



Transition of Nursing Home Populations and Benefits to Medicaid Managed Care

March 10, 2014



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 April 1, 2014:
 - NYC, Nassau, Suffolk and Westchester counties.
 - Transition continues October 1, 2014 in ROS.
- All eligible recipients age 21 and older in need of Long Term Placement will be required to enroll in MMCP or MLTC.
- Current beneficiaries residing in a skilled nursing facility prior to April 1, 2014 will remain in FFS Medicaid and will not be required to enroll in a plan.
- Long Term NH care is presently a benefit for enrollees of MLTC.



Nursing Home Transition Phase-In Schedule

Month	County
April 1, 2014 Phase 1	New York City – Bronx, Kings, New York, Queens, Richmond, Nassau, Suffolk, Westchester
October 1, 2014	For the above counties - voluntary enrollment in Medicaid managed care becomes available to individuals residing in nursing homes who are in fee-for-service Medicaid.
October 1, 2014 Phase 2	Albany, Allegany, Broome, Cattaraugus, Cayuga, Chautauqua, Chenango, Clinton, Columbia, Delaware, Dutchess, Erie, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Jefferson, Lewis, Madison, Monroe, Montgomery, Niagara, Oneida, Onondaga, Orange, Oswego, Otsego, Putnam, Rensselaer, Rockland, St. Lawrence, Saratoga, Schenectady, Schoharie, Steuben, Sullivan, Ulster, Warren, Washington
November 1, 2014 Phase 3	Chemung, Cortland, Schuyler, Seneca, Tioga, Yates
December 1, 2014 Phase 4	Genesee, Livingston, Ontario, Orleans, Tompkins, Wayne, Wyoming
January 1, 2015	All remaining counties – voluntary enrollment in Medicaid managed care becomes available to individuals residing in nursing homes who are in fee-for-service Medicaid.



Transition Policy

- Existing MMCP enrollees will NOT be dis-enrolled if they require long term placement.
- MMCP will be responsible for the NH benefit after March 31, 2014 for enrolled members.
- Individual will not 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.



Transition Payments

- For at least 3 years after a county is deemed mandatory for the NH population and benefit, plans will be required to pay contracted NHs either:
 - Benchmark Rate (FFS Rate)
 - Negotiated Rate which is agreed to by both parties

After the 3 year transition period, plans and NHs will negotiate a rate of payment



Pharmacy Services

- Pharmacy will be covered by the MMCPs
- Pharmacy costs are not included in the NH FFS rates
- Absent a negotiated agreement for this service the following will prevail:
 - During the 3 year transition period MMCPs must honor the current arrangements NHs have with pharmacies
 - If an enrollee is using a non formulary drug, MMCPs must allow the member to continue receiving the drug for 60 days.
 - After the 60 days, the MCO and provider may transition the member to a drug on the plan's formulary, as appropriate.



Reserved Beds - Bed Holds

- MCOs are required to continue following the current methodology during the transition period unless an alternative is negotiated and agreed to.
 - Reserved bed days related to leaves of absence for temporary hospitalizations shall be made at 50% of the Medicaid FFS rate.
 - Reserved beds related to non-hospitalization leaves of absence shall be at 95% of the Medicaid rate.



Network and Contracting



Network Requirements

Standard NH Requirement:

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



Network Requirements

- Specialty Nursing Homes
 - At least of 2 of each type per county, if available.
- If plans do not have a nursing home to meet the needs of its members, it must authorize out of network placement.
- 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 placement.



Provider Contracting

- All agreements must be negotiated in good faith.
- All Agreements will have the “New York State Standard Clauses for Managed Care Provider/IPA Contracts”.
- Due process rights must be included for providers that allow the provider to appeal any determination identified by the MCO.
- In the event a contract is terminated, for reasons other than imminent harm or fraud and abuse, the MCO may not require members to transfer to a participating NH.
- The rate of payment for the OON provider will be the fee for service rate in effect at the time of service.
- MCOs will establish a process to train contracted providers relating to claims adjudication.



Credentialing

- Credentialing NH employees is delegated to the NH.
- Plans must have a process to verify the NH is in compliance with Federal and State requirements.
- Plans will credential NH, but will minimize additional NH requirements.



Eligibility and Enrollment



Eligibility and Enrollment

- The decision to enter into a nursing facility involves the individual, family members, community members, and skilled professionals.
- The 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.



Long Term Placement

- Nursing home physician or a clinical peer makes the recommendation for permanent placement.
- Recommendation is based upon medical necessity, functional criteria, and the availability of services in the community, consistent with current practice and regulation.
- Nursing home transmits the recommendation and supporting documentation to the MCO for review and approval.
- Once MCO has authorized the long term placement, the NH sends LDSS-3559 form with the approval from the MCO to the local district.



Eligibility Process

- The nursing home and the MCO work together to gather documentation required by the LDSS to perform the eligibility determination.
- MCOs should utilize processes already in place at the NH for compiling required documentation and submitting application for eligibility determination.
- Once all documentation is received, LDSS has 45 days to complete the eligibility determination for long term placement.



Eligibility Determination

- Individuals in need of long term placement will have eligibility determined using institutional rules, including a review of assets for the 60 months look-back period and the transfer of assets rules.
- Post eligibility budgeting rules are used to determine the net available monthly income (NAMI) that must be contributed toward the cost of nursing home care for individuals who are otherwise eligible and are not subject to a transfer penalty.



Restriction/Exception Codes

- The LDSS, upon approval of post eligibility budgeting, will enter specific Restriction/Exception (R/E) codes into WMS to identify the type of long term placement for managed care enrollees.
- These R/E codes will appear on plan rosters.
- ePACES will also reflect this information.
- R/E codes will also drive MC premium rate payment.



Restriction/Exception Codes

Mainstream R/E codes:

- N1 Regular SNF Rate – MC Enrollee
- N2 SNF AIDS – MC Enrollee
- N3 SNF Neuro-Behavioral - MC Enrollee
- N4 SNF TBI - MC Enrollee
- N5 SNF Ventilator Dependent - MC Enrollee
- N6 NH Penalty (consumer is ineligible for NH services for determined period)

MLTC R/E code:

- N7 MLTC enrollee placed in SNF



Rosters

- MCOs will receive pertinent enrollee information via the Roster system. Included on the roster will be:
 - MC Rate Code
 - NH Provider ID
 - Effective Date of Long Term placement
 - Exception Code (R/E)
- Nursing Homes will continue to receive their FFS roster in the current method of delivery.



Eligibility Process

- If LDSS determines 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.
- For individuals who are Medicaid eligible under MAGI, the same look-back and transfer of assets rules are used, but there is no resource test and post eligibility budgeting rules do not apply.



Eligibility Process

- MCOs must recoup for any period of ineligibility resulting from a transfer penalty.
- MCO is responsible for collecting any NAMI but may delegate this function to the nursing home.
- For current enrollees, MCOs are responsible for paying the nursing home the fee for service rate or agreed upon negotiated rate for that facility while long term eligibility is established by the local district.
- Individuals not currently enrolled in managed care and in need of long term placement will obtain long term eligibility determination from the local district prior to enrollment.



Plan Selection and Enrollment

- After transition date, beneficiaries residing in a nursing home who are determined eligible have 60 days to select a plan for enrollment.
- New York Medicaid CHOICE will be available to assist beneficiaries with education and plan selection.
- Beneficiary will select from plans contracting with the nursing home in which the individual resides.
- If a plan is not selected within 60 days, a plan that contracts with the nursing home will be assigned.
- Lock in rules will not apply to these individuals.
- If a beneficiary wishes to transfer to another nursing home not contracting with his or her current plan, the individual will be allowed to transfer to that plan.



Scenario 1 – Current Enrollee Prior to 4/1/14

Example:

3/30/ 2014

- Permanent placement is recommended by NH for current MMCP enrollee
- Individual is dis-enrolled to FFS Medicaid

8/1/2014

- LDSS completes long term eligibility determination
- Enters eligibility determination into SDOH systems
- Notices sent to NH
- NH is responsible for Medicaid Renewals, NAMI collection



Scenario 2 – Current Enrollee Post 4/1/14

Example:

4/1/2014

- Permanent placement is recommended by NH for current MMC enrollee
- NH transmits recommendation to MCO for approval
- NH transmits LDSS-3559 with approval from MCO to LDSS

9/1/2014

- LDSS completes long term eligibility determination, enters results of determination and RE code into SDOH systems
- Notices are sent to MCO and NH
- Roster is sent to MCO, including date of eligibility and NAMI
- NH receives its fee for service/negotiated rate from MCO during the period eligibility is being established
- MCO can bill retrospectively for appropriate enhanced rate for periods of eligibility
- NH can bill MCO retrospectively for appropriate enhanced rate



Scenario 3 – New Enrollment Post 4/1/14

Example:

4/1/2014

- Individual in community or FFS Medicaid enters NH
- Permanent placement is recommended by NH
- NH transmits LDSS-3559 to local district

8/1/2014

- LDSS completes long term eligibility determination, enters results of determination and RE code into SDOH systems
- Notices are sent to NH
- Beneficiary selects MCO for enrollment within 60 days or is auto assigned to a plan contracting with the nursing home
- Dually eligible individuals must enroll in MLTCP

11/1/2014

- Effective date of plan enrollment
- Roster is sent to MCO, including associated NAMI
- MCO can begin billing prospectively
- No retroactive enrollment or billing for period prior to enrollment



Access to Care and Transitions



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.



Overview

- Transition roles
 - Hospital to NH; Community to NH
 - Authorization requirements
 - Challenges:
 - Disagreements;
 - No bed available;
 - OON requests;
 - Patient refusal of available bed
- Patient care after placement
 - Care planning roles
 - Authorization requirements
 - Other than RHCF services – hospital stays/MD visits in and out of RHCF



Transitions: Hospital to Nursing Home

- **Hospital Role:**

- Checks eligibility; Notifies MCO of stay and possible need for LTC
- Assembles discharge planning team
- Arranges meetings with enrollee, family and team
- Conducts PASRR, PRI
- Obtains information from MCO participating NHs on placement openings that meet enrollee needs
- Physician makes recommendation for transition and care plan based on:
 - Clinical needs of enrollee
 - Functional criteria
 - Availability of services in the community
- Communicates recommendation, care plan (specific enrollee needs) and supporting documentation to MCO for authorization



Transitions: Hospital to Nursing Home

- **Nursing Home Role:**
 - Responds to request for placement openings that meet enrollees needs
 - Communicates with Hospital and MCO on care plan development
 - Obtains authorization for stay prior to admission
 - Conducts mandatory assessments



Transitions: Hospital to Nursing Home

- **MCO Role:**
 - Provides plan liaison; reaches out to hospital when notified of stay
 - Has knowledge if enrollee already in receipt of LTSS
 - Member of discharge planning team, ensures:
 - Person centered care planning
 - Enrollee choice, enrollee education about care options
 - Decisions must not be based on financial incentives for hospital, plan or nursing home
 - Provides list of participating nursing homes/community providers
 - Assists in matching needs of enrollee to available providers or securing out of network
 - Assists in compiling documentation for authorization review



Transitions: Hospital to Nursing Home

- **MCO Role (continued):**
 - Upon receipt of recommendation for transition
 - Assesses care plan and clinical needs
 - Approves or adjusts the care plan to ensure member's needs are met
 - Considers member choice
 - Authorizes care plan and placement in timely manner and before discharge
 - Notifies providers, enrollees of determination
 - Arranges for UAS-NY assessments in NH



Transitions: Community to Nursing Home

- **Nursing Home Role:**
 - Checks eligibility; notifies MCO of need for long term stay
 - Conducts mandatory assessments
 - Arranges meetings with enrollee, family and team
 - Physician or clinical peer makes recommendation for transition and care plan based on:
 - Clinical needs of enrollee
 - Functional criteria
 - Availability of services in the community
 - Communicates recommendation, care plan (specific enrollee needs) and supporting documentation to MCO for authorization
 - Obtains authorization for stay prior to admission



Transitions: Community to Nursing Home

- **MCO Role:**
 - Provides NH plan liaison
 - Member of care planning team, ensures:
 - Person centered care planning
 - Enrollee choice, enrollee education about care options
 - Decisions not based on financial incentives
 - Assists in compiling documentation for authorization review
 - Upon receipt of recommendation for transition
 - Assesses care plan and clinical needs
 - Approves or adjusts the care plan to ensure member's needs are met
 - Authorizes care plan and placement in timely manner
 - Notifies providers, enrollees of determination
 - Arranges for UAS-NY assessments in NH



Transitions: Challenges

- Disagreement on care plan/placement
 - Enrollee contests decision or specific placement
 - Provider recommendation denied by MCO
 - MCO appeal, external appeal and fair hearing rights
 - Enrollee may change plans
 - ALC coverage in place until safe discharge
- No available community service/bed
 - Coverage in place until safe discharge
 - OON options
- Dispute over process/roles/billing
 - DOH complaint process
 - MLTC: 1-866-712-7197
 - MMCP: 1-800-206-8125



Transitions: Challenges

- LDSS determines enrollee not eligible for long term care
 - Self payor for nursing home stay
 - May transition to community care if needs can be met
- Enrollee changes their mind
 - Facilitate transition to community care if needs can be met
 - MCO arranges for home/community assessments



Appeals/Fair Hearing

- Timeframes in model contracts, provider manuals, member handbooks and determination notices
- Expedited where appropriate
- Enrollee has right to appeal to plan and right to fair hearing
 - **MLTC**
 - Care remains the same until appeal decision
 - Fair hearing rights if decision upheld
 - **MMCP**
 - Care changes on effective date of Action
 - Fair hearing rights upon initial denial, aid to continue only if file timely fair hearing
- External appeal available for medical necessity denials
- NH has own plan grievance and external appeal rights



Patient Care After Placement

- No change in Nursing Home responsibility for care
 - Conducts required mandatory assessments and evaluations
- MCO now part of care plan development
 - Person centered care plan
 - MCO arranges for UAS-NY assessment every 6 months and when enrollee condition changes
 - Coordinates with nursing home to share assessment data
 - MCO may review for service coverage and medical necessity
 - MCO reauthorizes stay under concurrent review at identified intervals, e.g., at time of assessment
- Care management
 - MCO oversees quality of care provided; care plan implemented and sufficient to meet enrollee's needs
 - MCO arranges for other covered services enrollee needs
 - MCO ensures enrollee has PCP
 - Refer to case management, if needed
- MCO and NH coordinate efforts to meet quality goals



Authorization for Transfers

- MCO may have on-site or on-call provider to examine enrollee
- Enrollee hospitalization
 - Emergency Care - No prior authorization
 - Urgent Care – No authorization if transferred to a network hospital
- NH notifies MCO of enrollee transfer to hospital and which hospital
- Prior authorization needed for non-network hospital
 - Unavailability of network hospital or clinical needs cannot be met at network hospital
 - If MCO not available 24/7 and all info submitted by NH on next business day, urgent on non-business day transfer covered while review pending



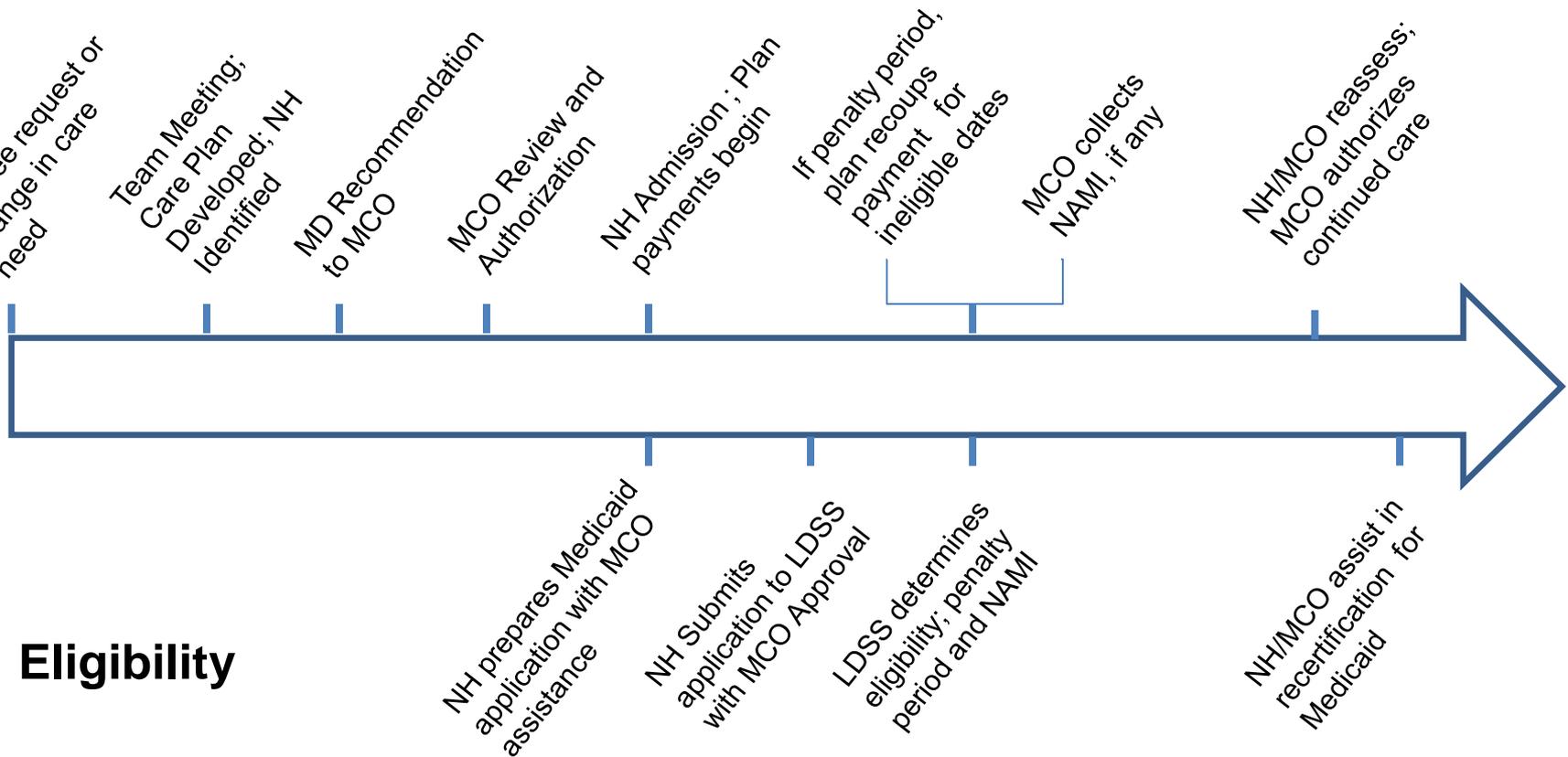
Authorizations for Other Care

- NH and MCO will follow authorizations procedures in the provider agreement for routine and elective care.
- Medical necessity determinations made as fast as the member's condition requires and in accordance with contractual requirements.
- MCO appeal, external appeal, fair hearing and complaint rights apply.



Timeline of Eligibility and Placement

Placement Process





Finance and Reimbursement



Issue #1 -- Billing/ Cash Flow

- Nursing Homes have concerns that cash flow will be disrupted with the shift to Managed Care

Discussion Point:

- The Department has taken steps to ensure that Nursing Home cash flow will not be negatively impacted by the shift to Managed Care. For example,:
 - Scenario 1 – Mainstream Managed Care patient is at NH for rehabilitation and goes into chronic care budgeting (CCB), the Plan will pay the NH at the benchmark rate during this period.
 - Scenario 2 – Managed Long Term Care patient regresses from the community into a long term NH stay, the Plan will pay NH the benchmark rate during the CCB process.
 - Scenario 3 – Fee-For-Service (FFS) patient requires long term NH stay and goes into CCB, the NH must wait until a determination is made and the member is deemed eligible for long term placement. At that point, NH can bill FFS retro to the eligibility date. Once enrolled in Managed Care, the NH must bill the Plan.
- Clean Claims:
 - Is there a role for DOH to implement a readiness review requirement to ensure that Nursing Homes can submit clean claims to Plans?
 - Should Plans and Providers consider including contract language that would be triggered when certain billing requirements (clean claims thresholds) are met?
- As an emergency stop gap when there are unavoidable billing problems between Plans and providers, the Department can eliminate or temporarily reduce the two week cash lag.



Issue #2 -- Rate Codes

- Are rate codes for mainstream Plan payments available?
- Will different tier codes be assigned? Unique tier code for SNPs?

Discussion Point:

- The Department has completed the process of establishing rate codes for Plan payment.
 - Mainstream:
 - 1821 Regular SNF Rate – MC Enrollee
 - 1822 SNF AIDS – MC Enrollee
 - 1823 SNF Neuro-Behavioral - MC Enrollee
 - 1825 SNF Traumatic Brain Injury - MC Enrollee
 - 1826 SNF Ventilator Dependent - MC Enrollee
 - MLTC:
 - 3479 Partial Cap 21+ Nursing Home Certifiable
 - HIV SNP: TBD (under development by AIDS Institute)



Issue #3 -- Plan Billing

- *How are ancillary services handled?*
- *Who is responsible for therapeutic and/or personal leave?*

Discussion Point:

- The following illustrates how an ancillary service such as physician services will be handled:
 - Mainstream – Included in premium/benefit
 - Scenario 1 – NH does cover physician benefit (in benchmark), Plan pays NH as part of benchmark rate
 - Scenario 2 – NH does not cover physician benefit (not in benchmark), Plan pays physician
 - MLTC – Not included in premium/benefit
 - Scenario 1 – NH does cover physician benefit (in benchmark), NH bills FFS
 - Scenario 2 – NH does not cover physician benefit (not in benchmark, physician bills FFS
- Therapeutic/ Hospital Leave days where a Nursing Home is required to reserve the bed for the patient the Plan will be required to pay the NH. The cost associated with these days have been included in the base data and are reflected in the premium.



Issue #4 -- Retroactive Rate Adjustments

- Under Managed Care, will retroactive payments come directly from DOH or Plans? Will they continue as single payments?

Discussion Point:

- DOH commits to updating the FFS benchmark rates as timely as is possible.
- The FFS benchmark rate will be updated at a minimum of twice a year to account for case mix updates.
 - As previously discussed and outlined in the Finance Sub-Workgroup, Plans will be responsible for ensuring that any retroactive changes to the benchmark rates will result in a payment to Nursing Homes that are utilizing the rate in their contracts.
 - Plans and providers who choose to negotiate an alternate payment arrangement that is not based on the benchmark will likely avoid retroactive payments.



Issue #5 -- Capital Component

- *Capital during the transition*
- *Concerns regarding CMS approval of capital proposal for the 3-year transition*

Discussion Point:

- DOH is confident that CMS will approve the three year transition proposal related to the operating and capital components, and additionally, the continuation of capital component of the benchmark beyond the three year period.
- This current proposal is intended to maintain stability and provide Nursing Homes with the resources to continue to pay long term debt commitments and access capital markets for future investments.



Issue #6 -- Benchmark Rates

- How will Managed Care contracts specify the various components (e.g. Cash Assessment, Universal Settlement, etc.) of the total reimbursement rate?

Discussion Point:

- The benchmark rate will include all aspects of the Nursing Homes reimbursement for a FFS patient, including but not limited to Operating, Capital, Per Diems, Cash Assessment and Quality.
- The benchmark rate will be updated and published on the DOH Public Website at least twice a year.
 - <https://www.health.data.ny.gov/> -- (web link activated this week)
- Plans and providers should coordinate through the contracting process how to incorporate the benchmark rate into Nursing Home reimbursement.
 - The Department does not object to Plans and providers appending benchmark rate sheets to contracts.



Issue #7 -- Net Available Monthly Income (NAMI)

- *Who will be responsible for collection of NAMI from the patient?*
- *How will personal Need allowance be distributed?*

Discussion Point:

- It is anticipated that NAMI will be collected by the Plans, however, Plans may delegate the responsibility to the NH via the contract process as currently allowed under MLTC.
- Upon the completion of the chronic care budgeting the Local District will notify the Plan of the NAMI amount to facilitate the collection process.
- Distribution of the Personal Needs Allowance should be coordinated between Plans and providers during the contracting process.
- In the future, the State is proposing to take over the collection of the NAMI for NH residents.



Issue #8 -- Shared Savings

- *How will providers be encouraged/rewarded for attaining cost savings under Managed Care contracts that will use existing FFS rates?*
- *Will these incentives be in Managed Care contracts or handled directly through DOH?*

Discussion Point:

- Shared Savings is being encouraged between all Plans and providers and has been included as a proposal in the 2014-15 Executive Budget.
 - Similarly, all Plans and providers participating in the Fully Integrated Dual Advantage (FIDA) Demonstration will be encourage to enter into Shared Saving arrangements as the State moves away from a traditional FFS billing mechanism.
- This proposal is high on the Departments' priority list and is being evaluated in the context of the Global Cap.
- Overall, the Department is encouraging Plans and provider to work toward alternative payment arrangements, rather than FFS



Open Finance Issues with CMS

- Capital after transition period
- MLTC blend of NH and mandatory populations for rate development
- MMC separate rate cell
- Risk Mitigation Pools
 - Community High Need Pool – Focus on mitigating the risk associated with community based individuals with high needs, including ventilator dependent recipients.
 - Nursing Home High Cost Pool – Establish to encourage Plans to contract with homes based on outcomes rather than price.



Questions?