



Department of Health

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Executive Deputy Commissioner

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Dear Provider:

In connection with the transition of the nursing home population and benefit to managed care, the Department of Health (DOH) is posting the benchmark rates to be used in contracts between Medicaid Managed Care Plans (“plans”) and providers. In addition, as required by Chapter 57 of the Laws of 2015, DOH is also providing two sets of revenue codes that have been adopted as a means of standardizing billing by nursing homes (“NHs”) to plans. This letter is intended to provide further guidance to plans and NHs on the benchmark rates and services covered thereunder, standardized revenue billing codes, and Net Available Monthly Income (NAMI) collection.

Benchmark Rate Requirement

The Department’s final policy paper related to the transition of the NH population and benefit to managed care as well as various frequently asked question documents address the benchmark rate payment requirement.

For three (3) years after a county is deemed mandatory for nursing home population enrollment, **plans are required to pay NHs that have contracted to participate in the plan’s provider network** either:

1. **Benchmark rate**, which is the existing Medicaid rate received by the nursing home under the fee-for-service (FFS) program (as defined and explained below) including the cash receipts assessment add-on amount; or
2. **Negotiated rate**, is negotiated between the NH and plan and is mutually agreeable by both parties.

As a default rate, **plans are required to pay non-participating NHs 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.

In addition, both during and after the 3-year transition period, plans must continue to pay NHs (both in-network and out-of-network) the capital component of the benchmark 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. The value of the capital component of the benchmark rate will be included in the premium paid by the State to the plans for the nursing home benefit.

Revenue Codes

Legislation included with the 2015 – 2016 final budget (Section 49 of Part B of Chapter 57 of the Laws of 2015) requires claims submitted by nursing homes to mainstream Medicaid Managed Care Plans and Managed Long term Care Plans to have standard billing codes. To this end, DOH has approved and is providing two sets of revenue codes that have been agreed upon and adopted for use by the plans. Please see Attachment B for additional information.

Net Available Monthly Income (NAMI)

Under the Medicaid chronic care eligibility budgeting process, a determination is made on the amount of monthly income that a permanently institutionalized individual must contribute toward the cost of nursing home care. This amount is known as the NAMI.

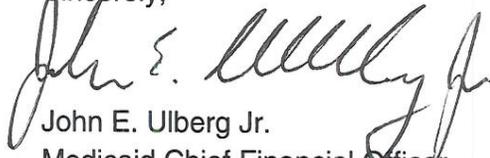
As part of the NH transition policy, the responsibility to collect NAMI amounts is being assumed by the plans. Plans may delegate the collection of NAMI to the NH, but this must be expressly agreed to by the provider in the participating provider contract. Monthly premium payments to the plans will reflect an offset for NAMI amounts. If the plan retains responsibility to collect NAMI, it should pay the facility the full contract rate multiplied by the days of care provided. If the plan delegates NAMI collection to the facility, the NAMI amount should be deducted from payments to the NH for those time periods during which the NAMI is collected by the NH.

The State has proposed to the federal government an arrangement by which the State (or its designee) will assume financial and organizational responsibility to distribute NAMI information, as well as collect NAMI income from all Medicaid recipients residing in nursing homes. However, until such time as the federal government approves this change, plan will continue to bear primary responsibility for NAMI collection.

During and after the transition of the nursing home population and benefit to Medicaid managed care, the State will continue to provide oversight of managed care plan operations, the contracting process, claims payment policies, network adequacy, enrollment processes and appeals and grievances. State oversight will contribute to collaborative relationships between plans and providers, as well as ensure consumer protections for this most vulnerable population.

Questions related to the benchmark rates should be directed to the Department at Robert Yankowski 518-473-4421.

Sincerely,



John E. Ulberg Jr.
Medicaid Chief Financial Officer
Division of Finance and Rate Setting
Office of Health Insurance Programs

Benchmark Rate Postings

Facility-specific benchmark rates are updated and published on the DOH Public Website at: http://www.health.ny.gov/facilities/long_term_care/reimbursement/nhr. These postings include the most current benchmark rates as well as benchmark rates for previous rate periods.

Essentially, there are four different sets of benchmark rates that are posted for any given rate period:

1. **Nursing Home – Medicare Eligible:** These rates apply to Medicaid beneficiaries who are eligible for Medicare Part B and reside in standard (“custodial care”) nursing home beds;
2. **Nursing Home – Non-Medicare Eligible:** These rates apply to Medicaid beneficiaries who are ineligible for Medicare Part B and reside in standard custodial care nursing home beds;
3. **Specialty – Medicare Eligible:** These rates apply to Medicaid beneficiaries who are eligible for Medicare Part B and reside in specialty nursing home beds; and
4. **Specialty – Non-Medicare Eligible:** These rates apply to Medicaid beneficiaries who are ineligible for Medicare Part B and reside in specialty nursing home beds.

Further information on these distinctions is as follows:

- Specialty nursing home beds refer to facilities and units within facilities that have been certified to operate specialty services and receive discrete Medicaid rates for doing so. These specialty certifications include AIDS, neurobehavioral (a/k/a behavioral interventions), pediatric, traumatic brain injury (TBI), and ventilator-dependent. With regard to pediatric services, please note that Medicaid beneficiaries under the age of 21 who require nursing home services are not yet required or eligible to enroll in a plan. Attachment A-1 provides further information on these specialty programs.
- Each beneficiary’s Medicare Part B eligibility status determines which Medicaid rate is the appropriate one to bill/pay. The Medicare eligible rate includes an offset amount (i.e., deduction) that represents an estimate of the amount of income the nursing home will receive from billing Medicare Part B for services that are included in its Medicaid rate (e.g., physician services, rehabilitation therapies, etc.). The non-Medicare eligible rate does not include this offset.

While specialty rates are not currently subject to adjustments for changes in facility case-mix index (CMI), the standard facility rates are adjusted twice each calendar year to reflect each facility’s most current CMI as follows:

1. **January benchmark rates**, reflecting each facility’s CMI from July of the previous year; and

2. **July benchmark rates**, reflecting an update of each facility's CMI to January of the current year.

The foregoing CMI updates are made prospectively (i.e., the CMI adjustment is on a 6-month delay pursuant to regulations). However, the following types of updates to the benchmark rates can have a retroactive impact on a NH's rate:

- reconciliation and updates to the cash receipts assessment add-on amount (both standard and specialty rates);
- the Nursing Home Quality Initiative, which is revised annually (standard rates only);
- any rate appeals processed for the facility (both standard and specialty rates);
- capital component revisions (both standard and specialty rates);
- CMI audits by the Office of the Medicaid Inspector General (standard rates only); and
- other Medicaid rate audits (both standard and specialty rates).

Plans are responsible for paying these retroactive rate adjustments to NHs in their network and for services provided out-of-network. Accordingly, plans and providers should agree through the contracting process on how to incorporate the benchmark rate requirement into the NH contract. DOH is committed to minimizing retroactive rate adjustments and will continue to work toward eliminating as many of the retroactive rate adjustments as possible.

The Department does not object to plans and providers appending benchmark rates to contracts. However, the minimum payment level must be the benchmark rate.

Components of the Benchmark Rates

The benchmark rate includes all components of the Medicaid rate paid for a FFS patient. Specifically, the benchmark rate includes **all** of the following:

- **The direct component**, which incorporates health and health-related services provided to residents. It is based on an adjusted statewide price and reflects each facility's case-mix index;
- **The indirect component**, reflecting administrative and support services. It is based on an adjusted statewide price;
- **The non-comparable component**, which includes various ancillary and support services. It is based on facility-specific costs;
- **The capital component**, which reflects applicable facility-specific costs related to financing (e.g., interest and principal payments) and leasing of facilities/equipment as well as depreciation and amortization charges and return of equity payments;
- **Per diem adjustments**, which include add-ons for dementia, TBI extended care, and bariatric care; statewide pricing transition adjustments; bed hold adjustments (a state budget savings initiative); and other miscellaneous adjustments;

- **Cash receipts assessment add-on**, which compensates facilities for the cost of the six percent assessment paid on Medicaid revenues; and
- **The nursing home quality initiative**, also known as the “quality incentive” or “quality pool.” This adjustment combines a negative adjustment to nearly all facilities to fund the pool, with positive adjustments to facilities receiving awards.

Further details on nursing home services and their inclusion in the benchmark rate are provided in Attachment A-2. Please note that although the cash receipts assessment add-on is billed under a separate rate code in FFS, it is in fact part of the benchmark rate and required to be paid by plans to both network and out-of-network NHs.

When referencing Attachment A-2, it is the responsibility of the plans and providers to identify which services are offered by the nursing home, which are reflected in the benchmark rate, and how they will be addressed in the contracted rate.

Nursing Home Discrete Specialty Services

The following services may be offered in an entire nursing home or in one or more discrete units of a nursing home. Each service requires special certification, entails specific programmatic requirements over and above those that apply to a standard nursing home, and is reimbursed differently than standard nursing home care.

Acquired Immune Deficiency Syndrome (AIDS)

Nursing homes may be designated as AIDS facilities or have AIDS discrete units approved by the Department. Such a facility is required to provide comprehensive and coordinated health services and the operator must provide or make arrangements for: case management services; substance abuse services, if appropriate; mental health services; HIV prevention and counseling services; pastoral counseling; TB screening and ongoing follow up, and specialized medical services including gynecology, as needed. Specific program requirements are enumerated in regulations at 10 NYCRR § 415.37.

Neurobehavioral (Behavioral Intervention Services)

This program must include a discrete unit with a planned combination of services with staffing, equipment and physical facilities designed to serve individuals whose severe behavior cannot be managed in a less restrictive setting. The program must provide goal-directed, comprehensive and interdisciplinary services directed at attaining or maintaining the individual at the highest practicable level of physical, affective, behavioral and cognitive functioning. Specific program requirements are enumerated in regulations at 10 NYCRR § 415.39.

Pediatric

The facility provides extensive age-specific nursing, medical, psychological and counseling support services to children with diverse and complex medical, emotional and social problems in a program recognized and approved by the Department to provide these services.

Traumatic Brain-Injured (TBI)

TBI care is a planned combination of specialized services provided in a nursing home unit designed specifically to serve traumatically brain-injured individuals with an expected length of stay of 3 to 12 months. The program provides goal-oriented, comprehensive, interdisciplinary and coordinated services directed at restoring the individual to the optimal level of physical, cognitive and behavioral functioning. A resident admitted for long-term rehabilitation is one who has suffered a TBI with structural non-degenerative brain damage, is medically stable, is not in a persistent

vegetative state, demonstrates potential for physical, behavioral and cognitive rehabilitation and may evidence moderate to severe behavior abnormalities. Specific program requirements are enumerated in regulations at 10 NYCRR § 415.40.

Ventilator Dependent

This program is intended to serve long-term ventilator dependent residents. Standards of practice should apply and services should be directed at restoring each resident to his or her optimal level of functioning and assisting each resident to achieve maximum independence from mechanical ventilation. Those residents who are assessed as potentially able to be weaned from dependence on support with mechanical ventilation or whose daily use of ventilator support has the potential for reduction may receive an active program of therapy and other supportive services designed for that resident to reduce or eliminate his or her need for use of a mechanical ventilator. Residents are assessed as to their ability to be discharged to home or to a home-like setting with or without supportive services. When such potential is identified, the facility shall initiate an active program of restorative therapy; which may include respiratory therapy, physical therapy, occupational or speech therapy. These support services are designed to assist the resident in the transition to the new setting. Facility discharge planning staff shall arrange for any home modifications, equipment or assistance expected to be required of the resident at home and will work with the lower level of care setting for a smoother transition if needed. Specific program requirements are enumerated in regulations at 10 NYCRR § 415.38.

About Nursing Home Services

Baseline Services Included in the Benchmark Rate

The following baseline services are included in the FFS (i.e., benchmark) rate:

- a semi-private room;
- board, including therapeutic or modified diets, as prescribed by a doctor;
- laundry and linen services;
- 24-hour-per-day nursing care;
- medical direction by a physician;
- administration of all medications;
- assistance and/or supervision, when required, with activities of daily living, including but not limited to eating; toileting, bathing, feeding and transfers;
- physical therapy, occupational therapy, speech pathology services and audiology services as prescribed by a doctor;
- oral hygiene care and routine and 24-hour emergency dental care administered by or under the direct supervision of a registered dentist, including transportation to an outside provider as needed;
- use of all equipment, medical supplies and modalities used in nursing home care, including but not limited to catheters, hypodermic syringes and needles, irrigation outfits, dressings and pads; except when specific items are prescribed for regular and sole use by a specific resident;
- general medicine cabinet supplies, including but not limited to non-prescription medications, materials for routine skin care, dental hygiene, care of hair, etc., except when specific items are prescribed for regular and sole use by a specific resident;
- use of customarily stocked equipment, including but not limited to crutches, walkers, wheelchairs or other supportive equipment, including training in their use, unless such items are prescribed by a doctor for regular and sole use by a specific resident;
- activities program, including but not limited to a planned schedule of recreational, motivational, social and other activities; and
- social services to meet the psychosocial needs of individual residents.

Services Offered That May be Included in the Benchmark Rate

The following services are offered in the nursing home, but the manner in which they are delivered and paid for varies from facility-to-facility. These services may be provided: (1) directly by the nursing home, in which case they are included in the FFS (i.e., benchmark) rate and may be billed to Medicare Part B; or (2) under arrangements with other service providers, in which case they are not included in the benchmark rate

but are billed directly by the service provider to the payer if eligible for FFS reimbursement:

- radiology and other diagnostic services such as x-ray, electrocardiogram (EKG) and electroencephalogram (EEG);
- approved laboratory and blood bank services;
- psychology and psychiatry services;
- respiratory care and therapy (i.e., inhalation therapy);
- podiatry services;
- utilization review services to determine appropriateness of nursing home placement;
- transportation to outside offices of doctors, optometrists, opticians, audiologists, diagnostic radiology and other diagnostic service providers, laboratory/blood bank providers and dialysis providers;
- transportation to outside activities; and
- optician and optometrist services;

The benchmark nursing home rate files posted on the Department's Public Website (http://www.health.ny.gov/facilities/long_term_care/reimbursement/nhr) include worksheets labeled "Non-comp Ancillaries" and "Transportation in Direct Component" which identify facility-specific amounts for these services. Zeros and negative numbers listed for facilities for these services indicate that the cost of the service is not reflected in the facility's benchmark rate.

Services Not Included in the Benchmark Rate

The following services are not included in the nursing home benchmark rate and are separately billable to Medicaid and/or other payers:

- prescription drugs;
- bed hold services. As previously noted, Medicaid bed hold services that would otherwise be considered covered under the State's regulations [see 10 NYCRR § 86-2.40 (ac)(4)] are subject to a separate payment and revenue code;
- hospice services offered in nursing homes that have contracts with licensed hospices to offer these services. Under this program, the hospice bills the Medicaid managed care plan for 95 percent of the benchmark (FFS) rate, and the hospice pays the nursing home directly at the contracted rate.
- respite (Scheduled Short Term Care) services, offered in those facilities that are approved to provide the service under the State's regulations [see 10 NYCRR Part 410]. As previously noted, these services are subject to a separate payment and revenue code;
- outpatient physical, occupational and speech therapy services, offered in facilities that have been approved to provide these services to non-residents of the nursing home;

- adult day health care (ADHC) and AIDS ADHC program services, which are offered by nursing homes approved to provide these services to non-residents of the nursing home;
- emergency transportation and ambulance services;
- items and services that the facility may charge to residents' funds if they are requested by a resident, which include: (1) telephone; (2) television/radio for personal use; (3) personal comfort items, including smoking materials, notions and novelties, and confections; (4) cosmetic and grooming items and services, in excess of those for which payment is made under Medicaid or Medicare; (5) personal clothing; (6) personal reading matter; (7) gifts purchased on behalf of a resident; (8) flowers and plants; (9) social events and entertainment offered off the premises and outside the scope of the activities program; and (10) non-covered special care services such as private duty nurses; and
- a private room, if a semi-private room is available and appropriate to the resident's needs.

As shown in the table below, the revenue codes for some services are identical in the two code sets while they differ for others. Plans and providers should agree on which set of rate codes to utilize through the contracting process, and make any corresponding modifications to differing rate codes currently in use.

Standardized Nursing Home Managed Care Billing Codes

| Service | Code Set #1 | Code Set #2 |
|---|-------------|-------------|
| Custodial Nursing Home Care | 100 | 120 |
| Discrete Specialty: AIDS | 160 | 160 |
| Discrete Specialty: Ventilator Dependent | 169 | 101 |
| Discrete Specialty: Neurobehavioral | 124 | 124 |
| Discrete Specialty: TBI | 121 | 199 |
| Discrete Specialty: Pediatric | 123 | 123 |
| Hospitalization Bed Hold | 185 | 185 |
| Other Leave of Absence Bed Hold | 183 | 183 |
| Therapeutic Bed Hold (authorized by medical professional) | 189 | 189 |
| Respite (Scheduled Short Term Care) | 663 | 663 |

With regard to bed hold payments, regulations at 10 NYCRR § 86-2.40 require that: (1) hospitalization bed hold days are reimbursed at 50 percent of the FFS (or benchmark) rate; and (2) therapeutic and other leave of absence bed hold days are reimbursed at 95 percent of the FFS (or benchmark) rate. All other services listed above are payable at 100 percent of the relevant benchmark rate.