



Medicaid Care Management Operations for Nursing Facilities

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AGENDA



- I. DHHS review of key program elements of Step 1
- II. Examples
- III. DHHS MCM program resources
- III. MCO Q&A Session with emphasis on:
 - Pharmacy
 - DME
 - Transportation
 - Care Management

I. Key MCM Program Elements

- Who is in Step 1? Step 2?
- What is the difference between “Mandatory”, “Voluntary” and “Exempt”?
- What services are in Step 1? Step 2?
- What services are included in per diem?
- What do Step 1 and 2 services mean to a nursing facility?
- How to find out which Health Plan a member is enrolled in?

Who is included in Step 1?



Everyone who is receiving Medicaid funded health care (with some exceptions):

- Some Medicaid beneficiaries are *voluntary* and can **“opt out”**:
 - Children in Foster Care
 - Home Care for Children with Severe Disabilities (Katie Beckett)
 - Children with Supplemental Security Income (SSI)
 - Dual Medicare and Medicaid eligible
 - Special Medical Services and Partners in Health Enrollees

Voluntary – or “opt out” participants – continue to receive regular (FFS) Medicaid.

- Option is time limited – after the first year (Step 1) these clients will be required to participate (in Step 2).
- Self-select 1 of the 3 Health Plans or “opt out” within the 60 day period or be autoassigned.
- Can change plans or “opt out” at any time in Step 1.

Exempt means these clients are not permitted to participate:

- Spend-down clients
- Recipients of Veterans Benefits
- QMB (Qualified Medicare Beneficiaries)
- SLMB (Special Low Income Medicare Beneficiaries)
- QDWI (Qualified Disabled Working Individual)

These clients *do not have to do anything* and remain exempt in Step 2.

Remaining Medicaid clients are *mandatory* – they are required to participate.

- Must select 1 of the 3 Health Plans within the 60-day period or they will be auto assigned.
- Mandatory participants have 90 days to switch Health Plans; next opportunity to switch is at the Annual Open Enrollment period.
- MCM becomes *mandatory* for everyone receiving Medicaid in Step 2 (one year after Step 1).

What does participation status mean for a nursing facility?



- Does not matter if the client resides in the community or in a nursing facility ... it is their participation status that determines whether or not they are in a Health Plan and included in Step 1.
- A facility could have residents in all 3 categories of participation, including residents whose participation status may change.

What services are included in Step 1?



- Physician visits
- Inpatient and outpatient hospital
- Pharmacy
- Behavioral Health Services
- Family Planning
- Home Health Services
- Speech Therapy
- Physical Therapy
- Occupational Therapy
- Audiology Services
- DME
- Personal Care Services
- Private Duty Nursing
- Adult Medical Day Care
- Ambulance Services
- Wheelchair Van
- Optometric Services
- Fluoride varnish by a physician (for children)

NOTE: Step 1 MCM participants receive *medical* services through their Health Plans.

Children's Dental Services are not part of MCM.

What services are included in Step 2?



- Long-term Care Services

Those services included in the Nursing Home per diem rate (set by DHHS).

- Home and Community Based Waiver Services (HCBS)

- Individuals with Developmental Disabilities (HCBS-DD)
- Individuals with Acquired Brain Disorder (HCBS-ABD)
- Children with Developmental Disabilities In-Home Supports (HCBS-IHS)
- Choices for Independence (HCBS-CFI)

What services are included in per diem?



- Refer to “Services Associated with the Nursing Facility Per Diem, 2/20/14” handout
- MCOs are not responsible for the costs of these services
- NFs remain responsible for providing these services/products

What do Step 1 and Step 2 services mean to a nursing facility?



- In Step 1, some residents are enrolled in a Health Plan and will receive their medical services (those services outside the per diem) through their Health Plan.
- In Step 1, the facility will continue to receive their per diem rate from NH Medicaid.
- The facility per diem will be included in Step 2.

How to find out which Health Plan a resident is enrolled in?



- To learn about a resident's Health Plan enrollment, use one of these methods:
 1. Online through the Xerox MMIS Health Enterprise Portal
 2. Electronic 270/271 enrollment transactions
 3. Automated Voice Response (AVR)
 4. Contact the Xerox NH Provider Relations Unit at (603)0223-4774 or (866)291-1674

II. Examples



- What is the role of the PCP? Medical Director?
- Who is authorized to speak to the Health Plan on behalf of a resident?
- What arrangements are made for leave of absence medications?

What is the role of the Health Plan PCP? NF Medical Director?



Health Plan PCP

- Residents enrolled in a Health Plan are routinely assigned a network PCP
- Residents are eligible to receive services from network PCPs via office or NF visits
- PCP services will be billed directly to the Health Plan

NF Medical Director

- NFs continue to be responsible for services specified in He-E 806.07
- Medical Directors do not need to enroll in the MCO health plan networks
- Services performed by NF Medical Directors are reimbursed by DHHS via the per diem rate

Who is authorized to speak to the Health Plan on behalf of a resident?



- All existing privacy requirements remain in effect: Only those with designated authority may speak/act on behalf of a resident
- General information exchanges between NFs/Health Plan about “process” or “what if” scenarios are permissible
- It’s a two way street: Without documented authority NFs cannot provide Health Plans with resident information and Health Plans cannot provide NFs with member information
- Residents without a legal guardian may designate authority to NF by completing documentation provided by the respective Health Plan – forms are available on the Health Plan website
- NFs should proactively work with guardians/family members/other caregivers to arrange for necessary authorization.
- Health Plans proactively should work with guardians/family members/other caregivers to arrange for necessary authorization.

What arrangements are made for leave of absence medications?



- LOA medication for NF residents is a covered benefit in the MCM program
- Health Plan pharmacy services must provide LOA medication dispensing
- Health Plans should provide NFs with process guidelines and appropriate contacts to facilitate LOA pharmacy dispensing

II. DHHS MCM Program Resources



The Recipient Participation Guide

<http://www.dhhs.nh.gov/ombp/caremgmt/documents/recipient-participation-guide.pdf>

MCO Provider Claims Submission Requirements

<http://www.dhhs.nh.gov/ombp/caremgmt/documents/mco-claims-submission.pdf>

Quick Reference Guide

<http://www.dhhs.nh.gov/ombp/caremgmt/documents/provider-handbook-mbp.pdf>

Paired with Quick Reference Guide:

MCM Operations: Managing Business Processes (Webinar and Slide Decks, plus Q&A)

<http://www.dhhs.nh.gov/ombp/caremgmt/media/video-11222013.htm>

DHHS Program Resources (cont.)



September and October Training Sessions:

How to Assist Your Clients (Webinar and Slide Decks, plus Q&A)

<http://www.dhhs.nh.gov/ombp/caremgmt/media/video-10092013.htm>

Additional Q&A Postings:

MCM Provider Question and Answer #1

<http://www.dhhs.nh.gov/ombp/caremgmt/documents/provider-qa.pdf>

MCM Provider Question and Answer #2

<http://www.dhhs.nh.gov/ombp/caremgmt/documents/provider-qa2.pdf>



QUESTIONS ???