

Long Term Care FAQs for MCOs

December 2016

1. Does the facility have to follow MCO policies regarding transfer and prior authorization requirements?

Yes. If an individual is enrolled in an MCO at the time of admission to the facility, the MCO must authorize a member's admission and continued stay in the facility by applying the Program's nursing facility medical eligibility criteria.

The MCO is responsible for preauthorizing the stay and the MCO is responsible for all payment of days of service provided to the member. The MCO is encouraged to monitor the continued need for nursing facility services and authorize days of service up to and including the 90th day, as long as the individual continues to be enrolled in the MCO.

2. If notification is not given by the facility to the MCO of a member's admission prior to or by the next business day, is the MCO permitted to deny the entire or partial stay (i.e., deny dates until date of notification) for lack of notification? Or must the MCO retrospectively review dates prior to notification?

The MCO can deny days of care until they are informed by the facility.

3. Is the facility required to inform the MCO of secondary insurance?

Yes. MCOs are expected to coordinate benefits, seek third party reimbursement and/or cost avoid as appropriate. The MCO must keep the member or member's representative informed of how these procedures will be applied.

4. Is there a benefit limit to the 90 days of coverage in a nursing facility, specialty pediatric hospital, or chronic hospital? Is the benefit 90 days per episode of care or 90 days per calendar year?

The benefit is per episode of care, not per calendar year.

5. How does the clock work regarding counting the 90 days -- continuous days in the facility or cumulative days?

The 90 days includes any hospital inpatient care as long as the member is discharged back to the facility.

6. If the member is admitted to a facility that is not contracted with the MCO, can the MCO transfer the member to one of their contracted facilities?

Yes.

7. When will a member in a facility who turns 65 or is enrolled in Medicare, and therefore is no longer eligible for HealthChoice, be disenrolled from the MCO?

The member will be disenrolled on the 91st day or the first day of the following month, whichever occurs first.

8. If the member doesn't meet medical necessity criteria for a skilled stay for the entire 90 days, does this mean the MCO pays for the member to stay in the facility for LTC services (if they need Long Term Care support) until they reach day 90?

The MCO is responsible for the stay as long as the member continues to meet the medical eligibility criteria outlined in Nursing Home Transmittals 213 and 237. On day 80 of the stay, the MCO can ask Medicaid's Utilization Control Agent (UCA), Telligen, to determine eligibility for the fee-for-service program.

The MCO is responsible to pay for nursing facility services through the 90th day, or until the UCA's determination of medical eligibility, whichever is later. The MCO will process the disenrollment to be effective day 91 as long as the member meets the State's medical eligibility criteria.

9. When patients no longer qualify for skilled nursing in a nursing facility, are the MCOs responsible for patients who qualify for an intermediate need?

See response to #8 above. It is essential that the MCO conduct continued stay reviews and discharge planning. At the point in the stay that a member does not meet medical eligibility criteria, the member can be discharged to the community.

Medicaid-covered nursing facility services include "skilled" and "intermediate" care.

10. If the member loses coverage with the MCO in the middle of the nursing facility stay and goes to fee-for-service (FFS), does the MCO continue to review up to the discharge date?

Medicaid's UCA, Telligen, is responsible for approving nursing facility medical eligibility for FFS.

11. What options are available for discharge during the 90 day stay?

The MCO may discharge the resident to an appropriate setting during the 90 day stay even if the individual continues to meet the medical eligibility criteria. The Department's Community First Choice program provides personal assistance services, supports planning and other transition services that will help ensure a safe transition from the facility to the home. Additional training can be made available on how enrollment to the program works and what services are provided. This program is operated by the Medicaid Long Term Services and Supports fee-for-service program. Medical day care services may also be available in the community to support individuals who are medically eligible for nursing facility services.