TRANSITION OF NURSING HOME POPULATIONS AND BENEFITS

TO MEDICAID MANAGED CARE

Frequently Asked Questions

January 2015

General

1. Who do these policies apply to?

   The NH transition policy applies to Medicaid Managed Care (MMC) Plans, Managed Long Term Care (MLTC) Plans and Fully Integrated Dual Advantage (FIDA) Plans unless otherwise noted.

2. How Is Nursing Home (NH) care currently covered under the Medicaid program?

   Currently, the vast majority of Medicaid-covered NH care is provided through the FFS program. Medicaid beneficiaries who need long-term NH care are not yet required to enroll in Medicaid managed care (MMC) plans. However, short-term NH care is already a covered benefit for Medicaid recipients enrolled in Managed Long Term Care (MLTC) plans and MMC plans, and long-term NH placement is covered by MLTC plans.

3. What is meant by transitioning the NH benefit into Medicaid managed care?

   This refers to the State's plan to include all NH care – both short-term and long-term placements – as a covered benefit under both MLTC and MMC plans. After the transition takes place, any individual who is enrolled in one of these plans will receive his/her NH care through the managed care plan, not through FFS.

4. What is meant by transitioning the NH population into Medicaid managed care?

   This refers to the State's plan to require certain Medicaid beneficiaries to enroll in, or remain enrolled in, an MLTC or MMC plan if they need NH care. After the transition takes place, any individual who is new to Medicaid and/or needs long-term placement in a NH will be required to enroll in one of these plans and receive his/her NH care through the managed care plan, not through FFS.

5. What is the transition date?

The transition will begin February 1, 2015 in the New York City counties of the Bronx, Kings, New York, Queens and Richmond. Nassau, Suffolk and Westchester counties will begin April 1, 2015. The transition date for the remaining counties in the State is July 1, 2015. Voluntary enrollment will be available to all eligible individuals beginning October 1, 2015.

6. What is meant by the "transition period"?

   The transition period generally refers to the time frame during which the NH benefit and population is gradually moved from FFS to Medicaid managed care. From a payment perspective, it more specifically refers to the initial 3-year period during which managed care plans are required to pay the NH the benchmark rate. After the first full year of transition, DOH will assess whether the 3-year rate transition period needs to be extended beyond 3 years.

7. How will the Nursing Home Transition work with FIDA?

   Consistent with MLTC and MMC, FIDA eligible individuals will be available to voluntarily enroll into FIDA beginning October 1, 2015. Individuals residing in nursing homes prior to February 1, 2015, will not be Passively Enrolled into FIDA. However, an individual new to custodial status in nursing homes as of February 1, 2015, will be Passively Enrolled into FIDA on or after August 1, 2015.

8. Which individuals will be required to enroll in a managed care plan, and which type of plan will they need to enroll in?

   After the transition date, any Medicaid recipient aged 21 and older who needs NH care on a long-term basis will be required to enroll in a Medicaid managed care plan, if he/she is not already enrolled in one. Medicaid recipients who are also Medicare eligible (i.e., "dual eligibles") will be required to enroll in an MLTC plan; Medicaid-only eligible recipients will be required to enroll in a MMC plan, unless they are need in services not covered by a MMC plan but covered by an MLTC.

9. What happens to individuals who were already residing in NHs on a long-term basis before the applicable transition date?

   If an individual is in a long-term placement in a NH and is also Medicaid-eligible for NH care, that person is not required to join an MLTC or MMC plan, will not be passively enrolled in a FIDA plan, and can continue receiving NH care on a FFS basis.

   Examples:

A NYC resident who is admitted to a NH in Queens for long term placement on 1/12/15 and applies for Medicaid coverage of NH care on 1/15/15, will not be required to enroll in a MLTC or MMC plan. Since the long term NH admission and the Medicaid application occurred prior to the month of implementation (February 2015), FFS coverage will be authorized.

A Suffolk County resident who is admitted to a NH for long term placement on 3/15/15, and applies for Medicaid coverage of NH care on 4/15/15, will be required, upon determination of their Medicaid eligibility to enroll in MLTC or MMC.

10. Can an individual who was already on a Medicaid-covered stay in a NH prior to the transition date voluntarily enroll in an MLTC, MMC plan or FIDA plan?

    Yes, if such an individual wants to voluntarily join an MLTC or MMC plan, he/she will be allowed to do so beginning October 1, 2015.

11. After the applicable transition date, if an individual is already enrolled in a Medicaid managed care plan and needs long-term placement in a NH, can he/she disenroll from the plan and receive services through FFS?

    No. Once the transition has taken effect, individuals in mandatory populations will be required to remain in a Medicaid managed care plan. However, the individual will be able to switch managed care plans at any time since there will be no "lock-in" provision for MLTC and MMC enrollees who are in long-term placements in NHs.

Medicaid Eligibility

12. When a Medicaid managed care member living in the community requires a long-term placement in a NH, how is financial eligibility for institutional Medicaid determined?

    Managed care members living in the community, including those receiving short-term NH services, who need long-term placement in a NH will have financial eligibility determined using institutional rules, including a review of the transfer of assets look-back period. The look-back period is the 60 months immediately prior to the month an institutionalized individual applies for coverage of nursing home care.

    For members who are eligible under the Modified Adjusted Gross Income (MAGI) category, the income and resource counting rules that apply under MAGI rules continue as long as the individual remains eligible in the MAGI category. If no transfer penalty is imposed, the MAGI individual is eligible for coverage of nursing home care.

For members who are not eligible under MAGI rules (individuals who are aged, blind or disabled), members who are resource eligible will have income eligibility determined under chronic care budgeting.

This budgeting methodology is used to determine the amount of monthly income (if any) that a permanently institutionalized individual must contribute toward the cost of NH care. Eligibility determinations will continue to be made by a local department of social services (LDSS) office.

13. Will spousal impoverishment budgeting be available to Medicaid managed care enrollees who need long-term placement and have community spouses?

    Yes. Spousal impoverishment budgeting rules apply to institutionalized spouses who are enrolled in MMC or MLTC and have a community spouse. Spousal impoverishment rules do not apply to institutionalized individuals who are eligible under a Modified Adjusted Gross Income (MAGI) category. For MAGI individuals in MMC, only the institutionalized spouse's income is counted in determining eligibility under MAGI rules.

14. Will NHs be reimbursed for services provided to MLTC and MMC plan members, while the institutional Medicaid eligibility determination is pending, and how should they bill for those services?

    If a determination is made that long-term placement in a NH is appropriate for an existing member of an MLTC or MMC plan, the plan should be billed for authorized NH services. The plan will pay the NH for its services while eligibility for institutional Medicaid is being evaluated by the local district. However, if the member is subsequently determined ineligible for institutional Medicaid, or if a transfer of assets penalty period is imposed, the MLTC or MMC plan may recoup its payments from the NH for the long-term placement, and as applicable, coordinate a safe discharge into the community, with supports, for the member.

15. How will the eligibility and NH reimbursement processes work for Medicaid beneficiaries who are not enrolled in an MLTC or MMC plan?

    If a Medicaid beneficiary who is <u>not</u> enrolled in an MLTC or MMC plan requires long-term placement in a NH, the existing processes for determining eligibility and reimbursing the NH under current FFS Medicaid will continue to apply. NHs will continue to be allowed to bill retroactively on a FFS basis for care provided by the NH for any period prior to managed care enrollment, as long as the beneficiary was determined to be eligible for institutional Medicaid during that period.

Once eligibility for institutional Medicaid is approved, any penalty period has expired, and the NAMI amount is determined, the resident will have 60 days to choose an MLTC or MMC plan, as appropriate. The State's enrollment broker, Medicaid Choice, will educate the resident about MLTC and MMC plan selection and the plans that contract with the NH in which he/she resides. The resident may choose a MLTC or MMC plan that does not contract with that NH, if he/she wishes to change NHs. If the beneficiary does not pick a MLTC or MMC plan, he/she will be enrolled in a MLTC or MMC plan that contracts with the NH where he/she resides.

16. Is the NH or the managed care plan responsible for assisting the MLTC or MMC member to complete his/her application for institutional Medicaid?

The NH and MLTC or MMC plan will assist the member to assemble and submit the necessary documentation to support an application for Medicaid coverage of a long-term NH placement to the LDSS. Since eligibility for coverage of nursing home care can be authorized for up to three months retroactive from the date of application, the member will have 90 days from the date of admission to the nursing home to submit an application for coverage of the long-term placement to the LDSS. The LDSS will notify the MLTC or MMC plan, member, and NH of its decision.

17. What happens if the application is not submitted within the 90 days?

The plan may deny coverage as the member is not eligible for the benefit; the member would have appeal and fair hearing rights. The plan would remain responsible for coordinating a safe discharge. Since Medicaid can be authorized only up to three months retroactive from the month of application, there may be months that cannot be covered.

18. Who will collect the NAMI from MLTC and MMC plan members?

The NAMI is the Medicaid beneficiary's net available monthly income (after applicable income deductions and disregards under chronic care budgeting) that must be applied toward the cost of his/her NH care. DOH has indicated that MLTC and MMC plans are responsible for collecting the NAMI, unless they contract with the NH or another entity to do so.

19. How are NH residents to receive their Personal Needs Allowance (PNA) pursuant to federal/state regulations while the MMC plan retains NAMI collection responsibility until State takeover?

If the nursing facility receives the resident's income directly or if the PNA is deposited into a resident's personal account that is maintained by the nursing home, the responsibility for the PNA remains with the NH.

20. What happens at recertification? Will counties continue to recertify eligibility? Will residents be dropped from the plan roster if the recertification process goes beyond the recertification date?

    LDSSs will continue to be responsible for determining and recertifying Medicaid eligibility under the established processes and timeframes. Failure to recertify will result in a loss of eligibility.

21. Will the LDSS-3559, "Residential Health Care Facility Report of Medicaid Recipient Admission/Discharge/Readmission/Change in Status" process to notify the LDSS of a hospitalization remain in place?

    Yes. Once the managed care plan has authorized the long-term placement, the NH will send Form LDSS-3559 with the approval from the plan to the LDSS.

22. How will a Medicaid beneficiary who is enrolled in a managed care plan be coded in the system?

Nursing Home Transition Rate Code Billing Matrix

			Managed Care Program			
R/E Code	Equivalent Rate Code	Description	MMC	HIV/SNP	MLTC	FIDA
N1	1821	Regular SNF Rate - MC Enrollee	X	X		
N2	1822	SNF AIDS - MC Enrollee	X	X		
N3	1823	SNF Neuro-Behavioral - MC Enrollee	X	X		
N4	1825	SNF Traumatic Brain Injury-MC Enrollee	X	X		
N5	1826	SNF Ventilator Dependent - MC Enrollee	X	X		
N6	3479	Partial Cap 21+Nursing Home Certifiable(valid through 3/31/15)			X	
	3478	MLTC Partial Cap Age 18+(effective 4/1/15)			X	
	3489	Primary FIDA, Age 21+, Dual Eligible				X
N7	N/A	NH Budgeting Approved- Awaiting M/C Enrollment				

NOTES:

- Rate derivation billing logic will be implemented for MMC only. All other Managed Care program plans will follow program specific billing guidance
- PACE, MAP, and MA plans will not be impacted by the transition

23. How will managed care plans and NHs receive roster information?

The managed care plans will receive pertinent enrollee information via the Roster system. Included on the roster will be: (1) the managed care rate code; (2) the NH Provider ID; (3) effective date of long-term placement; and (4) exception code. NHs will continue to receive their FFS roster in the current method of delivery.

24. Will a NH be paid by the MMC plan or MLTC plan?

For enrollees already in a plan, MMC plans must authorize all long term placements in nursing homes, and will pay the nursing home while the eligibility determination for coverage of nursing home care is conducted by the LDSS. This is the same for MLTC.

Network/Contracting

25. What is the meaning of "in-network" and "out-of-network" services?

Each Medicaid managed care plan contracts with various types of health care providers and practitioners to offer covered services. This group of contracted health care providers is known as the plan's network. Generally speaking, MLTC and MMC plans must offer at least two providers of each type of service in their networks. However, the NH network requirements for several counties will require more than two facilities per county (see below). Out-of-network services are those that are obtained from providers who are not part of the plan's network, also referred to as "non-participating providers".

26. Will managed care plans be required to contract with every NH?

No, although each MLTC and MMC plan does have to meet a state established minimum of network providers in each county in which the plan operates. Plans must contract with at least: 8 homes in Bronx, Kings, Queens, Nassau, Suffolk, Westchester, Erie and Monroe counties; 5 homes in New York and Richmond counties; 4 homes in Albany, Dutchess, Oneida and Onondaga counties; 3 homes in Broome, Chautauqua, Niagara, Orange, Rensselaer, Rockland, Schenectady and Ulster counties; and 2 in all other counties (where available). Plans must also include at least two of each type of specialty provider in each county (where available) in their network.

If a managed care plan enrollee selects an out-of-network NH and no other appropriate provider is available in the plan's network, the plan must enter into an out-of-network arrangement (which includes paying the Medicaid FFS rate) with the home.

FIDA plans are required to contract with 8 nursing homes in each county where the plan operates. In addition, FIDA plans must have contracts or payment arrangements with all nursing homes in each county the plan operates.

27. Are there certain elements that are required to be in a contractual agreement between a plan and a NH?

    Required contract provisions are discussed in the MCO and IPA Provider Contract Guidelines available on the Department's web site at: http://www.health.ny.gov/health_care/managed_care/hmoipa/docs/guidelines.pdf

28. Must a NH accept the benchmark rate (i.e., FFS rate) in a contract?

    No. A home may negotiate an alternative rate or reimbursement methodology as long as it is acceptable to both provider and managed care plan and represents a non-FFS alternative rate. However, a home may not "force" a plan to pay a higher rate than the benchmark. If the homes in a county are unwilling to contract with a plan at the benchmark rate, the plan will not be penalized if it does not meet the network requirements in that county.

29. Will managed care plans be required to cover bed hold services in a contract?

    Yes. During the 3-year transition period, managed care plans are required to continue following the bed hold coverage in effect under the Medicaid FFS program, unless the plan and provider have agreed to an alternate arrangement. After the transition period, bed hold will be subject to negotiation between plan and provider.

30. Will plans be required to monitor/audit eligibility for bedhold coverage? This would create a compliance issue for plans.

    Plans may or may not require prior authorization for bed hold arrangements. Please refer to Appendix F of the Medicaid Managed Care/Family Health Plus/HIV SNP Model Contract for authorization timeframes.

31. What if a managed care enrollee wants to be admitted to a specific NH that does not have a contract with the person's plan?

    If an in-network home that meets the needs of the enrollee is available, the enrollee would need to use the in-network home. Individuals already enrolled in a managed care plan and subsequently determined to be eligible for long-term NH placement will be permitted to change plans in order to have access to their preferred NH. Plans whose NH networks are inadequate, whether due to an insufficient number of

contracts or an insufficient number of contracted NHs with available beds, will be required, upon member request, to permit members eligible for NH placement to receive services at an out-of-network NH. MMC/MLTC plans authorizing an out-of-network placement may not require the person to move at a later point to a participating NH once network adequacy is restored. Voluntary transfer to a participating NH must be permitted.

Plans will be required to contract with at least one veterans' NH that operates in their service area. If the MMC/MLTC plan does not have a veterans' home in their network and a member requests access to a veterans' home, the member will be allowed to change enrollment into a MMC/MLTC plan that has a veteran's home in their network. While the member's request to change plans is pending, the MMC/MLTC plan must allow the member access to the veterans' NH and pay the NH the fee-for-service (Benchmark) Medicaid rate until the member has changed plans.

FIDA plans must have contracts or payment arrangements with all nursing homes in each county the plan operates.

32. Can a managed care plan require my NH to use a different pharmacy provider than we currently use?

Absent a negotiated agreement between the NH and Managed Care Organization (MCO), during the three year transition period, MCOs must accept the NH's current arrangement with pharmacies for the provision of services to enrollees placed in a nursing home post August 1, 2014.

For enrollees who may have been receiving drugs that are not on the MCO's formulary at the time of enrollment, MCOs must allow the member to continue receiving such drug for a 60-day period after enrollment. After the 60-day period, the MCO and provider must transition the member to a drug on the plan's formulary, as appropriate. Moreover, existing prescription drug policies applicable to Medicaid only nursing home patients in effect since July 7, 2011 will continue to be honored as follows:

a. *Reimbursement for prescription drugs will continue to be covered through the Medicaid pharmacy program and therefore billed outside of the nursing home benchmark rate;*
b. *Over the counter drugs, Physician administered drugs (J-code drugs), medical supplies, nutritional supplements, sickroom supplies, adult diapers and durable medical equipment will continue to be the responsibility of a nursing home and will be reimbursed within the nursing home benchmark rate; and*
c. *Immunization services inclusive of vaccines and their administration will remain in the nursing home benchmark rate.*

33. How will credentialing be handled between managed care plans and NHs?

Credentialing NH employees is delegated to the NH. Plans must have a process to verify the NH is in compliance with Federal and State requirements. Plans will credential NHs, but are instructed to minimize additional NH requirements.

34. How will the State monitor network development and adequacy?

The State monitors plan contracts and networks on a quarterly basis to ensure network adequacy standards are met. Each facility is expected to contract with at least one MMCP.

35. For network purposes, will there be any requirement for proximity of the facility to family/friends?

The enrollee will be required to select a participating nursing home or will be allowed to change plans to select an alternate nursing home. An enrollee will be able to select an out of network nursing home if his/her needs cannot be met by a participating provider.

36. 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?

Nursing homes should clearly identify non-salaried providers who treat members in the NH. The Department strongly encourages any non-salaried provider to contract with the plan to avoid denials in the future.

37. What are the applicability of managed care plan prior authorization requirements to OON nursing homes for hospitalizations?

The prior authorization requirements to OON providers remain unchanged. Providers must abide by plan requirements for authorization of services, whether a participating provider or out of network.

38. How will "fraud and abuse" be defined for contract termination purposes? How about "imminent harm"?

10 NYCRR Parts 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 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.

There is no statutory definition of "imminent patient harm". Providers may elect to define this term in their contracts.

Enrollment

39. Who will be the enrollment broker? What authority gives the enrollment broker access to the NH? Will managed care plans be disciplined if they market directly to residents?

    Medicaid Choice (Maximus) will be the enrollment broker. Maximus has no explicit authority to access a NH, but the State hopes NHs and Maximus will work cooperatively together. Once Maximus is notified through the Medicaid eligibility system of a Medicaid NH placement, they will reach out to the NH to arrange an on-site visit or call with the resident to review enrollment requirements and choices. The State will continue to take disciplinary action if plans market directly to NH residents.

40. If a permanent NH resident in FFS Medicaid (i.e., permanent placement prior to the date of mandatory managed care) is hospitalized and ineligible for NH bed hold, will he/she be required to enroll in a managed care plan upon return to permanent placement?

    Yes, the resident will be viewed as a new permanent placement and would be required to enroll in a managed care plan.

41. Is there an enrollment process for individuals with mental illness or cognitive impairment?

    The current PASRR Level 2 process will be utilized for individuals with mental illness or developmental disability.

42. What can providers do if they encounter problems or delays in getting authorization for services or in the appeals process?

Providers encountering such issues should call the DOH hotline. For MLTC call 1-866-712-7197; for MMC plans call 1-800-206-8125.

43. How will auto assignment work if more than one plan contracts with the facility where the resident is residing?

    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.

44. How will plan selection be made if the person is incapacitated and does not have a legal representative?

    The individual will be auto assigned to a plan that contracts with the nursing home in which he or she resides.

45. As a practical matter, how quickly can a person change plans while awaiting nursing home placement from a hospital or community?

    Plans are responsible to assist enrollees in selecting a participating nursing home and must cover OON placement only if par facilities cannot meet the member's needs; have no beds available; or if the enrollee is eligible for placement in a Veteran's Nursing Home, and there is no Veteran's Nursing Home in the plan's service area. The original plan will cover the Veteran's Nursing Home stay OON until the enrollee transfers to a plan that contracts with the Veteran's Nursing Home. If an enrollee is placed in a participating nursing home, and wishes to transfer to an OON nursing home (other than a Veteran's Nursing Home) the enrollee must request an enrollment into a plan that contracts with the desired nursing home or request the plan to cover OON. Managed care enrollment through the change of plans will be coordinated to prevent any gap in coverage; however, the enrollee may not disenroll into FFS Medicaid. The current plan will cover the consumer's stay in the contracted home, or OON NH if approved, and members will access preferred NH once enrollment in plan of choice is effective. Once enrollment in the new plan is effective, the new plan will cover the consumer's stay in the current home under transitional care requirements, and assist the member with authorization and transfer to the new nursing home. However, it is expected that both plans involved in the transition will coordinate care to eliminate any disruption in care and/or billing issues.

46. How will a nursing home find out in a timely way if one of its patients changes managed care plans?

The provider must check eligibility at the time of service, or weekly for nursing home services, for billing purposes.

Placement and Services

47. Who decides whether a Medicaid managed care member living in the community should move to a NH on a long-term basis?

    A recommendation for long-term placement must be made by a physician or clinical peer, based upon medical necessity, functional criteria, and the availability of services in the community. The process for transitioning a Medicaid managed care member to a long-term placement in a NH should include the member, his or her family, the NH, the managed care plan, hospital discharge planner (if applicable), and the LDSS. The PASRR and PRI will continue to be used, providing tools to help ensure that the member is placed in the least restrictive setting appropriate to his/her needs.

    The MLTC or MMC plan will identify a clinician or other appropriate liaison to work with members, NHs and hospitals on discharge planning activities for its members. The liaison will assist in coordinating the roles of the hospital and NH staff, ensure the member and his/her family are consulted, and facilitate communications between all interested parties. The member and his/her family must all be in communication with the other responsible parties to ensure an appropriate transition to placement in a NH. Once the decision to pursue a long-term placement is made, a recommendation must be made to the MLTC or MMC plan, as applicable, with supporting documentation. The MLTC or MMC plan must authorize all levels of care and ensure that the care is in the best interest of the member.

48. What if a NH resident, who is completing a Medicare short-stay episode and is newly eligible for permanent placement in a NH, selects a plan that does not include the NH in its network?

    DOH does not want NH residents to be forced to change NHs as a result of managed care enrollment. The State's enrollment broker will provide counseling on the available plans that contract with the resident's NH. However, if the resident nevertheless selects a plan that does not contract with his/her NH, the resident may have to move to a different home.

    There may be circumstances in which the resident would not have to move, even if his/her NH did not participate in the plan's network. For example, the MMC or MLTC plan might be willing to approve an out-of-network placement to avoid disrupting the resident's care. In addition, MMC and MLTC plans that have inadequate NH networks, due to an insufficient number of NHs under contract or an insufficient

number of beds, are required to permit members to be placed in their preferred out-of-network NH. Further, MLTC and MMC plans are required to authorize out-of-network NH placement when there is no participating facility with an available bed that meets the member's needs. Finally, it is worth noting that members may freely change MLTC and MMC plans to secure a placement in a preferred NH in another plan's network.

FIDA plans must have contracts or payment arrangements with all nursing homes in each county the plan operates.

49. What resident assessments will be performed?

The NH will be responsible for the same assessments (i.e., MDS) as currently required, which must be performed on the current schedule. The UAS-NY assessment – which is required when an individual enrolls in a plan and every six months thereafter, or when the resident experiences a significant change in condition – is done by the managed care plan or its contractor. The UAS-NY process is the same for NH residents as it is for community MLTC enrollees, but it is conducted in the NH setting.

50. Will the UAS-NY or MDS be the basis of coverage decisions?

Plans will be required to compare the UAS-NY assessed needs with the MDS assessments conducted by the NH and consider both when authorizing services, equipment and supplies for the member. The care plan, MDS, UAS-NY, medical record and input from the care management team will provide the plan with the necessary information for the authorization of services both in the NH and upon discharge from the NH.

51. How often will managed care plans reauthorize service?

Reassessments using the UAS-NY will be required every 6 months or if a significant change in condition of the resident occurs. Services will be authorized consistent with the results of the assessment. Some plans may authorize services for shorter periods, such as in the case of a therapeutic or post-acute stay.

52. May the NH resident retain their Primary Care Provider (PCP) in the community when they transition in to a NH?

Yes. If a member is transitioning from the community into a nursing home, the member should be allowed to retain their primary care provider in the community. If a MCO wishes to use the nursing home physician as the primary care provider for a member, the MCO must inform the Department and ensure that the nursing home physician maintains the responsibilities similar to those of other network

PCPs, including, but not limited to, disease management, referrals, and hours of availability.

53. What if the NH and/or resident disagree with a managed care plan's recommendation to transition the resident out of the NH?

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.

The plan is responsible for the cost of services during the time prior to the decision. However, if the plan's adverse determination is made at a time when the plan decides the discharge plan is not safe and the enrollee must remain in the nursing home, the plan continues to be responsible for the ALC nursing home payments. The plan may require an authorization request for ALC. If the determination confirms a safe discharge to the community, the plan may deny payment for continued stay. If the enrollee timely requests a fair hearing and aid continuing, and there is a provider order for the stay, the plan would pay for the stay until issuance of the fair hearing decision, as directed by the Office of Administrative Hearings.

54. 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.)?

Medical necessity dictates nursing home placement. For plan enrollees permanently placed, the plan may deny continued authorization based on a significant change in the enrollee's health status as per assessment, or the enrollee requests/prefers community setting and a safe discharge to the community is in place.

55. 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?

The transitional care policy provides continuity of care for new enrollees. The policy allows new enrollees to continue an ongoing course of treatment during a transitional period of up to ninety (90) days from the effective date of enrollment with the current care plan, or until the plan implements a new plan of care, whichever is later.

56. Will a facility's survey status affect whether it can accept placements from a plan?

As long as a facility has not been banned from receiving Medicare and Medicaid 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 its agreement with the nursing home or request action from the nursing home prior to allowing additional placements.

Reimbursement/Cash Flow

57. What is the NH "benchmark" rate and what does it include?

The NH benchmark rate is equivalent to each facility's FFS Medicaid rate, and is intended to represent a "benchmark" for rate negotiations between NHs and managed care plans. The benchmark rate includes the direct, indirect, non-comparable and capital components; statewide pricing phase-in adjustments through Dec. 2017; the Medicaid-only CMI adjustment and other adjustments and add-ons to the FFS rate; the 6 percent cash receipts assessment add-on; NH quality pool adjustments; and any universal settlement amounts (if an agreement is reached and payments are made through the rates). DOH has posted a listing of benchmark rates by facility at: http://www.health.ny.gov/facilities/long_term_care/reimbursement/nhr/.

58. 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.

The Department is currently working to update the benchmark rate file on the website to provide clearer information in detail and in total.

59. Will DOH still continue to set and pay FFS rates after the transition begins?

Yes. The transition of the NH population from FFS to Medicaid managed care is expected to take at least 3 years to complete. Furthermore, Medicaid FFS will remain the payer for nursing home resident beneficiaries who are not required to enroll in a managed care plan.

60. At what rate must plans pay NHs in their network during the transition period?

During the rate transition period (i.e., for 3 years after a county is deemed mandatory for NH population enrollment), MLTC and MMC plans must pay their contracted NHs either the benchmark rate or a negotiated rate (i.e., based on an alternative payment methodology other than FFS such as episodic, tiered, etc.) as long as it is acceptable to both the NH and managed care plan. The negotiated rate option is not intended to be an amount tied directly to the benchmark rate (e.g., benchmark rate

minus 10%, etc.); rather, it is supposed to be based on an alternative payment arrangement.

61. At what rate must plans pay NHs for out-of-network services?

    MLTC and MMC plans are required to pay non-participating NHs at the benchmark rate for out-of-network services. Unlike in-network services, this requirement is not limited to the 3-year transition period and is intended to be in place indefinitely.

62. Will MLTC and MMC plans be responsible to pay Medicare coinsurance and deductible amounts for dual eligible residents who receive Medicare Part A/Part B covered services?

    Yes. Plans will be responsible for paying Medicare coinsurance and deductible amounts that Medicaid is responsible for on behalf of enrolled NH residents.

    The FIDA program does not have any coinsurance or deductibles.

63. How will CMI adjustments be made to Medicaid rates after the transition begins?

    The current FFS rates are based on the CMI for all Medicaid patients in each facility. As the Medicaid population in NHs is gradually transitioned into managed care, the CMI in the FFS/benchmark rates will continue to be based on the entire population of Medicaid beneficiaries identified on the census roster. This includes both FFS and Medicaid managed care enrollees.

    The Department is committed to minimizing retroactive rate adjustments and will continue to work toward eliminating as many of the retroactive rate adjustments as possible.

64. Are there special rules around reimbursement of the capital component of the Medicaid rates?

    Yes. After the 3-year transition period, MLTC and MMC plans must continue to pay NHs (both in-network and out-of-network) the capital component of the benchmark (i.e., FFS) rate. DOH will continue to calculate the capital component under the prevailing methodology, and require via contractual agreement with the plans that they pay this amount to providers.

65. Will NHs be reimbursed by managed care plans for retroactive adjustments to the benchmark rates (e.g., CMI updates, cash receipts assessment reconciliations, adjudicated rate appeals, etc.)?

    Yes. Plans will be responsible for paying these retroactive rate adjustments to NHs in their network and for services provided out-of-network.

66. Delays in obtaining authorization from plans for permanent placement may create a 45-day lag in payment.

    It is anticipated that admission and the billing cycle begin after authorization is obtained. This would be part of the provider's contract negotiation process with the plan.

    In an effort to mitigate some of the cash flow issues experienced during an earlier transition, the Department organized a work group to mitigate these issues in real time. The Department has organized a similar group for the Nursing home transition.

67. 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 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. Plans must be explicit in all provider contracts. Perm placement is not created by authorization.

    The Department understands the concerns around cash flow and is willing to work with both the providers and the plans to ensure a smooth transition into care for all. We do not believe the billing/ payment lag will be an issue on clean claims as our understanding is most plans make payments on a weekly basis and can turn around claims in a faster time frame than the current NYS mandated lag would allow NYS to. However, we would encourage and support nursing homes who mandate language be added to contracts between plans and providers regarding a time period on turning around payments for clean claims.

68. Will there be a requirement that all plans are capable of receiving clean claims either electronically or by paper from providers? Will there be a contractual or other requirement that Plans must be able to accommodate electronic funds transfers?

Will there be a requirement that the contract between the NH and the Plan address this?

The Department implemented a readiness review requirement to document that plans are able to receive a clean claim from all of their network providers. This review demonstrated each plan's ability to accept electronic claims and paper claims, as well as determined the MC Plan's systems are compatible with current Nursing Home Systems.

69. Since there is no adjustment embedded in MLTC premiums and no distinct specialty rate codes for MLTC to bill, DOH indicated there will be a $10 million risk mitigation pool. How will this 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?

    The Department would like to discuss this in more detail with the plans and provider representatives. DOH continues to address these questions with CMS and looks forward to continued feedback from both plans and providers, and anticipates arranging for these discussions in the near future.

70. Subsequent to the transition, will CMI audits include residents enrolled in MMC plans or will they be limited to residents covered under the FFS program?

    It is anticipated that the audit plan will audit all Medicaid recipients, both MMC and FFS, as this represents the NH case mix adjustment.

71. We understand that some current 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.

    For Medicare covered services that are provided in the NH, the facility is required to continue billing as it currently does. The MLTCP rate takes into account Medicare reimbursement. The NH may retain Medicare reimbursement to which it is entitled for covered services.

72. Payments by plan if resident invokes rights under nursing home transfer/discharge regulations to appeal a transfer/discharge [10 NYCRR § 415.3(h)]

Under current transfer/discharge regulations, the individual is responsible for payment to the facility for a continued stay during a pending appeal. However, if an enrollee is in disagreement with the plan's determination, the enrollee may also exercise his or her due process rights by requesting a fair hearing and aid to continue. Fair Hearing determinations are binding.

In the FIDA program, an individual may appeal through the integrated appeals process and continue to receive services pending the appeal. If an individual has availed him or herself of continuing aid, the individual would not be responsible for payment to the facility.

73. 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?

    If the enrollee requests, and the Office of Administrative Hearings directs the State and plan to provide aid continuing, the plan will pay for the stay until the fair hearing decision.

74. Will there be training available to providers regarding changes to the billing process?

    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.