New York State Department of Health

Question and Answer Sheet Resulting from March 7th, 2012 Webinar:
New Populations and Benefits Transitioning to Mainstream Medicaid Managed Care

Homeless

Question	Answer
1. Could you explain what Maximus is?	Maximus is the enrollment broker that serves to educate and enroll the population. NY Medicaid Choice is the program name used by Maximus.
2. When will a companion guide be issued and e-load files be sent for testing the homeless indicator?	The companion guide and testing specs have been released to the managed care plans.
3. Can a provider send DOH a list of patients that frequently visit ED's and validate that that individual is on one of the mailing lists?	This is not recommended due to confidentiality concerns. The State can identify clients who frequent the EDs.
4. If a client does not have an address is their managed care application placed on hold or do they remain FFS?	They remain FFS.
5. Does the initial assessment of the homeless population have to be done by an RN?	The initial assessment must be done by a PCP or NP in order to be reimbursed by the MCO.
6. Is the first assessment an exam or just a one on one with a shelter case worker?	It could be both. Full history and physical is done for undomociled population because they are hard to reach. In order to be reimbursed by the plan, the assessment must be done by a provider that can bill Medicaid FFS; a shelter worker may not fit into this category.
7. If a client calls Medicaid Choice to enroll over the phone from a non-broker county, will that enrollment form be sent to the LDSS?	Not routinely. Non-broker counties will see the enrollment in a daily report that is available through the HCS. If a consumer completes an enrollment form and returns it to the broker, it will remain resident in the broker's system.
8. What happens if the homeless is in a nursing home but you don't have the current address? Will we be able to get the necessary authorization for care?	The county should be notified of the change of address to the nursing home. If the client is exempt or excluded, they can apply for a disenrollment from managed care, Otherwise, the Nursing home would need to report nursing home stay to the plan and apply for authorization.
9. Is the effective date for phase 1 of NYC homeless enrollment roll-out 30 days from 4/1, 30 days from when family actually gets the packet, or 30 days from 5/1?	It is 30 days from the date of the notice to the consumer alerting them that they must pick a plan.
10. Can enrollment be done directly by managed care plans or will all enrollments be done by NY Medicaid Choice.	Plans can be FE's and can work with individuals by calling Maximus to handle the enrollment over the phone. MCOs cannot enroll.
11. Will MCOs use uniform or standardized criteria forms and general procedures for	We have not required plans to use a standardized form. They should accept all referrals and do an

considering a request for case management for the homeless population?	assessment of the individual's needs once they get the referral.
12. Can you identify who the Homeless FQHC in Putnam is, we do not see them on any of the documentation that has been disseminated (so far)?	There are no FQHC's in Putnam County. Looking at data from CY 2010, Putnam County enrollees are utilizing FQHC's in neighboring counties (Dutchess, Westchester, Orange, and Rockland).
13. Can you assist in providing a listing of all shelters (NYC) with contact names and bed count?	We are obtaining a list from NYC DHS.
14. Will street homeless applicants be able to use the FQHC's facility address as their own in order to move forward with their coverage?	If they wish to and the facility is willing, this can be done.
15. Will FQHC's be allowed to use the facility's address on the application?	If they wish to and the facility is willing, this can be done.
16. If a homeless person is currently in a nursing home will they get an exemption until the 10/12 mandatory enrollment?	Yes
17. The homeless population moves around often. How would they receive their plan cards when the address changes so often? Just because we have a current address at this moment it could change the next day.	Recipients are mandated to report address changes to the LDSS. In addition, in NYC, the file match through DHS and HRA will change the address on file for persons on Temporary Assistance. All addresses are transmitted to the health plan through their monthly roster.
18. Can the potential homeless enrollee use the health home address for an application?	If they wish to and the facility is willing, this can be done.
19. Who and what determines an invalid address for homeless persons?	NY Medicaid Choice uses an address convention system which matches against addresses to verify validity.
20. In NYC, there are many providers who serve large homeless populations but who are not 330H FQHCs. Does the MCO's requirement to contract with FQHC's extend to those providers? If not, is there any way for a patient to remain with a provider whose employer cannot get contracted with the MCO to which the patient was assigned?	Plans currently have contracts with FQHCs which are available to members. We encourage providers to contract with MCOs and recommend members to select plans that contract with that provider. The only way a patient can remain with a provider that is not contracted is through obtaining prior authorization from the MCO.
21. What would you consider timely turn around for a non-par provider to receive authorization to provide service to a homeless member?	Prior and Concurrent authorizations have to be made within the time frames spelled out within the health plan's contract with the SDOH in Appendix F.1 Section 3.
22. If the assessment is conducted by the shelters where does this information go, is it provided to the provider, FQHC's and the MCO's?	The information should be shared with the MCO.
23. Will there be a different set of quality indicators for the homeless population than the mainstream population?	Not at this time. The DOH Quality Department will determine the need for specific measures for the homeless population.

24. Is a P.O. Box a "good" address for contact of a homeless person?	Yes
25. Can you clarify that the list of providers that were sent out was to plans in NYC only. My DOH plan manager indicated there was no such list for upstate counties. Is that correct?	Correct, we don't have a list of providers upstate but we have spoken to the counties and have checked that plans have FQHC providers in their network.

ESRD

Question	Answer
26. Will we inform the plan of ESRD patients that enroll in their plan?	Plans are provided with past claims information on all members that enroll.
27. Are ESRD patients currently receiving LTHHC services? If they are, will they be required to enroll in a plan beginning 4/1/12?	If enrolled in LTHHC program, there is a hierarchy on exemptions and exclusions, and they would remain excluded from MMC until that population is enrolled.

CDPAP

Question	Answer
28. When and in what counties will non-dual CDPAP transition?	September of 2012. Approximately750 persons in receipt of CDPAP are currently in managed care state-wide, these are not new enrollments. The benefit will be transitioned state-wide.
29. We didn't learn enough about the CDPAP population transition - will there be another webinar for this?	We are working with stakeholders to finalize this transition. DOH will consider a webinar.
30. For CDPAP transition - will this be for just those who are already enrolled in a MCO plan?	For non-duals in Mainstream managed care, this is a benefit expansion for people already enrolled in managed care.
31. How can CDPAP fiscal intermediaries find out the populations of their current consumers who will be moving to MCO?	Based upon the info we have, approximately 146 are in NYC and 619 are in the rest of the state. These are members currently enrolled but are receiving CDPAP fee-for-service.
32. Will plans be asked to contract with existing CDPAP providers and/or issue single-case agreements, similar to the personal care transition?	Plans will contract with Fiscal Intermediaries, however, we continue to work out the details of this transition.. More information will be provided shortly.

LBW Infants

Question	Answer
33. What information will managed care plans have to report to LDSS for LBW/SSI babies?	You don't have to report any more than you are currently reporting. If you have a newborn that would meet the criteria for SSI, the LDSS should be notified to begin a disability review unless the family has applied for SSI cash benefits for the baby.
34. Will plans still be required to report sick newborns to the LDSS even though the plan will	If the infant meets the criteria for SSI disability, it should be referred to the LDSS for disability

continue to manage the baby?	determination to be sure the baby is categorized correctly in the computer system.
35. When will we know for sure if the low birth weight newborns should go to managed care plan instead of fee for service 4/1/12. We have seen that it is still pending approval.	We have received the approval from CMS on this change and any babies born on or after 4/1 will be enrolled in a plan.
36. What happens to babies that have private insurance is HMO going to pay balance after insurance?	If the TPHI is comprehensive, the baby is excluded from being enrolled into managed care. If not comprehensive, since Medicaid is the payer of last resort, the plan would be expected to coordinate benefits

Nursing Home/Residential Home

Question	Answer
37. Does the nursing home population include AIDS residents?	We did not plan to exclude any groups, it would be all residents enrolled in the nursing home unless they otherwise have another exemption or exclusion (HIV is no longer a valid exemption from enrollment into managed care).
38. Will there be a webinar in the near future regarding nursing home transition?	Yes, if it is necessary.
39. What if a nursing home is not contracted with any Managed Care plans?	Nursing homes may want to begin reaching out to managed care plans to secure contracts. More information will be provided on the details of this transition at a later time.
40. Can you describe the residential health care benefit that is scheduled to begin 10/12? Does this include custodial care?	The scope of benefit is the same as the FFS program.
41. If someone in a NH is on MA only gets enrolls in managed care and then becomes a dual eligible will they be disenrolled from the managed care plan	Persons enrolled in managed care who become dual eligible are prospectively disenrolled from their health plan.
42. What type of support will be offered to Nursing Homes to assist in enrolling new members in Managed care?	More information will be provided on the details of this transition at a later time.
43. What if a person moves from one county to another, i.e. for special needs nursing home care? Are the providers obliged to pay for the inpatient stay and subsequent medical follow up?	Yes, with prior authorization.
44. Will long term SNF benefits be covered just like the regular Medicaid program does now?	Yes, subject to managed care plans prior authorization procedures.

Dental

Question	Answer
45. Is there any consideration to delaying the dental carve-in until August to allow additional time for network development?	There are only four plans upstate that do not provide dental. We are expecting that MCOs are augmenting those networks. Plan network adequacy will be further evaluated as we approach the time period.
46. Orthodontics is missing from the list. Isn't this benefit being phased in on 9/1/12?	The orthodontia benefit will be phased in 10/1/12.

Personal Care

Question	Answer
47. What will the relationship be between the plans and ongoing personal care for disabled infants? Will NYC-ACS still be involved?	We are uncertain about NYC-ACS involvement but once the infant is enrolled, the plan is responsible for personal care.
48. What is going to happen when a person in need of personal care services falls off roster and now no-one will be going into their home to do care until re-enrollment the following months?	The MCO will monitor whether an individual receiving personal care services has fallen off the roster and will notify the LDSS Managed care coordinator. In the event the member has no means of reimbursement for the service the LHCSA must assure a safe discharge.

Waiver

Question	Answer
49. Will the community based waiver program population ultimately be mandated to enroll in managed care?	We believe the waiver population will be enrolled in 2014-2015. This will take further planning, therefore, has been scheduled for later.
50. Will there be a webinar or training for HCBS Waiver and Medicaid Service Coordination providers under OPWDD?	The state may consider a webinar once we receive federal approval.
51. As you have stated, the Waiver enrollees are targeted for 2014-2015. I have been informed by representatives in our local offices that my HCBS waiver recipient clients have to be enrolled in MCO. There seems to be a disconnect between your department and the local NYC offices.	Training is being held and Medicaid Update articles are being published to provide the correct information.
52. The waiver programs listed in the Medicaid newsletter has a lot of services paid for by MA (independent living, community integration counseling, and care coordinators) are we going to be managing these benefits or just the medical care for these individuals?	Waiver participants are currently excluded or exempt from Medicaid managed care. The article included in the Medicaid update related to populations not included in the waiver, but have some of the same medical needs and characteristics (these are waiver look –a-likes).
53. As a HCBS Waiver agency it is difficult to obtain payment for our services for participants currently in managed care. Is there a department, or someone to contact to receive	For all waivers except the LTHHCP waiver, the waivered services are billable to FFS as a carved out benefit. Billing problems should be referred to CSC. LTHHCP participants are currently excluded from

assistance with the payment issue?	enrolling in managed care due to the overlap in a few services provided by that program and the MMCP.
54. What is the process to disenroll from managed care if you are a waiver case?	Contact Medicaid Choice at 1-800-505-5678 for enrollment broker counties; Call LDSS Managed Care Unit for non-enrollment broker counties.
55. As a HCBS Waiver provider, we will need trainings that will assist our organizations with preparing for the conversion to managed care for our population.	We agree. As mentioned above, further planning is necessary and training providers will be included in that preparation.

LTHHCP

Question	Answer
56. What options will be available for clients enrolled in programs such as LTHHC but not coded as such as a result of administrative delay?	There are no waiting lists for the waiver programs. If a person had self-identified that they were in a LTHHC program, we would not target them for enrollment into managed care. If the client is not enrolled in LTHHC they would be enrolled and would continue to receive the services they are currently receiving.
57. Are all current surplus patients on LTHHCP excluded for 3 years as you mentioned?	For ALL individuals non-dually eligible, surplus patients are not enrollable into mainstream managed care.
58. For patients who are in the LTHHC program and do not have the identifying code 30 attached to their Medicaid, how do we prevent them from being auto enrolled in a plan?	The procedure is for the LDSS to enter the 30 code for all persons in that program; which precludes enrollment in a plan.
59. The Lombardi Program patients will not be mandated to enroll until 2015 tentatively, is that correct?	Non-duals, January, 2013
60. There are a number of patients on our Lombardi program that are not properly coded, how can we avoid getting them auto-enrolled?	Ask the LDSS to correctly code them with the 30 code.

General/Miscellaneous

Question	Answer
61. Most managed care providers routinely deny coverage for inpatient addiction rehab. Will efforts be made to provide more oversight on this?	Providers should inform the SDOH of these problems and we can contact the plan accordingly. Please call our complaint line at 1-800-206-8125 if you have this issue.
62. Will DOH mandate the enrollment of OASAS addiction treatment center into any and all networks requested?	Behavioral health benefits will be handled by the BHO; we will not be expanding benefits to include behavioral health at this time.
63. Are there any CIDP providers upstate?	They exist in only 4 upstate counties. All of them are closing out at the end of March.
64. How long is the transitional care period?	Transitional care-period is 60 days if you are newly enrolling in a plan. This is modified slightly for personal care or services that individuals receive on

	an on-going basis.
65. You mentioned an end of exemption letter; will there be an end of exclusion letter also?	The letter serves for both exclusions and exemptions for persons who were self-identified as exempt or excluded.
66. You stated that if a consumer does not enroll you will auto-assign a plan for them, is there a particular plan that will be the auto-assign?	Auto-assigns go to plans based on our quality incentive program. Plans with quality incentive are eligible to receive auto-assignment enrollments.
67. Can you explain the 90 day grace period?	After enrolling in a plan, you have 90 days to change plans for any reason. After 90 days, you are locked into that plan for the balance of the first year and are not able to change plans unless you have good cause. It is important for enrollees to understand this ability to change especially if they are auto-assigned into a plan.
68. Are Article 28 patients that are non-code 95 exempt from the 4/1 transition?	If they are not a code 95, and are identified as a look-a-like group, they will be required to enroll in the future once we receive CMS approval. Individual may contact OPWDD to determine if they are eligible for a code 95.
69. Can providers get a sample packet of the mandatory packet?	Yes, we will provide you with a copy if requested.
70. Once CMS approval has been given, how long will it take to distribute the mailings?	There may be a slight lag but the mailings will begin as close to April 1 as possible.
71. Is there a list of definitions of some of the acronyms you used? ie HCBS/TBI, HCBS/CAH, ICF/DD, OPWDD	Home and Community Based Services/Traumatic Brain Injury, Home and Community Based Services/Care at Home, Intermediate Care Facility/Developmentally Disabled,
72. Will ASL interpretation services be provided by the broker?	The broker is required to provide translation services as well as services for the hearing/visually impaired.
73. Are peer support services covered in plans such as navigation, outreach, and engagement?	There is nothing in the contract about providing this service through peers, but case management is included for adults with chronic illnesses and physical or developmental disabilities, and children with special health care needs.
74. Why is there a disparity of reimbursements from the different Managed Care Programs? One managed Care is 100% of Medicaid fee schedule, then there are others with percentage off the fee schedule.	This is a result of plan and provider negotiation for a rate of payment. Plan/Provider reimbursements are not prescribed by the State.
75. In the 90-day grace period, how many times will the individual be able to switch plans and does the 90 days start over again?	We do not have a cap on the number of times an individual can switch and the 90 days does start over each time a new plan enrollment is effective.
76. If there is a 30-day grace period for an individual to choose a plan or request an exemption, is it expected that we will receive members for the 4/1 date.	No, the 4/1 is when the mailings will begin to be distributed.

77. How do OPWDD Medicaid funded case management and HCBS waiver organizations assist our families with getting the MCOs they choose to pay for the services they received?	Code 95 individuals who are in care through OPWDD are not being targeted to be enrolled at this time, however, they MAY enroll if they wish.
78. NY Medicaid Choice fax number	917-228-9212
79. If you apply for another exemption is there an expiration time limit for the additional exemption?	It depends on the exemption. Ex. Chronic illness exemption is only for a 6 month period, many of the other exemptions are valid for an annual period, or until the MRT process has that category targeted for enrollment.
80. For the look alike population, where are they being covered/served now?	In Medicaid fee-for-service.
81. If a custom wheelchair is ordered and approved by Medicaid today, it might take 3-4 weeks to order and deliver. I am assuming Medicaid will not give the provider a grace period on approved equipment if the client moves to a MCO. Should we not order equipment since technically we have no guarantee Medicaid approval is valid.	Under certain circumstances, DME providers may bill based on the equipment order date (rather than delivery date) when a FFS member switches to MMC after equipment is ordered but before it is picked up. Please refer to the eMedNY Provider Manual for DME, Policy Guidelines section, page 8.
82. What happens to approved equipment during this month for custom wheelchairs approved by Medicaid and the client changes to an MCO before we can deliver due to the lengthy ordering time for a wheelchair?	Under certain circumstances, DME providers may bill based on the equipment order date (rather than delivery date) when a FFS member switches to MMC after equipment is ordered but before it is picked up. Please refer to the eMedNY Provider Manual for DME, Policy Guidelines section, page 8.
83. How long does it take to make the change from Medicaid to an MCO once the client calls the enrollment line?	If the call is prior to the 3rd weekend of the month, the enrollment will be effective the 1st of the following month. If not, the effective date will be the first of the month, one month later.
84. Could you elaborate on behavioral health benefits for non-duals?	Appendix K of the MMC/FHPlus/HIV SNP contract provides a comprehensive list of covered and carved out services. The contract is available on the Department's web site at http://www.health.ny.gov/health_care/managed_care/providers/index.htm#model_contracts In general, Medicaid managed care plans cover most behavioral health services for non-SSI/SSI-related enrollees. SSI/SSI-related enrollees receive behavioral health services on a fee-for-service basis. However, some behavioral health services are carved-out of the managed care benefit package for ALL enrollees. These services include chemical dependence outpatient services provided by OASAS certified clinics and specialized mental health services for individuals with serious mental illness, including

	children diagnosed as Seriously Emotionally Disturbed, as listed in Appendix K. Risperdal® Consta®), paliperidone palmitate (Invega® Sustenna®) and olanzapine (Zyprexa® Relprevv™) are covered on a fee-for-service basis for SSI/SSI-related enrollees, only. Detoxification services are considered medical services and are covered by Medicaid managed care plans for all enrollees.
85. To which e-mail address should managed care plans issues be reported?	mctrnpop@health.state.ny.us
86. Is CASA one of the brokers?	No, CASA is not the broker. New York Medicaid Choice is the broker.
87. What is your web site address?	www.nyhealth.gov
88. Can a member request a hearing?	A fair hearing request will be handled in the same manner as they are currently.
89. Will there be any lag in coverage during this transition from Medicaid to managed care?	FFS remains in place while this transition is occurring.
90. What about the children that have a commercial primary insurance and are not exempt?	All persons with comprehensive commercial insurance are excluded from enrollment.
91. Will MCO plans pay for nutritional assessment and counseling sessions?	Appendix K of the MMC/FHPlus/HIV SNP includes nutritional counseling. See Section K.2., item 6. Preventive Health Services.
92. Will PWA patient qualify for any exemption(s)?	The HIV exemption is no longer valid.
93. If an application is submitted in January and enrollment processing for the HMO plan is still not complete, will backdated FFS coverage be made available to cover hospitalization or will a LOI request need to be submitted upon approval of HMO?	Fee for service coverage will apply if the person was eligible. Enrollment in Medicaid managed care is always prospective.
94. Will new applicants that are simultaneously enrolling in Medicaid and pooled trust be required to enroll in a MCO?	Yes