Nursing Facilities Webinar - July 2015
Chat Q&A

QUESTIONS ABOUT LOC CODES

Q: We have been having issues with incorrect LOC codes for our facility. Who should I work with to get this corrected?

Q: We have sent information on seven residents with incorrect data in CHAMPS. The info was sent in early June and resident records are still not corrected. Now we're at 25 residents with incorrect records. Where can we go as a second level? If the files are incorrect, we cannot receive payments.

Q: When a MI Health Link beneficiary disenrolls from the ICO how do we get the LOC 02 put back on?

Q: Families have brought in letters indicating they have disenrolled and CHAMPS shows no level of care now. How long before we see a resolve and who do we work with? Our local DHS office has done all they can and stated we needed to work with provider services which we have but we are now on month two with no resolve. What is the next step?

A: All of the questions above are related to LOC issues. We appreciate your patience as we work through some system issues that come with any new program. These LOC issues must be corrected on an individual basis. We have a specialized team that is working to quickly resolve LOC issues. Please send an email with the description of the issue and ONLY the Medicaid number of the individual who is having an LOC issue to: MSA-MHL-Enrollment@michigan.gov.

QUESTIONS ABOUT PAYMENT/REIMBURSEMENT

Q: Why were we not paid for the OBRA Training and Testing part of our Medicaid rate from our ICO?

A: We believe you are talking about the NATCEP portion of the Medicaid room and board. We investigated this issue and have learned that the NATCEP component was not included in the initial rates released to the plans in March 2015. We have received updated rates from the Reimbursement and Rate Setting Section and they have been distributed to the ICOs. Facilities should contact the ICO for a corrected payment.
ICO Contact list:
http://www.michigan.gov/documents/mdch/MI_Health_Link_ICO_Provider_Contracting_Contact_List_482398_7.pdf

Q: Our ICO paid us less than we expected. The QAS and room rate do not agree with the rate letters, etc. we have received. How can we correct that?

A: Facilities can provide a copy of their MDHHS rate letter to the ICO for verification of payment, as the rates are only released quarterly to the ICOs.
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Q: Will the QAS be included in the daily rate reimbursement, or will we get a lump QAS payment?

A: The QAS is included in the daily rate reimbursement.

Q: Why are only 90 days not being taxed instead of the full 100?

A: The 90 days is related to the ICO payment from the MDHHS. It is not based on the payment from the ICO to the nursing facility.

Q: How will we know where a beneficiary is in their 100 day benefit? Will these Medicare type days be deducted from the benefit days on the CWF (common working file)?

A: SNFs serving MI Health Link enrollees are expected to follow the current Medicare Advantage rules related to submitting no pay claims for the purposes of tracking skilled services provided under the Medicare SNF benefit. This is further outlined in section 90.2 of Chapter 6 of the Medicare Claims Processing Manual (which can be accessed at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c06.pdf). Section 90.1 of the guidance also addresses when someone opts-out of Medicare Advantage (and since dual eligible individuals may disenroll from Medicare Advantage plans on a month-to-month basis as well, this would also apply under the demos.)

Q: Is the ICO required to pay the entire Medicare rate during a co-insurance day less any patient pay?

A: The ICO establishes its own Medicare rates with each nursing facility, but is required to pay the Medicaid co-insurance rate after the PPA has been exhausted.

Q: Does MDHHS pay the nursing facility the co-insurance amount during the first 100 days of a skilled/Medicare stay, or is the amount included in what the ICOs are reimbursed?

A: In accordance with the three-way contract, the ICO is responsible to pay the nursing facility for co-insurance days starting on day 21 of a skilled or rehab stay at the current Medicaid rate for co-insurance days.

Q: If the ICO doesn't pay the co-insurance can we put it in the cost report for reimbursement?

A: No, the co-insurance cannot be included on the Medicaid cost report for reimbursement. This issue should be reported to MDHHS by e-mailing Integratedcare@michigan.gov. Please include the beneficiary ID number, the plan name and the dates of services for which the co-insurance days were billed and payment was not received.

Q: When someone is in their 90 day skilled nursing benefit, is there a Patient Pay Amount.? I was told at a conference that there would not be a PPA, but that person was determined to have a PPA.

A: Yes, residents are responsible for meeting their deductible (paying the PPA to the nursing home) before they are eligible for Medicaid services. The nursing home would collect the PPA starting the 21st day of a skilled/rehab stay or at the first of the month for a custodial stay.

Q: There have been issues with PPA dropping off of CHAMPS. Who do we work with to correct this?

A: Please send an e-mail with the beneficiary ID only and the PPA issue to MSA-MHL-Enrollment@michigan.gov.

Q: Doesn't MI Health Link cover dental and vision? Why offset the PPA?

A: MI Health Link does cover the State Plan services for dental and vision. There may be a charge for additional services beyond the Medicaid dental and vision coverage. That additional amount can be used to offset the PPA.

Q: When a MI Health Link beneficiary elects hospice during the month, is the nursing home or the hospice agency responsible for billing the room and board for the remainder of the month to the ICO plan?

A: We are seeking clarification from CMS on this issue.

Q: Would we still have to do no pay claims to Medicare?

A: Yes, the nursing facility should continue to submit the no pay claims to CMS so the CWF can be updated to track the resident's Medicare day utilization.

Q: Our concern is payment. Two months into the program has been billed and payment has only been received for one resident in May.

A: Please contact the ICO to resolve payment issues.
ICO Contact list:
http://www.michigan.gov/documents/mdch/MI_Health_Link_ICO_Provider_Contracting_Contact_List_482398_7.pdf

QUESTIONS ABOUT CARE COORDINATORS

Q: How do we get in contact with the Care Coordinators?

A: Contact your ICO – Contact list:
http://www.michigan.gov/documents/mdch/MI_Health_Link_ICO_Provider_Contracting_Contact_List_482398_7.pdf

Q: When are care coordinators supposed to be contacting their client to introduce themselves?

A: Some ICOs have elected to conduct early assessments which can begin as soon as 20 days prior to the enrollment effective date. The ICO must complete the Level I assessment (either in person or via the telephone) within 45 days of enrollment. We have suggested that the ICO Care Coordinator contact the nursing facility in advance of a visit to coordinate the meeting with the family or guardian. The resident may choose to have others, including facility staff, participate in this meeting.

Q: Is it true that care coordinators assist with Medicaid redeterminations? If so, do they help with follow up if needed?

A: The beneficiary remains responsible for the Medicaid redetermination, but the three-way contract does require that the ICO Care Coordinator assist the beneficiary in submitting appropriate materials timely for the redetermination process. Redetermination should be discussed during a care conference or care coordination meeting to assist the beneficiary or responsible party in submitting materials prior to the redetermination due date.

QUESTIONS ABOUT ENROLLMENT

Q: What will happen with new residents who are already Medicare but have new Medicaid eligibility? Will they be enrolled in the ICO or will they remain Medicare/Medicaid?

A: If a person in a nursing home becomes eligible for Medicaid and already has Medicare, the person can opt into MI Health Link. An on-going passive enrollment process is being developed and it will require the 60 and 30 day notices before a person is passively enrolled.

Q: We have residents who received opt out confirmation letters dated April and May 2015, but were enrolled in MI Health Link on June 1, 2015. Who would I contact to fix this issue?

A: If the intention was to both opt out and to cancel an enrollment, then the beneficiary should call the call center. The opt out only takes them out of passive enrollment.

Q: So are you saying if a person gets new Medicaid, they need to then opt out of MI Health Link if they don't want it?

A: If a person receives a passive enrollment letter and does not want to be enrolled in MI Health Link they can call Michigan ENROLLS to cancel the passive enrollment AND opt out of future passive enrollments. http://www.michigan.gov/mdch/0,4612,7-132-2945_64077-353802--,00.html

Q: Are the enrollees going to get cards? We have not seen any.

A: The ICO is responsible to mail a welcome packet with a new MI Health Link ID card to each enrollee. If the enrollee has a guardian or responsible party listed in CHAMPS, the packet could be mailed to that address and not the nursing home. Please check with the guardian or responsible party. You may also call the plan to assist the enrollee in requesting a card if it was mailed to the home and did not reach the enrollee.

Q: I thought I saw on the MDHHS website that nursing facility residents would be passively enrolled October 2015, not September.

A: No, the nursing facility residents in Wayne and Macomb counties will be passively enrolled with an effective date of September 1, 2015.

Q: We've noticed a lot of our hospice residents are being enrolled into ICOs. How are they checking beneficiaries when they decide to enroll them?

A: If the beneficiary was coded for Hospice at the time of passive enrollment, the beneficiary would not be eligible for MI Health Link enrollment. Often, we are seeing the beneficiary selected for passive enrollment and before the enrollment is effective, the beneficiary is electing Hospice services. These situations should be e-mailed to MSA-MHL-Hospice@michigan.gov for disenrollment, as the beneficiary is not eligible for the program. Please only include the Medicaid ID and the date of Hospice election.

QUESTIONS ABOUT ADMISSIONS

Q: When a MI Health Link enrollee living in the community is directly admitted to a SNF, would they be considered ICO-Medicare?

A: Yes, the new admission would be reported as ICO-Medicare days.

Q: Our facility is still waiting on authorization approvals and we couldn't just let the resident stay at the hospital while waiting for an authorization from the ICO. How do we get these authorizations done in a timely manner? We are told it can take up to 14 days for approval.

A: Please e-mail details of these issues (include only the Medicaid ID number to identify the beneficiary) to the INTEGRATEDCARE@michigan.gov e-mail box so we can have the contract manager contact the ICO to discuss the need for faster authorization.

Q: Do we send the MSA-2565-C to DHS and the Care Coordinator?

A: Facilities must continue to submit the MSA-2565-C to the local MDHHS office. A copy being mailed or a phone call to the Care Coordinator would also help with communication of admission to the nursing home. Only MDHHS local staff can establish the PPA.

Q: How will it work when a resident is admitted and only needs a level of care 02 and has a PPA? Would the ICO take over first or Medicaid?

A: If the beneficiary is enrolled in MI Health Link at the time of admission to the nursing facility, the facility will submit the DCH-2565-C form to the local office for processing, which includes establishing the PPA and the LOC 05 or 15 coding. The nursing facility would bill the ICO for services.

If the beneficiary is not enrolled in MI Health Link, the nursing facility will continue its normal process for fee-for-service Medicaid.

Q: You mentioned that individuals receiving skilled services do not need to be in dually certified beds but people receiving "custodial" care must be in a dually certified bed. What if a MI Health Link participant is not in a dually certified bed? Is the nursing home obliged to move the individual to a dually certified bed? What happens if they don't?

A: Nursing home residents who enroll in MI Health Link may stay in the current bed if it is not dually certified. We would always encourage the use of dually certified beds for dually eligible beneficiaries. If the resident needs custodial care following a rehab/skilled stay, the facility should move the resident to a dually certified bed if available with advance notice and choice of bed if possible, or the ICO should transition the person to the community with appropriate services. If a person is in a Medicaid only bed at the time of MI Health Link enrollment, the ICO must make arrangements for the person to receive skilled or rehab care or the person may choose to move to another facility with a dually certified bed. We are not able to correct the placement into a Medicare or Medicaid only bed that occurred prior to enrollment in MI Health Link. The contract does require the MI Health Link enrollee entering the nursing facility to be in a dually certified bed to avoid these issues. We are open to suggestions on how to best balance the needs of the beneficiary in these cases.

<u>60 DAY BREAK QUESTIONS</u>

Q: Does the 60 days basic rule apply like Medicare?

A: Yes it does. A beneficiary must have a 60 day break with no skilled or rehab care in order to qualify for a new Medicare stay of up to 100 days.

Q: In regards to the 60 days, currently with Medicare a resident who has not received skilled care for 60 days is entitled to a new benefit period after a 3 day hospital stay. If a resident has a 60 day break in skilled care will they be eligible for a new 90 day benefit with the health plans?

A: MI Health Link offers the same Medicare skilled/rehab benefit of up to 100 days. The 90 days is related to the payment to the ICO. The resident in this situation could qualify for a new Medicare stay of up to 100 days if the Minimum Data Set (MDS) assessment and physician order required skilled or rehab care.

Q: So, how is the 60 day break going to be tracked? Won't the CWF (common working file) need to get updated by the ICOs as they process and pay Medicare type bills?

A: The nursing facility would submit a no pay claim to CMS for a skilled/rehab day of care so the CWF can track the resident's use of traditional Medicare days of care paid for by the ICO.

GENERAL QUESTIONS

Q: Is UPHP able to re-assign PCPs that were randomly assigned to our residents?

A: An enrollee can select any PCP from the plan's network of providers. The enrollee or their authorized representative can contact the plan to do this.

Q: What about Medicare Part B benefits?

A: The ICO is responsible to provide the Medicare Part B benefits.

Q: Will therapy continue to send MSA forms or go directly through the ICO?

A: Authorization requests for therapy services should be submitted directly to the ICO.

Q: The ICOs have a different timely filing limit than Medicare and Medicaid? An ICO says their timely limit is 180 days. Medicare and Medicaid both currently give us one year.

A: Yes, managed care plans can set filing limits such as 180 days.

Q: How do we know when the ICOs are to follow Federal Medicare rules and when the ICOs can establish their own rules? For instance, if they can waive the 3 night stay and are not obligated to follow one year timely filing rule how do we know what else can differ from Medicare guidelines?

A: The three-day hospital stay is waived as a condition of this demonstration by CMS. Managed care plans, the ICOs, can establish rules around operations such as timely filing and payment. The ICO rules should be outlined in the provider contract that the nursing facility will enter into with the ICO.

Q: Is the skilled nursing benefit 90 days or 100 days like it is under traditional Medicare?

A: MI Health Link offers the Medicare benefit of 100 days of skilled or rehab care. The 90 days is for provider tax purposes and does not impact the Medicare benefit.

Q: You mentioned Medicare days are determined in 30 day segments, so the benefit for Medicare skilled services is 90 days. What happens to beneficiaries who continue to be eligible for the full 100 day Medicare skilled benefit? Is there a way for Individuals to receive those extra 10 days of skilled services?

A: The skilled care/rehab benefit is for 100 days and is based on medical necessity, as it is currently under Medicare. The ICOs must cover the Medicaid co-insurance days starting on day 21 until it is determined through the PPS/MDS assessment process that the person no longer needs skilled care or rehab, or the person exhausts the 100 days of skilled care or rehab. The person must have a 60 day break before they qualify again for another 100 days of skilled care or rehab.

Q: You mentioned that the medical expense deduction still works the same way as in traditional Medicaid. Do the other deductions and disregards also still apply? For example, is the home maintenance disregard (BEM100) still available to MI Health Link participants?

A: Yes, MI Health Link does not impact this option for Medicaid beneficiaries.