

Medicaid Managed Care

What You Need to Know to Be Successful

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Medicaid Eligibility: *General Overview*

- ▶ When determining someone's eligibility for Medicaid, Ohio follows a hierarchical approach
- ▶ Hierarchical approach considers:
 - ▶ Personal Information
 - ▶ Who is applying? Single adult, parent, child, someone over 65?
 - ▶ Household? Living arrangement and number of people in the household
 - ▶ Receiving other services like Supplemental Security Income (SSI)
 - ▶ Monthly benefits to people with limited income and resources who are disabled, blind, or age 65 or older
 - ▶ Income—various standards based on personal information
 - ▶ Possible resource/asset test—based on need for long term care AND category of Medicaid eligibility

Categories of Medicaid Eligibility: *General Hierarchical Order*

- ▶ Supplemental Security Income (SSI)
 - ▶ If an individual receives SSI, they automatically qualify for Medicaid
 - ▶ Current SSI for 2022 is \$841
- ▶ MAGI
- ▶ MAGI Group VIII (Adult Expansion Category)
- ▶ ABD (Aged, Blind or Disabled and not eligible for SSI but meets criteria)
- ▶ SIL (Special Income Level)
 - ▶ Only applies when an individual is seeking Medicaid payment for LTC services
 - ▶ 3 x SSI payment; SIL for 2022 is \$2523
- ▶ SIL with Qualified Income Trust (QIT)
 - ▶ Discards income about \$2523 by putting excess income in a QIT so individual can qualify for Medicaid

What is MAGI?

- ▶ MAGI stands for Modified Gross Addjusted Income
- ▶ MAGI started January 1, 2014, as part of the Affordable Care Act (ACA)
- ▶ MAGI-based budgeting is used to calculate a person's household size and income, using federal income tax rules and a tax filer's family size to determine Medicaid eligibility
- ▶ Incomes must be at or below 133% of the federal poverty level (FPL)
- ▶ Individuals must be between 19-64 years of age
- ▶ Cannot be a Medicare beneficiary. However beneficiaries who are determined disabled by SSA and are currently in the two-year waiting period for Medicare may be included.
- ▶ Appears in MITS as MAGI
- ▶ Does not have a patient liability if receiving LTC services

What is MAGI Group VIII?

- ▶ ACA expanded Medicaid to a new group of individuals beginning January 1, 2014
- ▶ New category allows individuals to qualify for Medicaid with income up to 138% of the FPL (133% plus 5% income disregard)
- ▶ Known as the “Medicaid Expansion Population”
- ▶ To date, 39 states (including DC) have adopted Medicaid expansion
- ▶ Ohio is one of the expansion states and began offering benefits January 1, 2014
- ▶ Identified in MITS as MAGI Group VIII—Alternate Benefit Plan
- ▶ *Key difference between MAGI and MAGI Group VIII with respect to managed care participation*

Medicaid Managed Care: *Enrollment Requirements*

- ▶ Most Medicaid beneficiaries in Ohio are required to join a managed care plan to receive their health care benefits
 - ▶ Children, Families and Adults (age 19-64 also known as MAGI) along with SSI and ABD individuals living in the community are part of the mandatory enrollment group
 - ▶ People excluded from Medicaid managed care include:
 - ▶ Medicaid individuals on a home and community based waiver (AL, PASSPORT)
 - ▶ Medicaid individuals who are institutionalized
 - ▶ Individuals eligible for both Medicaid and Medicare (this is not MyCare)
 - ▶ Buckeye Health Plan, CareSource, Molina Healthcare, Paramount Advantage and United Healthcare Community Plan all operate statewide
 - ▶ Re-procurement has occurred and beginning December 1, we start the Next Generation of Managed Care. New plans are: AmeriHealth Caritas, Anthem, Buckeye, Caresource, Humana, Molina and UnitedHealthCare

Next Generation of Managed Care

- ▶ October 1, 2022 begins Centralized Provider Credentialing through Provider Network Module (PNM)
 - ▶ Single entry point for all enrollments/revalidations and credentialing with plans
 - ▶ Part of a larger effort to modernize ODM's management information system also referred to as Ohio Medicaid Enterprise System (OMES)
 - ▶ Must have individual OH|ID; no longer able to log into MITS directly—log in thru PNM
- ▶ December 1, 2022 begins Next Generation of Medicaid Managed Care
 - ▶ Six new plans begin offering services to Medicaid beneficiaries statewide
- ▶ Before year-end 2022, new Fiscal Intermediary will be introduced
 - ▶ One Door for Prior Authorization submissions (LOC will still be in place in FFS)
 - ▶ Question out on concurrent reviews
 - ▶ One Door for Claims Submissions (Medicaid Managed Care and FFS)
 - ▶ One Door for Beneficiary Eligibility (includes Patient Liability)
 - ▶ Additional functionality that exists in MITS such as cost report submission and upload attachments for prior authorizations and claims

Medicaid Managed Care: *Enrollment Requirements Continued...*

- ▶ Effective January 2018, Managed Care “Day One” began
- ▶ Individuals who become eligible for Medicaid and are in a mandatory enrollment group will be enrolled on the first day of the month that MITS receives the eligibility information
- ▶ Coverage for “pending period” prior to information appearing in MITS will be Medicaid FFS
- ▶ Consumers have 90 days to choose a new managed care plan if they wish
- ▶ Consumers can then only change plans during open enrollment
- ▶ This is for Medicaid Managed Care only; does not effect MyCare Ohio enrollment

Nursing Facility Benefit Under Medicaid Managed Care

- ▶ Differs by eligibility group
- ▶ “Short term” in nature for all eligibility groups except MAGI Group VII
- ▶ “Short term” means:
 - ▶ First month of NF admission plus
 - ▶ Two consecutive, uninterrupted months thereafter, and
 - ▶ Until such time as there is no active discharge plan
- ▶ MAGI Group VIII remain on managed care forever or until such time as their eligibility group changes
 - ▶ Change to ABD? Benefit becomes “short term” in nature
 - ▶ Changes to Dual? Disenroll and enroll in MyCare if in MyCare county

Nursing Facility Benefit Under Medicaid Managed Care *Continued*

- ▶ Criteria for Coverage is the same as Medicaid
 - ▶ OAC 5160-3-08 Criteria for NF-based LOC
 - ▶ The individual has a need for a minimum of one of the following:
 - ▶ Assistance with a minimum of two activities of daily living or
 - ▶ Assistance with the completion of a minimum of one ADL plus medication administration or
 - ▶ A minimum of one skilled nursing service or skilled rehabilitation service or
 - ▶ Twenty-four hour support in order to prevent harm due to a cognitive impairment, as diagnosed by a physician or other licensed health professional acting within his or her applicable scope of practice, as defined by law.
- ▶ Contact OHCA should plan not honor ILOC and SLOC criteria
- ▶ Criteria is very important with respect to concurrent reviews

Disenrollment Process: Returning Consumers to Medicaid FFS

- ▶ OAC 5160-26-02.1 Managed health care programs: termination of enrollment rules state disenrollment can only take place when:
 - ▶ The MCP has authorized nursing facility services for no less than the month of nursing facility admission and for two complete consecutive calendar months thereafter and
 - ▶ For the entire period, the member has remained in the nursing facility without any admission to an inpatient hospital or long-term acute care facility and
 - ▶ The member's discharge plan documents that nursing facility discharge is not expected in the foreseeable future and the member has a need for long-term nursing facility care and
 - ▶ For the entire period, the member is not using hospice services and
 - ▶ The MCP has requested disenrollment, and ODM has approved the request.
- ▶ Disenrollments take effect on the last day of the month in which the request for disenrollment was made

Disenrollment for Special Circumstances

- ▶ Accidental Enrollment after Disenrollment d/t Institutionalization
 - ▶ This is occurring because living arrangement in Ohio Benefits does not show NF, it still shows Community
 - ▶ Must be caught in the month for which the accidental enrollment took place
 - ▶ If caught, contact managed care plan immediately, inform them of the error and ask them to process the disenrollment
 - ▶ If not caught the month it occurred, must work with the plan through the minimum benefit period of the month of admission/enrollment plus two consecutive, uninterrupted months thereafter and until such time as there is not active discharge plan

Medicaid Managed Care: Tips for Success

- ▶ Know & educate on the criteria for coverage—SLOC and ILOC
 - ▶ What documentation do you provided upon concurrent reviews?
 - ▶ Does person sending documentation understand the coverage criteria?
 - ▶ If skilled service has ended, does your documentation support ILOC criteria?
 - ▶ If documentation does not support SLOC or ILOC, Plans have right to cut coverage due to non medical necessity for nursing facility services
 - ▶ Think about both SLOC and ILOC criteria when admitting
 - ▶ Will the individual meet medical necessity for nursing facility coverage after the main reason for their stay is complete?
 - ▶ Think about discharge disposition
 - ▶ Do they have a home to return to?
 - ▶ If no home, do you expect them to be long term and do you have confidence the individual will meet Level of Care?

Medicaid Managed Care: Tips for Success *Continued*

- ▶ Know & educate on the NF benefit period
 - ▶ Who is tracking the first month of admission plus two consecutive months thereafter and until such time as there is no active discharge plan?
 - ▶ At least two weeks prior to end of the minimum coverage period, a discussion must occur on the individual's discharge disposition
 - ▶ Plans must keep individuals covered as long as there is an active discharge plan
 - ▶ Must meet at least an intermediate level of care (ILOC)
 - ▶ Providers must get a Level of Care prior to returning the person to Medicaid FFS
 - ▶ When disenrolling, Plans must document to ODM that individual meets LOC
- ▶ No retroactive disenrollments
 - ▶ Plans required to continue coverage, which is always based on medical necessity/LOC, if they don't disenroll the individual by the last day of the month

Medicaid Managed Care: Tips for Success *Continued*

- ▶ Communicate, communicate, communicate
 - ▶ If you know coverage criteria and minimum benefit period AND communicate, you will be successful!
- ▶ Check MITS monthly for eligibility changes and changes with Plans
 - ▶ See something funky; act immediately by calling plan, county and/or OHCA
- ▶ If plans do not conform to coverage criteria and cut benefits inappropriately, contact OHCA
- ▶ If all else fails, file a formal complaint with ODM at <https://www.ohiomh.com/ProviderComplaintForm.aspx>
 - ▶ ODM Contract Administrator will be assigned to work complaint

Thank you!

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