LeadingAge New York

HANYS Healthcare Association of New York State

NEW YORK STATE NYSHFA HEALTH FACILITIES ASSOCIATION, INC.

CONTINUING CARE LEADERSHIP COALITION CCLC

SOUTHERN NEW YORK ASSOCIATION, INC.

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

1. Cash Flow

Issue	Recommendation(s)	SDOH Response	Associations' Response
• 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	• MCOs are required to authorize services consistent with Appendix F of the Model contract (attached). Additional requirements may be referenced in provider contracts. See pages 7-12 of the Nursing Home policy paper. Enrollees receiving LTSS will receive 90 days transitional care from the previous provider. We are unclear as to what "presumptive authorization is referring to. Please clarify.	• Appendix F of the model contract requires MCOs to provide prior authorization within 14 days. When added to the 30 day timeframe for payment of clean claims, this could delay any payment to the nursing home (NH) for services for an existing enrollee by 45 days or more. • Presumptive authorization refers to the idea of presuming for some finite time that an individual needs NH care based on his/her clinical assessment rather than relying on a formal authorization. • Does the requirement for 90 days of transitional care mean that the plan will be required to cover services for a resident even if the plan is not prepared to authorize the care?
• 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	• It is the Department's understanding from the plan associations that plans will accommodate a bi-weekly billing requirement. Many plans currently process claims on an ongoing basis, with weekly payment cycles. DOH would support a NH requirement of this language in the contract	• The NH policy paper references bi-weekly billing but does not require plans to accommodate it. We are not clear what is meant by DOH supporting "a NH requirement of this language in the contract between the NH and the plan." If this refers to individual contracts, it

		between the NH and the plan. Please see page 18 of Nursing Home policy paper.	does not create the broader policy mandate we are suggesting. Frequency of billing is vitally important to maintaining adequate cash flow to the facilities. As it is now, many facilities currently bill weekly and experience a 21-day payment turnaround.
• Bill transmission	• Contractual or other requirement that plans must accommodate electronic billing in addition to paper billing.	• It is the Department's understanding that all plans accept both paper and electronic claims from the providers. While the preference is an for an electronic format, paper claims will be accepted. DOH would support a NH requirement of this language in the contract between the NH and the plan.	• Our information suggests that not all plans are currently capable of accepting electronic claims. Moreover, for those that do, there needs to be compatibility testing to ensure electronic claims are transmitted and received properly. We agree on the need for plans to also accept paper claims. As noted above, we are not clear what is meant by DOH supporting "a NH requirement of this language in the contract between the NH and the plan." If this refers to individual contracts, it does not create the broader policy mandate we are suggesting.
• 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	• See response above	• See response above
• Differing billing codes	• Convene group of DOH, plans and providers to discuss potential standardization efforts	• It is the Department's understanding that standardizing billing codes across all plans is a difficult undertaking. However, the Department is willing to convene a billing workgroup comprised of NH associations members and Plan representatives to address any emerging billing issues that are creating cash flow problems. The Department is interested in establishing this workgroup as soon	• We appreciate the Department's willingness to convene a billing workgroup, and recommend doing so as soon as possible. We also support the readiness review process that the Department suggests. However, the suggested July 1, 2014 downstate launch date for the transition would not provide sufficient time for convening the billing workgroup and conducting needed readiness

		as possible and in obtaining CMS suggestions regarding participants to include. In addition, the Department is contemplating a readiness review process to ensure a smooth transition from FFS to MC and is interested in CMS input implementing such a requirement. This may be a requirement for Plans to document that a test clean claim has been submitted by all of its network NH providers.	reviews. These steps need to be concluded prior to the enrollment effective date.
• 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	• With the changes outlined in the policy paper, including changes to the payment stream while chronic care budgeting determination is undertaken, phasing in of the population, and pursuing biweekly payments, the Department does not anticipate any major cash flow issues. However, the Department will work with those nursing homes that encounter billing difficulties, and is prepared to temporarily eliminate the two week lag if there is a clear need to do so. The Department is willing to allow cash advances or interim payment where possible.	• While we are hopeful that there will not be any major cash flow issues, we have noted that some community-based providers have experienced significant cash flow delays, and maintain that the Department should identify policy criteria and a process for advance or interim (i.e., concurrent) payments by plans. • We appreciate the Department's willingness to temporarily eliminate the two-week lag when there is a clear need to do so, and hope that process can be expedited as needed.
• 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	• The Department is working on a staffing plan and audit cycles to ensure that a nursing home's case mix is audited on a rolling 6 month basis. The Department, in conjunction with the OMIG, will present this plan at the next monthly Nursing Home Association meeting.	• We look forward to receiving and reviewing the State's audit plan. Subsequent to the transition, will these audits include residents enrolled in Medicaid managed care plans or will they be limited to residents covered under the FFS program?

• Payment to facility while chronic care eligibility determination is pending	• Requirement should apply to both mainstream and MLTC plans, if it doesn't already	• For enrollees already in a plan, MCOs must authorize all long term placements in nursing homes, and will pay the nursing home while Chronic Care eligibility determination is conducted by the LDSS. This is the same for mainstream and MLTC.	• We agree with the Department's clarification.

2. Other Payment Areas

Issue	Recommendation(s)	SDOH Response	Associations' Response
• 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	• The Department is establishing a pool to mitigate the risk associated with contracting with high cost Nursing Homes within a plan's network. Please refer to the Finance section of the Nursing Home policy paper. Pending CMS approval, the pool will be $10 million to help achieve this goal. The Department will continue to evaluate the need for this pool as it continues to transition to a price.	• How will the $10 million pool be funded and how will it operate? How was the $10 million amount determined, and will it be sufficient to compensate plans for all variations from the regional average rate (including specialty services, which have considerably higher rates) that they must pay for in-network and OON services? As progressively more Medicaid beneficiaries move into managed care in each year of the transition, will the $10 million be increased each year? These issues need to be resolved prior to implementation to ensure high risk patients and high risk homes are provided protection from adverse selection.
• 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	• The pool referred to above is designed to accommodate higher cost specialty facility volume.	• See response above.
• 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	• Please refer to the NH policy paper regarding the benchmark rate and how it will be utilized as the NH population transitions into managed care.	• Page 18 of the NH policy paper states that plans will be required to pay contracted NHs the benchmark rate or a negotiated rate for a three-year period, but it does not spell out how the requirement will

			be implemented which is our question. Clearly, OON payments will need to be made at the benchmark rate pursuant to statute. • Also, there is some confusion among plans and providers as to the per diem benchmark rate the plans are required to pay during the transition. The multiple columns/ data elements in the Excel worksheet on DOH's website are confusing. It should highlight the final Medicare eligible and non-Medicare eligible per diems the plans should be paying in addition to providing the detailed breakout.
• 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	• Please refer to the NH policy paper regarding NAMI collection. • The Department is pursuing a proposal for the State to assume the responsibility of NAMI collection (see page 19 of policy paper). DOH anticipates this proposal will be submitted to CMS for review within the next two weeks.	• Page 19 of the NH policy paper indicates that the responsibility for NAMI collection will shift to the plans, but the plan can delegate collection to the NH. Facilities and plans are still confused about where the responsibility resides. Neither the Department's response nor the NH policy paper addresses how residents are to receive their personal needs allowance funds pursuant to federal/state regulations if the plan bears NAMI collection responsibility. • We appreciate and support the Department's proposal for the State to assume this function, and hope that this takeover can occur expeditiously and in a way that minimizes contracting and administrative burdens on plans and providers.
• 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	• For Medicare covered services that are provided in the nursing home, the facility is required to bill as it currently does.	• Is the facility then entitled to retain the amounts it bills to Medicare for covered services? • We understand that some current

	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		contracts contain COB provisions that may preclude NHs from billing and retaining amounts they would otherwise be entitled to. • There was no Department response to the issue of cross-over claims.
• 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	• The Department has clarified this point in the Nursing Home policy paper and in correspondence with the members of the finance workgroup. Plans will be responsible for Medicaid coinsurance on a qualifying Medicare Part A/B covered service for all managed care enrollees.	• We were unable to locate a reference in the NH policy paper relative to payment of Medicare cost sharing amounts. What is meant by a "qualifying" Medicare Part A/B covered service? Does the requirement for plans to pay Medicaid cost sharing for Medicare Part A/B services rendered in the NH extend to OON services as well as in-network services? Is a facility required to obtain prior authorization from a plan to obtain payment for Medicaid cost sharing for Medicare Part A/B services?
• 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	• The Plan is responsible for nursing home charges while the consumer is enrolled. Once disenrolled from a plan, the individual must enroll in another plan to obtain Medicaid coverage. The new plan would then be responsible for any nursing home charges.	• If there is a gap in managed care enrollment between disenrollment by the first plan and enrollment in the new plan, how does the facility get paid for services during the gap period? Would payment be made through the FFS program? What happens if the NH doesn't have contracts with any other plans?
• 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	• The consumer remains covered under fee for service Medicaid until long term eligibility is established. Once approved and eligible, the consumer has 60 days to select a plan for enrollment.	• The question referred to situations when a recipient is enrolled in a plan in the community prior to admission to the NH, but the coding in eMedNY indicates that the person is in FFS.

• 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	• The Department has communicated to plans and providers, as stated in the policy document, that OON providers shall be paid at the benchmark rate. The benchmark rate would include the entire FFS rate, inclusive of operating, capital, quality, cash receipts assessment add-on and other per diems, including any universal settlement. Please refer to page 15 of the NH policy paper.	• The question relates to the reference on page 15 of the NH policy paper to the "fee for service rate in effect ***at the time of service***". We want to confirm that this wording still requires the plan to pay any retroactive adjustments to the benchmark rate for the OON service. Also, there is some confusion among plans and providers as to the per diem benchmark rate the plans are required to pay during the transition. The multiple columns/ data elements in the Excel worksheet on DOH's website are confusing. It should highlight the final Medicare eligible and Non-Medicare eligible per diems the plans should be paying in addition to providing the detailed breakout. This will be especially important for OON payments.
• 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.	• The current case mix adjustment is based on a Medicaid-only CMI. As part of the Medicaid population in the homes is transitioned into managed care, the case mix will continue to be based on the entire popluation of Medicaid recipients identified on the census. This includes both FFS and Medicaid managed care recipients.	• We agree with the Department's clarification.
• 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	• The Department has communicated in the NH transition policy paper and through multiple webinars that the plans will be responsible for retroactive changes to the benchmark rate. In addition, the Department has committed to minimizing the retroactive nature of the NH FFS rates.	• We appreciate the confirmation of plan responsibility for these amounts. Our question refers to the mechanics of how both plans and providers will be paid for these various types of adjustments, both prospectively and retrospectively.

	adjustments should be apportioned to FFS and managed care, and paid through plan and provider rates		
• 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	• The Department has moved away from auditing the assessment prior to utilizing it in the NH FFS rate, while it understands that the retroactive nature of the changes in case mix will complicate the payments made by the plans. This is the nature of the FFS rate. If plans and providers can mutually agree on an alternate payment arrangement, they may be able to avoid the retroactive rate concerns.	• The Department instituted a change in recent years that created a six-month time gap between when resident assessments are submitted and when the corresponding updated CMI becomes effective in the rates. The objective was to ensure that all state processing of the CMI could occur during the six-month period so that there would be no retroactive adjustments needed. We maintain that pre-payment audits should be conducted during this six-month period, obviating the need for the 5 percent payment limit and limiting the potential for rate retroactivity.
• Will plans be required to monitor/audit eligibility for bedhold coverage? This would create a compliance issue for plans.	• Clarification sought; no recommendation	• Plans will be responsible for reimbursing providers for the days when the nursing home would bill for a bed reservation day if the resident was in FFS Medicaid. Language relating to how bed reservation days shall be handled should be included in the contract between the plan and the provider.	• The clarification is appreciated. The question relates to whether the State will impose audit responsibility on the plans to ensure that all regulatory requirements associated with the payment of bed hold days are met and, if so, alludes to the compliance issue that this could create for plans.

3. Enrollment/Eligibility/Coverage

Issue	Recommendation(s)	SDOH Response	Associations' Response
• "Grandfathered" resident with a break in service. An individual is permanently placed before the transition date but is then hospitalized without the bed being	• 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	• Consistent with current policy, Medicaid eligible individuals with a break in service on or after the transition date will be required to enroll in a Medicaid managed care plan to receive covered services.	• We believe that if a "grandfathered" resident is re-admitted to the same NH within a 60-day period, that individual should remain in grandfathered status. The potential disruption

reserved. Facility readmits the person to the first available semi-private room (as required under regulations)		Individuals determined eligible for long term placement must select a managed care plan for enrollment within 60 days of his or her eligibility date or a plan will be selected via autoassignment.	associated with a transfer should not be compounded by a change in how Medicaid services are accessed and covered. The Department's clarification could also accelerate the transition and create a more unstable environment for plans and providers.
• How will auto assignment work if more than one plan contracts with the facility where the resident is residing?	• Clarification sought; no recommendation	• The auto assignment algorithm will be based on current methodology, and will consider the plans contracting with the NH in which an individual resides. No individual will be auto-assigned to a plan that does not contract with the nursing home.	• We agree with the Department's clarification.
• How will auto assignment occur if resident's nursing home has no contracts?	• Clarification sought; no recommendation	• Each nursing home is expected to contract with at least one Medicaid managed care plan. If there is no plan under contract with the nursing home in which an individual resides, he or she will not be auto assigned into a different plan.	• The NH policy paper does not appear to contain any reference to an expectation that each NH contract with at least one Medicaid managed care plan. The network expectations are likely to result in some number of facilities not obtaining contracts. The question refers to how a plan will be selected under auto assignment when the NH the resident is living in has no managed care contracts.
• How will plan selection be made if the person is incapacitated and does not have a legal representative?	• Clarification sought; no recommendation	• The individual will be autoassigned to a plan that contracts with the nursing home in which he or she resides.	• We agree with the Department's clarification.
• 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	• An enrollee who was recommended for permanent placement in a NH prior to the implementation date would be disenrolled from the plan and not required to enroll in Medicaid managed care. If the long term placement is requested after the implementation date, the plan would be required to authorize services based upon assessments and other information provided. In general, plans can conduct	• The question relates to coverage for permanent placement after the transition date for an individual who is already residing in the facility, and is enrolled in a plan. Assuming Medicaid chronic care eligibility is established, can the plan deny coverage for NH care for any time period while the person is still residing in the facility?

	objective standard based on the enrollee's acuity/care needs that would be used to presume the need for permanent placement	concurrent review and deny permanent placement if they believe the individual can be effectively placed in the community. All transitions must be patient centered.	
• 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	• The enrollee and/or provider should follow the standard appeals process currently in place or request a fair hearing. This process may be expedited if circumstances warrant.	• In this circumstance, will the plan be required to cover the NH care rendered during the entire pendency of the appeals process if the individual is otherwise eligible for services?
• 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	• The MCO is responsible for assessing the long term care needs of the individual using the state-required assessment tools, the Uniform Assessment System. The plan's assessments are in addition to any assessment required of the hospital, nursing home or other providers. The assessment and the medical provider's order become the basis for determining the needs of the enrollee. Following the appropriate assessments, the MCO in which the individual is enrolled is responsible for reviewing all documentation and approving or adjusting the care plan to ensure the needs of the consumer are appropriately met. The enrollee's due process rights remain unchanged.	• If the recommended care plan from the UAS conducted by the MCO conflicts with the care plan from the federally-mandated MDS conducted by the facility, how is this conflict to be resolved? Which assessment would take precedence with regard to establishing the needed NH services for the individual?
• 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	• Under current transfer/discharge regulations, the individual is responsible for payment to the facility for a continued stay during a pending appeal. If an enrollee is in disagreement with the plan's determination, the enrollee may exercise his or her due process rights by requesting a fair hearing and aid to continue. Those determinations are binding.	• We agree with the Department's clarification. If such transfer/ discharge appeals become more frequent under managed care, they could increase bad debt expenses to the facilities.

• 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 long as a facility has not been banned from receiving Medicare and Mediciad admissions, and grounds for its contract(s) to be terminated exist, the facility may accept placements from a plan. However, if a plan believes the quality of care is jeopardized, it may terminate or request action from the NH prior to allowing additional placements.	• We agree with the Department's clarification.
• 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	• The enrollment process must follow the current eligibility and enrollment processes, which require meeting pull down schedules. The pull down schedule determines the effective date of enrollment. Plans are only required to authorize OON placements if the contracted providers can not meet the needs of the enrollee.	• The question relates to an individual who is already enrolled in a plan and needs permanent placement in a NH, but the NH the person seeks admission to is not in the plan's network. If the enrollee cannot change quickly enough to a plan that contracts with the NH of choice, what is the current plan's responsibility to cover the stay as an OON benefit until a change in plan can occur? If there is a gap in coverage, can the home bill Medicaid FFS for those days?
• 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	• ePaces reflects current enrollment status. Providers are expected to verify eligibility and enrollment status as per current guidelines.	• According to some member facilities, ePACES enrollment information is not always current. We can attempt to obtain one or more examples. This could become a more frequent problem after the transition since NH enrollees will be able to enroll and disenroll at any time without a lock-in period.
• 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	• Clarification sought; no recommendation	• Yes. The indivudal is not required to change facilities if his or her care needs are appropriately met at the current facility.	• What is meant by the phrase "appropriately met"? Can a plan determine that the individual's needs are not being appropriately met and require the enrollee to relocate to an in-network facility? If so, under what circumstances?

facility and receive OON services?			
• 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	• For MAGI eligible individuals in MMC, only the institutionalized spouse's income is counted in determining long term eligibility under MAGI rules. Spousal impoverishment rules cannot not be used for institutionalized individuals in a MAGI eligibility group. For a MAGI individual who is also SSI-related, if application of spousal impoverishment rules is more beneficial, those rules must be applied. MAGI individuals whose household income is at or below 138% of the federal poverty level will not have a NAMI amount to contribute toward the cost of nursing home care.	• We appreciate the Department's clarification. Given these rules, if an individual enrolled in a mainstream plan and his/her community spouse would receive more favorable income treatment by being enrolled in an MLTC plan, can such an individual switch from mainstream to MLTC?
• 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	• During the penalty period the plan should not be paying for long term care services. The plan would be responsible for reimbursing the NH at the community rate.	• Please clarify what is meant by the sentence, "The plan would be responsible for reimbursing the NH at the community rate." What is the value of the community rate and should it be identified in the contract between the plan and nursing home? Absent a source for full payment of amounts due, may the facility exercise its ability under current regulations at 10 NYCRR § 415.3(h) to discharge for non-payment?
• 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	• Individuals who are not Medicaid eligble for long term placement must be disenrolled from MLTC. If the care needs of the individual can be met in the community, these services may be provided in the community and the individual may remain enrolled in the MLTCP.	• We appreciate the Department's clarification. In this scenario, when would the MLTC disenrollment become effective - as of the first day of the penalty period or when the eligibility determination is rendered? Would the facility then reserve the right to collect payment for services rendered during the penalty period from other sources?

			Does the individual have to re-enroll in a MLTC plan once the penalty period is over?
• 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	• Aid to continue will be in place pending a fair hearing decision. If the fair hearing decision determines the individual is ineligible, plans will be allowed to recoup all funds paid during the aid to continue period.	• We agree with the Department's clarification. • Can the Department provide guidance on a policy for the plan to recoup the funds from the NH? There is the potential for the recoupment to be a large amount which the facility may not be able to pay back all at once.
• 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	• The policy regarding timeframes for eligibility determination of Medicaid coverage of long term placement has been re-enforced with the LDSS.	• We appreciate the State's reinforcement of this policy with the LDSSs, and recommend continued monitoring during the transition period, as well as efforts to accelerate the State's 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.	• Yes, Plans shall cover the short term nursing home stay.	• We agree with the Department's clarification.

4. Network/Contracting

Issue	Recommendation(s)	SDOH Response	Associations' Response
• 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	• The State monitors plan contracts and networks on a quarterly basis to ensure network adequacy standards are met. Each facility is	• As previously noted, the NH policy paper does not appear to contain any reference to an expectation that each NH contract with at least

	contracts, reasons for the lack of contracts and whether network requirements need to be adjusted	expected to contract with at least one MMCP.	one Medicaid managed care plan. What will happen if there are NHs that do not obtain any contracts, and what impact could this have on access to services? We would be most interested in knowing how many NHs, particularly in the downstate region, currently have contracts for permanent placements vs. those that do not based on the most recent quarterly information.
• 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	• Placement in a specific facility is based upon a variety of factors, including the needs of the individual and the facility most able to meet those needs. Individuals may change plans in order to access their nursing facility of choice. Enrollmemt lock-in rules will not apply to this population, allowing nursing home residents to change plans to access a specific facility if appropriate. The effective date of enrollment would be based upon the current pull down schedule.	• We appreciate the Department's clarification. If the enrollee's facility of choice is not in the current plan's network and does not have a contract with any other plan, will the enrollee be able to access the facility on an OON basis?
• 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	• Nursing homes should clearly identify non-salaried providers who treat mlembers in the NH. The Department strongly encourages any non-salaried provider to contract with the plan to avoid denials in the future.	• We appreciate the Department's clarification.
• Applicability of managed care plan prior authorization requirements to OON nursing homes for hospitalizations	• Clarification sought; no recommendation	• The prior authorization requirements to OON providers remain unchanged. Providers must abide by plan requirements, whether a participating provider or out of network.	• We appreciate the Department's clarification.

• 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	• The State will continue to monitor the contractual agreements between the Nursing Home (provider) and the Managed Care Plans. The negotiated rate will only apply to alternative payment arrangements. If an existing contracted rate falls below the current market benchmark rate, the plan must increase the contracted rates to at least this threshold.	• We appreciate the Department's clarification. If the State identifies contract provisions at odds with the transition policy, will it seek to enforce the policy guideline only prospectively, or would any change be required to be made retroactive to the effective date of the transition?
• 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	• MCOs will create a process to train contracted providers regarding the claim adjudication process to promote understanding and improve the submission and payment of claims. Each MCO and nursing home must negotiate provider contracts in good faith.	• We appreciate the Department's clarification. The question refers to future instances when billing requirements are changed, and ensuring that providers are efficiently and effectively alerted to such changes.
• 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	• Federal and State Medicaid bed hold/bed reservation regulations (CFR 483.12 and 10YCRR 415.8 and 18NYCRR 505.9, respectively) identify the circumstances in which Medicaid reimburses a nursing facility to hold a bed for a patient who is temporarily absent from the facility. Absent a negotiated policy relating to bed holds, MCOs are required to continue following the current methodology during the transition period. After the three year transition period, MCOs should negotiate a bed hold policy with contracted nursing homes.	• We appreciate the Department's clarification. • There was no Department response to the issue of timely authorizations for bedholds.
• 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	• 10 NYCRR 98-1.21 (1) and (2) define fraud and abuse: Fraud means any type of intentional deception or misinterpretation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person in a managed	• We appreciate the Department's clarification on the definitions of fraud and abuse. However, there was no Department response as to how "imminent patient harm" is defined (please see the reference on page 15 of the NH policy paper).

		care setting, including any act that constitutes fraud under applicable federal or state law, committed by an MCO, contractor, subcontractor, provider, beneficiary, or enrollee or other person(s). • Abuse means provider practices that are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the state or federal government or MCO, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care in a managed care setting, committed by an MCO, contractor, subcontractor, or provider.	
• 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	• Due to the extensive regulatory framework of NHs, plans have agreed to allow the NH to credential downstream providers. However, plans may impose additional administrative requirements on contracted facilites that relate to quality or other operating requirements.	• We appreciate the Department's clarification. Please provide examples of "additional administrative requirements on contracted facilities that relate to quality or other operating requirements" that may be imposed.