TRANSITION OF NURSING HOME BENEFIT AND POPULATION TO MANAGED CARE
UNRESOLVED QUESTIONS/ISSUES AND RECOMMENDATIONS

1. Cash Flow

Issue	Recommendation(s)
• Delays in obtaining authorizations from plans for permanent placement	• Required contractual or other timeframes for making determinations on placements • "Presumptive" authorization under defined circumstances • Continuity of care requirement for 90-180 days after enrollment in a plan for person already placed
• Frequency of billing	• Contractual or other requirement that plans must accommodate billing on at least a biweekly basis, except where not currently practicable and mutually agreed to by the provider and plan
• Bill transmission	• Contractual or other requirement that plans must accommodate electronic billing in addition to paper billing.
• Bill payment and remittance	• Contractual or other requirement that plans must be able to accommodate electronic funds transfer and electronic remittance in addition to paper remittance and payment
• Differing billing codes	• Convene group of DOH, plans and providers to discuss potential standardization efforts
• Need for advances	• Identify policy criteria for advance or interim (i.e., concurrent) payments by plans • Develop expedited process for DOH to provide advance fee-for-service (FFS) check releases
• Delays in case-mix index (CMI) updates	• DOH should work with OMIG to eliminate current delay and provide CMI updates to facilities and plans on a semi-annual basis
• Payment to facility while chronic care eligibility determination is pending	• Requirement should apply to both mainstream and MLTC plans, if it doesn't already

2. Other Payment Areas

Issue	Recommendation(s)
• No adjustment embedded in MLTC premiums to account for varying nursing home rates	• Modify MMCOR report to include a schedule identifying benchmark rates and patient days paid by plan for all contracts and out-of-network (OON) activity for permanent placements. Use to update payments to plans on a quarterly basis through a reconciliation pool that results in plans being paid based on what they pay facilities

Issue	Recommendation(s)
• No distinct specialty rate codes for MLTCs to bill	• Adjust payments to MLTCs as suggested above to account for any specialty facility volume. These rates are much higher than average benchmark rates
• Concern that existing contracts may include a rate of payment less than the benchmark rate required during transition	• The rate requirements should be enforced as of the effective date of the transition to managed care, perhaps by requiring new contracts to cover this new benefit
• Party responsible for NAMI collection and distribution of personal needs allowance	• Standard contract provisions should include a default provision that assigns responsibility to the plan. Any variance would need to be voluntarily and expressly agreed to by contract • DOH should vigorously advocate with CMS for State takeover of these functions
• Party responsible for coordination of benefits (COB) and entitlement to COB amounts	• If the facility bills the lower Medicare Part B eligible rate to the plan, it should collect and be entitled to retain any receipts for Part B services furnished by the facility • Contract provisions should spell out other COB policies around collections and retention of funds • If a plan also has a Medicare product that a Medicaid enrollee is participating in, the plan should have the capability to cross-over the claim and pay items like co-insurance
• Responsibility for paying Medicare coinsurance for Part A/Part B covered services rendered in the nursing home for permanently placed residents	• Clarify that a plan is responsible for paying these amounts to the facility for an enrollee
• If a plan dis-enrolls resident, either for failure to pay NAMI or any other reason, how does facility get paid for services and would the resident be required to enroll in a different plan?	• Clarification sought; no recommendation
• Timely coding in eMedNY of plan enrollment – recipient appears as FFS when admitted from the community	• Recipient coding in eMedNY should be revised on or before effective date of enrollment in a mainstream or MLTC plan
• Definition of “fee for service rate in effect at the time of service” for purposes of paying for OON services?	• OON payments should encompass the entire FFS rate, inclusive of operating, capital, quality, cash receipts assessment add-on and other per diems including any universal settlement. The rate should be reconciled to reflect retroactive CMI updates applicable to the dates of service
• Will FFS rate for remaining nursing home patients be based on a CMI that includes or excludes the CMI of the MA-only patients enrolled in plans?	• The FFS rate should be based on the CMI for all Medicaid-only patients, including those in managed care. Otherwise, facilities may be under-compensated as a whole for CMI.
• How will plans and providers be paid for retroactive CMI updates, cash receipts assessment reconciliations and adjudicated rate appeals?	• These retroactive payments should be required under the contract language negotiated between the plan and provider • If possible, such adjustments should be made through the FFS system for prior periods, with the updated rates prospectively paid through plan rates • If not, then such retroactive adjustments should be apportioned to FFS and managed care, and paid through plan and provider rates

Issue	Recommendation(s)
• The 5 percent payment limit on CMI changes complicates payments made through plans	• CMI audits should be conducted on a pre-payment basis during the six-month period between submission and effective date in the rates, obviating the need for applying such a limit
• Will plans be required to monitor/audit eligibility for bedhold coverage? This would create a compliance issue for plans.	• Clarification sought; no recommendation

3. Enrollment/Eligibility/Coverage

Issue	Recommendation(s)
• "Grandfathered" resident with a break in service. An individual is permanently placed before the transition date but is then hospitalized without the bed being reserved. Facility readmits the person to the first available semi-private room (as required under regulations)	• Clarify that for purposes of mandatory enrollment, such a person is still grandfathered into FFS unless there is at least a 60-day gap in facility residency
• How will auto assignment work if more than one plan contracts with the facility where the resident is residing?	• Clarification sought; no recommendation
• How will auto assignment occur if resident's nursing home has no contracts?	• Clarification sought; no recommendation
• How will plan selection be made if the person is incapacitated and does not have a legal representative?	• Clarification sought; no recommendation
• Can plans deny coverage for permanent placements already made (e.g., person already in plan awaiting chronic care eligibility, person converting from short stay to permanent, etc.)?	• Plan should be required to cover placements made based on judgments of physician, hospital, resident, family and nursing home, retroactively to first day of enrollment/permanent placement and prospectively with 90-day continuity of care provision (with member ability to waive if a change in setting is desired and appropriate) • Alternatively, DOH could create an objective standard based on the enrollee's acuity/care needs that would be used to presume the need for permanent placement
• If the plan and nursing home disagree on whether the member can be safely discharged from the facility, how will this be resolved?	• DOH should develop uniform medical necessity/ discharge standards and reflect them in the managed care contracting standard clauses
• Duplicative and potentially conflicting assessments of residents enrolled in plans (i.e., MDS and UAS-NY) could have major operational, regulatory, quality of life and fiscal implications	• Operational aspects of this need to be fully explored and understood prior to implementation
• Payments by plan if resident invokes rights under nursing home transfer/discharge regulations to appeal a transfer/discharge [10 NYCRR § 415.3(h)]	• The plan should be required to pay the facility for the individual's continued stay during the pendency of the appeal
• Will a facility's survey status affect whether it can accept placements from a plan?	• Unless a facility has been banned from receiving any Medicare/Medicaid admissions or there are grounds for contract termination, survey status should have no bearing on this

• As a practical matter, how quickly can a person change plans while awaiting nursing home placement from a hospital or community?	• If the person seeks admission to a nursing home that is not in the current plan's network, perhaps the person's current plan should temporarily cover the stay as an OON benefit until a change in plan takes effect
• How will a nursing home find out in a timely way if one of its patients changes managed care plans?	• ePACES does not always have the most up-to-date information. More timely updates and/or some other notification requirement/ mechanism should be created
• An enrollee in a Medicaid plan receives Medicare-covered short-term care in a facility, and later needs permanent placement. If the facility does not have a contract with the plan or any other plan, will he/she still be able to choose to stay at the facility and receive OON services?	• Clarification sought; no recommendation
• Will community spouses of mainstream plan enrollees that need permanent placement be eligible for spousal impoverishment budgeting? If not, can such individuals enroll in an MLTC plan and obtain spousal budgeting that way?	• Clarification sought; no recommendation
• Mainstream enrollee found Medicaid ineligible due to transfer of assets, invoking a penalty period with no payment to the facility. Concern that plan has no financial incentive to facilitate community placement	• Plan should be required to share part of the community capitation with the nursing home by paying cost sharing amounts or paying for services provided to the resident that would otherwise be covered in the community • Alternatively, dis-enroll the individual from managed care for duration of the penalty period
• If an MLTC enrollee is found ineligible due to transfer of assets and the penalty period is still running, will the individual be dis-enrolled from MLTC?	• If the person remains enrolled in MLTC, the contract provisions need to allow the nursing home to pursue payment from the resident/responsible party for the services provided during the penalty period
• A plan enrollee is permanently placed from the community and found ineligible for Medicaid chronic care coverage for financial reasons. If a fair hearing is requested, will the plan have to continue to pay the facility until a decision is made?	• The policy requiring plans to continue paying facilities while an eligibility determination is pending should extend to fair hearings
• Local departments of social services (LDSS) not always adhering to regulatory timeframes for determining Medicaid eligibility for institutional care, which will now be problematic for both providers and plans	• LDSS eligibility processing activities should be carefully monitored over the next several months, and every effort should be made to accelerate the state takeover of long term care eligibility determination functions now planned for 2017
• A plan enrollee is admitted for and receives restorative care, is not a candidate for permanent placement but cannot be returned immediately to the community due to lack of suitable housing and/or for another reason. Will the plan be required to continue covering the nursing home stay?	• This service should be covered under the existing short-term nursing home benefit.

4. Network/Contracting

Issue	Recommendation(s)
• How will the State monitor network development and adequacy?	• No specific recommendation, although it would be in the State's best interests to know whether there are facilities without contracts, reasons for the lack of contracts and whether network requirements need to be adjusted
• For network purposes, will there be any requirement for proximity of the facility to family/friends?	• No specific recommendation, although the facility should be reasonably proximate and accessible to family/friends seeking to visit resident. Enrollee should be able to go OON for such services, if needed, to address this issue
• Will nursing home be required to ensure that individual health providers who provide care at their facility have participating network agreements with the same plans as the nursing home? If not, what are the disclosure requirements of the nursing home and the provider?	• Clarification sought; no recommendation
• Applicability of managed care plan prior authorization requirements to OON nursing homes for hospitalizations	• Clarification sought; no recommendation
• Will old contracts with different provisions (e.g., rate of payment below the benchmark rate, etc.) be voided by new standardized clauses and guidelines?	• Any new standards should be enforced as of the effective date of the transition to managed care, perhaps by requiring new contracts to cover this new benefit
• Concerns about being made aware in a clear manner of changes in billing procedures	• Require contracts to include provisions for a notification requirement that clearly denotes any material changes in billing requirements and where those changes are reflected in the billing manual and/or elsewhere
• Plans and providers are permitted to negotiate a different bedhold policy than is required in state regulations	• The state bedhold policy should be the default arrangement spelled out in standard contract provisions, with any variation expressly agreed to between the parties • Timely authorizations should be built in
• How will "fraud and abuse" be defined for contract termination purposes? How about "imminent harm"?	• Should have termination language in every contract reflecting agreed-upon definitions for these terms
• Exactly what other credentialing requirements may a plan impose on a provider?	• Clarify that credentialing requirements normally incorporated in state/federal oversight (e.g., verification of worker certification processes, etc.), if any, should not require further verification by plans