NEW YORK STATE OF OPPORTUNITY. Department of Health

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TRANSITION OF NURSING HOME POPULATIONS AND BENEFITS TO MEDICIAD MANAGED CARE FREQUENTLY ASKED QUESTIONS

1. By requiring a Medicare exempt letter, plans are not allowing electronic billing. How can DOH ensure electronic billing is processed correctly?

   Plans are responsible for ensuring that Medicaid is the payor of last resort. Plans are encouraged to utilize the most appropriate methods to verify Medicaid coverage while placing the least amount of administrative burden as possible on the provider. This can include electronic attachments, targeted review and provider education.

2. A MLTC Plan is holding claims for more than 120 days. The provider has not been given a formal denial on paper, an explanation of benefits (EOB), or anything indicating the reason claims are being denied. The Plan indicates that it is looking into the claims. The provider is awaiting 25K in payment.

   There are no changes to prompt payment laws under this transition. Providers may file a complaint with DFS if it is believed a plan is in violation of these laws.

3. Will a Medicaid Managed Care Plan allow a resident to stay in the NH indefinitely?

   As long as it is deemed medically necessary, the plan is required to cover appropriate

4. What are the responsibilities of a plan to pay in instances of: no further medical necessity and no discharge plan for member, safe discharges and attempts made by provider to find a safe discharge?

   The plan and provider should work together to arrange for a safe discharge. The plan remains responsible for covering NH services while the enrollee remains in the NH.

5. How will the Assisted living Program (ALP) be impacted by this transition?

   ALP residents remain excluded from MMC and MLTC enrollment under this transition.

6. Is there someone who will act as liaison between facilities and the health plans as issues arise?

   The NH and the Plan should work cooperatively to resolve issues. If unable to reach a resolution, plans and providers may contact DOH for assistance.

7. Is DOH addressing contracting "lock out?" Some MCOs are presenting are unwilling to negotiate contract terms once they have satisfied their network requirements.

   Plans are not required to negotiate with every nursing home. Plans must meet network standards set forth by the State. The Department is encouraging plans to contract with multiple nursing homes to meet the needs of enrollees.

8. What should a provider do if experiencing difficulties negotiating a contract with a MMC or MLTC?

   Providers that are unable to negotiate a contract with plans may file a complaint with DOH.

9. A NH provider has stated that a plan is retroactively denying care. For example, MMC plan authorized service through Tuesday of one week. On Wednesday following that Tuesday, the provider was sent a denial ending services on Tuesday and not authorizing further. What does a provider do to obtain payment for the days during which it is trying to find a place for patient? Who will pay the custodial care?

   The Plan is responsible to pay the NH until a safe discharge plan is in place. Plans and providers need to work collaboratively to establish such processes.

10. If a MLTC plan is responsible for recertification, why do some residents appear as not covered on E-Paces?

    Consumers are responsible for recertification. The plan and nursing home may assist with this process. Providers encountering these issues should submit specific cases to NYS DOH for inquiry.

11. How does a facility know the NAMI amount to collect from a MLTC resident before the budget letter is sent?

    The NAMI amount appears on the notice once eligibility is determined.

12. We have heard that some MLTC and MMC plans are unwilling to negotiate contracts, if a NH provider is unwilling to accept responsibility for collection of NAMI that falls to the plans.

    NAMI collection arrangements are based on the contract between the plan and the Nursing Home.

13. Some NH patients were passively enrolled into a FIDA plan. Can the facility dis-enroll these clients out of the FIDA plan and into traditional Medicare?

    Nursing facilities cannot "dis-enroll" FIDA participants from the FIDA program. If a FIDA participant wishes to dis-enroll from the FIDA program, he/she, or an authorized representative, can call New York Medicaid Choice to request disenrollment from FIDA and enrollment into an MLTC plan.

14. A Medicaid application was completed for a consumer admitted for long term placement in January 2015, with traditional Medicare as primary payer and Medicaid LTCP secondary. The completed forms were sent to HRA, including disenrollment documentation, and HRA has denied Medicaid to FFS request. Should FFS Medicaid have been allowed, the consumer dis-enrolled from MLTC, since the date of permanence was prior to the transition date of 2/1/2015 in NYC?

    The transition to Medicaid managed care is based on the date of permanence.

15. When a resident is admitted to facility for long term placement after the applicable transition date, and is approved for Medicaid, we notify the consumer that they must call Medicaid Choice and select a plan for enrollment. The consumer indicates that they will remain in FFS Medicaid until they are transferred to the hospital.

    The LDSS is responsible for entering the N7 code into the system for consumers found eligible for Medicaid coverage of long term NH placement. This triggers the outreach and enrollment process with the enrollment broker, New York Medicaid Choice (NYMC). NYMC will conduct outreach to eligible consumers or plan selection and enrollment. The NH is not responsible for directing consumers to initiate this process.

16. A dual eligible beneficiary is either: (1) receiving Medicare Part A hospice benefits in the community and requires admission to a nursing home; or (2) is admitted to a nursing home and subsequently elects to receive the hospice benefit. Assume that the person is not yet enrolled in a Medicaid managed care plan, but would otherwise be required to enroll since he/she is Medicaid eligible, is receiving custodial care and

it is after the transition date. Will the individual be required to enroll in a plan during the time he/she is receiving hospice services?

A Medicaid beneficiary who is already receiving hospice services either in the community or in the nursing home is excluded from the requirement to enroll in either a mainstream Medicaid managed care plan or a Managed Long Term Care plan for as long as he/she is receiving hospice services.

A consumer entering a nursing home for permanent placement after the transition date would be required to enroll in a MMC or MLTC plan. In the event the beneficiary was in need of hospice services at a later date, the care would be covered by the plan.

17. If a nursing home's benchmark rate includes payment for ancillary services that the facility provides directly (e.g., medical staff services, therapies, diagnostic services, etc.) which could also be billable to Medicare Part B, how would the reimbursement work under managed care?

    In such instances, the managed care plan would pay the nursing home the Medicare Part B eligible benchmark rate, which includes those ancillary services. As it does under fee-for-service, the nursing home would bill and retain any payments received from Medicare Part B for those ancillary services.

18. If a facility does not have any contracts, should that facility notify the Department and, if so, what will the Department do?

    The Department ensures that plans meet minimum provider network requirements, and may discern if a facility is considered an essential provider in the community. In that case, the Department may direct plans to contract with the facility.

19. Assume that a resident of a facility that is not part of any plan provider network, who is not enrolled in a plan, is otherwise required to transition to managed care (due to initiation of custodial care, etc.) but wants to remain in that facility. Will that resident still be required to enroll in a plan? If so, how would he/she be assigned to a plan?

    A resident of a facility that is not part of any plan provider network would not be required to enroll. Once the facility entered into a contract with a plan, beneficiaries in permanent status after the transition date would be enrolled in that plan.

20. How does the "grandfathered" resident rule operate in various scenarios?

Consumers in permanent status prior to the transition date are not required to enroll in a MMC or MLTC plan. If the consumer leaves the facility without bed hold in place or if bed hold days expire, the consumer is considered a new placement, and would be required to enroll in a plan to obtain Medicaid coverage for long term nursing home services.

21. FAQ #85 from the March 2015 FAQs states as follows: Q: "Will a resident of a NH with FFS Medicaid who is discharged to a hospital and is readmitted to the facility, and who was previously determined eligible for long term care, be required to enroll in managed care?" A: "Consumers who are admitted to the NH for a short term or rehab stay are not required to enroll in managed care. Consumers in receipt of fee for service Medicaid and in long term placement who are discharged to a hospital and readmitted to the NH will not be required to enroll in a managed care plan if bed hold is in place. If bed hold is not in place or has expired, the placement is considered to be new and the consumer would be required to enroll in a plan contracting with the nursing home." At issue is the wording around bed hold. In instances when Medicaid will not pay for the bed hold or ceases to pay for it, it is possible that the resident's family/friend voluntarily arranged to pay for the bed hold or that the facility is willing to hold the bed for the resident for a time period even though Medicaid is not making payment. In such instances, if the facility elects to not formally discharge the resident (and is not otherwise required to do so), the resident should not be required to enroll in a plan. Please clarify.

    Bed hold only applies to allowable Medicaid bed hold days. Once Medicaid bed hold days are exhausted, a consumer returning to the facility would be required to enroll in a plan.

22. FAQ #86 from the March 2015 FAQs states as follows: Q: "If a consumer is currently in the nursing home for long term care, perhaps under private pay, then needs to transition into Medicaid, is he or she required to enroll in managed care or do they have the option of traditional FFS Medicaid?" A: "Consumers whose long term placement is established prior to the transition date would not be required to enroll in a Medicaid managed care plan." This response seems to conflict with the information provided in FAQ #9 from the January 2015 FAQs, which suggests that such a person would be required to enroll in a plan after being determined Medicaid eligible. Please clarify.

    This transition is based upon the date of permanence, not the date of the Medicaid application or eligibility determination. Consumers in permanent status prior to the transition date would not be required to enroll in a MMC or MLTC plan.

23. Member nursing homes have reported referring residents/representatives to New York Medicaid Choice, only to reach representatives who were unfamiliar with the nursing home transition requirements.

NYMC field staff contact the facility and consumer to initiate outreach once the consumer is identified as eligible for enrollment.

24. Similarly, some local social services district personnel were unfamiliar with the transition requirements.

    DOH is conducting webinars and conference calls with the local departments of social services to ensure staff are knowledgeable about the process and requirements of this transition.

25. Plans and providers continue to have questions as well.

    New York City HRA offered a series of trainings to providers and other stakeholders on the nursing home transition in June, which were most helpful in clarifying the roles of the local district, facilities, plans and New York Medicaid Choice under the transition policy. We strongly encourage the Department to work with other local districts and these other stakeholders to conduct such trainings upstate. LeadingAge NY would be pleased to participate in this process.

    DOH continues to meet with plans and providers. Questions may be submitted to: MRTupdates@health.ny.gov.

26. Does this transition apply to specialty pediatric long-term care skilled nursing facilities or are specialty pediatric facilities excluded?

    This transition applies only to consumers age 21 and older at the time of permanent placement.

27. On 7/9/15, a Medicaid recipient under 21 years of age was admitted to St. Margaret's Center for long-term care skilled nursing services. While the admission date was after the Oneida County transition rollout date of 7/1/15, is this resident required to enroll in a managed care plan since the resident is under 21 years of age?

    This transition applied only to consumers age 21 and older at the time of permanent placement.

28. The 20 young adult beds are at 100% capacity. There are 9 residents (Medicaid recipients admitted prior to their 21st birthday) who remain in pediatric non-ventilator beds because there are no vacant young adult beds in our facility. For residents aged 21 and over, bed reservation regulations allow 14 eligible hospital

days and 10 therapeutic leave of absence days within a 12-month period. Do these bed reservation regulations apply to the 9 residents who remain in the pediatric non-ventilator beds?

This transition applies only to consumers age 21 and older at the time of permanent placement.