FHCA 2019 Annual Conference & Trade Show

CE Session #28 – Hiking the Statewide Medicaid Managed Care Trail

Tuesday, August 6 – 2:00 to 3:00 p.m.
Celebration 5-6 – Finance/Development

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

- Learn about the changes implemented in the SMMC program including integration with the MMA program and the new dental program
- Obtain valuable information on best billing practices to make claims processing smooth and an easier life for your billers
- Understand how to ensure payments are prompt and correct to keep the cash flows flowing

Seminar Description:

Changes implemented with the Statewide Medicaid Managed Care (SMMC) program this year present many new challenges for Medicaid long term care providers. Providers are faced with the implementation of a new Dental Program component, continuity of care requirements, Managed Medical Assistance (MMA) integration as well as new developments for the SMMC program. This session will provide an updated overview of the SMMC and MMA components and introduce the new dental requirement so providers have the knowledge and understating necessary to succeed in the managed care environment. Topics will include best billing practices, impacts to provider payments and cash flows, the importance of the contracting and negotiating process and avoiding common pitfalls while hiking the managed care trail. Attendees will learn how the old and new managed care components function together, contract and negotiating opportunities and billing practices that will make their lives easier and keep cash flows flowing.

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.

Lorne Simmons is a Senior Healthcare Manager on the Healthcare Team at Moore Stephens Lovelace, P.A. (MSL) and is a member of the Firm's Senior Housing and Long-Term Care Practice Groups. He has over 20 years experience in long term care, 15 of which are with MSL. Lorne has presented at Florida Health Care Association's Annual Conference on nine previous occasions including a session on the most recent Medicaid Managed Care initial program in 2013. He serves as the primary author of MSL's monthly Florida Health Care Association Pulse column and blog posts. Lorne is a member of the Florida Health Care Association Reimbursement Committee and has presented internal webinars and training sessions on Florida's Medicaid Managed Care Program.

Hiking The Medicaid Managed Care Trail

Presented by:
Lorne Simmons, Moore Stephens Lovelace PA
Julie Ann Kemman, Health Care Professional Consulting Services, Inc.

Learning Objectives

- SMMC Changes
- Reimbursement and Medicaid PPS Issues
- Credentialing and Contracting
- MMA Reimbursement effective 1/1/2019
- UMED Program
- Qualified Medicare Beneficiary
- New Dental and Transportation benefits
- Provider Payment Issues & Trends

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SMMC Changes for LTC Providers

- NF Services covered under Managed Medical Assistance (MMA) Plans
  - Clinical and Financial Requirements
  - PASRR Completed
  - Resides in the Facility
- New Managed Care Plans (MCOs) for Each Region
  - Comprehensive Plans
  - Long Term Care Plus Plans
- Retroactive Settlements And Prospective Payment System (PPS) Impact

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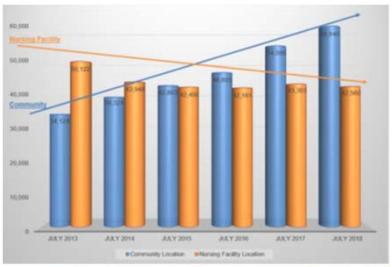
Transition Snapshot



Plans by Region

Plans by Region

Regions	Aetna	Humana	Molina	Simply	Staywell	Sunshine	United	FCC
Region 1		Comp			Comp	Comp		LTC+
Region 2		Comp			Comp	Comp		LTC+
Region 3		Comp			Comp	Comp	Comp	LTC+
Region 4		Comp			Comp	Comp	Comp	LTC+
Region 5		Comp		Comp	Comp	Comp		LTC+
Region 6	Comp	Comp		Comp	Comp	Comp	Comp	LTC+
Region 7	Comp	Comp		Comp	Comp	Comp		LTC+
Region 8		Comp	Comp		Comp	Comp		LTC+
Region 9		Comp			Comp	Comp		LTC+
Region 10		Comp		Comp	Comp	Comp		LTC+
Region 11	Comp	Comp	Comp		Comp	Comp	Comp	LTC+

Reimbursement Issues

- Retroactive Payments and Settlements
  - Still Effective for Days Prior to Oct 1, 2018
  - CHOWs and Cost Report Audits
  - After March 1, 2014 Settled With MCOs
  - Large Backlog on Settlements
- PPS Impact
  - No Retro Settlements Eff. Oct 1, 2018
  - New Providers assume effective rate at CHOW
  - No cost settlement on initial cost report or audits
  - Audit Adjustments Made at Next Rebasing
- Downward Substitutions

Downward Substitution

- Definition

  Use of less restrictive or lower cost services than otherwise might have been provided and clinically acceptable to meet treatment objectives

  - MMA Enrollee Suffers an Injury or Illness Requiring Short-Term NF or Rehab Stay
  - MMA Plans reimburse for NF services in lieu of inpatient hospital care
  - Up to 30 days coverage
  - Rates are negotiated with MCOs through Contract

Contracting with Medicaid Managed Care Plans

- Letters of Agreement or Single Case Agreement for each resident as gap until contract finalized.
- Authorization for payment required for claims.
- Once credentialing is completed the contract will be finalized then loaded into the Plan system for claim processing.

Contracting & Credentialing with Managed Care Plans.

- Addendum for Medicaid Medical Assistance (MMA)
- Recredentialing documents must be completed.
- Each Managed Care Plan has Contract and Provider Network Representatives.
  - Contact information for Provider Reps
  - Care Plan for each Resident should be reviewed

Managed Medical Assistance (MMA)

- Contract Change Provisions for 2018-2023 Effective 1/1/2019
  - MMA (Community) benefits pays NF stay up to 120 days from date of admission.
  - New Medicaid approval is enrolled into a plan for MMA benefits initially then LTC benefits effective.

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Managed Medical Assistance (MMA)

- Scenario #1: The individual admitted to the NF is not Medicaid eligible and therefore is not a health plan enrollee.
- Scenario #2: Medicare NF stay for a dually eligible enrollee who is eligible for MMA benefits but is not eligible for LTC benefits.
- Scenario #3: The health plan authorizes the MMA benefit coverage of NF services in lieu of continued inpatient care.
- Scenario #4: The enrollee admitted to the NF for LTC is eligible for MMA benefits before effective for LTC benefits.

Managed Medical Assistance (MMA)

- Authorization is required to be on file with the Medicaid Plan.
- Split coverage months.
- New set of challenges.

What is an Uncovered Medical Expense Deduction (UMED)?

- Uncovered Medical Expense Deduction aka UMED is a credit (allowance) received for out-of-pocket medical expenses. *Reduces Patient Responsibility due to SNF*
- Individuals who receive Medicaid under ICP, Hospice, HCBS Waivers (iBudget, SMMC LTC only) or PACE Program and have a patient responsibility are eligible.
- Calculation of medical expenses paid within the past six months are used to get an estimate of the medical costs expected to occur over the next six months as a projection period.

What Type of Medical Expenses can be Deducted under UMED?

- Deductible expenses including health insurance costs such as premiums, deductibles and co-payments (out-of-pocket).
- Medically Necessary Medical Services & Items:
  - Dental, Hearing/Audiology, Vision, Therapy, OTC, Vitamins, Nutritional and Incontinence.
- Nursing facility Private balance may have UMED calculated for costs prior to Medicaid effective date related to no retro eligibility.

What is required for UMED?

- Recipients must notify the DCF of (paid or unpaid) medical expenses for consideration.
- Proof of the expense with additional support of that balance may be required.
- New medical expenses and change of expense must be reported within ten days after receiving a bill/receipt.

More on Uncovered Medical Expense Deduction (UMED)

- Actual medical expenses paid verses the projection period are verified to reconcile.
- If projected amount is more/less than $120 the balance is averaged over the next projection period of 6 months.
- Process repeats every six months.

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Patient Responsibility vs. Share Of Cost

What is the difference between Share of Cost and Patient Responsibility? Terms are often used interchangeably while they are not the same.

- **Patient Responsibility** is used to refer to the amount of the individual's income that the Department of Children and Families (DCF) determines is paid towards the cost of Medicaid long-term care services.
- **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.

Qualified Medicare Beneficiary Program (QMB)

- QMB program is Medicaid benefit that covers low-income Medicare beneficiary to pay premium as well as deductibles, coinsurance within limits.
  - In 2015, 7.2 million individuals (1 out of 10 Medicare beneficiaries) were enrolled in the QMB program.
- All Medicare and Medicare Advantage providers and suppliers (not only those that accept Medicaid) must refrain from charging individuals enrolled in the QMB program for coinsurance and copays for covered services.
  - **Cannot collect private pay funds**

Overview of the SMMC Dental Benefit

- Where do these dental plans operate?
  - Every dental plan will operate statewide and provide statewide coverage. No more Medicaid fee-for-service (FFS) dental services.
- The Agency selected the following dental plans to operate statewide:
  - DentaQuest
  - LIBERTY
  - MCNA Dental
    - **Eligibility shows which Dental plan if effective for the recipient

Only the following recipients are NOT eligible to enroll in a dental plan:

- Individuals eligible through emergency medical assistance for aliens.
- Presumptively eligible pregnant women.
- Individuals enrolled in the Program of All-inclusive Care for the Elderly (PACE).
- Individuals eligible through the family planning waiver.
- Partial dual eligible (QMB, SLMB, QI1).
- Full dual eligible enrolled in a D-SNP or FIDE-SNP.

Changes to Transportation Benefit

- Medicaid plan pays under MMA plan for 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.
- No cost & No limit to the number of trips made during the year.
- 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.
- Uber & Lyft effective July 1, 2019 to provide more choices for transportation.

Provider Complaints

- **If you are unable to resolve your issue directly with the Managed Medicaid Plan -> File a Complaint**
  - AHCA addresses every complaint and monitors status.
  - Providers can submit a complaint:
    - Online at: www.flmedicaidmanagedcare.com/complaint/
    - Phone 1-877-254-1055
- **Escalated Claim Dispute Resolution Program:**
  - The Agency has contracted with MAXIMUS, an independent dispute resolution organization, to aid 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.

Managed Medicaid Plans Performance Measures & Complaints

- SMMC performance are measured in part by recipient and provider satisfaction.
- Some examples of reason to file AHCA complaint by recipient or provider are issue with missed/late services, not getting authorization/care, contracting, claim payment issues and unhappy with services.
- All complaints are reviewed by Agency staff and strive for successful complaint resolution.

Medicaid Coverage Issues

- ALL Medicaid Eligibility or Application issues are addressed via Department of Children and Families (DCF).
- New Adult Medicaid designated help desk

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Medicaid Payment Issues

- Authorization
- Split Month Coverage
- Nuances with the Plans
- Billing Requirements
- Projects - Escalation
- AHCA Complaints

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QUESTIONS??

REFERENCES

- https://duneganlaw.com/
- https://ahca.myflorida.com/medicaid/statewide_mc/outreach_presentations.shtml
- CMS QMB Billing FAQ 9.19.2017 https://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2017-09-19-QMB-FAQ.pdf

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