NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Acting Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

TRANSITION OF NURSING HOME POPULATIONS AND BENEFITS TO MEDICAID MANAGED CARE

Frequently Asked Questions Part 2
March 2015

For purposes of this Frequently Asked Questions document, the term "managed care" includes Medicaid Managed Care (MMC) and Managed Long Term Care (MLTC). The term "Medicaid Managed Care Plan" (MMCP) includes mainstream Medicaid Managed Care and HIV Special Needs Plan products. The term "Managed Long Term Care Plan" includes Partial Capitation and Medicaid Advantage Plus (MAP) products.

Rates and Billing

1. We have individuals who have been determined eligible for long term NH care by the LDSS, however the approval is through the current MLTC plan. The Electronic Provider Assisted Claim Entry System (EPACES) shows eligible PCP not MA Eligible, and so our billing is denied. How is the NH to obtain payment?

   If a consumer is enrolled in MLTC and subsequently receives permanent placement in a Nursing Home, the MLTC plan would be responsible for payment to the NH. The consumer would remain enrolled in MLTC, and Coverage Code = 30 would be appropriate.

2. How can pharmacies identify the plan in which a consumer is enrolled? Will there be an electronic request similar to Medicare Part D?

   When verifying, the message "ELIGIBLE PCP" will be returned, indicating coverage is in place under a Pre-paid Capitation Program (PCP). This status indicates the enrollee is PCP eligible, and is also eligible for limited Fee for Service (FFS) benefits. To determine the covered benefits, the provider must contact the PCP designated in the Insurance Code field.

3. Will the roster contain the new rate code or will plans use the R/E code to derive the correct rate code for billing and reconciliation?

   The plans will use the R/E codes N1-N5 to derive the correct rate for NH billing and reconciliation.

4. Will NHs continue to bill Medicare Part B for rehabilitation services, or bill the MLTC plan instead?

Billing policies have not changed under this transition. Plans are responsible for maximizing other insurance coverage, and Medicaid is the payer of last resort.

5. Are plans allowed to require a Medicare or primary payer denial prior to paying a custodial claim?

   Billing policies have not changed under this transition. Plans are responsible for maximizing other insurance coverage, and Medicaid is the payer of last resort.

6. Is a NH responsible for payment resulting from a transfer to a non-network hospital, if the care is not considered an emergency?

   For urgent care, when a nursing home determines it cannot provide care to meet the patient's needs, the nursing home may transfer the patient to a hospital. Prior authorization is needed if seeking transfer to a non-network hospital due to un-availability of a network hospital or enrollee's clinical needs cannot be met by a network hospital.

7. Please clarify the term "quarterly" regarding claims submission. Will NH bill the MCOs every three months?

   NHs will bill plans according to an agreed upon schedule and in accordance with the contractual arrangement between the plan and provider. However, in workgroup discussions, plans indicated a willingness to process claims bi-weekly.

8. Will all MCOs accept electronic claims? Will the payments be made with the same current Medicaid turnaround time?

   All plans will accept electronic claims. There is no change to prompt pay law, which plans must follow when reimbursing providers.

9. How will availability of claims training offered by plans to providers be monitored by DOH?

   Plans are required to provide training to providers regarding billing policies. If a provider identifies a plan not providing appropriate training, providers may contact DOH.

10. Are rate codes required on the claims submitted to MC plans?

    Rate codes are submitted to plans by the provider when billing.

11. Considering the benchmark rate does not include levels, how should plans reimburse rehabilitative services after a hospital admission?

The benchmark is based directly on the promulgated nursing facility rate. These rates include an average Medicaid only case mix for the facility based upon a census submitted by the facility. This average rate is paid to nursing facilities for six months and then revised based upon the next census. The nursing facility rate is not adjusted on a patient specific basis.

12. How does the plan pay for the cash assessment, since this is not included in the benchmark rate? Is it billable separately, and are there separate rate codes?

    The current benchmark currently includes Cash Receipts Assessment. This policy is currently under review.

13. Will there be a provision for NHs to bill plans on a weekly basis?

    Currently MCOs have agreed to allow submission of claims from Nursing Homes at least every 2 weeks (bi-weekly) or twice a month.

14. How should Nursing Homes bill for retroactive rate adjustments for Case Mix Index (CMI)?

    The Department is creating a schedule to allow the initial case mix rates to be issued during the month in which the rate is active, eliminating the need for retro billing. In addition, the Department is examining all rate schedules in an effort to issue statewide rate packages twice per year.

15. Is it expected that plans use the billing code sets previously discussed?

    Most plans have agreed to work with 2 sets of billing codes. NYSDOH is working on a survey to gather more specific detail from plans on the billing codes they will use.

16. What is included in the benchmark rate? Does the benchmark rate include physician ancillary services and assessments?

    Medical Staff Services is cost center 44 of the NH cost report, as part of the benchmark a per diem has been calculated and is displayed for Medical Staff Services. This is a non-comparable cost center and is reimbursed 'as reported' by the facility in the base year report, that is, no 'price' was determined for the non-comparable component.

17. What indicator is used to show the services included in the benchmark rate?

    There is no 'marker' on the rates or in the benchmark.

18. When will Plans be notified of the premium rate add-on for administering the long term NH benefit?

NYSDOH will notify plans of this as soon as possible.

19. Are benchmark rates site-specific? Are they based on Case Mix Index (CMI)?

    Yes, the benchmark rate is site (facility) specific. The benchmark rate does include the latest processed case mix.

20. Do managed care plans receive additional reimbursement from the State for contracting with a facility with a high property in its rate?

    There is a Nursing Home Price Mitigation Pool to provide additional funding to high cost Nursing Homes.

21. Will the case mix process be discontinued moving forward, and if so, when will it be discontinued?

    Consideration has not been given to discontinuing the case mix process.

Care Planning

22. Are the MCO representatives required to be invited to the scheduled care plan meetings in the NH that are tied to the Minimum Data Sets (MDS) schedule?

    This is a CMS policy and frequency is negotiated between plans and providers as a contractual issue.

23. Are the requirements for care planning for NH LTSS the same as requirements for the FIDA Plan?

    No. Please refer to the FIDA web site for more information about that program. http://www.health.ny.gov/health_care/medicaid/redesign/mrt_101.htm

24. What are the requirements for the sharing of care plan information between the MCO and the Nursing Home for an enrollee?

    The NH remains responsible for care provided, and the plan authorizes the care plan based upon medical necessity criteria. MCO may make a determination regarding the medical necessity of patient care. If agreement cannot be reached, plans and providers must utilize the Complaints and Appeals process to arrive at a determination.

25. Will the hospital roles for care and discharge planning be mandated as part of the hospital contract with the plans?

    Hospital discharge planning criteria have not changed under this transition.

Benefit

26. Will respite care continue to be carved out to FFS Medicaid?

    The MCO is responsible for respite days and bed hold days authorized by the MCO, per the Medicaid Managed Care/SNP Model contract.

27. If a patient is enrolled in Hospice, who is responsible for billing the plan, Hospice provider or the NH?

    The hospice provider will bill the MCO for room and board provided to patients residing in the nursing home and pass this amount to the nursing home.

28. Does FIDA cover long term nursing home benefits?

    Coverage of long term nursing home benefit is included in the FIDA benefit package.

Eligibility

29. Please clarify the MCO responsibility to pay the NH while the long term eligibility is established by the LDSS. Will the enrollee be placed on the plan's roster temporarily?

    Current enrollees will no longer be disenrolled due to permanent placement in a NH, so the enrollment will continue to appear on the plan's roster. The plan is responsible for reimbursement to the NH while the eligibility determination is conducted by the LDSS. If the recipient is not enrolled, they will not be required to enroll until after eligibility is determined by the LDSS.

30. Is the NH or the Plan responsible for verifying Medicaid eligibility and enrollment?

    Medicaid providers are responsible for verifying eligibility and enrollment prior to providing services, using the consumer's benefit card.

31. What is meant by the term, "engage the LDSS"? Who is the contact for homeless individuals?

    Plans bear an additional responsibility, other than financial, for arranging a safe discharge for the enrollee, regardless of housing status. Plans and nursing homes must partner with each other to engage the Health Home, if applicable, and the local district to arrange for safe housing suitable for the enrollees needs when arranging a discharge from the nursing home.

32. If a consumer is admitted to a nursing home for a short term stay following an inpatient hospital stay, is an eligibility determination by the LDSS, including a 60 month look back, required?

    No, plans are required to cover short term stays. There are no changes to the eligibility rules that districts will use to determine eligibility for Medicaid coverage of long-term nursing home care (permanent placement); including when the 60-month transfer of assets look-back period applies or the application of a transfer of assets penalty period.

33. Are NHs required to submit Medicaid applications for consumers admitted to the NH for a stay covered by Medicare Part A, when MLTC is the secondary payer?

    There is no change to the current Medicaid eligibility process.

34. Who is considered a viable representative for a consumer? Is an authorized Power of Attorney required, or is a health care proxy be sufficient?

    A consumer can authorize a facility or another individual to represent himself/herself in the Medicaid application process. A signed statement from the consumer is sufficient for this purpose. If the consumer is not capable of authorizing another individual to act on his/her behalf in submitting an application, anyone willing to act responsible on the consumer's behalf may submit the application. In this case, a legal representative such as a legal guardian may need to be appointed in order to obtain the necessary income and resource information to complete the application process.

35. Does the Asset Verification System (AVS) preclude a consumer from providing 5 years of financial documentation for a long term eligibility determination?

Information regarding the Asset Verification System will be issued separately in a forthcoming Administrative Directive.

Enrollment

36. Who does the plan notify if the enrollee leaves the nursing home and does not plan to return so that the roster can be updated?

    The consumer would remain enrolled in the health plan, and the Nursing Home is responsible for notifying the local district of any changes in status via DOH approved notice. The LDSS must end date the N1-N6 Restriction/Exception code. This action will remove the enrollee from the Nursing Home Plan report.

37. What are "lock-in rules" regarding managed care enrollment?

MMC and MLTC enrollees in long term care in a NH are not subject to lock-in rules and may change plans at any time.

38. When a consumer is admitted to a NH and a plan is selected for enrollment, what happens if the plan does not accept the enrollment? How is the NH reimbursed for services?

    Plans do not have the option of rejecting an enrollment.

NAMI

39. What is the format of the report containing NAMI information? Can DOH distribute a sample of the report?

    The file layout will be:

DISTRICT		*PIC X(02).*
CIN	*CIN*	*PIC X(08).*
CASE-NUM	*Case Number*	*PIC X(12).*
EXC-CD	*Exception Code*	*PIC X(02).*
NH-PROVIDER	*NH provider ID*	*PIC X(08).*
RE-FROM-DATE	*N code effective date*	*PIC X(08).*
PCP-PROVIDER	*NH provider ID*	*PIC X(08).*
NAMI-AMT	*NAMI amount*	*PIC X(10).*
ERROR	*Budget type error*	*PIC X(20).*

40. Can a mainstream MMC enrollee be disenrolled for non-payment of NAMI? If so, what are the parameters for disenrollment? If not, what are the guidelines?

    Consumers may not be disenrolled for non-payment of NAMI.

41. How common is delegation of Net Available Monthly Income (NAMI) collection by plans to NHs statewide?

    NAMI delegation is a contractual arrangement between plans and providers. DOH does not have access to this specific data.

42. Is the Plan delegation of NAMI collection to a NH a contractual matter? Is the NH allowed to refuse this delegation?

    NAMI delegation is a contractual arrangement between plans and providers. Nursing homes are not required to accept delegation of this task by a plan.

    It is recommended that plans discuss the collection of the NAMI and any communications nursing homes have developed for collection purposes with a nursing home. The Department does not have required forms or letters for this use. The

Medicaid eligibility notice will inform the consumer and, if applicable, the consumer's representative of the monthly NAMI amount to be paid.

43. What are the requirements for plans for providing NH residents with their $50 dollar personal needs allowance (PNA)?

    If a plan is collecting the NAMI from the consumer, a $50 personal needs allowance has already been subtracted from the consumer's income in arriving at the NAMI amount. Only in instances where the plan is representative payee for the consumer's income, must the plan set aside $50 for a personal needs allowance before collecting the NAMI. When the consumer indicates that they want the nursing home to maintain a personal needs allowance account, the plan must ensure that the $50 personal needs allowance is sent to the nursing home each month. If the plan is not representative payee for the consumer's income, the plan has no responsibility regarding the personal needs allowance.

44. Social Security requires all checks to be direct deposit, however many NH residents do not manage a check book. How will the NAMI payments be obtained from the NH resident in this case?

    Upon admission to a nursing home, the nursing home often becomes the representative payee for the consumer's social security benefit. This provides the nursing home with the ability to access the NAMI or portion thereof. In some cases, adult children or other relatives may be managing the consumer's income. In these cases, the family member will pay the NAMI each month. In other cases, a legal representative may be required in order to access the consumer's income for payment of the NAMI.

45. Will budgets be provided to the NH facility to document the NAMI amount to be collected?

    The plans will receive a copy of the enrollee's eligibility notice specifying the NAMI amount due. If the plan delegates the NAMI collection to the NH, the plan is responsible for advising the NH of the amount to be collected.

Systems

46. If a case is coded with N7, does this mean an enrollee is NOT to be moved to the NH program on the plan's system?

    The LDSS is responsible for entering the end date of the N7 code equal to the effective date of the MMC enrollment. Once enrolled, the local district must enter the end date for the N7 code and enter the applicable N1-N6 R/E code. The local district must be contacted to correct the coding if necessary.

47. Will plans receive any of the new R/E values (N1-N7) on the rosters prior to the implementation date? If not, when can plans expect to begin receiving the new N codes?

    The N1-N7 R/E codes will appear in the system and on the roster once the local districts receive notice and complete an eligibility determination for long term placement in a nursing facility for a Medicaid/Medicaid managed care recipient.

48. Will the NH receive the MCO roster in addition to the FFS roster?

    The Nursing Home will not receive a MCO roster. The Nursing Home will not receive a MMC enrollee on the NH FFS roster

Assessments

49. Will the Uniform Assessment System-New York (UAS-NY) and Nursing Facility Level of Care (NFLOC) continue to be utilized?

    The NH will be responsible for the same assessments (i.e., MDS) as currently required, which must be performed on the current schedule. The MCO is responsible for 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. What assessment tool will be utilized to determine level of care?

    All mandated assessments and evaluation criteria will continue under MMC and MLTC enrollment. For example, nursing homes receiving Medicaid or Medicare payment will continue to utilize the Minimum Data Set (MDS) to assess all consumers upon admission to the Nursing Home and periodically after admission. Care Assessment Areas (CAAs) will also continue to be required to formulate the individual's care plan.

51. NYSDOH guidance refers to the NH arranging for completion of the UAS-NY. What is the purpose of this assessment for a Long term Care resident in a NH?

    The UAS-NY assessed needs are compared with the MDS assessments conducted by the NH, and taken into consideration when authorizing services, equipment and supplies for the enrollee. The care plan, MDS, UAS-NY, medical record and input from the care management team provide the MCO with the necessary information for the authorization of services both in the NH and upon discharge from the NH.

52. Will the UAS-NY replace any current assessments, or will it be an additional assessment?

    Plans will be required to compare the UAS-NY assessed needs with the MDS assessments conducted by the NH, and take both into consideration when authorizing

services, equipment and supplies for the enrollee. 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.

53. If an enrollee is in long term placement in NH and is hospitalized, is a new Patient Review Instrument (PRI) required to return to NH? Or is the enrollee still considered long term and NH is the enrollee's home?

    The NH will be responsible for the same assessments (i.e., MDS) as are currently required, performed in accordance with the current schedule. Consumers in receipt of fee for service Medicaid and in long term placement who are discharged to a hospital and readmitted to the NH will not be required to enroll in a managed care plan if bed hold is in place. If bed hold is not in place or has expired, the placement is considered to be new and the consumer would be required to enroll in a plan contracting with the nursing home.

Authorizations

54. Does the NH need to obtain authorization from the plan for bed hold or therapeutic leave?

    Therapeutic leave must be included in a plan of care and requires a physician's order. It does not usually require prior authorization. Authorization should be obtained when the patient is transitioning to different levels of care. However, plans may require notification of bed hold and therapeutic leave to determine payment and benefit limit.

55. Will MCOs or MLTCs grant retro authorization if the NH does not obtain prior authorization?

    It is anticipated that admission and the billing cycle begin after authorization is obtained. There may be extenuating situations where retro-authorization may be needed in order to address a specific member. However, all non-emergent transitions in care should be authorized by the plan as part of the discharge planning process. This would be part of the provider's contract negotiation process with the plan.

56. Will facilities need to obtain authorization for payment from the MLTC or MCO for coinsurance or copays?

    Plan authorization is not required for payment of coinsurance or copayments from the MLTC. Consumers with Third Party Health Insurance are excluded from MMC enrollment.

Complaints, Appeals, and Disputes

57. How do a plan and provider obtain resolution when there is not agreement regarding a plan of care?

    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 NH 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.

58. The rules and regulations of the Commissioner of Health place ultimate responsibility for patient care on the NH board. If the MCO makes a determination regarding patient care, does the NH still bear the ultimate responsibility?

    The NH remains responsible for care provided, and the plan authorizes the care plan based upon medical necessity criteria. MCO may make a determination regarding the medical necessity of patient care. However, if there is a disagreement, the NH and enrollee should exercise appeal rights and aid to continue, if applicable..

59. What is the protocol for plans not approving a continued NH stay? MCOs may not provide advance notice for a denial of continued coverage.

    Plans must provide timely notice to the provider of any denial of service. Providers would follow the current complaints and appeals process if there is not agreement between plan and provider.

Communications

60. Will DOH have a meeting with NYC nursing homes to assist with understanding the process once they have some experience and case examples? Nursing homes would also be interested in information regarding how the cash flow is impacted and/or working.

    DOH currently has scheduled a series of standing meetings with plans and providers. If submitted in advance, time may be designated to discuss specific examples. If warranted, the DOH would be willing to have a meeting with NYC nursing homes.

61. Is there a DOH webpage that identifies contact information and phone numbers for each plan?

    The DOH website has a MCO directory with Provider Services phone number for each plan. However, we encourage you to work with each contracted plan to develop the most efficient contact and process to communicate and address issues.

62. Will DOH enforce the availability of a contact person at each plan for the NH transition?

    Plans and providers are encouraged to participate in workgroups and meetings designed by DOH to promote collaboration.

Network

63. Many MCOs appear to be contracting with the larger NH facilities to meet network requirements. What can smaller nursing homes do to obtain contracts with plans?

    DOH encourages nursing homes to contract with multiple plans whose service area includes the NH if possible. Based on the information we have on contracting, the majority of NH facilities have contracts with MCOs. For example, the most recent information shows that only 3 of the 43 NHs in the Bronx do not have a contract, 5 of the 40 in Brooklyn don't have a contract, 1 of the 18 New York NHs don't have a contract and four of the 55 NHs in Queens do not have at least one contract with a MMCP. As a result, this does not appear to be an issue as it relates to access. The DOH will continue to monitor.

64. Can an MMCP refuse to negotiate or contract with a NH?

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

65. What happens if a plan does not have the required number of nursing homes in a specified county by the transition date?

    Plans not meeting network requirements would be required to pursue additional contracts; the plan would be required to allow enrollees to receive services from out of network providers in the interim if they do not have capacity.

66. What is the expectation for plan surveillance over nursing homes in a plan's contracted network? Will the State continue to conduct annual certification surveys, or will plans be required to conduct similar activities?

Surveillance of nursing homes by the State has not changed under this transition. Plans are not required to conduct surveillance of NH, but are required to monitor the quality of care provided to enrollees.

67. A small rural nursing home is the only provider in the county, and receives many referrals from hospitals outside the county. Will the hospitals continue to be able to refer to the NH, or will hospitals be required to refer within their respective counties first?

    Plan enrollees must access services through the provider network. If a network provider meeting the enrollee's needs is not available, the plan must authorize the enrollee to receive services from an out of network provider. Referrals to a nursing home provider for consumers not enrolled in a plan would not be limited to plan participating providers.

68. What can DOH do to promote collaboration between plans and providers?

    Plans and providers are encouraged to participate in workgroups and meetings designed by DOH to promote collaboration.

Physician Services and Credentialing

69. How do nursing homes obtain compliance from a PCP in the community?

    Plans are responsible for oversight of providers and for ensuring care is provided in accordance with DOH requirements. The NH would need to communicate the requirement of the community PCP to the plan so that it is clear and can be conveyed to the PCP.

Miscellaneous

70. For facilities having long-term care Traumatic Brain Injury (TBI) beds, with specific DOH regulations allowing a year or longer for rehabilitation and regulation specific programming, are MMC plans allowed to move patients as soon as Physical, Occupational, or Speech Language Pathology Therapy is complete? If the facility is licensed to provide this care and regulations allow for this length of stay, must managed care plans take this into consideration?

    The Social Services Laws of 2011 limited the outpatient rehabilitation benefit (physical therapy, occupational therapy, and speech therapy) to 20 visits each per twelve-month benefit year. The Medicaid Redesign Team Proposal #34 (MRT #34) allows the exemption of this visit limitation for Recipients with a traumatic brain injury (TBI) (R/E code 81 or a primary diagnosis ICD-9 code in the 850 – 854 series) in an outpatient

setting. However; there is no limit for inpatient rehabilitation services, as this is based on medical necessity.

71. For SSI recipients, who is responsible for notifying SSA of a temporary NH or hospital placement to ensure SSI continues as permitted by law for a short period if medical documentation is submitted? Otherwise SSI payment stops after 30 days, putting in jeopardy the ability to maintain a home in the community.

    Although the SSI recipient or the recipient's representative should notify SSA of an admission to a nursing home, local SSA offices encourage nursing homes to timely report temporary or permanent placements. If the placement is temporary, SSI benefits will continue for 90 days. If the placement is permanent, the SSI benefits continue for 30 days.

72. Please describe the difference between the FIDA and MLTC programs?

    Please visit the NYSDOH Managed Long Term Care web site. http://www.health.ny.gov/health_care/managed_care/mltc/