



# Transition of Nursing Home Populations and Benefits to Medicaid Managed Care

December 18, 2013



# Policy Development

- Nursing Home transition policy developed in collaboration with Nursing Home Associations and providers; Health Plan Associations and managed care plans; and Consumer Advocates .
- Nursing Home transition sub-groups were created for:
  - Eligibility and Enrollment;
  - Access and Quality;
  - Network and Contracting; and
  - Finance



# Proposed Transition Dates

- Pending CMS approval, transition begins March 1, 2014:
  - NYC, Nassau, Suffolk and Westchester counties.
  - Transition continues September 1, 2014 in ROS.
- All eligible recipients over age 21 in need of Long Stay/Custodial Placement will be required to enroll in MMCP or MLTC.
- Current custodial care consumers in a skilled nursing facility prior to March 1, 2014 will remain FFS and will not be required to enroll in an plan.
- NH care is presently a benefit for enrollees of MLTC.



# Voluntary Enrollment

- Six months following transition period for a geographic area:
  - Any nursing home resident may enroll in MMCP on a voluntary basis.
  - Begins September 1, 2014 for individuals in first phase who are in a long stay/custodial placement in a nursing home.
  - These individuals will be exempt rather than excluded from enrollment in managed care (MMCP and MLTC).



# Transition Policy

- Existing MMCP enrollees will not be dis-enrolled if they require long stay custodial placement.
- MMCP will be responsible for the NH benefit after February 28, 2014 for enrolled members.
- No individual will be required to change nursing homes resulting from this transition.
- New placements will be based on the individual's needs and the plan's contractual arrangements.
- Plans must ensure that placement is in the most integrated, least restrictive setting available to meet the enrollee's needs.



# Eligibility and Enrollment

- The decision to enter into a nursing facility involves the individual, family members, community members, and skilled professionals.
- This plan should focus on the needs and desires of the individual and his or her goals.
- Family members, community supports and professionals must understand that the plan must support the values of the individual and his or her objectives.
- The Olmstead Decision requires that services, programs, and activities are administered in the most integrated and least restrictive setting appropriate to meet the needs of the individual.



# Eligibility and Enrollment

- Recommendation for long stay/custodial care placement is based on all currently required assessments and evaluations.
- Recommendation is based upon medical necessity, functional criteria, and the availability of services in the community, consistent with current practice and regulation.
- The MCO is responsible for reviewing all documentation and approving or adjusting the care plan to ensure the needs of the consumer are appropriately met.



# Medicaid Eligibility and Enrollment

- Determination of Chronic Care Eligibility
  - LDSS has 45 days from date all required documentation is received to make eligibility determination.
  - Individuals in need of long stay/custodial care will have eligibility determined using institutional rules for chronic care budgeting.
  - Individuals who are resource eligible and are not subject to a transfer penalty will have income eligibility determined using chronic care budgeting.
  - If the local district determines that there are uncompensated transfers during the look-back period, a transfer penalty is imposed and the individual is ineligible for coverage of nursing home care until the completion of the penalty period.



# Eligibility and Enrollment

- For Enrollees already in a plan, MCOs must authorize all long stay custodial placements in nursing homes, and will pay the nursing home while long term eligibility is being conducted by the local district.
- Recipients or individuals not enrolled in an MCO or newly eligible and in need of NH care will obtain a chronic/long term care eligibility determination from the local district prior to enrollment.
  - Consumers residing in a nursing home who are determined eligible will have 60 days to select a plan for enrollment.
  - New York Medicaid CHOICE is available to assist with education and plan selection.
  - If a plan is not selected within 60 days, a plan contracting with the nursing home in which the consumer resides will be assigned.
  - Lock in rules will not apply to these consumers.



# Access to Care and Quality



# Guiding Principle

- A member of the MCO or the member's designated representative is included in determining the most appropriate setting for the receipt of services, equipment and supplies. The choice of settings will consider the MCO network, the needs of the member and the most integrated least restrictive setting to meet those needs.

# Recommendation for Permanent Placement

- Initial recommendation is made by nursing home physician.
  - Based on medical necessity
  - Functional criteria
  - Availability of services in the community
- MCO reviews all documentation and approves or adjusts the care plan to ensure member's needs are met.

# Transition Planning

- **There may be several transitions between settings before the final transition to community based setting or nursing home setting**

# MCO Role in Transition Planning

- **Arranges for comprehensive assessments**
- **Identifies a person at MCO who is in contact with discharging facility, member, community, provider and family.**
- **MCO reviews request during the discharge planning process to ensure a smooth transition**
- **Member choice of nursing home considered**
- **Authorizes OON when necessary**

## Transition from Hospital to Nursing Home or Nursing Home to Community

- **Team approach with enrollee, family, providers and MCO**
  - **Planning to meet enrollee's needs in the least restrictive, most integrated setting**
  - **Discharge plan must be patient centered and focus on the patient's needs**
  - **MCO must be notified of the impending discharge**
  - **Treating facility is responsible for caring for the enrollee**
  - **MCO must be an active participant in assessing, authorizing and arranging for needed services**

# Coverage and Medical Necessity Determinations

- **MCO/Hospital/Nursing Home will develop agreed upon notification procedures**
- **Discharging facility will notify MCO within a sufficient period of time to assure adequate time for authorizations**
- **The MCO will make determinations based on the assessments, provider order, clinical record, input from the care management team and member**

# Enrollee Choice

- All transition planning includes the enrollee and family
- MCO will inform enrollee and family about community and nursing home options available and how to determine the most appropriate setting prior to choosing.

# Care Plan Development

- **During or after care plan development the MCO may review for service coverage and medical necessity.**
- **Medical necessity determinations made as fast as the member's condition requires and in accordance with Contractual requirements.**

# Appeals/Fair Hearing

- **MCOs may determine that transition to another facility or community is more appropriate**
- **Member has all fair hearing, internal and external appeal rights – expedited where appropriate.**

# Enrollee Request for Services

- MCO, nursing home and hospital will respond to enrollee's request for services in a least restrictive setting in a timely manner.
- Decisions should not be based on financial incentives for the hospital or nursing home.

# Homeless Enrollees

- **Special consideration for homeless enrollees during discharge planning**
- **MCO and nursing home engage LDSS in process to find a safe location for enrollee.**

# MCO Authorizations for Care

- NH and MCO will follow authorizations procedures in the provider agreement and existing procedures.
- Emergency Care - No prior authorization
- Urgent Care –
  - No authorization if transferred to a network hospital
  - Prior authorization needed to non network hospital (unavailability of network hospital or clinical needs cannot be met at network hospital)

# Off Hours Authorizations

- **MCOs without 24/7 authorizations processes**
  - **Nursing home must request an authorization on the next business day with all necessary documentation**
  - **MCO must cover all urgent hospital services provided and applicable bed holds while authorization is pending.**

# Nursing Home Responsibilities in Authorization Process

- **Notify MCO of enrollee transfer to hospital and which hospital**
- **Follow authorization policies and procedures specified in the MCO provider manual for routine and elective care**

# Cross Training

- **Educating NH and MCO about each other's responsibilities will help to ensure smooth transitions.**
- **DOH will arrange webinars and materials to describe nursing home/MCO statutory and regulatory requirements.**
- **Describe the roles and responsibilities of the MCO and nursing home in care plan development.**

# Share Best Practices

- **Nursing homes and MCOs with experience with Institutional Medicare SNPs can share some best practices**
  - **Adapt those practices for MMC and MLTC**



# Network and Contracting

# Network Requirements

- **Standard NH Requirement:**
  - 8 – Queens, Bronx, Suffolk, Kings, Erie, Westchester, Monroe, Nassau
  - 5 – New York, Richmond
  - 4 – Oneida, Dutchess, Onondaga, Albany
  - 3 – Broome, Niagara, Orange, Rockland, Rensselaer, Chautauqua, Schenectady, Ulster
  - 2 – All other counties (or 1 if only one NH in the county)

# Network Requirements

- Specialty Nursing Homes
  - A Minimum of two of each type if available in each county.
- If plans do not have a nursing home to meet the needs of its members, it must authorize out of network.
- Members will be allowed to change plans to access the desired nursing homes (no lock –in).
- If beds are not available at the time of placement, the plan must authorize out of network.

# MCO/NH Contract Termination

(for reasons other than imminent patient harm or a finding of fraud)

- **Enrollees residing at the departing NH may choose to continue residing at the NH.**
- **MCOs to authorize NH services on an out-of-network basis. The OON payment will be at the NH ffs rate at the time of service.**
- **All other services will be provided by network providers or with approval to go out of network by the plan.**

# Provider Contracting

- A subgroup is being established to further discuss the need for Key Contract Provisions.
- The main contract will be reviewed and approved by the DOH.
- Only submitted for approval if material amendments are made to the agreement.

# Credentialing

- **Delegation of Credentialing NH employees to the NH.**
- **Plans must have a process to verify the NH is complying with Federal and State requirements.**
- **Plans will credential NH, but will minimize additional NH requirements.**



# Finance and Reimbursement

# Nursing Home Reimbursement

*For 2 years after a county is deemed mandatory for nursing home population enrollment plans will be required to pay contracted nursing homes either:*

1. *The Fee For Service/ Benchmark Rate\**  
**OR**
2. *A Negotiated Rate, acceptable to both Plans and Nursing Homes*

- **Fee-For-Service/Benchmark Rate** – will include all the existing scheduled fee-for-service pricing/transition phase-in adjustments through 2017, as well as the Universal Settlement, if an agreement is reached.
  - Any existing contracted rates must increase if they fall below the current market Benchmark Rate at any point.
- **Negotiated Rate**– will allow Nursing Homes and Plans to engage in other financing agreements, such as sub-capitation, and will encourage alternative payment arrangements.
  - State will continue to review the terms of the contract under the current review process to ensure that plans and providers are achieving acceptable agreements.

**\* Rate components will include operating, capital, quality and assessment (Assessment will remain the Nursing Homes' responsibility to pay the state)**

# Nursing Home Capital Component

*After the 2 Year transition period, Nursing Homes will continue to receive the calculated capital component in the benchmark rate:*

- *Such capital component will be paid pursuant to a contractual arrangement between the Plan/ State/ Nursing Homes*

- This proposal is intended to provide Nursing Homes/mortgage holders with continued financial stability
- A pool/price corridor will be established to ensure that plans that contract with Nursing Homes containing large per-diems are not disadvantaged
- Modifications (if any), which may arise as a result of the Nursing Home Capital Work Group, will be reflected in the capital rate and will be incorporated into plan premiums.

**\*CMS has rejected the state request to pass through capital cost on a fee for service basis**

# Shared Savings Proposal

*With FIDA Plans/ Providers will be required to enter into alternate payment arrangements. DOH is also working with the Global Cap Work Group to foster/ require these alternative payment arrangements across all MC programs.*

- Multi- year plan to require HMO's to engage providers in payment arrangements other than FFS (sub-cap, bundled payments, shared savings, etc.)
- Establish a workgroup comprised of plans/ providers and DOH to develop goals/ timelines.
  - True reform and maximum system efficiency will only occur with alternative payment Methods
  - Both Plans and providers should share risk and reward
  - A deliberate planned implementation is critical so as not to force providers into risk arrangements that they're not prepared to administer.

# Premium Development

*State/Mercer will establish New Premium Groups and Actuarially Sound Premiums for both Mainstream Managed Care Programs and Managed Long Term Care Programs.*

- There is consensus among consumer advocates, plans and providers that reimbursement should align with the overall acuity of the patients. However, it is the departments concern that there will not be enough data available for the NH population to fully develop a blended acuity adjusted rate.
- Long Term Goals
  - Create an acuity based rate for the entire population. This could be in the form of:
    - One blended (community/ NH) rate cell
    - Or two rate cells for High and Low acuity patients.
- Short Tem Goals
  - Establish a NH Rate Cell with two pools to mitigate the risk of the population and incentivize community placement. The two pools would be:
    - High Need Pool, and a
    - Community Place Pool

# NAMI Proposal

- *The State or State's designee will assume financial and organizational responsibility to distribute NAMI information, as well as collect NAMI income from all Medicaid recipients residing in a Nursing Home*
  - *\*Proposal will be linked to The 1115 Waiver, which will be used as the avenue to effectuate this proposed transition of NAMI responsibility*

**Benefit to Patients** – they would not be confronted with the risk of MLTC disenrollment

- Separating the collection duties and the associated friction from Nursing Homes will aid in providing a better living environment for both the patient and families
- Providers, free from the NAMI responsibility, will focus more time and care on patients

**Benefits to Providers** – Cost Savings will make them more financially stable

- The proposed transition will eliminate them from the Collection Business
- This transition will allow providers to focus more care and time on patients in place of collection/administration efforts

**State and oversight administration can establish a new point-of-entry system in correlation with Medicaid's overall effort to redesign entry into the program:**

- collect NAMI more efficiently and potentially secure resources up front
- The state is in a better position to judge whether NAMI collection is appropriate or not
- Some cases are not appropriate for NAMI collection – the State can perform care management to distinguish these cases individually and assess when money should remain with patients.

# Quality

*The Department of Health remains committed to rewarding facilities who demonstrate high quality of care.*

- Four current/proposed quality incentive programs:
  - The Quality Incentive Program for mainstream Medicaid managed care (MMC)
  - Nursing Home Quality Pool (NHQP)
  - The Quality withhold as part of the FIDA demonstration
  - A workgroup has been established for MLTC quality starting with pay for reporting
- Initially, incentive dollars will remain at current levels, but as the nursing home populations shifts into MMC or FIDA, Nursing Home quality measures and dollars will be proportionally moved from the NHQP into other quality incentive programs.

# Operational Issues

- **Claiming/Billings between the Nursing Homes and the MC plans.**
  - **Nursing homes would like a smooth transition for billing the MCO's**
  - **Potential training courses on billing could be written into contracts to help SNFs learn and understand how they will be expected to bill for the care provided.**

# Nursing Home Transition Rate setting Time line

<b>Rate Development Milestones</b>	<b>Date</b>
Finalize Policy Decisions	December 23, 2013
Release Notice: Nursing Home FFS rates	January 22, 2014
Develop premiums within MMC and MLTC	February 1, 2014
Publish Premiums	February 15, 2014



**Questions?**