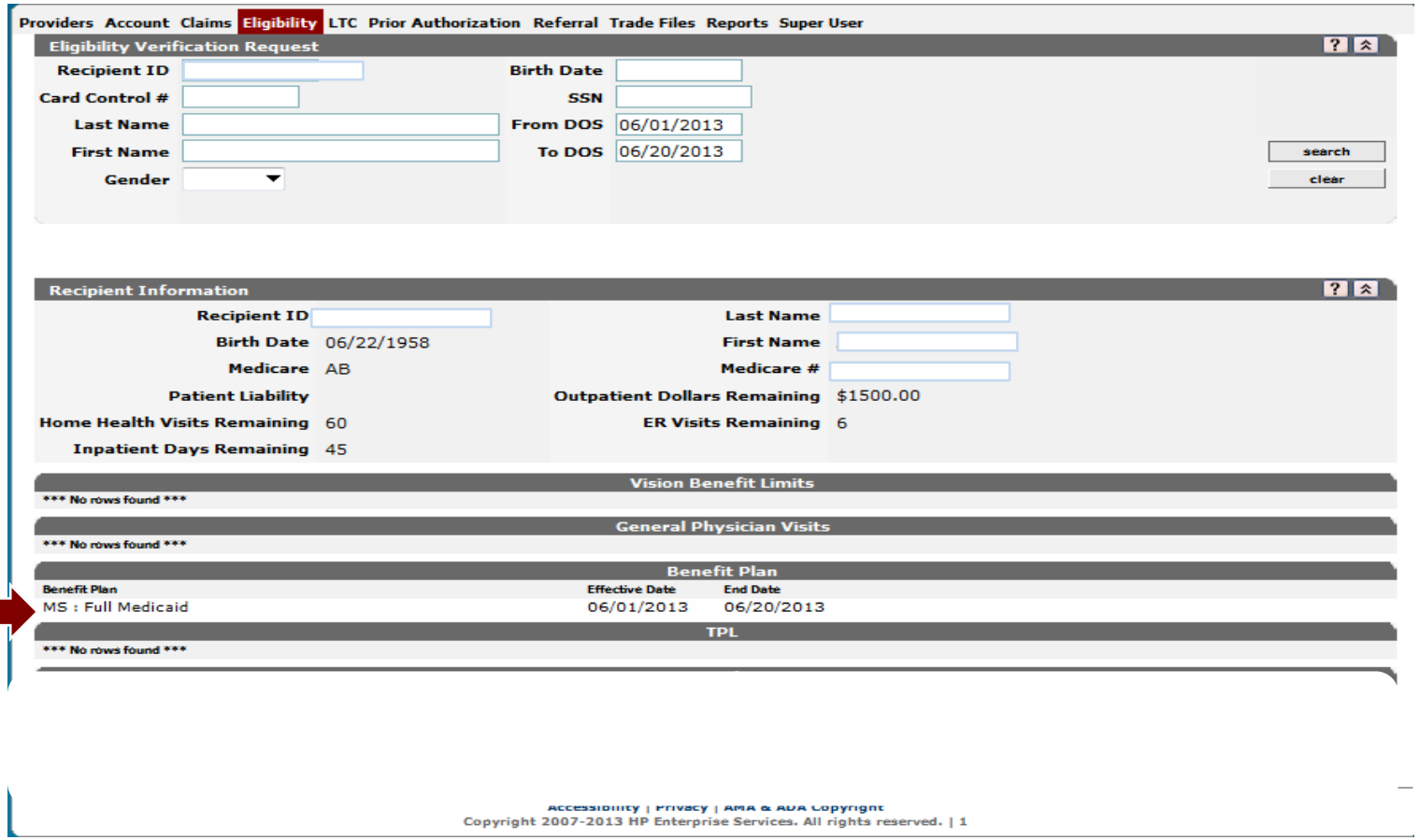
This indicates that recipient is enrolled in a fee-for-service Long-term Care plan, or a **Provider Service Network (PSN)**

Steps to Verify Eligibility

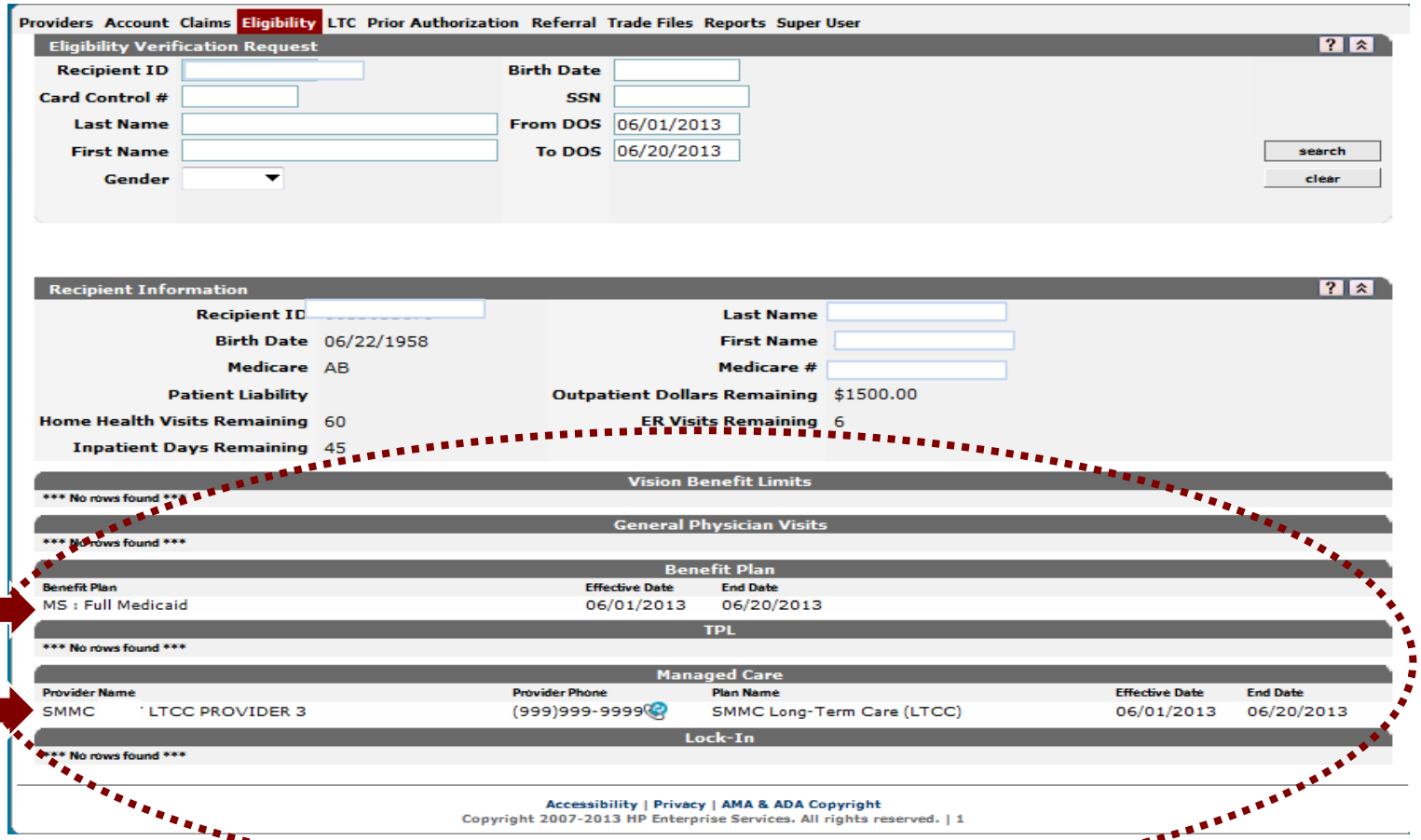
- Read and review all the eligibility information.
- Confirm whether the recipient is enrolled in managed care or fee-for-service.
- Check whether recipient has full Medicaid coverage or limited benefits.
- Verify that the recipient is Medicaid eligible on the date of service and for the specific Medicaid service.

Read and review all the eligibility information.

Sample of resulting error when **only** the first lines are read when verifying eligibility.



Sample of resulting error when **only** the first lines are read when verifying eligibility.



Managed Care Coverage

A provider must verify whether the recipient is enrolled in a Long-term Care plan or fee-for-service prior to delivering services.

Managed Care Enrollment Verification

- Eligible SMMC Long-term Care recipients are enrolled in HMOs or a PSN and required to use a provider contracted in the provider network for all the Long-term Care program services.
- The provider must have a contract with the managed care plan.
- The provider must contact the managed care plan to receive authorization to provide services.
- LTC program-covered services provided to recipients enrolled in managed care should be billed to the Long-term Care plan directly.

Verify that the recipient is Medicaid eligible on date of service and for the specific Medicaid service.

SUMMARY

When Verifying Medicaid Eligibility Answer the Following Questions:

- Did you accurately check recipient eligibility?
- Is the recipient currently enrolled in Managed Care?
- Does the recipient have LTC coverage?
- Is the recipient eligible for the date of service and the specific Medicaid service?
- Do you have authorization from the LTC plan prior to rendering services?
- Did you document the verification of recipient eligibility?

Resources

- Questions can be emailed to: FLMedicaidManagedCare@ahca.myflorida.com
- Updates about the Statewide Medicaid Managed Care program are posted at: www.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.

Additional Information

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