Statewide Medicaid Managed Care (SMMC)

Contract Provisions for 2018-2023

Nursing Facility (NF) Services Covered by Managed Medical Assistance (MMA)

This document provides information about paying for NF services under the enrollee's MMA benefits.

MMA benefits must pay for any medically necessary Medicaid NF stay, up to 120 days from date of admission, when the enrollee *is not* also eligible for Long-term Care (LTC) benefits and NF services are provided in accordance with provisions in the SMMC contract and all state and federal rules and regulations, including:

- 42 C.F.R. 435.725;
- 42 C.F.R. 483.122;
- Attachment II, Exhibit II-A, Section VI.A.1.a.;
- the Florida Medicaid Nursing Facility Services Coverage Policy in Rule 59G-4.200, F.A.C.; and
- Rule 59G-1.040, F.A.C., Pre-Admission Screening and Resident Review (PASRR).

When the individual admitted to the NF is not eligible for full Medicaid benefits, the individual applies for Medicaid to cover the cost of NF services.

When an individual is not eligible Medicaid and then is determined eligible for ICP Medicaid benefits, they are express enrolled into a health plan for MMA benefits and may receive only MMA benefits until they are enrolled in a health plan with LTC benefits.

The health plan's MMA benefits pay for NF services from the date of enrollment into the health plan through the date of enrollment into a health plan with LTC benefits.

Medicaid State Plan Coverage and Eligibility Requirements

Florida Medicaid reimburses for NF services as a State Plan benefit when the recipient meets both clinical and financial eligibility requirements as follows:

Clinical Eligibility Requirements	Financial Eligibility Requirements	Technical Eligibility Requirements
NF level of care has been determined by the Comprehensive Assessment and Review for Long-Term Care Services (CARES) if ages 21 years and older, or the Children's Multidisciplinary Assessment Team (CMAT), if under the age of 21 years.	Meets the requirements for the Institutional Care Program by the Department of Children and Families	Resides in the facility.
Pre-Admission Screening and Resident Review (PASRR) has		

been completed in accordance with Rule 59G-1.040, F.A.C.		
CARES or CMAT is provided with a properly completed Medical Certification for Medicaid Long-term Care Services and Patient Transfer Form, as incorporated by reference in Rule 59G-1.045, F.A.C., that certifies the individual needs NF services.		

Additional NF coverage options available under the SMMC program.

Under the Statewide Medicaid Managed Care program, the health plan may provide NF services in lieu of inpatient hospital services. In this instance, the health plan must not be count the NF days as inpatient hospital days for eligible enrollees. The enrollee must complete the PASRR prior to admission to the NF.

The following four scenarios detail various requirements for MMA reimbursement of NF services.

Scenario #1: The individual admitted to the NF is not Medicaid eligible and therefore is not a health plan enrollee.

- The NF anticipates the individual will be a long-term care resident and will likely qualify for the Medicaid Institutional Care Program (ICP Medicaid).
- The NF assists the individual in immediately applying to the Department of Children and Families (DCF) for ICP Medicaid coverage and requests a NF level of care (LOC) assessment by CARES.
- The individual gains Medicaid eligibility through the ICP Medicaid requirements, which means that the individual has received a NF LOC recommendation from CARES.
  - The recipient is express enrolled in an MMA plan and is awaiting enrollment into the LTC program.
  - *This ICP Medicaid eligible recipient should select either a Comp plan or LTC plus plan. If the ICP Medicaid eligible recipient selects an MMA-only plan first, the recipient must quickly change plans to a type of health plan that offers LTC benefits.*
- The health plan can identify ICP Medicaid eligible enrollees on 834 enrollment file by any aid category that begins with MI. The only exception is for the aid category MI T, which signifies a penalty period of temporary ineligibility for NF services; the MI T enrollee is eligible for coverage of any benefit except NF services.
- **The health plan will pay the NF days under the MMA benefit from the date of enrollment in the MMA plan through the date of enrollment into the LTC program.**

Scenario #2: Medicare has authorized a NF stay for a dually eligible enrollee who is eligible for MMA benefits but is not eligible for LTC benefits.

- The NF anticipates the dually eligible enrollee will have a short-term stay, as authorized by Medicare for rehabilitation after a qualifying hospital stay.
- The enrollee is not currently eligible for ICP Medicaid.
- The nursing facility (on behalf of the health plan) submits the CF-ES 2506A form to DCF within 10 days of admission, but no later than the last day of the month of NF admission; this automatically triggers the DCF to determine if the enrollee qualifies for ICP Medicaid coverage.

- Medicare is providing full coverage for the first 20 days; the health plan will have to cover Medicare NF claims for coinsurance and deductibles. *Medicare covers up to 100 days in a NF after a qualifying hospital stay*.
- **The SMMC health plan covers the NF claims for Medicare coinsurance and deductibles under the MMA benefit beginning on day 21 of the NF stay until the Medicare benefit is exhausted (100 days) or until the enrollee is discharged, whichever is sooner.**
- **If the enrollee's length of stay extends beyond their Medicare coverage of NF services, the health plan covers the NF days under the MMA benefit <u>from the date in which ICP Medicaid eligibility is effective</u> until the date of enrollment into a LTC plan.**

<u>Scenario #3: The health plan authorizes the MMA benefit coverage of NF services in lieu of continued inpatient hospital care.</u>

- The NF anticipates the individual will have a short-term stay of three weeks, as authorized by the health plan for NF services in lieu of inpatient hospital care. The enrollee may be eligible for MMA benefits but not eligible for LTC benefits, or the enrollee may be eligible for both MMA and LTC benefits.
- The enrollee is not eligible for ICP Medicaid.
- The nursing facility (on behalf of the health plan) submits the CF-ES 2506A form to DCF within 10 days of admission, but no later than the last day of the month of NF admission; this automatically triggers the DCF to determine if the enrollee qualifies for ICP Medicaid coverage.
- **The health plan authorizes payment for three weeks of NF services under their MMA in-lieu of benefits offered under the SMMC program. The health plan will work with the NF on discharge planning to facilitate a return to the community as quickly as possible.**
- If the enrollee needs NF care beyond the three weeks initially authorized by the health plan, the NF must request reauthorization through the health plan and the health plan must determine NF services continue to be medically necessary in-lieu of hospital services. **The health plan may authorize payment for additional NF care under their in-lieu of benefits offered under the SMMC MMA program.**
- If the enrollee's condition continues to decline and the health plan believes the enrollee is in need of LTC**, the health plan covers the NF days under the MMA benefit <u>from the date in which ICP Medicaid eligibility is effective</u> until the date of enrollment into a LTC plan.**

<u>Scenario #4: The enrollee admitted to the NF for LTC is eligible for MMA benefits but is not eligible for LTC benefits.</u>

- The NF anticipates the enrollee will be a long-term care resident and will qualify for the Medicaid Institutional Care Program (ICP Medicaid).
- The nursing facility (on behalf of the health plan) submits the CF-ES 2506A form to DCF within 10 days of admission, but no later than the last day of the month of NF admission; this automatically triggers the DCF to determine if the enrollee qualifies for ICP Medicaid coverage. The health plan immediately requests a NF LOC assessment by CARES.
- The individual gains ICP Medicaid eligibility, which means that the individual has received a NF LOC recommendation from CARES.
  - The recipient is express enrolled in an MMA plan and is awaiting enrollment into the LTC program.
  - *This ICP Medicaid eligible recipient should select either a Comp plan or LTC plus plan. If the ICP Medicaid eligible recipient selects an MMA-only plan first, the recipient must quickly change plans to a type of health plan that offers LTC benefits.*

- The health plan can identify ICP Medicaid eligible enrollees on 834 enrollment file by any aid category that begins with MI. The only exception is for the aid category MI T, which signifies a penalty period of temporary ineligibility for NF services; the MI T enrollee is eligible for coverage of any benefit except NF services.
- **The health plan will pay the NF days under the MMA benefit from the date of enrollment in the MMA plan through the date of enrollment into the LTC program.**

Resource Links:

- Nursing Facility Services Technical Guide for Statewide Medicaid Managed Care - *COMING SOON*
- Code of Federal Regulations (CFR): https://www.ecfr.gov/cgi-bin/ECFR?page=browse
- Florida Administrative Code (F.A.C.): https://www.flrules.org/Default.asp
- Florida Statutes (F.S.): http://www.leg.state.fl.us/Welcome/index.cfm?CFID=92950455&CFTOKEN=16012508
- SMMC 2018-2023 Contract: http://ahca.myflorida.com/Medicaid/statewide_mc/plans_FY18-23.shtml

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The Florida Medicaid program has an email alert system to notify interested parties of "late-breaking" health care information. An email will be delivered to your mailbox when Medicaid policy clarifications or other health care information is available that is appropriate for your selected provider type. To subscribe to the automated alert system, complete the online form at https://ahca.myflorida.com/Medicaid/alerts/alerts.shtml.

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