Questions and Answers from the 2021 IHCP Roadshow Panel Discussion: Long-Term Care

The Indiana Health Coverage Programs (IHCP) hosted a panel discussion on Wednesday, May 5, 2021, for long-term care (LTC) providers as part of the 2021 IHCP Roadshow. This document provides a summary of the questions and answers discussed during the panel.

What are the guidelines for presumptive eligibility when someone is going into long-term care? Should a provider pursue PE coverage for a member when the member needs to go into an LTC facility?

Uninsured Hoosiers who qualify for Presumptive Eligibility (PE) as outlined in the *Presumptive Eligibility* provider reference module may apply for PE until eligibility for Medicaid coverage is determined. Please note that a member with PE (or initial contact person acting on their behalf) must fill out a full Medicaid application. If a full application is not completed or denied, the member would be without coverage and the provider would be without a payor source.

When possible, an individual's Medicaid eligibility should be determined *prior to* entering an LTC facility. The IHCP acknowledges that this is not always possible and encourages individuals or their initial contact person to fill out a full application shortly after the individual enters an LTC facility, to ensure a payor.

What is included in the nursing facility per diem rate? Are providers able to bill for additional services outside of the per diem rate?

The LTC per diem rate covers room and board, nursing care, and all other services listed in *Indiana Administrative Code 405 IAC 5-13-3* and *405 IAC 5-31-4*, including the following:

- The cost of all medical and nonmedical supplies and equipment, which includes those items generally required to assure adequate medical care and personal hygiene of patients
- Durable medical equipment (DME) and associated repair costs, routinely required for the care of patients

Please refer to the *Long-Term Care* provider reference module for a complete list.

Providers cannot bill for services outside of the per diem. Nonstandard items of DME and associated repair costs that have received prior authorization must be billed to the IHCP directly by the DME provider.

What is the PASRR process? What is the process for obtaining the proper Level of Care assignment for members?

Preadmission Screening and Resident Review (PASRR) is a one- to three-step process, depending on the resident's diagnosis and pay source:

- All residents entering a Medicaid-certified nursing facility must have a **Level I assessment** completed prior to entering the facility.
- If the person's Level I indicates a possible mental health or intellectual disability diagnosis, then a **Level II assessment** must also be completed prior to entering the facility.
- A **Level of Care (LOC) assessment** must be done if any of the following circumstances apply:
    - The resident has Medicaid as a pay source.
    - The resident is required to have a Level II assessment completed.
    - The resident is entering the nursing facility from out of state.

The LOC assessment involves completing an in-person or, in some situations, phone- or document-based interview with the resident, gathering medical history for the resident, and completing the online assessment through AssessmentPro.

For complete information about the PASRR process, including details about completing the LOC assessment, please reference the *Indiana PASRR Provider Manual* on the maximusclincalservices.com website.

Who completes the PASRR assessments and reports the findings to the Division of Aging?

The Level I and LOC assessments are completed by either the nursing facility, a hospital or a case manager from an Area Agency on Aging. All assessments are reviewed by clinical reviewers at Maximus Ascend, which reports to the Division of Aging.

Is reimbursement available while the PASRR is pending?

No, the PASRR and LOC must be completed before services are eligible for reimbursement. The IHCP's standard policy is that the assessments for a PASRR or LOC must be completed prior to the member entering the nursing facility.

The 1135 waiver allows for members to be in a nursing facility for up to 30 days before the PASRR and LOC assessments are completed. The reimbursement policy does not change based on this waiver. More information on the 1135 waiver can be found on the *Section 1135 Waiver Flexibilities – Indiana Coronavirus Disease 2019* page at medicaid.gov.

What steps should a provider take if there are reimbursement issues or errors with an LOC?

If a provider recognizes an error with a level of care (LOC), the provider should send an email to PASRR@fssa.in.gov. If a fee-for-service (FFS) claim has reimbursed incorrectly due to an LOC error, the claim can be resubmitted within 180 days after the LOC is corrected. Providers should enter a claim note of "Retro LOC change," when submitting the claim. This claim note will force the claim to suspend, be reviewed by an analyst, and process correctly. If providers have questions about entering a claim note, they can contact their Gainwell Technologies provider consultant.

Is the LOC viewable in the Provider Healthcare Portal for all member benefit categories?

An LOC is only viewable in the IHCP Provider Healthcare Portal for member benefit categories that permit reimbursement for nursing facility care. There is a known issue in which LOCs for some members with Qualified Medicare Beneficiary (QMB)-Only coverage are not viewable.

Why was the liability on the Provider Healthcare Portal not matching the amount deducted from claims from March 1, 2020, through Feb. 28, 2021? What changed with liabilities starting on March 1, 2021?

The Families First Coronavirus Response Act (FFCRA), which was passed in March 2020, offered extra federal assistance to states that agreed to meet certain criteria. Guidance was also given that states must maintain the same "amount, duration and scope" of Medicaid coverage for each member throughout the public health emergency (PHE). This included not increasing the financial amount that members in nursing facilities or on Home- and Community-Based Services (HCBS) waivers must contribute toward the cost of their care ("patient liability" or "waiver liability"). As a result, IHCP member liability payments were not tied to their income from March 2020 through February 2021.

In November 2020, the CMS issued new regulations to give more flexibility in how the requirements of the FFCRA are met. Using these flexibilities, the IHCP has returned to its prior rules for calculating liabilities. Beginning March 1, 2021, liabilities will be assessed based on the current monthly countable income and other standard eligibility criteria used prior to the PHE.

Refer to *IHCP Bulletins* BT202033 and BT202107.

Who is responsible for paying each component of care when LTC members receive both nursing facility and hospice services?

When a member enters hospice, the hospice provider is responsible for coordinating and providing all care related to the terminal condition, which includes paying for nursing facility care. When a hospice member receives services in a nursing facility, the hospice provider bills Medicaid for the applicable hospice service charges and 95% of the nursing facility's per diem rate. The hospice provider then reimburses the nursing facility at a contracted rate.

Per *405 IAC 1-16-4*, the nursing facility and the hospice provider must first have a written agreement (contract) stating the hospice provider takes full responsibility for the professional management of the individual's hospice care. This contract must also specify that the nursing facility agrees to provide room-and-board services as described in *U.S. Code 42 USC 1396d(o)(3)*. Hospice services cannot be provided until both parties have finalized a contract.