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Authorized Signature

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Topic: Medical Benefits

Subject: Reminders and resources related to authorization and billing for services to Oregon Health Plan (OHP) clients seeking long-term care (LTC) services

Applies to:

- | | |
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| <input type="checkbox"/> All DHS employees | <input type="checkbox"/> County Mental Health Directors |
| <input checked="" type="checkbox"/> Area Agencies on Aging | <input checked="" type="checkbox"/> Aging and People with Disabilities |
| <input type="checkbox"/> Children, Adults and Families | <input checked="" type="checkbox"/> Other (please specify): DMAP staff |
| <input type="checkbox"/> County DD Program Managers | |

Message:

Due to Modified Adjusted Gross Income (MAGI) and Hospital Presumptive Eligibility (HPE) determinations, you may encounter MAGI- or HPE-eligible OHP (Medicaid) clients seeking nursing facility (NF), [K-Plan](#) or State Plan Personal Care Services, including home and community based services.

To make sure you are referring OHP clients and providers to the appropriate resources, please review the following information related to [LTC eligibility](#), certain [OHP Plus services delivered through nursing facilities](#), and [billing for LTC services](#).

1. AAA/APD determines LTC eligibility

The [local AAA/APD office](#) continues to review and approve LTC service eligibility for all Medicaid clients, including MAGI- and HPE-eligible clients.

- Oregon Administrative Rule (OAR) [411-070-0040\(2\)](#) (*Screening, Assessment, and Resident Review; Pre-Admission Screening*) requires that the local AAA/APD office perform Pre-Admission Screenings before Medicaid clients are admitted to an NF.

- APD's Office of Licensing and Regulatory Oversight (ORLO) issued an [Administrator Alert to nursing facility directors](#) reminding them to contact the local office to prior-authorize NF services for Medicaid clients. The alert confirms that this process also applies to MAGI- and HPE-eligible clients.

You can find up-to-date information related to LTC eligibility determinations for MAGI-eligible clients on [APD's Affordable Care Act staff tools page](#).

2. OHP Plus services delivered through nursing facilities

Post-hospital extended care (PHEC) and hospice services to Medicaid NF residents are **not** considered LTC services. Both services are provided through the OHP Plus benefit package.

PHEC:

This benefit is for Medicaid-only (BMH) members who meet Medicare criteria for a 1-20 day NF placement following a qualifying hospital stay. After day 20, the PHEC benefit ends, and AAA/APD must review for LTC eligibility. To learn more about PHEC eligibility criteria, see [OAR 411-070-0033](#).

- **Who authorizes PHEC services?** The coordinated care organization or fully capitated health plan (CCO/FCHP) authorizes PHEC for CCO/FCHP members; the local AAA/APD office authorizes PHEC for all other OHP members (including PCO members).
- **Who is responsible for payment (days 1 through 20)?** Who pays depends on who authorized the service and whether the member is enrolled in a CCO/FCHP.
 1. **If the CCO/FCHP authorized the service**, providers should contact the CCO/FCHP.
 2. **If AAA/APD authorized the service**, providers should contact DMAP.
 3. **If there is no authorization on file**, providers should seek authorization from the CCO/FCHP (if the member was in a CCO/FCHP during the qualifying hospital stay) or the local AAA/ APD office (for all other members).
- **Who is responsible if the member's enrollment changes?** If the member's enrollment status changes at any time during days 1-20, providers will need to contact DMAP to make sure the member is returned to the status that was in effect at the time of the qualifying hospital stay so that their claims can process appropriately.
- **Who is responsible for days 21 through discharge for CCO/FCHP members?** A CCO/FCHP is only responsible for PHEC coverage (days 1 through 20); days 21 forward are LTC services to be billed to DMAP, as

long as the AAA/APD office has approved LTC eligibility for the member. Only bill the CCO/FCHP for no more than 20 days; bill DMAP for days 21 forward.

Hospice services for NF residents

Hospice agencies are federally required to reimburse NFs for room and board provided to Medicaid residents receiving hospice services.

- **Who is responsible for payment?** Hospice agencies must bill DMAP for hospice services and NF room and board to all OHP members who elect hospice care (including CCO, FCHP and PCO members).
- **To learn more:** See OAR 410-142-0290(6) of DMAP’s [Hospice Services guidelines](#).

3. Providers should bill LTC services to DMAP for all OHP members

CCOs and physical health plans (FCHP/PCO) are **not** responsible for payment of LTC services. When CCO/Plan members are deemed eligible for LTC services, providers need to bill DMAP, not the CCO/Plan, for those services.

- LTC services are **not** included in OHP Plus benefits (MMIS codes BMH, BMD, BMM).
- LTC services are assigned separate MMIS benefit package codes (for example, NFC for nursing home services). To view other benefit package codes, view DMAP’s [MMIS benefit code descriptions](#).

For a more detailed description of LTC services, please see this [fact sheet about Oregon’s Long-Term Care System](#).

If you have any questions about this information, contact:

LTC eligibility	
PHEC authorization for FFS/PCO members	Local AAA/APD office
CCO/Plan services	MAP Account Representatives
Nursing facility and PHEC policy	Becky Callicrate, Medicaid LTC Policy Analyst becky.callicrate@state.or.us
Hospice services policy	Judith Van Osdol, Hospice Policy Analyst judith.p.van-osdol@state.or.us