pennsylvania
DEPARTMENT OF HUMAN SERVICES

COMMUNITY HEALTHCHOICES (CHC)

OPERATIONS MEMORANDUM #2018-05

SUBJECT: When Nursing Facilities (NF) Should Bill a CHC-Managed Care Organization (MCO), a HealthChoices (HC)-MCO, the Fee-for Service (FFS) Program, or a Hospice Provider

TO: CHC-MCOs

FROM: Bureau of Coordinated and Integrated Services

DATE: June 25, 2018

PURPOSE

NF providers enrolled in Pennsylvania's Medical Assistance (MA) Program will primarily bill a CHC-MCO for providing services to residents eligible to receive NF services under the MA Program. However, depending upon a NF resident's eligibility and enrollment status, a NF may need to bill a HC-MCO or the FFS Program for a limited period of time. The CHC-MCO is responsible for payment of NF services rendered to a CHC Participant on or after their start date with the CHC-MCO, assuming the County Assistance Office (CAO) determines the Participant is eligible to receive long-term care (LTC) services. The MA Program is the payor of last resort. This Operations Memorandum explains CHC-MCO responsibility, in accordance with Sections V-O and VII-E-2 of the CHC Agreement, in several NF resident billing scenarios.

PROCEDURES

NF resident moves from FFS to CHC

If the NF resident is determined eligible to receive LTC services, the NF will be reimbursed under the department's FFS program for the retroactive period and from the date of application through the date eligibility is determined. The CHC-MCO will reimburse the NF beginning the day after eligibility is determined. This is also the day the resident is enrolled in CHC. If a resident is ineligible for LTC services based on a

penalty period, the CHC-MCO must monitor a Participant's penalty period. The 834 daily file displays penalty periods.

NF resident moves from HC to CHC

The HC-MCO will reimburse the NF up to 30 consecutive days as a covered service under physical health. The 30-day period begins with the date of admission and includes hospital reserved bed days, therapeutic leave days and transfers between NFs during the 30-day period. The 30-day period may run concurrently with a Medicare stay. The HC-MCO will reimburse the NF for day 31 through the date the eligibility determination is made if the resident is determined eligible to receive LTC services. The CHC-MCO will reimburse the NF beginning the day after eligibility is determined, which is the day the resident is enrolled in CHC. If the HC Participant is determined ineligible for LTC services, the Participant will remain in HC.

CHC community participant needs NF services

The CHC-MCO will reimburse the NF up to 30 consecutive days as a covered service under physical health. The 30-day period begins with the date of admission and includes hospital reserved bed days, therapeutic leave days and transfers between NFs during the 30-day period. The 30-day period may run concurrently with a Medicare stay. The CHC-MCO will reimburse the NF for services provided beyond 30 days if the CHC Participant is determined eligible for LTC care services. If the CHC Participant is determined ineligible for LTC services, the CHC-MCO may not pay for services that a Participant is not eligible to receive. The CHC-MCO must monitor a Participant's penalty period if applicable. The 834 daily file displays penalty periods.

CHC participant receiving hospice care in a NF

The CHC-MCO will reimburse the NF for room and board if the CHC Participant is determined eligible for LTC services and is receiving the routine home care day hospice benefit or the continuous home care day hospice benefit through Medicare or MA. The CHC-MCO will not reimburse the NF for room and board if the CHC participant is receiving the inpatient respite care hospice benefit or the general inpatient care hospice benefit since the hospice benefit paid to the hospice provider covers a stay in an inpatient facility.

Communications

The PA162 eligibility notice displays an individual's eligibility, gross patient pay and/or penalty period. The County Assistance Office (CAO) mails copies to the NF resident/representative and NF.

The Electronic Verification System (EVS) is a real-time, online recipient eligibility verification system. EVS accurately provides the most current eligibility status information for MA recipients 24 hours a day, seven days a week. It verifies eligibility information clearly, concisely, and rapidly. The information provided by EVS notifies providers of the recipient's eligibility, allowing providers to make informed decisions regarding the billing for services to be rendered. A few of the items available on EVS are recipient eligibility, third party resources, recipient inpatient patient pay/gross patient pay amount and MCO enrollment and enrollment dates. More information is available at *Internal Link Redacted*

The daily process for the 834 Daily file creates a file for each CHC-MCO and Behavioral Health (BH)-MCO that reflects changes that were applied to the Client Information System (CIS) that day for their recipients. Any online modification of address, category of assistance, county and district indicators, facility code, change of MA eligibility or plan coverage, or central office transaction will result in a record being written to this file. Third-party liability (TPL) data is included in this file when it overlaps with managed care coverage. More information is available at *Internal Link Redacted*

NEXT STEPS

1. Review this information with appropriate staff.
2. Contact the Bureau of Coordinated and Integrated Services if you have questions.