NEW YORK STATE | Department of Health | Office of Health Insurance Programs

Nursing Home/Managed Care Task Force

June 7, 2017

Billings for Pharmacy Services for MMC and MLTC Members Served in a Nursing Home

- Pharmacy Services are excluded from the NH benchmark rate.
- Since pharmacy is a covered benefit in MMC, the pharmacy bills the MCO directly
  - The Department is aware of contractual agreement between MCOs and NHs to have the NH bill the MCO for pharmacy services (again outside benchmark rate)
- For MLTC, pharmacy is not a covered benefit, therefore, pharmacy bills FFS (Medicare Part D in the case of a Dual)
- Please see Page 12 of the DOH NH Transition Document: https://www.health.ny.gov/health_care/medicaid/redesign/docs/nursing_home_transition_final_policy_paper.pdf

Retroactive Benchmark Rate Updates

- The Nursing Home reimbursement system relies on historical CMI data that is updated every six months
- Accordingly, it is the responsibility of the MCO to adjust its rates consistent with the updated benchmark rate posted on the DOH website
  - DOH updates the nursing home rates twice annually:
    - January 1st, which updates both the case mix index as well as the capital component, and July 1st, which updates the case mix index only
- DOH has instituted changes in the current case mix collection process, which allows for the rates to be posted by the effective date

Distinct Nursing Home Rate Cell

- As part of the final SFY 2017-18 Budget agreement, the Executive committed to exploring a separate rate cell with CMS
- Previously CMS flatly rejected this concept on the basis it was anti-Olmstead, instead supporting the current blended rate
- Over the course of the summer, DOH will explore the separate rate cell for MLTC with CMS; the earliest target date for a new cell is likely April 2018
- It important to note that the Department reconciles the NH rate quarterly on a plan-by-plan basis for actual NH enrollment -- the equivalent to a separate rate cell

Mainstream Billing

- The request for Medicaid eligibility determination to the LDSS does not change with the Nursing Home transition
- The nursing home retains responsibility for submission of the LDSS-3559, or DOH-approved equivalent, indicating a change in status or request for increase in coverage to the LDSS
- Applications for Medicaid remain the responsibility of the applicant/recipient, or his/her authorized representative
- The Department encourages plans to work together with Nursing Homes to develop communication systems or protocols regarding enrollees placed in nursing homes

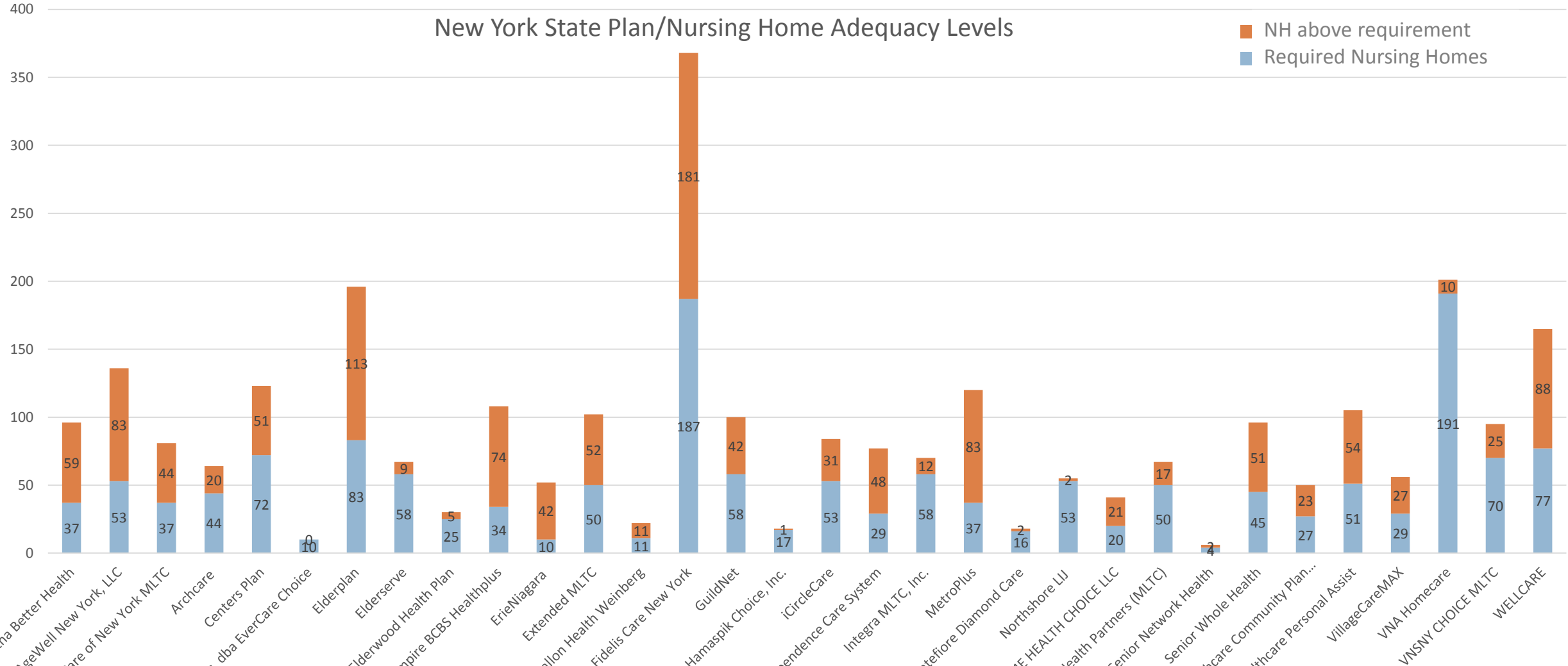
Financial Eligibility

- Policy 15 OHIP/ADM-01 states the following:
  - Once Plan enrollment is effective, the enrollment will appear on the Plan's monthly roster and Nursing Home report, along with any monthly NAMI contribution
  - The NAMI amount will be pulled from the Medicaid budget stored in Medicaid Budget Logic (MBL)
  - The Plan, in place of the nursing home, must receive a copy of any eligibility notice sent regarding an enrollee's NAMI
  - The Administrative Directive can be found at: https://www.health.ny.gov/health_care/medicaid/publications/docs/adm/15adm01.pdf
- If the Plan has arranged for the nursing home to continue to collect the NAMI, as most have, the Plan must notify the nursing home of the NAMI amount
- Nursing homes are no longer receiving this information from local districts

Prompt Payment Insurance Law (§3224-a)

- Sets standards for the prompt, fair and equitable settlements of both patient claims and provider services
- Requires HMOs and insurers to pay electronic claims and bills within 30 days of receipt; the timeframe for paper claim is 45 days
- Specifies that each claim or bill processed after the 30-day period is a separate violation and must include the payment of interest
- Permits the Superintendent of Financial Services to impose penalties on a company, HMO or insurer, and any person for violations, failing to cooperate with and failing to respond to the Department of Financial Services
- The Department urges Plans and providers to engage in mutual arrangements for the most timely payment options
- This law can be found at: http://www.dfs.ny.gov/insurance/hppmtlaw.htm

Network Adequacy – MLTC Plans



NEW YORK STATE Department of Health

Network Adequacy – MLTC Plans

- The Department has been tracking the number of nursing homes without MLTC contracts
- As a result of the Nursing Home transition, Managed Care Organizations are required to contract with a range of two to eight nursing homes; this is a minimum requirement based on county
- On average, MLTC Plans are 68 percent ***over*** these minimum regulations
- According to data as of April 2017, only three nursing homes in New York City were without contract, and twenty-seven were without contract within the rest of the State

Network Adequacy – Contracted Facilities

- The following facilities are currently *not* contracted with an MLTC Plan:
  - NYC (3):

Incarnation Children's Center Inc
Samaritan Senior Village, Inc.
Hollis Park Manor Nursing Home

  - Rest of State (27):

St. Margaret's Center	Nyack Manor Nursing Home
United Health Services Hospital Inc- Binghamton general Hospital	Oasis Rehabilitation and Nursing, LLC
The Commons on St. Anthony Street, A Loretto Skilled Nursing Community	John T Mather Memorial Hospital of Port Jefferson New York Inc
FASNY Firemens Home	Jeffersons Ferry
Canterbury Woods	Kendal at Ithaca
Erie County Medical Center	Woodland Pond at New Paltz
Fox Run at Orchard Park	Andrus on Hudson
Terrace View Long Term Care Facility	Elizabeth Seton Pediatric Center
Samaritan Keep Nursing Home Inc	Kendal On Hudson
Samaritan Senior Village, Inc.	Rosary Hill Home
Lakeside - Beikirch Care Center, Inc	Sunshine Children's Home and Rehab Center
New Roc Nursing and Rehab	The Osborn
UPSTATE University Hospital at Community General	Westchester Meadows
Helen Hayes Hospital	

Topics for Discussion

Comments/Questions and Responses

- *Issue*: Network Adequacy
  - *DOH Response*: If a Plan terminates a contract with a nursing home provider, a resident within that facility is not required to change Plans or facility; in this instance, there is a single source agreement for that resident
- *Issue*: Reimbursements are not sufficient
  - *DOH Response*: The rates as set by the Department are based on actuarial limits of how managed care rates are set
- *Issue*: Complex Forms
  - *DOH Response*: The Department encourages Plans and providers to start a dialogue on modifying or creating a uniform authorization form that addresses operational issues in processing and information collection, and is willing to facilitate discussions towards this goal

Comments/Questions and Responses

- *Issue*: Billing Code Issues
  - *DOH Response*: Please reference the DOH Facilitated Universal Billing Codes Policy within the Benchmark Rate Policy document: https://www.health.ny.gov/facilities/long_term_care/reimbursement/nhr/benchmark/jun2015_benchmark_letter.htm
- *Issue*: Authorization Process
  - *DOH Response*: Model Contract Appendix F.1 3 (b), (c) and (d) provides information regarding time limits for authorization: http://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf
  - Further guidance on the authorization process is also contained in the *Nursing Home Transition: Final Policy Paper*: https://www.health.ny.gov/health_care/medicaid/redesign/docs/nursing_home_transition_final_policy_paper.pdf

Comments/Questions and Responses

- *Issue*: Plans not going into nursing homes to complete evaluations
  - *DOH Response*: Plans are required to conduct several assessments on all their members within nursing homes; for more information, please reference the care management requirements in the model contract
- *Issue*: Plans are not transitioning members out of the nursing home and into the community, due to financial considerations
  - *DOH Response*: The discharge from NH denial issue is only to be based on health and safety concerns

Comments/Questions and Responses

- *Issue*: Plans are avoiding LTC members / Plans are selecting facilities to contract with based on lowest benchmark rates (Plans are not paying the benchmark rate) / Nursing homes are falling into disrepair
  - *DOH Response*: There are several safeguards and incentives in place to ensure that these issues do not happen:
    1. There is a funding pool that compensate Plans who contract with high quality nursing home facilities
    2. The capital rate component is passed through directly to nursing homes from Plans for improvements
    3. Plans are **required** to uphold the Benchmark Rate, which has been renewed
  - The Department encourages Plans and nursing homes to reference recent NHQI rankings, available at: https://www.health.ny.gov/health_care/medicaid/redesign/nhqi/2016/quintile_ranking.htm

Additional Topics for Discussion

- *Issue*: Transition process is flawed because there are few immediate incentives for nursing homes or consumers to ensure timely application submission, and little opportunity for Plans to directly manage the application submission process
- *Issue*: Delays in local district application approval, as well as resource-intensive efforts to track application status, intensify the underpayment of revenue to Plans for enrollees permanently placed in nursing homes
- *Issue*: Even when applications are successfully submitted and eligibility is approved, it is common for Plans to receive inappropriate payment for permanently placed enrollees