FHCA 2019 Annual Conference & Trade Show

CE Session #24 – Hiking Through Assisted Living Facilities: Medicaid Muddy Waters and More

Monday, August 5 – 7:00 to 8:00 p.m.

Celebration 9-10 – Assisted Living

Upon completion of this presentation, the learner will be able to:

- Provide light on assisted living facilities Medicaid Reimbursement and Funding
- Provide useful and simple information to better understand and navigate Medicaid benefits and payments for assisted living facilities
- Provide additional knowledge and resources related to assisted living Medicaid

Seminar Description:

This session will provide a basic overview of Medicaid in the assisted living environment under the Statewide managed care model. Explore the formula applied for assisted living facilities Medicaid managed care reimbursement and focus on funding changes if any and position for future magnification to find the money. Many takeaways will be provided to explore the challenges of understanding both Medicaid and Medicare benefits for the novice and intermediate adventurers.

Presenter Bio(s):

Julie Kemman has over 27 years of experience working within the long term care community. Julie holds a Bachelor's in Business Administration from Northwood University and is also a Certified Professional Compliance Officer. Julie started her career in the skilled nursing center business office and has held regional and divisional financial positions. Julie is currently the CEO of Health Care Professional Consulting Services, Inc. (HCPCS) that began operations in July 2005. HCPCS provides a variety of business system and financial operation consulting services in addition to training and education.

Navigating the Muddy Waters of the Medicaid Program for Assisted Living Facilities

Presented by:
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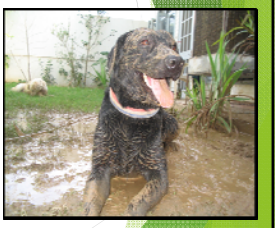
Health Care Professional Consulting Services, Inc. dba HCPCS, Inc.

Learning objectives

- Understand the Florida Medicaid Program including:
  - Overview of Managed Medicaid Program and it's changes for 2018-2023.
  - Enrollment types
  - Credentialing and Contracting Processes
  - Claims Management
  - Upcoming Changes



MANAGED MEDICAID PROGRAM OVERVIEW

- Medicaid Basics
- Determining Eligibility and Patient Responsibility
- Medicaid Fiscal Intermediary

Florida Medicaid Stakeholders

- The Medicaid Program is administered by the Agency for Health Care Administration (AHCA).
- The Department of Children and Families (DCF) determines recipient eligibility for Medicaid.
- DXC Technologies processes Fee for Service claims and manages the Florida Medicaid web portal known as Florida Medicaid Management Information System.

State Medicaid Managed Care (SMMC) Stakeholders

- Statewide Medicaid Managed Care program (SMMC)
  - AHCA contract procurement awards Managed Care Companies to coordinate care and provide services to Medicaid eligible recipients.
  - Managed Care Companies pay ALF for their care under the Home and Community Based Services Program (HCBS) linked to the LTC Program for ALF.

Florida Medicaid Facts

- 2018 Snapshot of Statewide Medicaid Managed Care program (SMMC) enrollment.
  - 3.1 million enrollees receive services through 16 Medicaid health plans.
  - 3 million in MMA health plans including Dental services, also Includes specialty plans
  - 100,000 in LTC or Comprehensive health plans

Florida Medicaid Facts

- 1 of 9 Adults ages 19-64
- 2 of 5 Children
- 4 of 7 Nursing Home Residents
- 2 of 5 Individuals with Disabilities
- 1 of 5 Medicare Beneficiaries

Statistics from Kaiser Family Foundation

How the Reimbursement Flows

- Managed Care Plans receive monthly fixed amount for each member known as capitation payment rate.
- Medicaid Managed care plan is responsible for arranging and paying for all covered services regardless of the cost.

State Medicaid Managed Care Program Types MMA & LTC

- Statewide Medicaid Managed Care (SMMC)
- Two Types of integrated SMMC Plans
  - Managed Medical Assistance Program (MMA).
  - Long Term Care Medicaid (LTC)
- All programs offer minimum required services mandated by the state.

State Medicaid Managed Care Program Types MMA & LTC

- Each plan can offer additional services below outlines the state mandated minimum benefits:
  - Bed Hold
  - Cellular Phone Service
  - Dental Services
  - Emergency Financial Assistance

State Medicaid Managed Care Program Types MMA & LTC continued

- Hearing Evaluation
- Mobile Personal Emergency Response System
- Non-Medical Transportation
- Over-The-Counter (OTC) Medications/Supplies
- Support to Transition Out of a Nursing Facility
- Vision Services

MMA covered services include:

- Advanced registered nurse practitioner services
- Laboratory and imaging services
- Ambulatory surgical treatment center services
- Medical supply, equipment, prostheses and orthoses
- Assistive Care Services
- Mental health services
- Emergency services
- Podiatric services
- Physician services, including physician assistant services
- Prescription drugs
- Hearing services
- Renal dialysis services
- Home health agency service

MMA minimum required covered services include:

- Nursing care
- Nursing facility services for enrollees under the age of 18 years
- Dental services
- Optical services and supplies
- Optometrist services
- Physical, occupational, respiratory, and speech therapy
- Respiratory equipment and supplies
- Hospice services
- Hospital inpatient services
- Substance abuse treatment services
- Hospital outpatient service
- Transportation to access covered services

MMA Additional Offered Services

- Influenza vaccine
- Outpatient hospital services
- Physician home visits
- Pneumonia Vaccine
- Influenza Vaccines
- Shingles Vaccines

State Medicaid Managed Care Program Types MMA & LTC

- Statewide Medicaid Managed Care (SMMC) Long term Care (LTC) program
  - Individuals must be enrolled in the Long-term Care program if they are:
    - A resident residing in an Assisted Living Facility and eligible for Medicaid. This would be administered through HCBS services.
    - 65 years of age or older AND needs a minimum ALF level of care.
    - 18 years of age or older AND are eligible for Medicaid by reason of disability AND needs minimum ALF level of care or hospice.

Minimum LTC covered services

- Adult companion care Intermittent and skilled nursing
- Adult day health care
- Assisted living
- Medication administration
- Assistive care services
- Behavioral management
- Nutritional assessment/ risk reduction
- Care coordination/ Case management
- Personal care Caregiver training
- Personal emergency response system

Minimum LTC covered services

- Assistive care services
- Medication management
- Attendant nursing care
- Nursing facility
- Hospice
- Transportation, Non-emergency
- Home accessibility adaptation
- Respite care
- Therapies: occupational, physical, respiratory and speech

SMMC Plan Changes and Benefits

- Dental is newly mandated benefit:
  - All Medicaid recipients are required to enroll in a dental plan whether they are enrolled in an MMA or LTC plan or are receiving their services through the fee-for-service system.
  - Three plans have been contracted to provide Dental program benefits. All plans operate within all regions of the state.
    - Liberty-Liberty Dental Plan of Florida
    - MCNA –Managed Care of North America
    - DentaQuest of Florida

Dental Benefits

- Dental program goals and benefits:
  - **5% average reduction** in Potentially Preventable Dental Related Emergency Department Visits by year one.
  - By year five the goal is to increase that to **9% average reduction.**
  - The goals are intended to be reached by providing:
    - Preventative, Diagnostic, Restorative, Periodontics, Oral Maxillofacial Surgery and Adjunctive General services.

Transportation Benefits

- SMMC Plans provide non-emergent transportation to Medicaid, Child Welfare and Long Term Care members.
- Residents should be encouraged to use their transportation benefit when traveling between their home, medical appointments, healthcare facilities and/or pharmacy.
- Transportation benefit is offered at no cost. No limit to the number of trips made during the year.
- Effective Florida HB11 effective 7/1/19 allows managed Care plans to contract with transportation companies (i.e Lyft and Uber) to provide non-emergent transportation to physician and dental appointments.
- Note: During an emergency 911 should be called.

HCBS Medicaid Program

- The Assisted Living Waiver serves adults with disabilities and frail elders when they:
  - Reside in specially licensed adult assisted living facilities and
  - Are at risk of placement in a nursing facility.
- Part of LTC SMMC program

HCBS Medicaid Program Enrollment

- In order for a provider to be reimbursed for rendering a home and community-based service (HCBS) to an eligible recipient, the provider must be enrolled as a HCBS Medicaid specific provider.
  - Aged and Disabled Adult Waiver.
  - The Aged and Disabled Adult Waiver serves frail elderly and adults with disabilities who are at risk of placement in a nursing facility.
    - Note: Medicaid has not changed the program codes to differentiate between Waiver & Diversion Programs.

HCBS Medicaid Program Waiver types associated with ALFs

- Aged and Disabled Adult Waiver
  - The Aged and Disabled Adult Waiver serves frail elderly and adults with disabilities who may reside in community and are at risk of placement in a nursing facility.
- Assisted Living Waiver
  - The Assisted Living Waiver serves adults with disabilities and frail elders who reside in assisted living facilities and who are at risk of placement in a nursing facility.

HCBS Medicaid Program Waiver Programs found in ALFs

- Nursing Home Diversion Waiver
  - The Nursing Home Diversion Waiver serves individuals 65 years and older who are dually eligible for Medicare and Medicaid and who are at risk of nursing home placement.

PROVIDER ENROLLMENT OPTIONS

Medicaid Provider Enrollment Options

- Limited Enrollment
  - Less tedious application/approval process.
  - The communities who only have residents assigned to health plan, Limited Enrollment is an acceptable option to get paid.
  - SMMC Plans may solicit this type of enrollment.

Medicaid Provider Enrollment Options

- Full enrollment
  - Fee-for-service providers must seek traditional full Enrollment in order to directly bill Medicaid for reimbursement.
  - Without full enrollment then other reimbursement from the SMMC Plans.
    - Full Enrollment allows Medicaid FFS payments
    - Required when a resident has lapse in Medicaid and/or not enrolled in LTC managed plan.

Medicaid Regions

Region 1: Escambia, Okaloosa, Santa Rosa and Walton

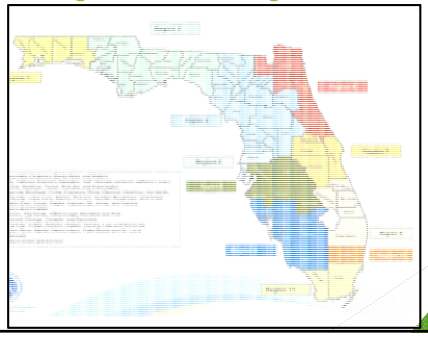
Region 2: Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, and Washington

Region 3: Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee, and Union

Region 4: Baker, Clay, Duval, Flagler, Nassau, St. Johns, and Volusia
Region 5: Pasco and Pinellas Region 6: Hardee, Highlands, Hillsborough, Manatee and Polk

Region 7: Brevard, Orange, Osceola and Seminole
Region 8: Charlotte, Collier, DeSoto, Glades, Hendry, Lee, and Sarasota
Region 9: Indian River, Martin, Okeechobee, Palm Beach and St. Lucie
Region 10: Broward
Region 11: Miami-Dade and Monroe

Regions and Coverage Areas

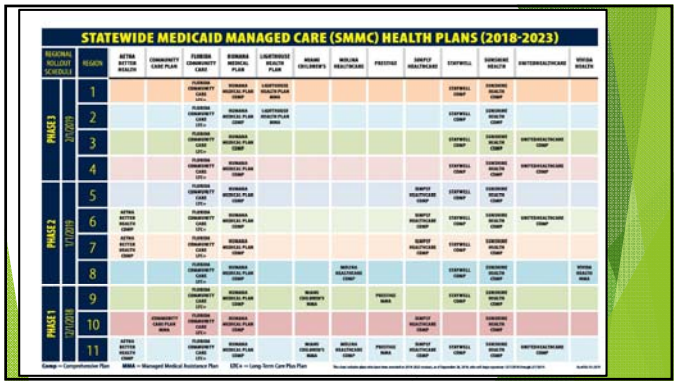


Credentialing with Managed Care Plans in your region.

- If New Medicaid Provider then once enrollment via AHCA is approved contracting is next step.
- Credentialing application and documents must be completed.
- Each Managed Care Plan has contracting and provider network representatives assigned to community within specific region.

Contracting with Medicaid Managed Care Plans

- Once credentialing is completed the contract will be finalized prior to be loaded into the Plans system for claim processing system.
- Contract should reflect published market rate of highest apartment.
- Note: Promotional rates should not be reflected for contracting purposes.



Managed Care Phone Numbers

- Aetna: 800-441-5501
- Clear Health Alliance: 844-405-4296
- Community Care: 855-819-9506
- Florida Community Care: 833-FCC-PLAN
- Humana: 800-477-6931
- Lighthouse Magellan Complete Care FL: 844-243-5181
- Molina Prestige: 855-322-4076

Managed Care Phone Numbers continued

- Positive: 888-456-4718
- Simply: 844-405-4296
- Staywell/WellCare: 866-334-7927
- Sunshine Health: 844-477-8313
- United Healthcare: 877-842-3210
- Vivida: 844-243-5175

RESIDENT ENROLLMENT & RECERTIFICATION

Medicaid application approval
Annual Medicaid recertification
Florida Medicaid Web Portal & DCF Provider View

Medicaid Application Process

- Medicaid eligible resident completes an application for the specified Medicaid program type they require.
- Department of Children determines eligibility and approves or denies application on varying criteria.
  - Financial: Income/Assets
  - Clinical: Level of Care
  - Timeliness of documents mandated or application closed/denied.

Verifying Eligibility

- The Florida Medicaid Management Information System has two separate sections.
  - AHCA Florida Medicaid Web portal.
    - Shows Residents Medicaid program codes (MW:A= AL Waiver or MI:I = Institutional Care Program)
    - This section also shows which plan the resident is enrolled and if the recipient has MMA, LTC, or both as well as other benefits information.

Verifying Eligibility

- The DCF Provider view
  - This section shows Medicaid application status and any items that are missing for approval
  - It also shows Medicaid approval status and if there is a patient liability or share of cost.

Patient Responsibility Vs. Share Of Cost

- Are "patient responsibility" and "share of cost" the same thing? No. While these terms are often used interchangeably, 'patient responsibility' and 'share of cost' are not the same.
- The term 'patient responsibility' is used to refer to the amount of the individual's income that the Department of Children and Families (DCF) determines is the amount the recipient must pay towards the cost of Medicaid long-term care services.
- The term 'share of cost' is used to refer to the amount of medical expenses the individual must incur before DCF can determine the individual eligible for the Medicaid 'Medically Needy' program.
- A recipient must submit the appropriate medical bills to the DCF before DCF can determine the individual has met their 'share of cost' and is eligible for the Medicaid 'Medically Needy' program.
- Managed Medical Assistance (MMA) and Long-term Care (LTC) plans have to use patient responsibility to determine and reduce payments to facilities.
- MMA and LTC plans must reduce payments to facilities by the amount of the enrollee's patient responsibility.

Patient Responsibility in ALF under SMMC LTC

- Key components in calculating patient responsibility
  - Income
  - Personal needs allowance (PNA)
  - Uncovered medical expense deductions (UMED)
- How does DCF calculate PNA?
  - Monthly amount for room & board that an ALF charges enrollee and adding 20% of the current year poverty level.
- 2019 Monthly Federal Poverty Level is $1041.00

Calculating Patient Responsibility in ALF under SMMC LTC

- To calculate patient responsibility DCF reduces their total gross income by the enrollee's PNA.
- $1700.00 Monthly ALF Room & Board All inclusive rate
- $208.00= 20% of Federal Poverty Level (FPL) $1041
- $1908.00 Personal Needs Allowance
- $1980.00 Monthly SSI check
- -1908.00 PNA (Monthly room & board & Monthly FPL)
- $0.00 UMEDs deduction
- **$72.00 Monthly patient responsibility.**

This is an example of a LTC enrollee and MCO monthly payment to an ALF.

- $1700.00 Monthly ALF R&B all inclusive rate
- -$1100.00 Max Managed Care Contract Reimbursement amount
- -$72.00 Patient responsibility
- **$1028.00 Payment due from MCO (ADL Assistance)**
- **Enrollee is responsible for difference between payment from MCO and monthly ALF R&B**
- **$672.00 is due from resident each month and may keep the remaining of the $1,980.00 income. $1,308 is for out of pocket expenses.**

Another Example

- To calculate patient responsibility DCF reduces their total gross income by the enrollee's PNA.
- $2750.00 Monthly ALF Room & Board
- $208.00= 20% of Federal Poverty Level (FPL)
- $2958.00 Personal Needs Allowance
- $3402.00 Monthly Income (SSI, Pension, etc)
- -2958.00 PNA (Monthly room & board & Monthly FPL)
- $104.22 UMED deduction (Insurance premium, other medical)
- **$339.78 Monthly patient responsibility.**

- To calculate patient responsibility DCF reduces their total gross income by the enrollee's PNA.
- $2250.00 Monthly ALF Room & Board
- $208.00= 20% of Federal Poverty Level (FPL)
- $2458.00 Personal Needs Allowance
- $889 Monthly Income (SSI, Pension, etc)
- -2458.00 PNA (Monthly room & board & Monthly FPL)
- $0.00 UMED deduction (Insurance premium, other medical)
- **$0.00 Monthly patient responsibility.**

Examples Continued

- $2750.00 Monthly ALF R&B
- -$1100.00 Max Managed Care Contract Reimbursement amount
- -$339.78 Patient responsibility
- **$760.22 Payment due from MCO**
- **Enrollee is responsible for difference between payment from MCO and monthly ALF R&B**
- **$1989.78 is due from resident each month and resident gets to keep $1412.22 for out of pocket expenses.**

- $2250.00 Monthly ALF R&B
- -$1100.00 Max Managed Care Contract Reimbursement amount
- -$0.00 Patient responsibility
- **$1100.00 Payment due from MCO (Calc is > greater = max)**
- **Enrollee is responsible for difference between payment from MCO and monthly ALF R&B – Must have $54/spending allowance**
- **$835 is due from resident each month. Resident gets to keep $54 for out pocket expenses (OSS).**

The Florida Optional State Supplementation Program

- Abbreviated as OSS, is offered by the Florida Department of Children & Families. It provides financial assistance to low-income seniors that cannot live independently and require residential care.
- Assistance comes in the form of a cash payment made directly to the individual that requires care or their legal guardian. It is intended for the room and board portion of the fees charged by the residence. Other assistance is available for care services.
- As of 2018, individuals are also allowed a personal needs allowance of $54.

Annual Medicaid Application Recertification Process

- The Medicaid eligible resident and SMMC Plan will receive notification form regarding annual recertification.
- This must be completed by the resident timely!
- Must include any assets, income, expense changes that could effect eligibility or patient responsibility.
- DCF provider view maintains enrollment & recertification data.

MEDICAID BILLING AND CLAIMS FOLLOW

Case Managers & Authorizations

- Make sure you have contact information for Plan case managers.
- Plan Case Manager is responsible for authorizations (care and hospital bed holds).
- Billing needs to match contracted billing codes and the billing codes need to also match authorizations
  - This will prevent denials.

Payment & Reimbursement Stakes

- Understand your Managed Medicaid contracts.
- Prepare clean claims.
- Submit Claims via web portal or through a claim system via 835p EDI file.
- If you send paper claims this will slow the payment roll…
- Submit claims timely according to contract terms.

Important ALF forms

- Client Discharge/Change Notice DCF 2506A
  - Within 10 working days of the Medicaid recipient's admission/discharge from/to a nursing facility, DCF must receive a completed DCF #2506A Form (Client Discharge/Change Notice).
  - Should be completed by ALF upon discharge and admission to rehab SNF.
    - Can be faxed to local DCF office. Link below provides each regions local fax #
    - https://www.myflfamilies.com/contact-us/
- DCF 1823 Resident Health Assessment form for Assisted Living Facilities.
  - Must be completed for each ALF resident

DCF form 2515 CERTIFICATION OF ENROLLMENT STATUS HOME AND COMMUNITY BASED SERVICES (HCBS)

- This form is required to be filled out by case manager of Managed care plan.
- This form allows reduction in patient responsibility when a resident transfers from post acute facility (SNF, Rehab).
- The published market rate for residents' room & board for semi-private needs to be entered on this form.

Managed plans Performance Measures and Complaints

- Plans performance are in part measured by recipient and provider satisfaction.
- If ALF Community has an issue with contract/payment and has billed correctly and timely.
- Plans satisfaction rates are measured and in part determined based on successful complaint resolution.

Provider Complaints

- Make attempt to resolve with plan
  - Document:
    - Who: Resident Name and Identification Number
    - What/Why: service authorization issues, incorrect patient responsibility, etc.
    - When: Dates of Service, Date of denial, etc.
  - When calling staff should always document the following:
    - Name of plan representative
    - Call reference number
    - Details of conversation
- Give the plan a chance to correct the issue before making a formal complaint.

Provider Complaints

- If Complaint is not resolved with plan:
- **Report a Complaint with Florida Medicaid**
  - ALF Community Medicaid provider may file complaint for various reasons.
  - AHCA addresses every complaint and monitors status.
  - Providers can submit a complaint:
    - Online at: www.flmedicaidmanagedcare.com/complaint/
    - Phone 1-877-254-1055

Provider Complaints

- **Escalated Claim Dispute Resolution Program:**
  - The Agency is contracted with MAXIMUS, an independent dispute resolution organization, to provide assistance to health care providers and health plans to resolve claim disputes. Application forms and instructions on how to file claims disputes can be obtained from MAXIMUS by calling 1-866-763-6395 (select 1 for English or 2 for Spanish) and then selecting Option 2.

CHANGES ON THE HORIZON

Effective July 1, 2019, AHCA is now responsible for rule making authority for assisted living facilities. SB 184 transfers the powers, duties, and functions of Department of Elder Affairs relating to assisted living facilities, hospices, adult day care centers, and adult family care homes to the Agency for Health Care Administration.

Transportation

- HB 411 by Rep. Danny Perez (R-Miami)/Sen. Jeff Brandes (R-St. Petersburg), which allows a transportation network company (TNC), such as Uber or Lyft, to provide non-emergency medical transportation to Medicaid recipients. TNCs will be required to follow the same rules required of other Medicaid transportation companies.
- This legislation, was effective July 1, 2019 with hopes to have positive impact due to more choices for reliable transportation under the Medicaid managed care system.

QUESTIONS

Disclaimer

Disclaimer: contain all information necessary or available, and although we have tried to include accurate and comprehensive information in this educational presentation, please remember it is not intended as legal, tax, business, financial or other professional advise.

Furthermore, this educational presentation is not inclusive of all of the updates, changes, rules and citation impacting your provider.

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Important Links

- http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/Managed%20Care/Streamlined%20Credentialing%20(Limited%20Enrollment).pdf
- https://ahca.myflorida.com/Medicaid/index.shtml
- http://ahca.myflorida.com/medicaid/review/specific_policy.shtml
- Home.flmmis.com

References

- Florida Medicaid Provider General Handbook
- MMA & LTC Program Snapshots
- AHCA SMMC Program information sheets
- AHCA's SMMC Overview 12/04/18 presentation.