

Nebraska Medicaid Managed Care Program Hospice Carve-In Questions and Answers Effective July 1, 2015

- 1. If an individual is on hospice with a hospice provider on June 30, 2015, does the hospice provider need to re-obtain authorization to continue care on July 1, 2015?**

The Managed Care Organizations (MCOs) will honor Nebraska Medicaid prior authorizations for clients receiving hospice services. The MCOs have requested provider contact regarding prior authorizations, as each MCO has its own review process to determine that all needed services are being provided.

- 2. If an individual is on Nebraska Medicaid Fee-for-Service (FFS) on June 30, 2015 and receiving hospice care at home, does that individual become eligible for Managed Care on July 1, 2015, since he or she is part of the new carve-in population?**

Yes, if the individual is included in a category mandatory for Managed Care enrollment.

- 3. If an individual is on FFS, does the provider submit a bill to FFS for services provided through June 30, 2015, and then submit a bill to the MCO from July 1, 2015 moving forward?**

Yes.

- 4. What happens during the July 1, 2015 transition if the hospice provider currently providing services is not part of the MCO network? Do they discontinue services? Is there a process in place that addresses this?**

The physical health MCOs request provider contact as soon as possible in such situations. The MCOs will work with hospice providers on payment during the transition. Each MCO has a process in place to address this type of situation.

- 5. Does the Prior Authorization form indicate how long the hospice authorization is for?**

Yes, however the authorization forms and timeframes may vary between MCOs.

- 6. Does the patient need to be reauthorized if the patient was originally authorized for 6 months, but continues to require care?**

The MCO may request a new authorization form or extend authorization based on the patient needs and the MCO's policy.

- 7. Is the authorization inclusive of all hospice services such as Chaplain and Bereavement counseling?**

The MCO reviews each member's case to ensure that the appropriate services are being provided based on the member's needs. The MCO requires the submission of a new authorization form if new services are requested.

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8. What will be the process for authorization?

The MCOs report the process will remain the same. The provider will work with the doctor to determine the patient's need for hospice services.

9. If one is receiving Hospice in their home and transitions to the Nursing facility, how is it billed?

The MCOs will notify Medicaid of the need for the individual to be waived out of Managed Care due to a move to the facility. If it is determined the person needs to be waived, then Nebraska Medicaid FFS coverage will be initiated.

10. Will the Hospice provider's reimbursement be affected if a family member or individual caring for the person needs relief and the patient goes to Inpatient Respite Care?

If respite care is being requested, it is considered an additional service so the MCO will need to be contacted for authorization. Each MCO can explain their provider reimbursement procedure at that time. Per the network agreement between the MCO and the hospice provider, the MCO will get a bill from the hospice provider that reflects the respite stay in the facility. The MCO will pay the hospice provider and the provider will pay the facility for the respite care. The member will not be waived from Managed Care to Fee-For-Service for respite services provided in a nursing facility.

11. What is going to be the process for someone who wants to reside at a licensed inpatient hospice facility?

Medicaid funds cannot be used to pay room and board at a licensed inpatient hospice facility for a Managed Care member. The provider is encouraged to contact the MCO to determine if the MCO would consider providing room and board as a value added service.

12. Who pays for Hospice care when the individual resides in an ICF (Intermediate Care Facility for Persons with Developmental Disabilities) such as Mosaic?

Individuals residing in ICFs are not enrolled in physical health Managed Care. Providers will need to submit claims to Nebraska Medicaid Fee-for-Service for these clients.

13. Who pays for Hospice care when a person resides in a Veterans Home?

The Veterans Home is responsible for the hospice care of an individual residing in a Veterans Home.

14. When a member is in acute care and needs to transition to custodial care hospice, how is this paid?

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If the member requires hospice in a custodial care setting, the MCO will submit a request to the Managed Care Unit to waive the member out of Managed Care when the transition occurs. The hospice provider will need to submit claims to Nebraska Medicaid Fee-For-Service for hospice care provided in the nursing facility.

- 15. If a member goes to a nursing facility for respite care and it is determined by the provider that the person is no longer suitable for home hospice, will the member will be waived out of Managed Care?**

Yes, the MCO will submit a request to the Managed Care Unit to waive the member out of Managed Care when the transition occurs.

- 16. Will Out-of-State Providers be paid by the MCOs?**

Out-of-state providers need to first be enrolled into Nebraska Medicaid. Once a provider is enrolled as a Nebraska Medicaid Provider, each MCOs will work directly with the out-of-state provider on network enrollment.

- 17. Will a member be waived out of Managed Care if he or she goes to a nursing facility for general inpatient care?**

No, general inpatient care is short term and is designed to stabilize the patient, so the patient can return home.

- 18. If one becomes Medicaid eligible and is enrolled in Managed Care, when does he or she become active to begin receiving Managed Care benefits?**

The individual will become active the 1st of the month in which he or she is enrolled into Managed Care. For example, if one is enrolled on July 16, he or she begins receiving Managed Care benefits on July 1.

- 19. Are there MCO contact names that a home hospice provider could contact to inquire about becoming part of an MCO's network?**

- *Aetna Better Health of Nebraska: Tammy Clemens, 402-995-7068*
- *Arbor Health Plan: Adam Steffen, 402-507-5885*
- *UnitedHealthCare Community Plan: John Bielecki, 1-952-202-8700*

- 20. Are there MCO contact names that a home hospice provide can contact to inquire authorization concerns or issues?**

- *Aetna Better Health of Nebraska: Karma Boll, 402-995-7039*

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- *Arbor Health Plan: Chris Sorensen, 402-507-5891*
- *UnitedHealthCare Community Plan: Barb Palmer, 402-445-5671*

21. If a home hospice patient needs acute care in a facility and it is after hours/on a weekend, does the Hospice provider need to get pre-authorization?

Yes.

22. What is the process to get a prior authorization after hours/on the weekend?

For urgent after hours hospice authorizations, Aetna Better Health of Nebraska's prior authorization telephone number is 1-888-784-2693. Non-urgent authorization requests may be faxed to Aetna Better Health of Nebraska at 1-844-213-9659.

Arbor Health Plan has 24 hour phone coverage. Member Services will answer the call, take a message and contact the nurse on call. Hospice providers should place immediate need calls to the Utilization Management (UM) phone line at 866-729-0076.

UnitedHealthcare Community Plan has a 24-hour fax line (866-622-1428) which hospice providers will need to use for after hour prior authorization requests. The telephone number for prior authorization requests is 866-604-3267.

23. How quickly can a hospice provider expect a response from the MCO for an immediate need after hours/on the weekend?

Aetna Better Health of Nebraska: 2 hours
Arbor Health Plan: 1-2 hours
UnitedHealthcare Community Plan: 72 hours