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TRANSITION OF NURSING HOME POPULATIONS AND BENEFITS TO MEDICAID MANAGED CARE

Frequently Asked Questions
June 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

1. What is the Per Member Per Month (PMPM) rate? What are the current benchmark rates for MLTC and MMC?

   The Department is currently developing the PMPM with its actuary, Mercer. The current benchmark rates can be found on the Department's website.

2. Is there a separate rate cell for MCOs for long term NH enrollees in order to ensure plan receptivity to enroll these consumers?

   There is a separate rate cell for Medicaid Managed Care, and a blended rate for Managed Long Term Care.

3. When updated rates are posted to the DOH website, will multiple years be listed or will a blended rate be issued?

   Posted rates will be for single years, and rates will not be blended across years.

4. What is the rate for pediatric nursing homes under this transition?

   This transition applies only to consumers age 21 and older.

5. Are plans expected to map to the new rate codes form the R/E code? Or will the equivalent rate code be furnished on the roster?

   Rate codes will be furnished on the roster.

6. Can a Plan apply for stop-loss for a non-permanent placement? How does it work during a member's period of ineligibility?

   Per the Managed Care Model Contract for Medicaid Managed Care/Family Health Plus and HIV Special Needs Plans, plans will be compensated for medically necessary and clinically appropriate Medicaid reimbursable non-permanent nursing home inpatient rehabilitation services provided to MMC Enrollees in excess of sixty (60) days during a calendar year at the lower of the plan's negotiated rates or Medicaid rate of payment. The plan would still be eligible for inpatient acute and inpatient mental health stop loss.

7. Are the plans supposed to pay the CRA amounts for specialty patients? The specialty benchmark rates on the website don't contain the CRA per diem. I believe there were supposed to be edits to those files to make them clearer and I would suggest the addition of the CRA to the specialty rate file is part of those edits.

   Benchmark rates have been updated. CRA is in the benchmark rate for Specialty's and is to be included for payment.

Billing

8. Please clarify the time frame within which a MCO must pay a clean claim.

   Plans must follow prompt pay law when reimbursing providers in accordance with N.Y. ISC. LAW § 3224-a. Plans must pay claims within thirty days of receipt of an electronic claim and within 45 days of receipt of a paper claim.

9. What is the time frame for billing? What is considered untimely submission of the claim?

   Current Medicaid billing policies are not changed under this transition. Providers should adhere to timely filing requirements in the provider contract, which must allow at least 90 days from the date of service. Plans and providers may negotiate billing terms when contracting for this service. Non-participating providers have 15 months to submit a claim involving Medicaid services.

10. Will the DOH support a need for a quicker payment timeframe than exists in prompt pay regulation?

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

11. Will there be DOH governance over the required revenue and Healthcare Common Procedure Coding System (HCPCS) codes that the Managed Care organizations may require for correct billing?

    DOH is currently working with the industry and plans regarding universal billing.

12. Are plans able to recoup from the NH facility when there is a period of ineligibility? Does the NH's ability to reserve all rights in that circumstance to collect from the plan enrollee or responsible relatives remain unchanged?

    Plans are able to recoup from the NH facility for a period of ineligibility. The rights of the NH to collect from plan enrollees or responsible relatives has not changed under this transition.

13. Are plans able to bill for stop-loss for enrollees transitioning from a rehab or short term stay to long term placement?

    Per the Managed Care Model Contract for Medicaid Managed Care/Family Health Plus and HIV Special Needs Plans, plans will be compensated for medically necessary and clinically appropriate Medicaid reimbursable non-permanent nursing home inpatient rehabilitation services provided to MMC Enrollees in excess of sixty (60) days during a calendar year at the lower of the plan's negotiated rates or Medicaid rate of payment. The plan would still be eligible for inpatient acute and inpatient mental health stop loss.

14. Since there are issues with CMS approval of the NH rates, should plans continue capitation billing as usual until informed otherwise? Will issuers then be given the opportunity to retroactively adjust the billing with timely filing edits relaxed?

    Yes. Plans should continue to bill as usual until directed differently by NYSDOH.

15. Will the continuation of payment rules requiring plans to cover a consumer transferring to another plan apply to all changes in plan enrollment?

    For consumers transferring to another plan, the current enrollment remains in effect until the transfer is effectuated. While the enrollee's request to change plans is pending, the MMCP remains responsible for the stay. Once the consumer is enrolled in a new plan, the new MMCP is responsible for authorizing care under the transitional care policy.

Benefit

16. Once Plan enrollees transition into the NH for long term care, must these enrollees receive care management?

    Care management must be provided in accordance with the guidelines posted to the DOH website for MRT #90, Supplemental Information. For MMC, care management must be provided in accordance with Appendix S of the MMC/FHP/HIV SNP Model Contract.

17. Will therapeutic leaves remain at 10 per calendar year?

    There is no change in the allowable days for Therapeutic Leave. Bed Hold leave banks are determined by anniversary date, not calendar year or fiscal year.

18. Does "other therapeutic leave" include short term personal leave?

    Yes, other therapeutic leave refers to non-medically beneficial home visits or visits for personal reasons.

19. Is the NH paid 95% to hold the bed during a therapeutic leave?

    The reimbursement rate is 95% for Therapeutic Bed Hold days if the resident meets all eligibility requirements: at least 30 days in the facility, with at least one day being Medicaid as the primary payer, and the nursing home must be at 95% occupancy on day one of the leave.

20. When calculating a bed reserve benefit, how is a 12 month period calculated? Is it a calendar year running from July through June?

    Effective July 19, 2010, each resident shall have an anniversary date for bed hold day availability that is the date of their established residency in the nursing home. It is not the admission date; residency is established once the resident has been in the nursing home for 30 days with at least one of those days with Medicaid as the primary payer. Nursing home residents with previously established residency status when the changes of 2010 went into effect were assigned the default anniversary date of July 19, 2010.

21. Is it the expectation of DOH that plans know what are the non-comp services provided by each nursing home contracting with the plan?

    Yes, for services outside the baseline covered services, it is the expectation of DOH that plans are able to discern those services provided by NHs contracting with the plan. This is useful, not only for billing by NH and third party vendors, but also for discharge planning and care management purposes. Nursing homes must be knowledgeable about third party vendors are contracted providers with the different plans with which the NH contracts.

22. How is transportation covered for a NH resident who travels to the community to see his or her community PCP?

    Transportation providers must bill the enrollee's health insurance plan when the enrollment is through a Medicaid Managed Care plan, and the plan covers non-emergency transportation as part of its benefit package. At this time, only plans in Nassau and Suffolk counties cover non-emergency transportation as part of the benefit package. One notable exception is NYS Catholic Health Plan/Fidelis, which covers non-emergency transportation in Rockland County.

    Most plans operating in Nassau and Suffolk counties include both emergency transportation and non-emergency transportation in the benefit package, with the exception of Health Insurance Plan of Greater New York (HIP). HIP only covers emergency transportation. Transportation may be arranged through the State vendor (Logisticare for NYC and Medical Answering Service (MAS) for the rest of the State).

For Managed Long Term Care, non-emergency transportation to a provider in the community is covered by the plan, and is not provided by a contracted State vendor.

23. How is emergency transportation covered after the transition date?

Emergency transportation is reimbursed by FFS Medicaid through eMedNY, except for in Nassau and Suffolk counties, where it remains in the MMC benefit package. For MLTC, emergency transportation is covered under fee for service Medicaid for partial plans, and is covered by MAP as a Medicare benefit.

Enrollment

24. When a MLTC enrollee is discharged from a hospital to a nursing home for long term placement, and the NH selected is not in the plan network, how can the transfer to the new plan be effectuated?

For consumers transferring to another plan, the current enrollment is effective until the transfer is effectuated and the plan may approve an out of network NH placement during this period. The new enrollment will be prospective, and will be effective the first day of the month. New York Medicaid Choice is available to assist consumers with plan selection and enrollment.

Eligibility

25. What is non-chronic budgeting? Are there NAMI implications? Who determines the possible 6-month non chronic budgeting?

"Non-chronic budgeting" is a term that is sometimes used to describe the treatment of a consumer's income during a period of temporary placement in a nursing home. During temporary placement, an individual retains income up to the Medicaid income level in determining eligibility and any contribution toward the cost of care. If the consumer is expected to return to a community setting, based on medical diagnosis and prognosis of the treating physician and as authorized by the plan, the consumer will continue to retain net income up to the Medicaid income level instead of a $50 personal needs allowance. There is no set durational limit, for example 6 months, for temporary status in a nursing home; however, for Medicaid eligibility purposes, the consumer's status should be re-evaluated periodically based on medical evidence. Note: For married consumers who are not eligible under the Modified Adjusted Gross Income (MAGI) category, spousal impoverishment rules may apply if the individual is expected to remain in an institution for at least 30 consecutive days.

26. Who is responsible for submitting the request for a Medicaid eligibility for permanent placement to the LDSS?

The request for Medicaid eligibility determination to the LDSS does not change with this 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.

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Authorizations

28. Is prior authorization for a bed hold required from plans for an enrollee entering an inpatient hospital stay?

    Absent a negotiated agreement, prior authorization is not required for bed hold during an inpatient hospital admission. It is not the Department's intent to require prior authorization for bed hold.

29. How are plans notified of the number of bed hold days remaining following an inpatient admission for an enrollee in long term placement?

    Nursing homes are required to provide timely notification to plans of any bed hold in place and the number of days for enrollees entering a network hospital for an inpatient stay.

30. Since it appears plans would generally be approving a permanent placement, it would seem simpler to indicate that plans have the right to disapprove a permanent placement within 90 days. If so, will DOH be issuing guidance for this type of action?

    Plans are responsible for authorizing permanent placement of an enrollee. This responsibility will not change with the transition of NH to managed care.

31. Are plans allowed to deny payment of coinsurance when an enrollee enters a non-participating nursing home?

    Plans are required to cover coinsurance of a Medicare covered stay in a NH even if the member is in an out of network NH.

32. If an enrollee in the hospital selects a NH that does not contract with the plan in which he or she is enrolled, must the enrollee go to a network NH? If the consumer selects a NH not in the plan network, does the selected NH lose the admission?

    Except for veterans, enrollees must select a NH from the plan provider network. If an out of network NH is selected by the enrollee, he or she must transfer to a MMCP that contracts with the selected NH. For enrollees transferring to another plan, the current enrollment is effective until the transfer is effectuated. The new enrollment will be prospective, and will be effective

the first day of the month. The original MMCP may authorize an out of network stay at the selected NH to allow the enrollee access, and would reimburse the NH at the benchmark rate until the enrollee has changed plans. Otherwise, the consumer may access the selected NH through the new plan's network once enrolled.

33. When a current enrollee in MMC is admitted to a NH for long term care, can a plan deny coverage, stating the enrollee is able to receive LTSS in the community?

    A MCO may deny a long term NH admission if the medical necessity determination supports the enrollee residing in the community with appropriate supports.

34. What happens when a NH resident enrolled in MMC requires emergency hospitalization is sent to an out of network hospital?

    No prior authorization is needed for emergency care. For dually eligible consumers enrolled in a MLTC plan, services must be coordinated between Medicare and Medicaid. For non dually eligible MLTC consumers, Medicaid FFS will cover the inpatient stay. For MMC enrollees, the MMC plan is responsible for emergency services and arranging for post-stabilization care as per the MMC Model Contract.

Discharge and Care Planning

35. What is the responsibility of the plan if there is not a location available for a safe discharge? Are plans required to provide 10 days notice if stopping payment?

    Plans are required to provide 10 day notification to the enrollee if reducing or ending care. Plans bear an additional responsibility for arranging a safe discharge for enrollees, and may not terminate payment if a safe discharge location is not in place. The NH is responsible for providing evidence of attempts to locate appropriate placement. Plans may assist the NH in securing a safe discharge for an enrollee.

36. What is the plan's responsibility for arranging a safe discharge for enrollees who are homeless?

    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 to engage the Health Home and the local district to arrange for safe housing suitable for the enrollees needs when arranging a discharge from the nursing home. The NH is responsible for providing evidence of attempts to locate appropriate placement. Plans may assist the NH in securing a safe discharge for an enrollee.

37. If a consumer is discharged from a nursing home, and there is no bed hold or if bed hold lapses, this is considered a break in service. When the consumer is readmitted he/she loses grandfathered status and must enroll in a plan. Our enrollees are concerned that requiring plan enrollment in these cases without some reasonable grace period (perhaps 30 days) will cause unnecessary disruption for beneficiaries who are likely to continue needing NH care.

    Plan enrollment does not impact NH admission or care. A consumer new to Medicaid would enroll in a plan that contracts with the NH of choice and would be covered under Medicaid

FFS until the enrollment was effectuated, at which time the plan would begin coverage. Current enrollees would experience no disruption in care and would remain enrolled in the current plan upon entering a NH for permanent placement.

NAMI

38. If a NH is delegated the responsibility for collecting NAMI on behalf of the MCO, who has primary responsibility if the NAMI cannot be collected?

    NAMI collection arrangements are based on the contract between the plan and the Nursing Home.

39. If the Nursing Home is unable to obtain NAMI payments, is the plan responsible for making the Nursing Home whole?

    NAMI collection arrangements are based on the contract between the plan and the Nursing Home.

40. If the NH provider agrees to collecting NAMI, does the NH reimburse the plan for the NAMI amount or does it send NAMI payment from a resident directly to Medicaid? If yes, how are Plans required to reconcile that amount from NH reimbursements?

    If a Nursing Home provider agrees to collect NAMI for a managed care plan, the Nursing Home would not need to reimburse the plan or the State for the NAMI amount. Through the contracting process, managed care plan and Nursing Homes may coordinate the NAMI collection as part of reimbursement from the managed care plan to the Nursing Home.

Systems

41. Will the NH file contain retroactive dates in the RE-FROM DATE field?

    The "from date" will be the date that the plan is responsible for nursing facility services. It can be a retroactive date.

42. Is the RE-FROM DATE field the date the NH rate code is in effect for the plan receiving the report?

    Yes.

43. How will this information be shared for Medicaid members who enrolled through the Exchange?

    There will be no Exchange consumers permanently placed in Nursing Homes. If an Exchange consumer is in need of permanent placement, his/her case will be referred back to the local district for NH eligibility determination.

44. Is there particular information on the 834 that we should pay attention to? Will the NH File Layout contain info for both Exchange enrolled and non-Exchange enrolled recipients?

    There will be no N codes on NYSoH consumer cases at this time. NH consumers must transfer back to WMS, using the current 834 process (XT). Once on WMS, the N codes and appearance on the roster will be occurring.

45. Is there no more than one RE code bed type per recipient? In other words, a recipient cannot have more than one RE code? For example, if an AIDS patient is also on a vent, will there be one RE code?

    There can only be one N code per consumer; the system edits them against each other. The bed type should be selected on status/severity of the individual's care, meaning a vent should trump other types. Currently there is no payment difference, however at a later date, each rate will be paid distinctly based upon N code.

Pharmacy

46. Does the physician drug fee schedule identify the physician administered drugs that are covered under the benchmark rate?

    The Medicaid covered physician administered drugs are listed in the physician provider manual's fee schedule.

Miscellaneous

47. How can providers clearly identify the type of plan into which a consumer is enrolled, i.e., MMC vs. MLTC? On line resources do not clearly indicate the type of plan.

    DOH advises providers to contact the PCP designated in the Insurance Code field in ePACES to determine exactly what services are covered. Providers should confirm covered benefits with the managed care plans or refer to their contract. Provider manuals and managed care information are available at eMedNY.org. Providers should refer to those resources or call the managed care plan listed in ePACEs to verify coverage.

LDSS

48. The "Frequently Asked Questions" document on the DOH website refers to "short term NH services" and "long-term placement in a NH"; does this refer to a non-permanent admission (as opposed to a 29 day short-term rehabilitation) and permanent admission respectively?

    A short term stay is a temporary admission, not permanent status.

49. How will LDSS know which R/E code needs to be entered? Will the LDSS-3559 be revised to reflect this information?

The new DOH form replacing the LDSS-3559, which is in the final approval process, will indicate the bed type and appropriate RE code. DOH will issue a GIS with instructions for using the new form.

50. On the January 2015 PowerPoint slides found on the DOH website, there is one that mentions "Consumer Representation"; is this exclusive to the managed care plans or does it apply to LDSS too? What is the proper procedure if the NH claims the consumer is incapable of verbally naming and/or signing an authorization to represent and there is no one with the legal authority to do so on the consumer's behalf?

    Nothing changes from the current practice. 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.

51. Is the mandatory enrollment for long-term NH residents based upon the date of admission to the facility, the date of application for NH coverage, or both?

    This policy applies to consumers in need of permanent placement on or after the implementation date for the district. Fully eligible consumers in permanent placement prior to the applicable implementation date are excluded from mandatory enrollment in MMC or MLTC at this time.

52. The information on the DOH website indicates that the MMCP and NH will assist the consumer in obtaining documentation to establish eligibility for NH coverage. Do the plan and NH need to be copied on all requests for documentation, even if there is no authorization for them to represent the consumer?

    The LDSS is responsible for issuing notices to the consumer and any authorized representative as appropriate. Plans and NHs are expected to work jointly to obtain any required documentation. Unless named as an authorized representative, the LDSS may not send such notification to the NH.

53. If a current FFS long-term NH resident moves from one nursing home to a different NH with no intervening hospital stay, does the admission to the second NH trigger the mandatory enrollment into a MMCP? Would the admission to a second NH trigger mandatory enrollment if there was an intervening hospital admission, with or without a bed hold?

    After the transition date for the district, consumers in receipt of fee for service Medicaid and in permanent 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. Moving to a different NH without an intervening hospital stay is considered a new NH admission, and the consumer would be required to enroll in a MMCP or MLTCP contracting with the NH if otherwise eligible.

54. Currently, our district often receives PRIs with the LDSS-3559, should we also be receiving a copy of the Preadmission Screening and Resident Review (PASRR)?

    There is no change in the NH assessment requirements. The PRI is not an eligibility requirement and does not need to be submitted to the district.

55. A MMCP enrollee is admitted to the NH for a non-permanent stay then changes to permanent after 90 days; a 60 month resource review is conducted after the LDSS is notified of the permanent placement; uncompensated transfers which will result in a penalty period are found: when will the penalty period start; the month of admission, the month the enrollee became permanent, or the month after the month the enrollee became permanent?

    For MMCP enrollees, the penalty period would begin the first of the month of admission.

56. Currently, a MLTCP can disenroll a consumer who does not turn over their overage to the plan. Can a consumer be disenrolled from a MLTCP (or a MMCP) if they do not turn over their NAMI to the plan?

    Failure to pay NAMI does not affect Medicaid eligibility status and is not a valid reason for disenrollment. Plans and Nursing Homes are free to pursue reimbursement through other means.

57. Once a consumer is enrolled in a MMCP, will the system automatically flip the coverage code from 01 to 30? Will all coverage codes flip, if necessary?

    Coverage codes will change as per WMS coverage coding procedures. There is no change to this process with the NH transition.

58. How will the LDSS be notified of an enrollment of a consumer into a MMCP or MLTCP?

    NYMC will issue an enrollment report to the districts which will segregate NH enrollee information. LDSS are responsible for reviewing enrollment reports on a regular basis as in the past.

59. There is mention of a new R/E report via HCS and BICS that will contain the N codes. Would this include the N7 code as well? Could this report be used to identify cases requiring a coding change once enrolled?

    Consumers with N7 codes would not be enrolled, so the N7 code would not appear on the NH enrollment report to the LDSS. Once enrolled, the information will appear on the enrollment report, and the LDSS is responsible for changing the N7 code to N1-N6 as appropriate.

60. How would the LDSS handle applications that are submitted with a managed care plan already chosen? The N7 code triggers outreach activities, but we may already know what plan the consumer has requested. Is this still a NYMC responsibility, or would our local Managed Care Unit have to enroll? How does this change the process?

    If applications are received with a plan selection indicated, the district may transmit that information to NYMC for outreach and enrollment. Responsibility for outreach and

enrollment activities would not fall to districts utilizing services of the enrollment broker under this transition.

61. Consumer applied prior to the transition date for the district. While the application is being processed, the consumer leaves the NH, and then returns to a NH without a bed hold. Would this consumer then be required to enroll in a plan since the NH admission is after the applicable transition date?

Consumers entering a NH for long term placement without bed hold after the transition date are required to enroll in a plan.

62. 15 OHIP/ADM-01 states that R/E code 90 is entered on cases awaiting a long term eligibility determination. What is the purpose of the R/E 90 code?

Entering the R/E 90 would prevent auto assignment while the eligibility determination is in process.