

## **NYS Medicaid Billing Policies regarding Hurricane Sandy:**

### **I. General Principles:**

- a. Medicaid intends on paying claims in a timely fashion to avoid cash flow issues for healthcare facilities as a result of this emergency.
- b. Payments were developed using policies and existing state plan methodologies where applicable to develop fair and equitable payments for both evacuated and receiving facilities as it relates to patient care. These payments will be applied for the initial five days for nursing facilities.
- c. Medicaid payments for nursing facility residents will be made to the facility (hospital or nursing home) which provided the actual services to the resident beyond the initial five day period.
- d. All Medicaid fee-for-service submitted claims related to patients affected by this emergency, whether transferred out or received between health care providers or other service providers must include "DR" (Disaster Related) in the condition code field of the claim. This will provide the Office of Health Insurance Programs (OHIP) with the ability to track these claims to determine appropriate payments made as well as for research related to this emergency.

### **II. General Billing Policies/Scenarios:**

**1. A nursing home patient who was transferred to a hospital** - the nursing home would get 100% of the average downstate daily nursing home rate and the hospital would get 100% of the average downstate Alternate Level of Care (ALC) rate for the initial five days. An average downstate specialty nursing home rate will apply for the specialty nursing home residents. For billing after the initial five day period, see Section II-6 below.

**2. A nursing home patient is transferred to another nursing home (NH)**- both the transferring NH and receiving NH will receive 100% of the average downstate daily nursing home rate for the initial five days. An average downstate specialty rate will apply for the specialty residents. For billing after the initial five day period, see Section II-5 below.

**3. A hospital patient who was transferred to another hospital and subsequently discharged from the receiving hospital**- the evacuating hospital would have received a transfer payment up to the full inlier DRG amount if already billed as per normal Medicaid transfer policy. The evacuating hospital will now be brought up to a full DRG if they previously received the transfer payment for this emergency. The receiving hospital would be paid the full DRG at the appropriate APR-DRG level of care for the stay based upon diagnosis upon admission and services provided by receiving hospital as per current Medicaid payment policies.

**4. Other – Nursing Home to Shelter or Temporarily Home** – the transferring nursing home would receive 95% of the average downstate daily nursing home rate for the initial five days.

**5. Payment for Medicaid nursing facility residents after the initial five day period** - Medicaid payments for nursing facility residents will be made to the licensed Medicaid provider which provided the actual services to the resident beyond the initial five day period. A reconciliation will be implemented for both evacuating and receiving facilities.

- The sending facility will not be reimbursed by the NYS Medicaid Program beyond the initial five day period. Receiving facilities will be reimbursed at their specific rate subsequent to the initial five day period.
- If a sending or receiving nursing home has already negotiated payments for patients evacuated as of the date of the issuance of this Guidance (February 6, 2013), it will be taken into account as part of the reconciliation process.

**6. Payment for Medicaid nursing home patient who was transferred to a hospital after the initial five day period** – Medicaid payments for a nursing home patient in the hospital beyond the five day period will be the facility's specific Alternate Level of Care (ALC) rate. A reconciliation will be implemented for both evacuating and receiving facilities. The sending facility will not be reimbursed by the NYS Medicaid Program beyond the initial five day period.

### **III. General Billing Policies for Patient Care Services:**

#### **1. Transportation:**

Reimbursement for transportation -- the initial transport as part of the pre-landfall emergency evacuation should be covered under FEMA Public Assistance Category B (Emergency Protective Measures). (Transportation back to the originating facility post-emergency is a different issue; consult your FEMA contact.) Providers should work through their FEMA contact (the local county FEMA representative) for specifics. FEMA funds can be requested for transportation expenses if not covered by other parties (Medicare, Medicaid or commercial policies). Medicare will not recognize these additional transportation costs related to this emergency.

For ambulance transportation – if OHIP determines that these transports were medically necessary (based upon life-safety) in an emergency situation for Medicaid patients, the ambulance companies could be paid directly. There are two levels of Transportation: Basic Living Support (BLS) and a Higher Level (HL).

## 2. Capital:

Could FEMA dollars be used for damage expenses? ***Facilities in counties that may be declared disaster counties by the President, must apply to FEMA through their county for reimbursement for damages. The kick off for FEMA will be applicants' conferences which would be scheduled by FEMA.***

## 3. Operating:

Are expenses that were incurred for preparing for the storm reimbursable? For example, if additional costs incurred on overtime in preparation of evacuation, but then evacuation wasn't necessary, can those expenses be reimbursed? ***These costs are not reimbursable by Medicaid, but may be eligible for consideration by FEMA, but you would have to apply directly to FEMA.***

## 4. Other Important Technical Information:

- a. Reconciliation - The Department will be establishing a reconciliation process to determine the correct payments made to facilities affected by Hurricane Sandy in accordance with the scenarios presented in Section II. A key factor in this process will be the "DR" code on the claims submitted. Providers may be requested to submit additional information after reports are generated from the eMedNY system for claims with that code.
- b. In order for Medicaid to consider reimbursement related to any of the above services, the provider must be able to submit the following information on a reconciliation survey so that verification after the fact can be completed.
  - i. Medicaid Patient ID number
  - ii. Dates of Service
  - iii. What facility was the resident transferred to/received from