Ohio Medicaid in 2016

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CRISE REPLACEMENT SYSTEM

Ohio Benefits (Ohio Benefit Worker Portal)

- Web based system that will replace CRISE
- Nursing home and waiver cases will be the last to convert
- Counties are operating 2 computer programs
- Healthy Start family Medicaid cases have been converted
- Medicaid expansion (MAGI) cases are in Ohio Benefits system
- Target date for full conversion, 2016
- MITS does interface with Ohio Benefits
- Some individuals have a case in both CRISE and Ohio Benefits
  - Example: eligible for QMB in CRISE, but MAGI Medicaid in Ohio Benefits

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No Cost of Living Increase For 2016

- Social Security and Railroad Retirement benefits as well as Veteran's Administration Benefits did not change for 2016 so there was no COLA and no across the board patient liability changes.
- Other retirement benefits such as PERS and SERS may have changed January 1 so a new 9401 must be sent to the county if there was an income change.
- Personal Needs Allowance Account for individuals in an ICF-IID facility increased to $50.00 per month as of January 1, 2016.
- SSI payments did not increase so Assisted Living standards will remain the same for 2016 as they were in 2015.

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Register of Ohio – Medicaid Rules

Rules for Ohio Department of Medicaid

- http://www.registerofohio.state.oh.us/jsps/publicdisplayrules/processPublicDisplayRules.jsp?agencyNumberString=5160&actionType=all&doWhat=GETBYFILINGAGENCY&Submit=Search

OAC Rules

- http://codes.ohio.gov/oac Medicaid Eligibility
- http://codes.ohio.gov/oac/5160 Medicaid Providers

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Medicaid Spenddown

- Allows individuals who have income over the Medicaid eligibility threshold but otherwise meet the requirements for Medicaid under the aged, blind or disabled (ABD) categories to receive coverage.

- Individuals with income over the standard are assigned an amount of medical expenses they must incur each month (spend down) prior to receiving Medicaid benefits.

- Recipient can either:
  - Pay their spenddown to the county directly and receive their Medicaid card for the entire month or
  - Provide proof of incurred expenses and card is released on the date the spenddown is met.

The JFS 09401 should note the spenddown when applicable.
NF must collect the spenddown in lieu of PL if noted on the 09401.

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Conversion From 209 B to 1634

- ODM will be converting from a 209 (b) state to a 1634 state in 2016.
- SSI recipients will automatically be eligible for Medicaid.
- Medicaid eligibility criteria will change; the spenddown program will end.
- Resource limit will be $2,000.
- Medicaid Need Standard will parallel the SSI Standard.
- Nursing homes will be affected due to the requirement for a MILLER TRUST.
  - Residents with income over a certain dollar amount ($2,199) will have to put their funds in a Miller Trust.
  - ODM has contracted with Automated Health Systems to work with recipients in setting up a Miller Trust.
- Opportunities for Public Comment – Public notice for amendment of MyCare and waivers due to 1634 conversion; posted February 1, 2016 – comments due March 2, 2016.
  - http://medicaid.ohio.gov/RESOURCES/PublicNotices.aspx

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Miller Trust – Qualified Income Trust (QIT)

QIT– Key characteristics that make it different from other types of trusts:

- Can contain only the individual's income—lump sums would not be added
- Must be used for income only and cannot shield other assets
- Allows for money to be recovered by the State*
- Must be properly executed and name the State as a beneficiary
- Is irrevocable
- Cannot contain spousal or family resources; more complicated if there is a spouse with payment of a spousal maintenance needs allowance (MNA)

*The Trust should contain language such as, "Upon the death of the beneficiary, the trust assets shall be paid to the Medicaid agency of the State of Ohio up to the total amount of the Medicaid payments made to or on behalf of the beneficiary."

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Miller Trust – Step 1

State identifies impacted individuals and sends notification

Notifications are sent to individuals 90 days before program implementation.

- Explain the 1634 change and the individual's option to open a Qualified Income Trust
- Provide implementation timelines and when action needs to be taken
- Refer the individual to vendor for additional guidance

Individuals impacted by this change include:

- Individuals residing in a Nursing Facility or an Intermediate Care Facility
- Individuals participating in a Home and Community Based Service waiver
- Multiple notifications may be sent to individuals to inform them of 1634 changes and remind them to take action

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Miller Trust – Step 2

Vendor provides education and assistance to these individuals

- Vendor contacts individual and determines if they need a Qualified Income Trust
- Vendor educates individuals about Qualified Income Trust, including:
  - Qualified Income Trust Requirements
  - Implementation timeline and when action must be taken
  - State approved Qualified Income Trust form
- Vendor provides assistance with establishing a Qualified Income Trust, including help filling out the Qualified Income Trust form.
  - Medicaid vendor provides these services at no charge to the recipient; not required to use the vendor; once a trust is set up the role with the vendor ends.

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Miller Trust – Step 3

Vendor assists individual with opening an account for trust deposits:

- Individual must create a bank account used exclusively for Qualified Income Trust deposits.
- Vendor assists individual in working with financial institutions to open an account for Qualified Income Trust deposits.
- The account can be opened in any bank that provides this service.
- Banks may charge a fee to administer the Qualified Income Trust account; bank fees can be paid from the trust - do not need to use resident's PNA account.
- Estimated that around 5,000 recipients will be affected.

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Miller Trust – Step 4

Trust information is provided to the county for eligibility processing

Individuals must provide:

- Proof that a Qualified Income Trust has been established
- The CDJFS office is responsible for documenting information and processing eligibility for the individual
- Not Medicaid eligible until the trust is set up

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Miller Trust – Step 5

Individuals make monthly deposits into trust:

- The individual is responsible for making monthly deposits into the Qualified Income Trust account.
- The monthly deposit amount is dependent on the individual's income and changes when income changes.

State monitoring:

- The State will establish a process to monitor monthly Qualified Income Trust transactions.

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Miller Trust – 1634 State

- Medicaid intends to send initial notification letters 90 days prior to the effective date of the Miller Trust - per Medicaid there is no guarantee of meeting the proposed July 1 effective date.
- The vendor will be tracking signed trusts by nursing facility. Pending Medicaid recipients that might require a trust will not be on the report generated by the state to the vendor - CDJFS caseworkers need to be educated on the process.
- Income is based on gross income and Medicaid eligibility cannot be given until the trust is signed AND money put in the trust. There will be no ability to authorize 3 months retro Medicaid benefits for applicants who must set up a QIT.
- There may be a need to apply unpaid NF bills to future liability as past medical since eligibility could be delayed.
- Budget process remains the same; patient liability is calculated using the same criteria.

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RUG III to RUG IV

- Ohio will use RUGs IV 57-group model using hierarchical classification.
- Will use December 2015 and March 2016 quarterly case mix scores.

As of July 1, 2016 the PA1/PA2 flat fee will go from $130.00 to $115.00 per day.

Facilities will be required to cooperate with the ombudsman when they are attempting to relocate residents who are PA1/PA2—proven failure to cooperate will reduce flat rate from $115.00 to $91.70 per day.

Statute requires that for a center to keep the higher rate of $115.00, ODM must be satisfied that the SNF is, "Cooperating with the long-term care ombudsman program in efforts to help the nursing facility's low resource utilization residents receive the services that are most appropriate for such residents' level of care needs." The intent of this language is that if the ombudsman chooses to work with a patient to help them transition to the community, the SNF cannot impede that effort.

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Medicaid Managed Care

- MyCare Ohio
- Medicaid—Traditional ABD
- Medicaid—Expanded/Extended

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Mycare Ohio

- 7 Regions in Ohio—29 counties participating
- 5 managed care plans: CareSource, Aetna, Molina, United Healthcare, and Buckeye.
- 3 Year demonstration
- ODM announced in January that the intent is to extend MyCare to December 31, 2019; 2 years beyond the current end date.
- If completed there would be no expansion of MyCare to new regions or counties until after the extended contract ends.

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MyCare Ohio Enrollment as of December, 2015

- Total statewide enrollment - 91,824

- 66% were opt in members

Enrollment by plan:

- CareSource leads with 22,556 total enrollees
- Aetna Better Health – 20,145
- United Healthcare – 18,540
- Molina Healthcare – 15,407
- Buckeye Health Plan –15,176

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MyCare Dually Enrolled

When a resident selects the MyCare plan for both Medicare and Medicaid, the plans process Skilled days based on RUGS. For coinsurance the plans vary in their processes.

- BUCKEYE: Process like Medicare PART A—after 20 days they track unpaid coinsurance and the following year will pay a percentage of coinsurance back to the facility—same % as Medicare pays toward bad debt. Plan will track the coinsurance and send a report to providers after the end of the year - review for accuracy, track coinsurance days and compare to the report. Following the report, reimbursement for the coinsurance will be made.

- CARESOURCE: Originally paid RUGs for all covered skilled days without deduction for coinsurance.

- New policy:
  - Has been applying coinsurance days to skilled claims.
  - Will be reprocessing the claims from 2015 that had coinsurance days applied with -0- payment—internal project—providers should not rebill.
  - For calendar year 2015, CareSource will handle the bad debt portion of the coinsurance by providing a one-time payment to SNF providers based on the Medicare bad debt rate of 65%.
  - 2015 SNF claims must be received by CareSource on or before February 29, 2016, to be considered for the 2015 coinsurance bad debt one-time payment.
  - CareSource will calculate coinsurance for 2015 dates of service in April 2016 and will make a one-time payment to SNF providers in May 2016. Payment will include a list of residents affected, an advance list will not be sent out.

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MyCare Dually Enrolled

- MOLINA: Sent a contract amendment to participating SNFs that increased payments for <u>all</u> claims by 1% effective September 1, 2014. This was Molina's way of compensating for unpaid coinsurance for members who are dually enrolled. Molina revised their bad debt policy for 2016. Instead of adding 1% of the provider's rate for all MyCare Ohio claims (Medicare and Medicaid), Molina is lowering the add on to 0.975%. **Note: the add on is available only to participating (contracted) providers and only if the provider executes the contract amendment that Molina sent.*

- AETNA: Increases payments for skilled dual eligible claims by 2% to cover coinsurance and bad debt (must sign amendment). Aetna deducts coinsurance from days 21-100, compensates by adding 2% to the rate paid for all Medicare primary skilled stays—does not apply this "bump" in payment to Medicaid custodial payments.

- UHC: Paying at Medicare RUGS for all covered skilled days without deduction for coinsurance.

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MyCare – Hospice

- Aetna and United Healthcare—Bill plan directly for room and board using revenue 0658 .
- Molina—Sent out contract amendments to SNFs to implement direct payment for hospice room and board; as of March 1, 2016 NFs will bill Molina the R&B charges for hospice residents using Revenue 0658.
- Plans will pay NF 95% of per diem unless negotiated differently.
- CareSource, Buckeye—Hospice agency bills MyCare plan for room and board and pays NF—must use hospice provider contracted with the MyCare plan.

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MyCare Policies

- Plans say they are now able to process lump sums - to be billed with Value Code 31.
- MyCare plans should all be paying bed hold days—Medicaid tracks 30 days paid in MITS, uncertain how MyCare plans track; if they know how many days were utilized before enrollment.
- Check contract for billing timeframes—claims will deny if not filed timely (ex. UHC allows only 90 days to submit unless more time was negotiated in contract).
- All plans say they are now able to accept crossover coinsurance claims from Medicare for Part A and Part B; be sure to monitor.

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Traditional Medicaid ABD

- ***Medicaid Managed Care for Medicaid only ABD (Aged, Blind Disabled) Recipients***

NOT Medicare Eligible

- Resource limits apply
- Patient Liability is calculated
- No bed holds days paid by plans unless negotiated
- MCP is responsible for payment; authorization must be obtained

- If enrolled AFTER admission to a NF that is considered an error; the plan should request disenrollment from ODM. The county caseworker generally is unable to assist with this process.

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Traditional Medicaid

- Participating managed care plans:
  - Buckeye Community Health Plan
  - CareSource
  - Molina Healthcare of Ohio
  - Paramount Advantage
  - UnitedHealthcare Community Plan of Ohio
  - All 5 plans are available to recipients in all 88 counties

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Traditional Medicaid Managed Care

When a MCP member is placed in a nursing facility (NF) and is not using a hospice service, the MCP is responsible for payment of medically necessary NF services. MCP members may be disenrolled upon request to ODM by the MCP if all of the following are met:

- The MCP has authorized NF services for the month of NF admission and for one complete consecutive calendar month thereafter;
- For the entire period in (a) above, the member has remained in the NF without any admission to an inpatient hospital or long-term acute care (LTAC) facility;
- Member's discharge plan documents that NF discharge is not expected in the foreseeable future and the member has a need for long-term NF care.

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Traditional Medicaid Managed Care

Possible Future Change –

- If all criteria are met to disenroll the long term resident from the plan, the disenrollment would be at the end of the third month (90 days maximum) instead of at the end of the second month.

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Extended-Expanded Medicaid

MAGI (Modified Adjusted Gross Income) effective January 1, 2014 as part of the Affordable Care Act.

- Generally not eligible if in receipt of Medicare—exception - 65 or older or Medicare eligible and parent/caretaker of a minor child; and financially eligible under MAGI standards.
- Includes community adults ages 18 through 64 with income below 133% of the federal poverty limit.
- All MAGI cases are processed in the new Integrated Eligibility System—Ohio Benefits—not in CRISE.
- Same 5 MCP that contract for Traditional Medicaid recipients.
- Some individuals have a pending Medicaid or waiver case in CRISE but also sign up for MAGI Medicaid in the new benefit portal.
- According to county sources, a recipient stays on Expanded Medicaid unless they turn 65, become eligible for Medicare, or qualify for traditional Medicaid and can be "shifted" to Medicaid ABD.

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MAGI Expanded Medicaid

- Eligible recipients will be in MITS, check for coverage each month
- Income guideline for a single individual is $1,317 per month as of March 1, 2016
- If applicant is new to Medicaid, billing number assigned begins with # 9
- Level of care is manual/paper; not entered in CRISE
- Resources for OBWP recipients are waived
- There is no patient liability assigned
- Medicaid card looks the same as any other
- 09401 is required and should denote MAGI
- ALL recipients must select a managed care plan—may admit with a Medicaid card and enroll in MCP after admission—don't get caught—MUST have an auth. from the MCP to receive payment; check MITS often
- If enrolled in a MCP after admission to a NF, resident will remain in the MCP
- No coverage for bed hold days

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Managed Care Complaint

Online Provider Complaint Form
http://medicaid.ohio.gov/PROVIDERS/ManagedCare/ProviderComplaint.aspx

Must file a dispute with the managed care plan but if unable to resolve, inform Medicaid via the complaint form. Use for all managed care programs.

- Benefit/Access continues to be the top complaint.
- Billing is the main member grievance followed by plan administration/benefits.
- According to ODM there were 128 provider complaints during the last quarter of 2015. Of those, 109 were related to payment.

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Resources for Managed Care

- For Managed Care problems, questions, enrollment errors, to make changes, to verify managed care plan coverage, and other options
  - Phone: 1-800-324-8680
  - http://ohiomh.com/
- Website to Managed Care Plan Information
  - http://medicaid.ohio.gov/PROVIDERS/ManagedCare.aspx
- Bureau of Managed Care:
  - Phone: 614-466-4693

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Long Term Care Contacts

Cheryl Guyman, MS, MBA, Nursing Facility Policy Administrator, Ohio Department of Medicaid

- Phone: 614-752-4709
- Email: cheryl.guyman@ohio.Medicaid.gov

Claim Problems:

- NF Direct bill mailbox nfdirectbill@medicaid.ohio.gov
- (Do not use this mailbox when Medicaid dates in MITS need to be corrected, contact county caseworker)
- Supervisor—Michelle Neubauer

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Medicaid Initiatives

- According to Cheryl Guyman, the Medicaid long term services and supports web page is being updated to include fact sheets on various issues, one was already published on the quality indicators, another regarding cost reports.

- The department is changing the definition of short and long stay for Medicaid purposes to adopt a 90 day cutoff. During that period, a SNF would receive payment for services to a person who has a valid Medicaid number without reference to the asset test. Presumably, there also will be no patient liability for this period.

- ODM intends to confirm in writing that patient liability should not be applied to Part A coinsurance unless Medicaid pays some amount toward the coinsurance. Instead, ODM intends to instruct centers to maintain a credit balance on their books to apply to future Medicaid payments.

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Claims Calendar

The 2016 Claims Submission Calendar

- http://medicaid.ohio.gov/PROVIDERS/Billing/TradingPartners.aspx
- Under “Production”

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Medicaid Audits

- Cost Report Audits
  - Done when discrepancies found between cost report amounts and actual paid claims.

- Room and Board (R&B) and Patient Liability (PL) Overpayment Audits (formerly referred to as CPAO).
  - Annual process—if no errors no report is generated.
  - 5 Year audit when a facility is sold or withdraws.

- Initial overpayment reports are mailed the first quarter of every calendar year. In February 2016, FY 2011 reports will be mailed; according to the state all NF providers will receive a report this year.

- Audit findings have increased significantly according to nursing facilities.

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Medicaid Audits

- When you receive your audit report, you should check the box that says, “Provider is requesting to participate in a bureau level resolution process.”
- Review all cases on the report but respond within the 30 days allotted to avoid penalties.
- Due to the fact that the state matches detail information in MITS to paid claims, there are errors on the report. For instance, the patient liability amount applied to the claim from the 09401 may be different from the amount in the CRISE budget which updates MITS; OR there may be no information in MITS under Long Term Care Facility Placements so the audit will assume the resident was not in the facility and days should not have been paid.
- If a level of care was completed by AAA but not entered into CRISE, the resident will appear on the report in the overpaid “days” section. Contact Area Agency on Aging if copy of LOC is needed, or if LOC needs to be generated and the PASRR was completed properly.

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Medicaid Audits

Per Melissa Stills, audit supervisor:

- Manual review is done of findings (Check CRISE budget, CLRC caseworker notes etc.) before forwarding report to facility.
- Facilities must either pay the fine or request the bureau level resolution.
- Auditors will reset deadlines if the facility is cooperating.
- If audit not resolved, auditor will recommend a final report and a 30 day notice will be issued. This date cannot be changed, facility then has 30 days from mailing date to provide any additional documentation and after the 30 days, the audit is finalized. Any money owed is taken directly from the NF payment.
- Unpaid claims is a separate issue and not addressed in the audit, will not be used to offset audit findings.
- Bed hold days may require justification if billed during Medicare skilled stay, proof of hospital admission and discharge and time of exit from facility may be requested.
- Full paid days that overlap date of hospital admission (billed as Rev. 101 due to the 8 hour rule) may appear on report.
- 119 hearings are no longer permitted since the rule changes.

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Medicaid Audits

- Do not submit claims when Medicaid eligibility is posted in MITS without having other required information—LOC and 9401.
- Always do PASRR—including for managed care admissions.
- Always obtain a level of care and do not bill dates that precede the LOC approval date—managed care plans do the **LOC** review if in a plan at admission.
- Always have a 09401 to support filing a claim and patient liability amounts for months billed.
- Return the **09401** to the county for completion or correction if not accurate as this will be NFs support for challenging audit findings.
- Room and board payment box on 09401 should be checked with a begin date.

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Medicaid Cost Report

- As a condition of participation in the Medicaid program, each NF shall file a cost report, including attachments, within 90 days after the end of the reporting period. The cost report covers a calendar year.

- In theory you can enter information and input data into the cost report and save throughout the year. The problem is that if you enter it too early you could be using an old ACR version; must make sure you open and save the ACR data file with newest version for the CY before exporting/submitting it to ODM.

- New automated cost report software—must be downloaded.

- http://medicaid.ohio.gov/PROVIDERS/ProviderTypes/LongTermCareFacilities/AutomatedCostReporting.aspx

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Medicaid Cost Report

- 2015 Cost report - in Attachment 8 are instructions for reporting staff retention and use of the Preferences for Everyday Living Inventory (PELI).
- Be aware that the retention schedule on Attachment 8 should include only, "W-2 employees," full and part time, do not report contract employees on this schedule.
- Hospice days should be included in the cost report under column 11, “Other.”
- Medicaid cost report Fact Sheet:
  - http://medicaid.ohio.gov/Portals/0/Providers/ProviderTypes/LongTermCare/FactSheets/nf-CostReport.pdf

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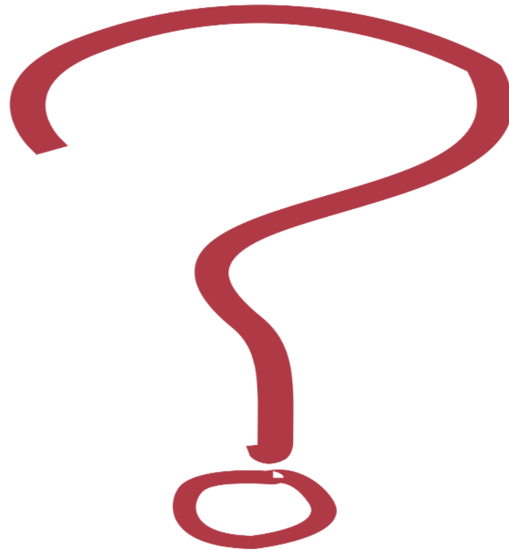
Questions?



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