



**QUESTIONS FROM HOME CARE ASSOCIATION
EOHHS RESPONSES
JULY 31, 2013**

Question	EOHHS Response
Who will be the first line of contact for home care and hospice agencies regarding client issues (something agencies would address with a social worker in the current system)?	For Rhody Health Options, the first line of contact would be the lead care manager at the contracted health plan. The health plan will provide the agencies with contact phone numbers prior to go live. For the Connect Care Choice Community Partners (CCCCP) program, the individual's lead care manger would be the first line of contact.
Where will referrals come from?	Referrals for home care will come from either the CCCCCP state staff lead care manager or the lead care manager at the contracted health plan.
What can home care and hospice clients expect of the transition process? i.e. gaps in service due to authorization delays, or reduced services due to fewer hours authorized?	There should be no gaps in services for any clients currently receiving LTSS. The health plan will honor the existing level of authorized service hours for a period of time, and will work with the member/caregiver/agency to develop a new plan of care, if that is appropriate. EOHHS will closely monitor any reductions in levels of service authorizations. Under CCCCCP, the state would continue to authorize services. Health Plans have required time frames, per DOH regulation, to respond to prior authorization requests for services.
Will the new system have the same consideration for high-acuity clients as the current one does?	EOHHS needs more detail to respond to this question.
Will the new ICI administrator give consideration to taking over or re-working the current EDS software, as it is already available and familiar to providers, and is free of charge in a system where the home care and hospice industry is already under-reimbursed?	The contracted health plan will work with agencies that bill using PES in order to create a billing method that will work for both parties. The contracted health plan currently does not use the PES program.
Who will be responsible for keeping authorizations current?	Either the CCCCCP state staff or the RHO health plan, depending on where the member is enrolled. The provider has the responsibility to request authorizations or extensions/modifications of authorizations for any level

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	of care or service that requires prior authorization.
Who will be responsible for notifying agencies of changes to a client's payer source?	The provider is always responsible to verify eligibility on an on-going basis. This gives the provider the opportunity to deal with possible eligibility issues as quick as possible.
Providers have been told in the past that "possession of an authorization is no guarantee of payment." What reassurance does a provider have that they will be paid for services rendered in the new ICI system?	<p>Authorizations are given based on the information that is available at the time the authorization is granted. In some cases the member maybe retroactively terminated but the plan can assist you with these cases to resolve. (This also speaks to the importance in verifying eligibility.)</p> <p>For CCCCCP the payment system remains unchanged as do the requirements for verifying eligibility.</p>
What payment frequencies can agencies expect from the new ICI administrator?	<p>The RHO Health Plan will pay claims weekly.</p> <p>For 4CP, the payment will continue under the FFS payment process.</p>
What recourse, other than withholding services, does a home care or hospice agency have if the new ICI administrator is not making timely payments to claims?	EOHHS would not support withholding services to clients. Agencies are responsible for submitting clean claims for payment using correct billing codes and in a timely fashion. Providers have appeal rights with the RHO health plan if a claim is denied. Providers will also have a dedicated provider representative at the health plan to contact if there are billing issues. This provider rep is the first line responder for these billing issues at the health plan.
Currently, it is not the responsibility of the home care agency to obtain doctor's orders for non-skilled home care services through DHS programs. Who will this responsibility fall to in the new system?	For RHO health plan enrollees, a physician requested prior authorization has been and will continue to be required for non-skilled services.
Will home nursing care or hospice agencies be appropriately compensated for nursing visits – both initial and quarterly?	Please define "appropriately compensated". Any conversations regarding provider reimbursement should be directed to the RHO plan.
Is the ICI also responsible for a client's nursing home and/or hospital expenses? If not, what is the incentive to keep individuals in their homes?	<p>The RHO health plan is responsible for all Medicaid funded services, including nursing home payments and/or hospital services when Medicaid is the primary payer. If Medicare is the primary payer, then Medicare reimburses inpatient hospital care, up to the current coverage requirements.</p> <p>For CCCCCP, the payments continue under the FFS.</p>
How will home care agencies receive referrals in the future?	The question regarding referrals was answered above.

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<p>Will they still be from caseworkers at DHS? How will clients decide whether they want to use the State Medicaid (can dual eligible stay just as they are if they want – where home care agencies bill HP?), Rhody Health Partners, PACE or Connect Care Choice? Who will clients be talking to in order to decide this?</p>	<p>DHS workers will still be responsible for eligibility for LTSS.</p> <p>Clients will be mailed letters and fact sheets with information about all programs, and will be given a dedicated Help Line phone number to call to get more information. Copies of the consumer letters are on the EOHHS website. Clients will be auto-assigned to one of the two programs, but will be able to opt-out to fee-for-service Medicaid if they choose to.</p>
<p>Will Medicaid only home care agencies be treated any differently than home care agencies that do Medicare <u>and</u> Medicaid as it relates to referrals?</p>	<p>Please define “treated differently”.</p>
<p>What will home care agencies be able to talk to their clients about as far as the plans go, especially if there are no family members to explain anything to them? Clients may be uncomfortable calling an 800 number for the state when they know the home care nurses that go out to assess them every 60 days.</p>	<p>EOHHS would appreciate assistance in explaining the positive value of having two programs. If you have particular clients that you would like the RHO insurer to contact them directly, we can provide you a mechanism to do so. At no time should a provider be making the choice of insurers on their patient’s behalf.</p>
<p>Will insurance companies be reimbursing for initial admissions and assessments, re-assessments, etc. by home care agencies?</p>	<p>All reimbursement questions should be directed to the RHO health plan.</p>
<p>Will Medicaid-only home care agencies need to have some type of contract with a Connect Care Choice company in order to take care of their clients like home care agencies will with insurance companies?</p>	<p>If a home care agency is already enrolled as a FFS provider, they do not need to take any additional action to continue to see CCC members.</p>
<p>Will home care BHDDH, Medicaid-only pediatric and adult clients remain as is, with agencies billing HP as they do now?</p>	<p>BHDDH funded services for DD clients are carved out from the RHO contract. All other home care services are authorized and reimbursed by the RHO health plan.</p>
<p>Will all insurance companies (and CCC) be required to sign contracts with ALL Medicaid and Medicare home care agencies interested in obtaining contracts with them?</p>	<p>The RHO health plan is required to have a network of home care providers that meet quality standards and that is adequate to meet the needs of the members enrolled in the health plan.</p> <p>For CCCC, the current Medicaid providers do not need to take any action.</p>
<p>If the cases will be coming from insurance company workers, will they be providing diagnoses for the clients like the state</p>	<p>This may depend on how the care managers get the member’s medical information. This is in the process of being reviewed and can be answered</p>

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<p>caseworkers do now? If they do, can it be required that they provide the diagnoses as well as the accurate ICD-10 code for the diagnoses so that they will not be able to deny billing for the home care agencies billing with the wrong code?</p>	<p>at a later date.</p>
<p>Is there any information that is licensure/service specific under ICI for home care, home nursing care, home hospice, or inpatient hospice that RIPHC members should be aware as ICI moves forward?</p>	<p>The agencies should have current state licenses to operate. For CCCCCP, the current Medicaid provider requirements do not change.</p>