Medicaid Care Management
Operations for Nursing Facilities

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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

MCO Provider Claims Submission Requirements

Quick Reference Guide

Paired with Quick Reference Guide:
MCM Operations: Managing Business Processes (Webinar and Slide Decks, plus Q&A)
http://www.dhhs.nh.gov/ombp/caremgt/media/video-11222013.htm
September and October Training Sessions:

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

http://www.dhhs.nh.gov/ombp/caremgt/media/video-10092013.htm

Additional Q&A Postings:

*MCM Provider Question and Answer #1*


*MCM Provider Question and Answer #2*

QUESTIONS ???