

Ohio Medicaid Managed Care Home Health & Private Duty Nursing (PDN) Benefits

September 2007

Managed Care Enrollment: Covered Populations

Ohio has complied with the mandates set forth in Ohio's 2006-2007 budget bill (Am. Sub H.B. 66, 126th General Assembly) requiring the enrollment of all Covered Families and Children consumers with limited exceptions and certain Aged, Blind or Disabled (ABD) consumers in the full-risk managed care program. As of June 2007, Ohio Health Plans' Bureau of Managed Health Care is responsible for the oversight of Medicaid services for more than one million Covered Families and Children (CFC) enrolled in managed care plans (MCPs). In addition, approximately 120,000 Aged Blind and Disabled (ABD) consumers are enrolled in MCPs. Home Health providers need to be aware that the following ABD Medicaid consumers will be excluded from managed care enrollment:

- children under twenty-one (21) years of age
- consumers dually eligible for Medicare and Medicaid
- consumers with a spend-down liability
- those enrolled in a home and community-based waiver program
- those whose permanent residence is a nursing facility (NF) or ICF/MR

Additionally, CFC consumers who are under 19 years of age may choose not to enroll in an MCP if they are:

- eligible for Supplemental Security Income (SSI) under Title XVI
- receiving foster care or adoption assistance under Title IV-E
- in foster care or out-of-home placement, or
- receiving services through the Ohio Department of Health's Bureau for Children with Medical Handicaps (BCMH).

Home health and PDN providers must continue to follow OAC rules in chapter 5101:3-12 for consumers who remain in the fee-for-service (FFS) Medicaid program. Home Health providers should maintain their Medicaid provider numbers in order to continue to serve fee-for-service Medicaid consumers. Home health and PDN services provided during MCP enrollment must be authorized by the MCP and will not be paid by FFS Medicaid.



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Managed Care Enrollment Verification

Individuals enrolled in MCPs receive a permanent membership card prior to their first day of enrollment, which replaces the monthly fee- for-service Medicaid card. The MCP membership card includes the following information:

- the member's name
- the MCP name
- the enrollee's primary care physician name and telephone number
- MCP Member Services phone number
- the enrollee's MMIS number

Enrollees can change their MCP within the first 3 months of enrollment and annually thereafter, and at other times with the approval of the BMHC. Therefore, verification of eligibility and MCP enrollment prior to home health service provision and monthly thereafter for all Medicaid enrollees is important. Verification is available through the Interactive Voice Response System (IVR) at 1-800-686-1516. The system first verifies Medicaid eligibility and after a 6-second delay follows with MCP enrollment, if this applies. MCP-contracted providers may also verify eligibility on-line using the MCP's website; non-contracted providers may verify enrollment by fax or phone.

FFS Medicaid Patients Transitioning to MCP Coverage

Enrollees or providers who contact the MCP regarding continued home health and PDN services provided by FFS Medicaid may obtain payment for the continuation of services (at the existing service level) from the date of the member or provider's contact until the MCP makes a prior authorization determination. MCPs are also required to cover services that were prior authorized by the FFS Medicaid program, specifically durable medical equipment and private duty nursing. MCP coverage is required from the date of the member or provider's contact with the MCP regarding continued coverage until the MCP has made a prior authorization determination. If the MCP makes a determination that the transitional FFS prior authorized services are to be denied, reduced, or terminated, the MCP will issue a state hearing notice to the member. If any home health or PDN services are to be continued, the MCP may choose to transition these to a contracted provider.



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Managed Care Provider Contracting

Home Health/PDN services provided to Medicaid MCP enrollees must be authorized by the MCP. Some MCPs prefer to work only with the providers with which they have a contract. Home health providers may contact MCPs directly to discuss contracts for service provision to the managed care population. Rates for services are negotiated between the MCP and the home health/PDN provider. Medicaid FFS billing rules do not apply to contracted MCPs. Regional MCP contact numbers and website links are available on the Medicaid managed care provider website at <http://www.jfs.ohio.gov/ohp/bmhc/pro-man-care.stm>.

Coverage Requirements and Prior Authorization for Home Health/PDN Services

Ohio Administrative Code Rule 5101:3-26-03 requires MCPs to cover Medicaid-covered medically necessary home health and PDN for both CFC and ABD enrollees. Limits on services are allowed on the basis of medical necessity or utilization control. Service limits and coverage criteria specified in chapter 5101:3-12 of the OAC also apply to MCP enrollees. Prior authorization for home health and PDN is currently required by all MCPs. Providers must obtain authorization before accepting a new admission for any Medicaid managed care enrollee. MCP payment is not required if prior authorization has not been obtained. MCPs are allowed 14 calendar days or as expeditiously as the enrollee's health condition requires to make a standard authorization decision. If a provider documents that the standard authorization timeframe could seriously jeopardize the enrollee's life or health, an expedited authorization can be requested, and a decision made no later than 3 working days after the request or as expeditiously as the enrollee's health condition requires (OAC 5101:3-26-03.1). Providers should mark such requests as "expedited" in order to clearly communicate the request for expedited review.

Questions about this notice may be directed to BMHC@odjfs.state.oh.us or (614)466-4693.

