

POLICY

1) How was Nursing Home (NH) care covered under the Medicaid program prior to the transition to managed care?

The vast majority of Medicaid covered NH care was provided through the FFS Medicaid program. Medicaid beneficiaries who needed permanent NH care were not required to enroll in Medicaid managed care plans. However, short-term NH care was previously a covered benefit for Medicaid recipients enrolled in Managed Long Term Care (MLTC) plans and Medicaid Managed Care (MMC) plans, and permanent NH placement was also covered by MLTC plans

2) What is meant by transitioning the NH population into Medicaid managed care?

This refers to the State's plan to require certain Medicaid beneficiaries to enroll in, or remain enrolled in, an MLTC or MMC plan if they need NH care. After the transition date, any individual who is new to Medicaid and/or needs permanent placement in a NH is required to enroll in one of these plans and receive his/her NH care through the managed care plan, not through FFS Medicaid.

3) What programs do these policies apply to?

The NH transition policy applies to Medicaid Managed Care (MMC) Plans, Managed Long Term Care (MLTC) Plans and Fully Integrated Dual Advantage (FIDA) Plans unless otherwise noted.

4) What is meant by the "transition period"?

The transition period generally refers to the time frame during which the NH benefit and population is gradually moved from FFS to Medicaid managed care. From a payment perspective, it more specifically refers to the initial 3 year period during which managed care plans are required to pay the NH the benchmark rate. After the first full year of transition, DOH will assess whether the 3-year rate transition period needs to be extended beyond 3 years.

5) Has CMS approved the transition schedule shown in the MRT 1458 Timeline?

CMS has approved the NH transition schedule shown in the MRT 1458 timeline.

Note: the remaining tasks in the MRT 1458 Timeline were moved, and are now covered under MRT 8401.

6) What is the transition date?

The transition was February 1, 2015 in the New York City counties of the Bronx, Kings, New York, Queens and Richmond. Nassau, Suffolk and Westchester counties began April 1, 2015. The transition date for the remaining counties in the State is July 1, 2015. Voluntary enrollment became available to all eligible individuals beginning October 1, 2015.

7) Is there a date when the transition will begin in central New York counties?

The transition in these counties was effective July 1, 2015.

8) Are the transition date and effective date the same thing?

Yes, this terminology refers to the date the transition is effective for a county or location.

9) Which individuals will be required to enroll in a managed care plan, and which type of plan will they need to enroll in?

After the transition date, any Medicaid recipient aged 21 and older who needs NH care on a permanent basis is required to enroll in a Medicaid managed care plan, if he/she is not already enrolled in one. Medicaid recipients who are also Medicare eligible (i.e., "dually eligible") are

required to enroll in an MLTC plan; Medicaid only eligible recipients are required to enroll in a MMC plan, unless they are need in services not covered by a MMC plan but covered by an MLTC.

10) Is the mandatory enrollment for permanent 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.

11) Does short term NH services 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.

12) Can a consumer be disenrolled from MMC to FFS Medicaid program?

Most Medicaid eligible consumers are required to be enrolled in MMC or MLTC to obtain Medicaid covered services. A consumer may be disenrolled to FFS Medicaid if he or she is determined to be exempt or excluded from enrollment.

13) What happens to individuals who were already residing in NHs on a permanent basis before the applicable transition date?

If an individual is permanently placed in a NH prior to the transition date, and is also Medicaid-eligible for NH care, he or she is not required to join an MLTC or MMC plan, will not be passively enrolled in a FIDA plan, and can continue receiving NH care on a FFS basis.

14) After the applicable transition date, if an individual is already enrolled in a Medicaid managed care plan and needs permanent placement in a NH, can he/she disenroll from the plan and receive services through FFS?

No, individuals in mandatory populations are required to remain in a Medicaid managed care plan. However, the individual may switch managed care plans at any time since there will be no "lock-in" provision for MLTC and MMC enrollees who are in permanent placements in NHs.

15) How will the Nursing Home Transition work with FIDA?

Consistent with MLTC and MMC, FIDA eligible individuals will be able to voluntarily enroll into FIDA beginning October 1, 2015. Individuals residing in nursing homes prior to February 1, 2015, will not be Passively Enrolled into FIDA. However, an individual new to custodial status in nursing homes as of February 1, 2015, will be Passively Enrolled into FIDA on or after August 1, 2015.

16) Please describe the difference between the FIDA and MLTC programs?

Please visit the NYSDOH Managed Long Term Care website
http://www.health.ny.gov/health_care/managed_care/mltc/

17) Will managed care plans be disciplined if they market directly to residents?

The State will continue to take disciplinary action if Medicaid Managed Care plans market directly to NH residents. MLTC plans continue to be allowed to conduct marketing activities within the NH.

18) Will a Medicaid Managed Care Plan allow a resident to stay in the NH indefinitely?

As long as it is deemed medically necessary, the plan is required to cover appropriate care.

19) How will the Assisted Living Program (ALP) be impacted by this transition?

ALP residents remain excluded from MMC and MLTC enrollment under this transition.

20) Does this transition apply to specialty pediatric long-term care skilled nursing facilities or are specialty pediatric facilities excluded?

This transition applies only to consumers age 21 and older at the time of permanent placement.

21) On 7/9/15, a Medicaid recipient under 21 years of age was admitted to St. Margaret's Center for long term care skilled nursing services. While the admission date was after the Oneida County transition rollout date of 7/1/15, is this resident required to enroll in a managed care plan since the resident is under 21 years of age?

This transition applied only to consumers age 21 and older at the time of permanent placement.

22) The 20 young adult beds are at 100% capacity. There are 9 residents (Medicaid recipients admitted prior to their 21st birthday) who remain in pediatric non-ventilator beds because there are no vacant young adult beds in our facility. For residents aged 21 and over, bed reservation regulations allow 14 eligible hospital days and 10 therapeutic leave of absence days within a 12-month period. Do these bed reservation regulations apply to the 9 residents who remain in the pediatric non-ventilator beds?

This transition applies only to consumers age 21 and older at the time of permanent placement.

23) For SSI recipients, who is responsible for notifying SSA of a temporary NH or hospital placement to ensure SSI continues as permitted by law for a short period if medical documentation is submitted? Otherwise SSI payment stops after 30 days, putting in jeopardy the ability to maintain a home in the community.

Although the SSI recipient or the recipient's representative should notify SSA of an admission to a nursing home, local SSA offices encourage nursing homes to timely report temporary or permanent placements. If the placement is temporary, SSI benefits will continue for 90 days. If the placement is permanent, the SSI benefits continue for 30 days.

24) When a current enrollee in MMC is admitted to a NH for permanent care, can the MMC plan deny coverage, stating the patient requires LTSS greater than 120 days? Must the plan cover the enrollee until he/she is enrolled in MLTC?

Both the population and the benefit are transitioning into MMC. MMC enrollees requiring permanent NH services must be provided these services as a covered benefit by the MMC plan and would not be required to enroll in a MLTC plan unless they begin receiving Medicare and become dually eligible, or are otherwise excluded from MMC enrollment.

ELIGIBILITY:

1) When a Medicaid managed care member living in the community requires a permanent placement in a NH, how is financial eligibility for institutional Medicaid determined?

Managed care members living in the community, including those receiving short term NH services, who need permanent placement in a NH will have financial eligibility determined using institutional rules, including a review of the transfer of assets look-back period. The look-back period is the 60 months immediately prior to the month an institutionalized individual applies for coverage of nursing home care. For members who are eligible under the Modified Adjusted Gross Income (MAGI) category, the income and resource counting rules that apply under MAGI rules continue as long as the individual remains eligible in the MAGI category. If no transfer penalty is imposed, the MAGI individual is eligible for coverage of nursing home care. 4 For members who

are not eligible under MAGI rules (individuals who are aged, blind or disabled), members who are resource eligible will have income eligibility determined under chronic care budgeting. This budgeting methodology is used to determine the amount of monthly income (if any) that a permanently institutionalized individual must contribute toward the cost of NH care. Eligibility determinations will continue to be made by a local department of social services (LDSS) office.

2) 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.

3) Will spousal impoverishment budgeting be available to Medicaid managed care enrollees who need permanent placement and have community spouses?

Yes. Spousal impoverishment budgeting rules apply to institutionalized spouses who are enrolled in MMC or MLTC and have a community spouse. Spousal impoverishment rules do not apply to institutionalized individuals who are eligible under a Modified Adjusted Gross Income (MAGI) category. For MAGI individuals in MMC, only the institutionalized spouse's income is counted in determining eligibility under MAGI rules.

4) Will the LDSS-3559, "Residential Health Care Facility Report of Medicaid Recipient Admission/Discharge/Readmission/Change in Status" process to notify the LDSS of a hospitalization remain in place?

Yes, this requirement has not changed under the transition. Once the managed care plan has authorized the permanent placement, the NH will send Form LDSS-3559 with the approval from the plan to the LDSS.

5) Will the revisions to LDSS-3559 tell the local district the correct N1-N6 code to use? Is a space provided for the NH to specify on the LDSS-3559 if the consumer is in a specialty SNF or specialty bed?

Yes, the revisions to the LDSS-3559 form will include the bed or facility type and definition of the code to use

6) How long does the NH have to submit the request to the LDSS for increased coverage for permanent placement at a NH?

The NH is required to advise the LDSS of a request for increased coverage within 48 hours of a change in status for a consumer via submission of the DOH-3559 or its approved local equivalent.

7) 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.

8) Custodial authorizations are issued by the plan at initial determination for permanent placement as per transition document instructions. For NYC, HRA requires the plan to complete 2159 document. Plans have no way to determine when NH has submitted documentation necessary for N code determination.

DOH encourages plans to work together with Nursing Homes to develop communication systems or protocols regarding enrollees placed in the NH. This would enable plans and NHs to collaborate and document when notifying the local district as required of any changes or admissions.

9) Do all Medicaid applications continue to be submitted to the district? Who will provide the district contact person and number? Is there one district per NH?

Medicaid applications will continue to be submitted to the LDSS as is done currently. Nursing homes will continue to work with the specific LDSS responsible for provision of Medicaid to its consumers as in the past. The district of fiscal responsibility is responsible for providing Medicaid to an otherwise eligible consumer who is a resident of NYS and resides within the district.

10) Is it common for NHs to complete the Medicaid application? May family members complete the application and submit to the LDSS?

The consumer or a designated representative is generally responsible for submitting an application for Medicaid coverage. The consumer may designate the Nursing Home to complete the application and submit to the district. If a resident is incapacitated, the NH, plan or anyone willing to act responsibly on behalf of the resident may complete and submit an application for Medicaid.

11) Who is considered a viable representative for a consumer? Is an authorized Power of Attorney required, or is a health care proxy be sufficient?

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 responsibly 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.

12) Will there be a specific person assigned to help the NH complete Medicaid applications?

Medicaid applications will continue to be completed and submitted following processes currently in place.

13) Is the NH or the managed care plan responsible for assisting current MLTC or MMC members to complete his/her application for institutional Medicaid?

The NH and MLTC or MMC plan will assist current member's to assemble and submit the necessary documentation to support an application for Medicaid coverage of a permanent NH placement to the LDSS. Since eligibility for coverage of nursing home care may be authorized for

up to three months retroactive from the date of application, the member will have 90 days from the date of admission to the nursing home to submit an application for coverage of the permanent placement to the LDSS. The LDSS will notify the MLTC or MMC plan, member, and NH of its decision.

14) 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 for current enrollees. Unless named as an authorized representative, the LDSS may not send such notification to the NH.

15) What happens if the application is not submitted within the 90 days?

The plan may deny coverage as the member is not eligible for the benefit; the member would have appeal and fair hearing rights. The plan would remain responsible for coordinating a safe discharge. Since Medicaid can be authorized only up to three months retroactive from the month of application, there may be months that cannot be covered.

16) Must the LDSS adhere to the 45 day requirement to reach a determination for eligibility?

The LDSS has 45 days to complete the eligibility determination for permanent placement.

17) Are NHs required to submit Medicaid applications for consumers admitted to the NH for a stay covered by Medicare Part A, when MLTC is the secondary payer?

There is no change to the current Medicaid eligibility process.

18) How long does the LDSS have to complete a disability determination?

The LDSS has 90 days to make a disability determination. Medicaid eligibility is determined after the disability determination is completed.

19) While the Medicaid eligibility determination is conducted by the LDSS, does the consumer remain in the NH?

For consumers in a NH for whom permanent placement is recommended, the consumer would remain in the NH while the eligibility determination is conducted by the LDSS. If the consumer is a current plan enrollee, the plan would continue to cover the consumer pending the outcome of the financial eligibility determination.

20) Please clarify the MCO responsibility to pay the NH while the long term eligibility is established by the LDSS. Will the enrollee be placed on the plan's roster temporarily?

Current enrollees will no longer be disenrolled due to permanent placement in a NH, so the enrollment will continue to appear on the plan's roster. The plan is responsible for reimbursement to the NH while the eligibility determination is conducted by the LDSS. If the recipient is not enrolled, they will not be required to enroll until after eligibility is determined by the LDSS.

21) Will NHs be reimbursed for services provided to MLTC and MMC plan members, while the institutional Medicaid eligibility determination is pending, and how should they bill for those services?

If a determination is made that permanent placement in a NH is appropriate for an existing member of an MLTC or MMC plan, the plan should be billed for authorized NH services. The plan

will pay the NH for its services while eligibility for institutional Medicaid is being evaluated by the local district. However, if the member is subsequently determined ineligible for institutional Medicaid, or if a transfer of assets penalty period is imposed, the MLTC or MMC plan may recoup its payments from the NH for the permanent placement, and as applicable, coordinate a safe discharge into the community, with supports, for the member.

22) If the eligibility determination takes longer than 45 days, should plans expect to pay the Nursing Home rate pending the outcome of eligibility determination? Is there a point of contact at the LDSS for plans to determine the status of the eligibility determination?

For MMC, plans reimburse at the contracted or benchmark rate while an eligibility determination is conducted. Districts may exceed this time period if it is documented that additional time is needed for the individual or the individual's representative to obtain and submit required documentation. Plans will be notified when the eligibility determination has been made through a notice. Plans are not encouraged to routinely contact the LDSS regarding the status of an eligibility determination as districts may not have the resources to respond to such inquiries.

23) Some Nursing Homes fail to submit necessary documentation if a member has died and/or moved from the home. Others are under the impression that it is no longer their responsibility since the member is enrolled in a managed care plan. Does the plan recoup under these circumstances?

NH responsibility for notification to the LDSS and submission of documents under this transition has not changed. Plans should work cooperatively with the NH to submit documentation and notification timely. The NH is required to advise the LDSS within 48 hours of a change in status for a consumer via submission of the DOH-3559 or its approved equivalent. If the Nursing Home fails to submit appropriate notification to the district timely, the plan may recoup payment to the NH.

24) Is the NH or the plan responsible for verifying Medicaid eligibility and enrollment?

Providers remain responsible for verifying Medicaid eligibility and enrollment status at the time services are provided. For NH residents this should occur at least weekly.

25) Who is responsible for completing the Medicaid recertification, the NH or the plan? If a resident drops from the roster, is the plan obligated to pay the NH?

The consumer or designated representative is ultimately responsible for completing and submitting a Medicaid recertification. However to ensure no gaps in eligibility, NH and/or plans are encouraged to assist consumers with the recertification process. If an enrollee does not appear on a plan's first or second roster, the plan is not obligated to pay the nursing home.

26) What happens at recertification? Will counties continue to recertify eligibility? Will residents be dropped from the plan roster if the recertification process goes beyond the recertification date?

LDSSs continue to be responsible for determining and recertifying Medicaid eligibility under the established processes and timeframes. Failure to recertify will result in a loss of eligibility.

27) If a MLTC plan is responsible for recertification, why do some residents appear as not covered on E-Paces?

Consumers are responsible for recertification. The plan and nursing home may assist with this process. Providers encountering these issues should submit specific cases to NYS DOH for inquiry.

28) How do counties notify the plans when a client uses bills and/or receipts to meet part of their spenddown for MLTC services?

According to GIS 13 MA/018, "Fair Hearings Decision Reversing Agency Denials of Medicaid Application," districts must use LDSS-3183, "Provider/Recipient Letter Financial Obligation toward Medical Expenses," for this purpose.

29) If a consumer is in a NH for a rehabilitation stay and is transitioning to permanent placement, must the NH notify the LDSS of the change in status?

For any changes in status, the NH must transmit form LDSS-3559 or its approved local equivalent to the district as notification of a change in status. This transmittal must also include authorization from the plan for consumers who are enrolled in managed care.

30) If a consumer is admitted to a nursing home for a short term stay following an inpatient hospital stay, is an eligibility determination by the LDSS, including a 60 month look back, required?

No, plans are required to cover short term stays. There are no changes to the eligibility rules that districts will use to determine eligibility for Medicaid coverage of permanent nursing home care (permanent placement); including when the 60-month transfer of assets look-back period applies or the application of a transfer of assets penalty period.

31) 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.

32) If an enrollee is determined to be ineligible for Medicaid coverage of long term care at a NH due to a transfer penalty, is the consumer disenrolled to FFS Medicaid to receive this benefit?

Active MMC enrollees will not be disenrolled to FFS Medicaid. MMC plans are responsible for covering the enrollee for community services during a penalty period. Enrollees in MLTC will be disenrolled from the plan if determined to be ineligible.

33) If there is a penalty period, is the nursing home free to bill the consumer?

During a penalty period, the NH is allowed to pursue payment through the same sources as in the past.

34) How will the eligibility and NH reimbursement processes work for Medicaid beneficiaries who are not enrolled in an MLTC or MMC plan?

If a Medicaid beneficiary who is not enrolled in an MLTC or MMC plan requires permanent placement in a NH, the existing processes for determining eligibility and reimbursing the NH under current FFS Medicaid will continue to apply. NHs will continue to be allowed to bill retroactively on a FFS basis for care provided by the NH for any period prior to managed care enrollment, as long as the beneficiary was determined to be eligible for institutional Medicaid during that period. Once eligibility for institutional Medicaid is approved, any penalty period has expired, and the NAMI amount is determined, the resident will have 60 days to choose an MLTC or MMC plan, as appropriate. The State's enrollment broker, Medicaid Choice, will educate the resident about MLTC and MMC plan selection and the plans that contract with the NH in which he/she resides.

The resident may choose a MLTC or MMC plan that does not contract with that NH, if he/she wishes to change NHs. If the beneficiary does not pick a MLTC or MMC plan, he/she will be enrolled in a MLTC or MMC plan that contracts with the NH where he/she resides.

ENROLLMENT

1) Does the Asset Verification System (AVS) preclude a consumer from providing 5 years of financial documentation for a long term eligibility determination?

Information regarding the Asset Verification System will be issued separately in a forthcoming Administrative Directive.

2) Who is the current enrollment broker? How does the enrollment broker arrange for education and plan selection process with NH residents?

Medicaid Choice (Maximus) is the current enrollment broker, and is working cooperatively with NH's to assist consumers with enrollment. Once Maximus is notified through the Medicaid eligibility system of a Medicaid NH placement, it conducts outreach to the NH and the consumer to arrange an onsite visit or call to review enrollment requirements and choices.

3) Who is available to assist enrollees, or consumers not yet enrolled, in selecting a new plan for enrollment?

The enrollment broker, NYMC is available to assist consumers and enrollees or their authorized representatives with plan selection and enrollment. For districts not utilizing the services of the enrollment broker, the LDSS is responsible for the provision of these services to consumers.

4) How is the district notified once a plan has been chosen for enrollment?

The districts are notified via the monthly Enrollment Report of the plan selected and the effective date of enrollment.

5) When a resident is admitted to a facility for permanent placement after the applicable transition date, and is approved for Medicaid, we notify the consumer that they must call Medicaid Choice and select a plan for enrollment. The consumer indicates that they will remain in FFS Medicaid until they are transferred to the hospital. Who is responsible for outreach?

The LDSS is responsible for entering the N7 code into the system for consumers found eligible for Medicaid coverage of permanent NH placement. This triggers the outreach and enrollment process with the enrollment broker, New York Medicaid Choice (NYMC). NYMC will conduct outreach to eligible consumers or assist with plan selection and enrollment. The NH is not responsible for directing consumers to initiate this process.

6) Does the enrollment broker provide customer service representatives who are fluent in languages other than English?

Yes, the enrollment broker has resources sufficient to meet the language needs of consumers.

7) How is a plan selected if consumer is incapacitated and does not have a legal representative?

The consumer will be auto assigned to a plan that contracts with the nursing home in which he or she resides.

8) Is there an enrollment process for individuals with mental illness or cognitive impairment?

The current PASRR Level 2 process is utilized for individuals with mental illness or developmental disability.

9) What are "lock-in rules" regarding managed care enrollment?

MMC and MLTC enrollees in permanent care in a NH are not subject to lock-in rules and may change plans at any time.

10) Following the October 2015 voluntary enrollment date, will there be a mandatory enrollment for those residents grandfathered in Nursing Homes?

As of October 1, 2015, all current FFS Medicaid recipients eligible for permanent placement who are residing in a NH prior to the applicable transition date are not required to enroll in a managed care plan but are allowed to enroll if they so choose.

11) Can an individual who was already on a Medicaid-covered stay in a NH prior to the transition date voluntarily enroll in an MLTC, MMC plan or FIDA plan?

Yes, if such an individual wants to voluntarily join an MLTC or MMC plan, he/she may enroll beginning October 1, 2015.

12) Plans are requesting clarification regarding the voluntary enrollment process for current NH residents in receipt of fee for service Medicaid. Plans have seen new members appear on the roster with the appropriate N code assigned, but outreach by member or NH to the plan was not conducted. Is the plan required to accept a new MCO NH member if they have not completed the coverage process and are not yet deemed fully eligible for institutional Medicaid?

Current adult Medicaid fee for service recipients in permanent placement in a Nursing Home may voluntarily enroll in a MMC or MLTC as of October 1, 2015. The Medicaid eligibility and look-back have already been completed by the local district and the consumer is fully eligible for coverage of long term care. The consumer or authorized representative may contact New York Medicaid Choice to begin the plan selection and enrollment process. New York Medicaid Choice is responsible for outreach to the local district to process the enrollment.

13) How does auto assignment work if more than one plan contracts with the facility where the resident is residing?

The auto assignment algorithm is based on current methodology, and considers the plans contracting with the NH in which an individual resides. Individuals will not be auto-assigned to a plan that does not contract with the nursing home in which he or she resides.

14) How does 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?

Once eligibility is established and in place, the LDSS is responsible for entering the N7 as directed in 15 OHIP/ADM-01. If applications are received with a plan selection indicated, the district may transmit this information to NYMC for outreach and enrollment. Responsibility for outreach and enrollment activities remains the responsibility of districts not utilizing services of the enrollment broker under this transition.

15) When a consumer is admitted to a NH and a plan is selected for enrollment, what happens if the plan does not accept the enrollment? How is the NH reimbursed for services?

Plans do not have the option of rejecting an enrollment.

16) Will the CFEEC be involved in the enrollment process for individuals not already enrolled in a MLTC?

Yes, the Conflict Free Evaluation and Enrollment Center (CFEEC) is available to evaluate an individual in the community with long term care needs who is not presently in a MLTC plan and would direct them to NYMC for additional education. If an individual is already residing in a NH, they have established a need for long term care services and an evaluation by the CFEEC is not indicated.

17) Some NH patients were passively enrolled into a FIDA plan. Can the facility dis-enroll these clients out of the FIDA plan and into traditional Medicare?

Nursing facilities cannot "dis-enroll" FIDA participants from the FIDA program. If a FIDA participant wishes to dis-enroll from the FIDA program, he/she, or an authorized representative, can call New York Medicaid Choice to request disenrollment from FIDA and enrollment into an MLTC plan.

18) If a consumer is in long term placement in a nursing home and in receipt of Medicaid prior to the transition date, is he or she considered "permanently placed", or must all residents enroll in a managed care plan?

Current consumers in permanent placement in a Nursing Home prior to the applicable transition date may remain in FFS Medicaid and are not required to enroll in a plan.

19) How does the "grandfathered" resident rule operate in various scenarios?

Consumers in permanent status prior to the transition date are not required to enroll in a MMC or MLTC plan. If the consumer leaves the facility without Medicaid bed hold in place or if Medicaid bed hold days expire, the consumer is considered a new placement, and would be required to enroll in a plan to obtain Medicaid coverage for permanent nursing home services.

20) If a consumer is in a NH for a short term rehabilitation stay and requires permanent placement after the transition date, must the consumer enroll in a MCO?

Consumers requiring permanent Nursing Home care after the transition date are required to enroll in a plan to receive this benefit once eligibility is established, unless otherwise exempt or excluded.

21) If a consumer in a short term rehabilitation stay in a NH submits an application for Medicaid coverage prior to the transition date, then after the transition date requires permanent NH placement, is s/he required to enroll in MMC?

Consumers in permanent placement in a NH after the transition date must enroll in a plan to receive this benefit.

22) 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 permanent placement without bed hold after the transition date are required to enroll in a plan.

23) If a consumer is currently permanently placed in the nursing home, perhaps under private pay, then needs to transition into Medicaid, is he or she required to enroll in managed care or do they have the option of traditional FFS Medicaid?

Consumers whose permanent placement is established prior to the transition date are not required to enroll in a Medicaid managed care plan.

24) If a client enters a nursing home and is enrolled in a Medicaid Managed Care plan, does the LDSS disenroll the client from the plan and enter N7code? Or does the LDSS use the N1 and change it to N7 so Maximus can do the education and enrollment into a MLTC plan once the LTC eligibility determination is approved?

Both mainstream Medicaid Managed Care (MMC) and Managed Long Term Care (MLTC) plans cover the long term Nursing Home services.

As of the transition date, districts must no longer disenroll an individual from their MMC or MLTC plan when entering a Nursing Home for permanent placement. The plan would continue to cover the NH placement pending the outcome of the financial determination. Once the chronic care budgeting is approved, and any penalty period has ended, the LDSS enters the appropriate N1-N5 code, for MMC to reflect the facility or bed type, or the N6 code for MLTC cases only.

25) If a consumer is currently in a Nursing Home for long term care, but is pended, must he or she enroll in managed care or remain in fee for service once eligibility is approved?

If a consumer is in permanent placement in a Nursing Home prior to the transition date, that individual is not required to enroll in a MLTC or MMC plan, will not be passively enrolled in a FIDA plan, and may continue receiving Nursing Home care on a FFS basis.

26) A consumer is currently permanently placed in a NH and is in receipt of FFS Medicaid. That individual is then transferred to a hospital. If the NH has no bed hold due to the high vacancy rate, does this trigger a new admission to a NH when the client returns to the NH? Is the individual then enrolled into MLTC or MMC?

Yes, if there is no Medicaid bed hold in place and the consumer is re-admitted to the NH, this would be considered a new NH admission. The consumer would be required to enroll in a MMC or MLTC plan.

27) If a current FFS permanent 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.

28) If a permanent NH resident in FFS Medicaid who is in permanent placement prior to the date of mandatory managed care enrollment is hospitalized and ineligible for NH bed hold, will he/she be required to enroll in a managed care plan upon return to permanent placement?

Yes, the resident is viewed as a new permanent placement and is required to enroll in a managed care plan.

29) 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.

30) Will a resident in permanent placement in a NH with FFS Medicaid coverage, who is discharged to a hospital and is readmitted to the facility, be required to enroll in managed care?

Consumers in receipt of fee for service Medicaid and in permanent placement who are discharged to a hospital and readmitted to the NH are not required to enroll in a managed care plan if Medicaid bed hold is in place. If Medicaid bed hold is not in place or has expired, the placement is considered to be new and the consumer is required to enroll in a plan contracting with the nursing home.

31) Another question states as follows: Q: "If a consumer is currently in the nursing home for permanent care, perhaps under private pay, then needs to transition into Medicaid, is he or she required to enroll in managed care or do they have the option of traditional FFS Medicaid?" A: "Consumers whose permanent placement is established prior to the transition date would not be required to enroll in a Medicaid managed care plan. Please clarify.

This transition to managed care is based upon the date of permanence, not the date of the Medicaid application or eligibility determination. Consumers in permanent status prior to the transition date are not required to enroll in a MMC or MLTC plan. However, consumers who leave the facility without available Medicaid bed hold days in place are required to enroll in a plan upon readmission to the facility.

32) Assume that a resident of a facility that is not part of any plan provider network, who is not enrolled in a plan, is otherwise required to transition to managed care (due to initiation of custodial care, etc.) but wants to remain in that facility. Will that resident still be required to enroll in a plan? If so, how would he/she be assigned to a plan?

A resident of a facility that is not part of any plan provider network would not be required to enroll. Once the facility entered into a contract with a plan, beneficiaries in permanent status after the transition date would be enrolled in that plan.

33) 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.

34) When a MLTC enrollee is discharged from a hospital to a nursing home for permanent 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 the interim period. The new enrollment is prospective, and is effective the first day of the month. New York Medicaid Choice is available to assist consumers with plan selection and enrollment.

35) How will an enrollee in a nursing home change plans? When does the enrollment become effective?

Consumers in a nursing home who are enrolled in a plan will contact New York Medicaid Choice to transfer to a new plan. Enrollment is effective prospectively on the first of the month following pull down.

36) As a practical matter, how quickly can a person change plans while awaiting nursing home placement from a hospital or community?

Plans are responsible to assist enrollees in selecting a participating nursing home and must cover out of network (OON) placement only if par facilities cannot meet the member's needs; have no beds available; or if the enrollee is eligible for placement in a Veteran's Nursing Home, and there is not a Veteran's Nursing Home in the plan's service area. The original plan will cover the Veteran's Nursing Home stay OON until the enrollee transfers to a plan that contracts with the Veteran's Nursing Home. If an enrollee is placed in a participating nursing home, and wishes to transfer to an OON nursing home (other than a Veteran's Nursing Home) the enrollee must request an enrollment into a plan that contracts with the desired nursing home or request the plan to cover OON. Managed care enrollment through the change of plans will be coordinated to prevent any gap in coverage; however, the enrollee may not disenroll into FFS Medicaid. The current plan will cover the consumer's stay in the contracted home, or OON NH if approved, and members will access preferred NH once enrollment in plan of choice is effective. All enrollments are prospective, effective the first of the month. Once enrollment in the new plan is effective, the new plan will cover the consumer's stay in the current home under transitional care requirements, and assist the member with authorization and transfer to the new nursing home. However, it is expected that both plans involved in the transition will coordinate care to eliminate any disruption in care and/or billing issues.

37) Who does the plan notify if the enrollee leaves the nursing home and does not plan to return so that the roster can be updated?

The Nursing Home is responsible for notifying the local district of any changes in status via DOH approved notice. The LDSS must end date the N1-N6 Restriction/Exception code and update any Principal Provider and card code entries. This action will remove the enrollee from the Nursing Home Plan report. The consumer remains enrolled in the health plan to access services in the community.

38) If a plan has a member in permanent placement in a nursing home who is identified as HARP eligible, how does the plan effect a disenrollment?

Current MMC enrollees who are identified as HARP eligible may have an H code appearing in the system. MMC enrollees who are HARP eligible, and who are in need of permanent placement

in a Nursing Home would remain enrolled in the MMC. There may be cases with an overlap in timing of HARP eligibility notification and permanent placement status. Plans should notify New York Medicaid Choice of the need to transfer the consumer from a HARP to the MMC to access NH services, or to stop a HARP enrollment from being processed.

AUTHORIZATIONS

1) Does the NH need to obtain authorization from the plan for bed hold or therapeutic leave?

Prior authorization is not required if an enrollee is transferred from the NH to a network hospital. Prior authorization is required if seeking to transfer an enrollee to a non-network hospital due to un-availability of a network hospital or member's clinical needs cannot be met by a network hospital. If a transfer requiring prior authorization is requested during non-business hours, the nursing home must request authorization with all necessary documentation the next business day. The MCO is required to cover urgent hospital services provided and applicable bed holds while authorization is pending. The NH is responsible for notifying the plan that an enrollee was transferred to a hospital and to which hospital the enrollee was transferred. Once the transfer is approved, the NH should follow plan procedures for continued authorization of applicable bed holds.

2) 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.

3) Will MCOs or MLTCs grant retro authorization if the NH does not obtain prior authorization?

It is anticipated that admission and the billing cycle begin after authorization is obtained. There may be extenuating situations where retro-authorization may be needed in order to address a specific member. However, all non-emergent transitions in care should be authorized by the plan as part of the discharge planning process. This would be part of the provider's contract negotiation process with the plan.

4) Can plans deny coverage for permanent placements already made (e.g., person already in plan awaiting chronic care eligibility, person converting from short stay to permanent, etc.)?

Medical necessity dictates nursing home placement. For plan enrollees permanently placed, the plan may deny continued authorization based on a significant change in the enrollee's health status as per assessment, or the enrollee requests/prefers community setting and a safe discharge to the community is in place.

5) Will facilities need to obtain authorization for payment from the MLTC or MCO for coinsurance or copays?

Plan authorization is not required for payment of coinsurance or copayments from the MLTC. Consumers with Third Party Health Insurance are excluded from MMC enrollment.

6) How often will managed care plans reauthorize service?

Reassessments using the UAS-NY will be required every 6 months or if a significant change in condition of the resident occurs. Services will be authorized consistent with the results of the

assessment. Some plans may authorize services for shorter periods, such as in the case of a therapeutic or post-acute stay.

7) What are the applicability of managed care plan prior authorization requirements to OON nursing homes for hospitalizations?

The prior authorization requirements to OON providers remain unchanged. Providers must abide by plan requirements for authorization of services, whether a participating provider or out of network.

8) 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 permanent NH admission if the medical necessity determination supports the enrollee residing in the community with appropriate supports.

9) 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.

ASSESSMENTS

1) What assessment tool will be utilized to determine level of care?

All mandated processes and evaluation criteria will continue under MMC enrollment. For example, nursing homes receiving Medicaid or Medicare payment will continue to utilize the Minimum Data Set (MDS) to assess all residents upon admission to the facility and periodically after admission. Care Assessment Areas (CAAs) will also continue to be required to formulate the individual's care plan.

2) What resident assessments will be performed?

The NH will be responsible for the same assessments (i.e., MDS) as currently required, which must be performed on the current schedule. The UAS-NY assessment – which is required when an individual enrolls in a plan and every six months thereafter, or when the resident experiences a significant change in condition – is done by the managed care plan or its contractor. The UAS-NY process is the same for NH residents as it is for community MLTC enrollees, but it is conducted in the NH setting.

3) What assessment tool will be utilized to determine level of care?

All mandated assessments and evaluation criteria will continue under MMC and MLTC enrollment. For example, nursing homes receiving Medicaid or Medicare payment will continue to utilize the Minimum Data Set (MDS) to assess all consumers upon admission to the Nursing Home and periodically after admission. Care Assessment Areas (CAAs) will also continue to be required to formulate the individual's care plan.

4) NYSDOH guidance refers to the NH arranging for completion of the UAS-NY. What is the purpose of this assessment for a Long term Care resident in a NH?

The UAS-NY assessed needs are compared with the MDS assessments conducted by the NH, and taken into consideration when authorizing services, equipment and supplies for the enrollee. The care plan, MDS, UAS-NY, medical record and input from the care management team provide

the MCO with the necessary information for the authorization of services both in the NH and upon discharge from the NH.

5) Will all NH residents need an assessment via UAS? Who is responsible for conducting this assessment? Will the MCO conduct an assessment in the Nursing Home setting when the resident is in long term care?

The NH is responsible for the same assessments (i.e., MDS) as are currently required, which must be performed following the current schedule. The UAS-NY assessment is required when: an individual enrolls in a MLTC plan; an MMCP enrollee is need of long term services and supports; every six months thereafter; and when the resident experiences a significant change in condition. The UAS-NY assessment is conducted by the managed care plan or its contractor. The UAS-NY process is the same for NH residents as it is for community MMCP enrollees, but it is conducted in the NH setting.

6) Will the UAS-NY or MDS be the basis of coverage decisions?

Plans are required to compare the UAS-NY assessed needs with the MDS assessments conducted by the NH and consider both when authorizing services, equipment and supplies for the member. The care plan, MDS, UAS-NY, medical record and input from the care management team provides the plan with the necessary information for the authorization of services both in the NH and upon discharge from the NH.

7) Will the Uniform Assessment System-New York (UAS-NY) and Nursing Facility Level of Care (NFLOC) continue to be utilized?

The NH will be responsible for the same assessments (i.e., MDS) as currently required, which must be performed on the current schedule. The MCO is responsible for the UAS-NY process is the same for NH residents as it is for community MLTC enrollees, but it is conducted in the NH setting.

8) When is the UAS done during the evaluation for Nursing Home eligibility?

The UAS-NY assessment is required when: an individual enrolls in a MLTC plan; an MMCP enrollee is need of long term services and supports; every six months thereafter; and when the resident experiences a significant change in condition. Plans are required to compare the UAS-NY assessed needs with the MDS assessments conducted by the NH and consider both when authorizing services, equipment and supplies for the member. The care plan, MDS, UAS-NY, medical record and input from the care management team will provide the plan with the necessary information for the authorization of services both in the NH and upon discharge from the NH.

9) Will the UAS-NY replace any current assessments, or will it be an additional assessment?

Plans are required to conduct the UAS-NY assessment when authorizing services, equipment and supplies for the member. This does not replace any MDS or other assessments NHs are required to conduct. The care plan, MDS, UAS-NY, medical record and input from the care management team will provide the plan with the necessary information for the authorization of services both in the NH and upon discharge from the NH.

10) If an enrollee is in permanent placement in NH and is hospitalized, is a new Patient Review Instrument (PRI) required to return to NH? Or is the enrollee still considered permanent and NH is the enrollee's home?

The NH will be responsible for the same assessments (i.e., MDS) as are currently required, performed in accordance with the current schedule. 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.

11) 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.

PLACEMENT

1) Who decides whether a Medicaid managed care member living in the community should move to a NH on a permanent basis?

A recommendation for permanent placement must be made by a physician or clinical peer, based upon medical necessity, functional criteria, and the availability of services in the community. The process for transitioning a Medicaid managed care member to a permanent placement in a NH should include the member, his or her family, the NH, the managed care plan, hospital discharge planner (if applicable), and the LDSS. The PASRR and PRI will continue to be used, providing tools to help ensure that the member is placed in the least restrictive setting appropriate to his/her needs. The MLTC or MMC plan will identify a clinician or other appropriate liaison to work with members, NHs and hospitals on discharge planning activities for its members. The liaison will assist in coordinating the roles of the hospital and NH staff, ensure the member and his/her family are consulted, and facilitate communications between all interested parties. The member and his/her family must all be in communication with the other responsible parties to ensure an appropriate transition to placement in a NH. Once the decision to pursue a permanent placement is made, a recommendation must be made to the MLTC or MMC plan, as applicable, with supporting documentation. The MLTC or MMC plan must authorize all levels of care and ensure that the care is in the best interest of the member.

2) What are the criteria for the MCO when determining whether an enrollee is in need of permanent placement?

The recommendation for permanent placement is made by the nursing home physician or clinical peer, and must be based upon medical necessity, functional criteria, and the availability of services in the community, consistent with current practice and regulation. The MCO makes a determination for permanent placement based on the plan's written medical necessity criteria, informed by the clinician's recommendation, the assessment and person centered care plan.

3) Are the MCO representatives required to be invited to the scheduled care plan meetings in the NH that are tied to the Minimum Data Sets (MDS) schedule?

This is a CMS policy and frequency is negotiated between plans and providers as a contractual issue.

4) 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.

5) Is there any requirement for the sharing of care plan information between the MCO and the Nursing Home for an enrollee?

The plan is responsible for ensuring that, for each enrollee in receipt of long term services and supports, these services are authorized pursuant to a patient-centered services plan as per the Medicaid Managed Care Model Contract, Section 10.35. The MCO and Nursing Home must establish a process by which the care plan is developed and updated, usually through meetings with the enrollee convened by the provider with an MCO representative as a team member, and routinely shared with the plan, which may be included as part of the authorization request for the stay.

6) Are the requirements for care planning for NH LTSS the same as requirements for the FIDA Plan?

No. Please refer to the FIDA web site for more information about that program.
http://www.health.ny.gov/health_care/medicaid/redesign/mrt_101.htm

7) Will the hospital roles for care and discharge planning be mandated as part of the hospital contract with the plans?

Hospital discharge planning criteria have not changed under this transition.

8) When a plan enrollee is discharged from the NH to the community, who is involved in the discharge planning?

Transitioning an enrollee from a NH to the community requires formal patient centered discharge planning involving the enrollee, the enrollee's family, NH providers and the MCO. Plans and providers must collaborate in planning for a safe and adequate discharge of all enrollees. MCOs must ensure that appropriate community supports are in place prior to discharge.

9) 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.

10) What happens when a MCO says an enrollee who is a NH resident no longer needs LTC, but the resident has no community address to which to be discharged? Does the plan continue payment until discharge?

In the absence of a safe and adequate discharge, the enrollee must remain in the nursing home, and the plan will continue to be responsible for the nursing home payments until a safe discharge can be arranged.

11) 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.

12) Who is the contact for homeless individuals?

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 with each other to engage the Health Home, if applicable, and the local district to arrange for safe housing suitable for the enrollees needs when arranging a discharge from the nursing home.

13) 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.

14) Does the requirement for 90 days of transitional care mean that the plan will be required to cover services for a resident even if the plan is not prepared to authorize the care?

The transitional care policy provides continuity of care for new enrollees. The policy allows new enrollees to continue an ongoing course of treatment during a transitional period of up to ninety (90) days from the effective date of enrollment with the current care plan, or until the plan implements a new plan of care, whichever is later.

COVERED BENEFITS:

1) How is transportation covered for enrollees residing in a NH who travel to see his or her community PCP?

Non-emergency transportation is covered by Medicaid Fee for Service (FFS). Non-emergency transportation for Medicaid Managed Care enrollees must be arranged through the State vendors, Logisticare in NYC, and Medical Answering Services (MAS) for Rest of State counties. This includes enrollees seeking non-emergency transportation in Nassau and Suffolk counties, effective 12/1/2015.

Note: Fidelis enrollees in Rockland County must contact the plan to arrange non-emergency transportation.

For MLTC, enrollees must contact their plan for non-emergency transportation.

2) How is transportation covered for a FFS NH resident who travels to the community to see his or her community PCP?

Non-emergency transportation for FFS NH residents must be arranged through State vendors, Logisticare in NYC, and Medical Answering Services (MAS) for upstate counties, and is covered under Medicaid Fee-for-Service (FFS). This includes enrollees seeking non-emergency transportation in Nassau and Suffolk counties, effective 12/1/2015.

3) How is emergency transportation covered after the transition date?

For both MLTC and MMC enrollees, emergency transportation is reimbursed by Medicaid Fee for Service. This includes emergency transportation in Nassau and Suffolk counties, effective 12/1/2015.

For Medicaid Advantage Plan (MAP) enrollees, emergency transportation is covered by the plan as a Medicare benefit.

4) Will respite care continue to be carved out to FFS Medicaid?

The MCO is responsible for respite days and bed hold days authorized by the MCO, per the Medicaid Managed Care/SNP Model contract.

5) We are a clinic that sees Nursing Home patients for Audiology services. These services are not furnished by the Nursing Homes. Therefore, when this transition goes into effect, who will be responsible for paying us? We have contracts with the Nursing Homes. Will we be required to have a contract with the MCO if it is responsible for payment?

For MMC and MLTC enrollees, audiology services are covered by the plan, and plans are responsible for authorizing services. For NHs whose rate does not include audiology, those services would be provided via contract with the MLTC / MMC plan.

6) How are vaccines and immunizations covered by MMC and MLTC in the NH?

For MMC, immunization services inclusive of vaccines and their administration are included in the nursing home benchmark rate. For MLTC partial plans, vaccines and immunizations are covered by Medicare as primary payer for dually eligible enrollees. For non-dually eligible enrollees in MLTC in partial plans, vaccines and immunizations are covered under FFS Medicaid. For MAP enrollees, these services are covered by the plan.

7) 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.

8) Does FIDA cover permanent nursing home benefits?

Coverage of permanent nursing home benefit is included in the FIDA benefit package.

9) A dual eligible beneficiary is either: (1) receiving Medicare Part A hospice benefits in the community and requires admission to a nursing home; or (2) is admitted to a nursing home and subsequently elects to receive the hospice benefit. Assume that the person is not yet enrolled in a Medicaid Managed Care plan, but would otherwise be required to enroll since he/she is Medicaid eligible, is receiving custodial care and it is after the transition date. Will the individual be required to enroll in a plan during the time he/she is receiving hospice services?

Medicaid beneficiary who is already receiving hospice services either in the community or in the nursing home is excluded from the requirement to enroll in either a mainstream Medicaid managed care plan or a Managed Long Term Care plan for as long as he/she is receiving hospice services.

A consumer entering a nursing home for permanent placement after the transition date is required to enroll in a MMC or MLTC plan. In the event the beneficiary was in need of hospice services at a later date, the care would be covered by the plan.

10) For facilities having long-term care Traumatic Brain Injury (TBI) beds, with specific DOH regulations allowing a year or longer for rehabilitation and regulation specific programming, are MMC plans allowed to move patients as soon as Physical, Occupational, or Speech Language Pathology Therapy is complete? If the facility is licensed to provide this care and regulations allow for this length of stay, must managed care plans take this into consideration?

The Social Services Laws of 2011 limited the outpatient rehabilitation benefit (physical therapy, occupational therapy, and speech therapy) to 20 visits each per twelve-month benefit year. The Medicaid Redesign Team Proposal #34 (MRT #34) allows the exemption of this visit limitation for

Recipients with a traumatic brain injury (TBI) (R/E code 81 or a primary diagnosis ICD-9 code in the 850 - 854 series) in an outpatient setting. However; there is no limit for inpatient rehabilitation services, as this is based on medical necessity.

PHARMACY

1) How will pharmacies be notified that a NH resident has been enrolled in a MMCP and how will the pharmacy identify that MMCP?

Medicaid providers are responsible for verifying eligibility and enrollment prior to providing services, using the consumer's benefit card.

2) Can you confirm that the 60 day transition of care period for pharmacy benefits is required absent a negotiated agreement with the facility?

During the three (3) year transition phase, MMCPs must honor the current arrangements NHs have with pharmacies. If an enrollee is using a non-formulary drug, MMCPs must allow the enrollee to continue receiving the drug for 60 days. After the 60 days, the MCO and provider must transition the enrollee to a medication on the plan's formulary, as appropriate.

3) Do Medicaid Managed Care Plans (MMCP) and Managed Long Term Care plans (MLTCP) both exclude pharmacy services from the daily NH rate?

MLTC does not cover medications in the benchmark rate. Consumers enrolled in a MLTC Partial plan will continue to be covered under FFS Medicaid. For Medicaid Advantage Plus plans, coverage is through Medicare Part D. For MMC, reimbursement for prescription drugs will continue to be covered through the Medicaid pharmacy program and billed outside of the nursing home benchmark rate. Over the counter drugs, physician administered drugs (J-code drugs), medical supplies, nutritional supplements, sickroom supplies, adult diapers and durable medical equipment will continue to be the responsibility of a nursing home and are included in the benchmark rate.

4) 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.

5) Can a managed care plan require a NH to use a different pharmacy provider than it currently uses?

Absent a negotiated agreement between the NH and Managed Care Organization (MCO), during the three year transition period, MCOs must accept the NH's current arrangement with pharmacies for the provision of services to enrollees placed in a nursing home post August 1, 2014. For enrollees who may have been receiving drugs that are not on the MCO's formulary at the time of enrollment, MCOs must allow the member to continue receiving such drug for a 60-day period after enrollment. After the 60-day period, the MCO and provider must transition the member to a drug on the plan's formulary, as appropriate. Moreover, existing prescription drug policies applicable to Medicaid only nursing home patients in effect since July 7, 2011 will continue to be honored as follows: a. Reimbursement for prescription drugs will continue to be covered through the Medicaid pharmacy program and therefore billed outside of the nursing home benchmark rate; b. Over the counter drugs, Physician administered drugs (J-code drugs), medical supplies, nutritional supplements, sickroom supplies, adult diapers and durable medical equipment will continue to be the responsibility of a nursing home and will be reimbursed within

the nursing home benchmark rate; and c. Immunization services inclusive of vaccines and their administration will remain in the nursing home benchmark rate.

PHYSICIAN SERVICES & CREDENTIALING

1) May the NH resident retain their Primary Care Provider (PCP) in the community when they transition in to a NH?

Yes. If a member is transitioning from the community into a nursing home, the member should be allowed to retain their primary care provider in the community. If a MCO wishes to use the nursing home physician as the primary care provider for a member, the MCO must inform the Department and ensure that the nursing home physician maintains the responsibilities similar to those of other network 15 PCPs, including, but not limited to, disease management, referrals, and hours of availability.

2) What happens when a PCP in the community is not credentialed to see an enrollee in a nursing home?

Enrollees may retain their PCP in the community after transitioning from the community into a Nursing Home. The PCP may provide medical care to the resident in settings other than the Nursing Home. A PCP who is not credentialed may not practice in the Nursing Home.

3) What is the nursing home's responsibility to allow the consumer to see his/her community PCP while living in the nursing home if the nursing home has not credentialed that PCP?

Unless a contract between a Nursing Home and a managed care plan provides otherwise, a Nursing Home has no responsibility to a resident's credentialed community PCP. The contract between a plan and a NH may address nursing home credentialing criteria and processes to enable a consumer to retain a community PCP if the consumer wishes to do so. The contract may also address a Nursing Home's responsibilities to a community PCP an enrollee wishes to retain after moving into the nursing home. Managed care contractual provisions aside, Nursing Homes must maintain compliance with nursing home requirements of 10 NYCRR 415.15

4) What should a plan do if a NH will not credential a community PCP, or if PCP refuses to go to the NH?

MCOs are required to credential all providers participating in the plan network. Nursing homes are required to credential, or decline to credential, any physician wishing to practice medicine in the nursing home.

5) Can an enrollee still use his/her community physician if the community PCP is an out of network provider?

If a nursing home declines to credential or grant privileges to a community PCP, or a community PCP is unwilling to go to nursing home, the enrollee may be allowed to continue seeing the provider in the community, it is up to the plan to decide if they will cover the out of network (OON) provider.

6) A Medicaid Managed Care enrollee may continue to see his or her Primary Care Provider after going into a NH for long term services. Will the PCP be required to continue seeing the enrollee once the admitted to the NH? Also, will the NH be required to permit this? Is the PCP required to do anything to provide services as the community PCP in the NH? Are

there certain regulations related to this for NHs? This becomes complicated unless the PCP and NH are required to follow the member’s desire to keep their PCP.

All Medicaid Managed Care plan enrollees must be assigned a PCP. Enrollees may retain their community PCP when transitioning from the community to a nursing home, physicians providing care to residents in the NH must be granted privileges by the nursing home, and the nursing home may decline to grant these privileges to the enrollee’s community PCP unless the contract between the NH and the enrollee’s plan provides otherwise. Through the contract with MMC and MLTC plans, a nursing home may agree to a community PCP becoming the “physician of record” for an enrollee once the enrollee is admitted to the nursing home. As the physician of record for the resident, the physician is accountable for providing care in accordance with the provisions of 10 NYCRR 415.15. This physician is also accountable for maintaining compliance with all MMC or MLTC plan requirements governing physician services.

Alternatively, MMC and MLTC plans may use a physician already credentialed by the nursing home as the PCP for an enrollee, but must inform DOH and ensure that the nursing home physician maintains responsibilities similar to those of other network PCPs, including but not limited to: disease management, referrals and overall coordination of services.

7) To ensure a smooth transition into a nursing home, the community PCP usually coordinates care with the nursing home. When an enrollee transitioning into a NH elects to use the NH PCP, when does the community PCP stop providing services?

The community PCP will work with the NH to provide transitional care. When an enrollee is placed in the nursing home, the plan must be notified of PCP changes and the new PCP will coordinate services beginning the date the plan assigns a PCP to the enrollee.

8) How will credentialing be handled between managed care plans and NHs?

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 NHs, but are instructed to minimize additional NH requirements.

CONTRACT and NETWORKING:

1) What is the meaning of “in network” and “out of network” services?

Each Medicaid managed care plan contracts with various types of health care providers and practitioners to offer covered services. This group of contracted providers is known as the plan’s provider network. Generally speaking, MLTC and MMC plans must offer at least two providers of each type of service in their networks. However, the NH network requirements for several counties may require more than two facilities per county (see below). Out of network services are those that are obtained from providers who are not part of the plan’s network, also referred to as “non-participating providers”.

2) What if a managed care enrollee wants to be admitted to a specific NH that does not have a contract with the person’s plan?

If an in network home that meets the needs of the enrollee is available, the enrollee must use the in network home. Individuals already enrolled in a managed care plan and subsequently determined to be eligible for permanent NH placement are permitted to change plans in order to have access to their preferred NH. Plans whose NH networks are inadequate, whether due to an insufficient number of contracts or an insufficient number of contracted NHs with available beds, are required, upon member request, to permit members eligible for NH placement to receive

services at an out of network NH. MMC/MLTC plans authorizing an out of network placement may not require the person to move at a later point to a participating NH once network adequacy is restored. Voluntary transfer to a participating NH must be permitted. Plans will be required to contract with at least one veterans' NH that operates in their service area. If the MMC/MLTC plan does not have a veterans' home in their network and a member requests access to a veterans' home, the member will be allowed to change enrollment into a MMC/MLTC plan that has a veteran's home in their network. While the member's request to change plans is pending, the MMC/MLTC plan must allow the member access to the veterans' NH and pay the NH the fee-for-service (Benchmark) Medicaid rate until the member has changed plans. FIDA plans must have contracts or payment arrangements with all nursing homes in each county where the plan operates.

3) A small rural nursing home is the only provider in the county, and receives many referrals from hospitals outside the county. Will the hospitals continue to be able to refer to the NH, or will hospitals be required to refer within their respective counties first?

Plan enrollees must access services through the provider network. If a network provider meeting the enrollee's needs is not available, the plan must authorize the enrollee to receive services from an out of network provider. Referrals to a nursing home provider for consumers not enrolled in a plan would not be limited to plan participating providers.

4) What happens when a NH resident enrolled in MMC requires emergency hospitalization and 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.

5) What if a NH resident who is completing a Medicare short-stay episode and is newly eligible for permanent placement in a NH selects a plan that does not include the NH in its network?

DOH does not require current NH residents to change NHs as a result of managed care enrollment. The State's enrollment broker will provide counseling on the available plans that contract with the resident's NH. The resident should select a plan for enrollment that contracts with the NH in which he or she resides. However, if the resident selects a plan that does not contract with his/her NH, the resident may have to move to a different home. There may be circumstances in which the resident would not have to move, even if his/her NH did not participate in the plan's network. For example, the MMC or MLTC plan might be willing to approve an out of network placement to avoid disrupting the resident's care. In addition, MMC and MLTC plans that have inadequate NH networks, due to an insufficient number of NHs under contract or an insufficient number of beds, are required to permit members to be placed in their preferred out of network NH. Further, MLTC and MMC plans are required to authorize out of network NH placement when there is no participating facility with an available bed that meets the member's needs. Finally, it is worth noting that members may freely change MLTC and MMC plans to secure a placement in a preferred NH in another plan's network. FIDA plans must have contracts or payment arrangements with all nursing homes in each county the plan operates.

6) Will managed care plans be required to cover bed hold services in a contract?

Yes. During the 3-year transition period, managed care plans are required to continue following the bed hold coverage in effect under the Medicaid FFS program, unless the plan and provider

have agreed to an alternate arrangement. After the transition period, bed hold will be subject to negotiation between plan and provider.

7) Will plans be required to monitor/audit eligibility for bed-hold coverage?

This would create a compliance issue for plans.

Plans may or may not require prior authorization for bed hold arrangements. Please refer to Appendix F of the Medicaid Managed Care/Family Health Plus/HIV SNP Model Contract for authorization timeframes. It is not the Departments intent to require prior authorization for bed hold.

8) For network purposes, will there be any requirement for proximity of the facility to family/friends?

The enrollee is required to select a participating nursing home or will be allowed to change plans to select an alternate nursing home. An enrollee may select an out of network nursing home if his/her needs cannot be met by a participating provider.

9) How will the State monitor network development and adequacy?

The State monitors plan contracts and networks on a quarterly basis to ensure network adequacy standards are met. Each facility is expected to contract with at least one MMCP.

10) Will nursing home be required to ensure that individual health providers who provide care at their facility have participating network agreements with the same plans as the nursing home? If not, what are the disclosure requirements of the nursing home and the provider?

Nursing homes should clearly identify non-salaried providers who treat members in the NH. The Department strongly encourages any non-salaried provider to contract with the plan to avoid denials in the future.

11) If a facility does not have any contracts, should that facility notify the Department and, if so, what will the Department do?

The Department ensures that plans meet minimum provider network requirements, and may discern if a facility is considered an essential provider in the community. In that case, the Department may direct plans to contract with the facility.

12) What can DOH do to promote collaboration between plans and providers?

Plans and providers are encouraged to participate in workgroups and meetings designed by DOH to promote collaboration.

13) How does NYSDOH and the enrollment broker identify the plans having contracts with each NH?

The enrollment broker has access to the NYSDOH Health Provider Network (HPN), allowing it to enroll consumers in an appropriate Plan contracting with the NH in which the consumer resides.

14) Will managed care plans be required to contract with every NH?

No, although each MLTC and MMC plan must meet a state established minimum of network providers in each county in which the plan operates, plans are not required to contract with every NH. Plans must contract with at least: 8 homes in Bronx, Kings, Queens, Nassau, Suffolk, Westchester, Erie and Monroe counties; 5 homes in New York and Richmond counties; 4 homes in Albany, Dutchess, Oneida and Onondaga counties; 3 homes in Broome, Chautauqua, Niagara, Orange, Rensselaer, Rockland, Schenectady and Ulster counties; and 2 in all other counties

(where available). Plans must also include at least two of each type of specialty provider in each county (where available) in their network. If a managed care plan enrollee selects an out of network NH and no other appropriate provider is available in the plan's network, the plan must enter into an out of network arrangement (which includes paying the Medicaid FFS rate) with the home

FIDA plans are required to contract with 8 nursing homes in each county where the plan operates. In addition, FIDA plans must have contracts or payment arrangements with all nursing homes in each county the plan operates.

15) Are there certain elements that are required to be in a contractual agreement between a plan and a NH?

Required contract provisions are discussed in the MCO and IPA Provider Contract Guidelines available on the Department's web site at:

http://www.health.ny.gov/health_care/managed_care/hmoipa/docs/guidelines.pdf

16) Many MCOs appear to be contracting with the larger NH facilities to meet network requirements. What can smaller nursing homes do to obtain contracts with plans?

DOH encourages nursing homes to contract with multiple plans whose service area includes the NH if possible. Based on current data, the majority of NH facilities have contracts with MCOs. The DOH will continue to monitor network adequacy.

17) Can an MMCP refuse to negotiate or contract with a NH?

Plans are not required to negotiate with every nursing home, however plans must meet network standards set forth by the State. The Department is encouraging plans to contract with multiple nursing homes.

18) What should a provider do if experiencing difficulties negotiating a contract with a MMC or MLTC?

Providers that are unable to negotiate a contract with plans may file a complaint with DOH.

19) We have heard that some MLTC and MMC plans are unwilling to negotiate contracts, if a NH provider is unwilling to accept responsibility for collection of NAMI that falls to the plans?

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

20) What happens if a plan does not have the required number of nursing homes in a specified county?

Plans not meeting network requirements are required to pursue additional contracts; the plan is required to allow enrollees to receive services from out of network providers in the interim if it does not have capacity.

21) What is the expectation for plan surveillance over nursing homes in a plan's contracted network? Will the State conduct annual certification surveys, or are plans required to conduct similar activities?

Surveillance of nursing homes by the State has not changed under this transition. Plans are not required to conduct surveillance of NH, but are required to monitor the quality of care provided to enrollees.

22) Is DOH addressing contracting "lock out?" Some MCOs are presenting as unwilling to negotiate contract terms once they have satisfied their network requirements.

Plans are not required to negotiate with every nursing home. Plans must meet network standards set forth by the State. The Department is encouraging plans to contract with multiple nursing homes to meet the needs of enrollees.

23) Will a facility's survey status affect whether it can accept placements from a plan?

As long as a facility has not been banned from receiving Medicare and Medicaid admissions, and grounds for its contract(s) to be terminated exist, the facility may accept placements from a plan. However, if a plan believes the quality of care is jeopardized, it may terminate its agreement with the nursing home or request action from the nursing home prior to allowing additional placements.

NAMI

1) Can a mainstream MMC enrollee be disenrolled for non-payment of NAMI? If so, what are the parameters for disenrollment? If not, what are the guidelines?

Consumers enrolled in MMC and MLTC may not be disenrolled for non-payment of NAMI.

2) Currently, a MLTCP can disenroll a consumer who does not turn over their coverage 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 from MMC or MLTC. Plans and Nursing Homes are free to pursue reimbursement through other means.

3) 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.

4) 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.

5) How common is delegation of Net Available Monthly Income (NAMI) collection by plans to NHs statewide?

NAMI delegation is a contractual arrangement between plans and providers. DOH does not have access to this specific data.

6) If the NH provider agrees to collect 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 plans and Nursing Homes may coordinate the NAMI collection as part of reimbursement from the managed care plan to the Nursing Home.

7) Is the Plan delegation of NAMI collection to a NH a contractual matter? Is the NH allowed to refuse this delegation?

NAMI delegation is a contractual arrangement between plans and providers. Nursing homes are not required to accept delegation of this task by a plan. It is recommended that plans discuss the

collection of the NAMI and any communications nursing homes have developed for collection purposes with a nursing home. The Department does not have required forms or letters for this use. The Medicaid eligibility notice will inform the consumer and, if applicable, the consumer’s representative of the monthly NAMI amount to be paid.

8) How does a facility know the NAMI amount to collect from a MLTC resident before the budget letter is sent?

The NAMI amount appears on the notice once eligibility is determined.

9) Will budgets be provided to the NH facility to document the NAMI amount to be collected?

The plans will receive a copy of the enrollee’s eligibility notice specifying the NAMI amount due. If the plan delegates the NAMI collection to the NH, the plan is responsible for advising the NH of the amount to be collected.

10) How are NH residents to receive their Personal Needs Allowance (PNA) pursuant to federal/state regulations while the MMC plan retains NAMI collection responsibility until State takeover?

If the nursing facility receives the resident’s income directly or if the PNA is deposited into a resident’s personal account that is maintained by the nursing home, the responsibility for the PNA remains with the NH.

11) What are the requirements for plans for providing NH residents with their \$50 dollar personal needs allowance (PNA)?

If a plan is collecting the NAMI from the consumer, a \$50 personal needs allowance has already been subtracted from the consumer’s income in arriving at the NAMI amount. Only in instances where the plan is representative payee for the consumer’s income, must the plan set aside \$50 for a personal needs allowance before collecting the NAMI. When the consumer indicates that they want the nursing home to maintain a personal needs allowance account, the plan must ensure that the \$50 personal needs allowance is sent to the nursing home each month. If the plan is not representative payee for the consumer’s income, the plan has no responsibility regarding the personal needs allowance.

12) Social Security requires all checks to be direct deposit, however many NH residents do not manage a check book. How will the NAMI payments be obtained from the NH resident in this case?

Upon admission to a nursing home, the nursing home often becomes the representative payee for the consumer’s social security benefit. This provides the nursing home with the ability to access the NAMI or portion thereof. In some cases, adult children or other relatives may be managing the consumer’s income. In these cases, the family member will pay the NAMI each month. In other cases, a legal representative may be required in order to access the consumer’s income for payment of the NAMI.

13) What is the format of the report containing NAMI information? Can DOH distribute a sample of the report?

DISTRICT		PIC X(02)
CIN	CIN	PIC X(08)
CASE-NUM	Case Number	PIC X(12)
EXC-CD	Exception Code	PIC X(02)

NH-PROVIDER	NH provider ID	PIC X(08)
RE-FROM-DATE	N code effective date	PIC X(08)
PCP-PROVIDER	NH provider ID	PIC X(08)
NAMI-AMT	NAMI amount	PIC X(10)
ERROR	Budget type error	PIC X(20)

BILLING:

1) Will plans be required to pay a NH until discharge occurs, rather than date a plan decides long term NH services are no longer required? Sometimes it takes several days to coordinate community services.

Plans are responsible for reimbursing the NH through the date of discharge, and must collaborate in planning for a safe and adequate discharge of all enrollees. MCOs must ensure that appropriate community supports are in place prior to discharge.

2) Will a NH be paid by the MMC plan or MLTC plan?

For enrollees already in a plan, MMC plans must authorize all permanent placements in nursing homes, and will pay the nursing home while the eligibility determination for coverage of nursing home care is conducted by the LDSS. This is the same for MLTC.

3) Is a NH responsible for payment resulting from a transfer to a non-network hospital, if the care is not considered an emergency?

For urgent care, when a nursing home determines it cannot provide care to meet the patient's needs, the nursing home may transfer the patient to a hospital. Prior authorization is needed if seeking transfer to a non-network hospital due to un-availability of a network hospital or enrollee's clinical needs cannot be met by a network hospital.

4) 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.

5) 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 MMCP is responsible for authoring care under the transitional care policy.

6) 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.

7) A NH provider has stated that a plan is retroactively denying care. For example, MMC plan authorized service through Tuesday of one week. On Wednesday following that Tuesday, the provider was sent a denial ending services on Tuesday and not authorizing

further. What does a provider do to obtain payment for the days during which it is trying to find a place for patient? Who will pay the custodial care?

The Plan is responsible to pay the NH until a safe discharge plan is in place. Plans and providers need to work collaboratively to establish such processes.

8) A MLTC Plan is holding claims for more than 120 days. The provider has not been given a formal denial on paper, an explanation of benefits (EOB), or anything indicating the reason claims are being denied. The Plan indicates that it is looking into the claims. The provider is awaiting 25K in payment.

There are no changes to prompt payment laws under this transition. Providers may file a complaint with DFS if it is believed a plan is in violation of these laws.

9) We have individuals who have been determined eligible for permanent NH care by the LDSS, however the approval is through the current MLTC plan. The Electronic Provider Assisted Claim Entry System (EPACES) shows eligible PCP not MA Eligible, and so our billing is denied. How is the NH to obtain payment?

If a consumer is enrolled in MLTC and subsequently receives permanent placement in a Nursing Home, the MLTC plan would be responsible for payment to the NH. The consumer would remain enrolled in MLTC, and Coverage Code = 30 would be appropriate.

10) If the roster does not reflect a permanent placement stay by the 90th day that a plan has authorized, can the authorization be terminated and monies recouped?

If the NH fails to submit the required notification to the LDSS as appropriate, the plan may terminate the authorization. However, if the NH has submitted notification timely and the delay in updating the roster is due to the pending financial eligibility determination by the LDSS, the plan may not take negative action against the nursing home.

11) When the member appears within the correct R/E code on the roster, it is prospective only. Does the plan automatically back date the enrollment in NH category by 90 day and bill accordingly? What happens to any days that were authorized prior to the 90 days?

The "N" code should reflect any retroactive authorized coverage for which the consumer is eligible.

12) Who covers the consumer responsibility when he or she is eligible for both Medicare and Medicaid?

MLTC plans are required to cover Medicare copayments and coinsurance, with Medicare as the primary insurance and Medicaid as the payer of last resort

13) Will NHs continue to bill Medicare Part B for rehabilitation services, or bill the MLTC plan instead?

Billing policies have not changed under this transition. Plans are responsible for maximizing other insurance coverage, and Medicaid is the payer of last resort.

14) Are plans allowed to require a Medicare or primary payer denial prior to paying a custodial claim?

Billing policies have not changed under this transition. Plans are responsible for maximizing other insurance coverage, and Medicaid is the payer of last resort.

15) How can pharmacies identify the plan in which a consumer is enrolled? Will there be an electronic request similar to Medicare Part D?

When verifying, the message "ELIGIBLE PCP" will be returned, indicating coverage is in place under a Pre-paid Capitation Program (PCP). This status indicates the enrollee is PCP eligible, and is also eligible for limited Fee for Service (FFS) benefits. To determine the covered benefits, the provider must contact the PCP designated in the Insurance Code field.

16) By requiring a Medicare exempt letter, plans are not allowing electronic billing. How can DOH ensure electronic billing is processed correctly?

Plans are responsible for ensuring that Medicaid is the payer of last resort. Plans are encouraged to utilize the most appropriate methods to verify Medicaid coverage while placing the least amount of administrative burden as possible on the provider. This can include electronic attachments, targeted review, and provider education.

17) 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.

18) 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.

19) 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 biweekly.

20) Please clarify the term "quarterly" regarding claims submission. Will NH bill the MCOs every three months?

NHs must bill plans according to an agreed upon schedule and in accordance with the contractual arrangement between the plan and provider. However, in workgroup discussions, plans indicated a willingness to process claims bi-weekly.

21) Will there be a provision for NHs to bill plans on a weekly basis?

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

22) The NH policy paper references bi-weekly billing but does not require plans to accommodate it. We are not clear what is meant by DOH supporting "a NH requirement of this language in the contract between the NH and the plan." If this refers to individual contracts, it does not create the broader policy mandate we are suggesting. Frequency of billing is vitally important to maintaining adequate cash flow to the facilities. As it is now, many facilities currently bill weekly and experience a 21-day payment turnaround. Plans must be explicit in all provider contracts. Perm placement is not created by authorization.

The Department understands the concerns around cash flow and is willing to work with both the providers and the plans to ensure a smooth transition into care for all. We do not believe the billing/ payment lag will be an issue on clean claims as our understanding is most plans make payments on a weekly basis and can turn around claims in a faster time frame than the current NYS mandated lag would allow NYS to. However, we would encourage and support nursing

homes who mandate language be added to contracts between plans and providers regarding a time period on turning around payments for clean claims.

23) Will there be a requirement that all plans are capable of receiving clean claims either electronically or by paper from providers? Will there be a contractual or other requirement that Plans must be able to accommodate electronic funds transfers? Will there be a requirement that the contract between the NH and the Plan address this?

The Department implemented a readiness review requirement to document that plans are able to receive a clean claim from all of their network providers. This review demonstrated each plan's ability to accept electronic claims and paper claims, as well as determined the MC Plan's systems are compatible with current Nursing Home Systems.

24) Can the plan authorization at the time the member is moved to permanent placement be delayed and no payment issued to the NH until the patient is certified at which point the authorization is retroactively created for the 90 days?

No, the placement is based on medical necessity, not payment or reimbursement.

25) How are plans paid for the time which is authorized for the custodial bed days paid prior to 90 days from the certification date?

Plans will receive retroactive adjustment to payment to reflect updates to the N codes and Medicaid eligibility.

26) Delays in obtaining authorization from plans for permanent placement may create a 45-day lag in payment.

It is anticipated that admission and the billing cycle begin after authorization is obtained. This would be part of the provider's contract negotiation process with the plan. In an effort to mitigate some of the cash flow issues experienced during an earlier transition, the Department organized a work group to mitigate these issues in real time. The Department has organized a similar group for the Nursing home transition.

27) Will all MCOs accept electronic claims? Will the payments be made with the same current Medicaid turnaround time?

All plans accept electronic claims. There is no change to prompt pay law, which plans must follow when reimbursing providers.

28) Will there be training available to providers regarding changes to the billing process?

MCOs will create a process to train contracted providers regarding the claim adjudication process to promote understanding and improve the submission and payment of claims. Each MCO and nursing home must negotiate provider contracts in good faith.

29) How will availability of claims training offered by plans to providers be monitored by DOH?

Plans are required to provide training to providers regarding billing policies. If a provider identifies a plan not providing appropriate training, providers may contact DOH.

30) How should Nursing Homes bill for retroactive rate adjustments for Case Mix Index (CMI)?

The Department is creating a schedule to allow the initial case mix rates to be issued during the month in which the rate is active, eliminating the need for retro billing. In addition, the Department is examining all rate schedules in an effort to issue statewide rate packages twice per year.

31) If a patient is enrolled in Hospice, who is responsible for billing the plan, Hospice provider or the NH?

The hospice provider will bill the MCO for room and board provided to patients residing in the nursing home and pass this amount to the nursing home.

32) Are NHs able to bill the plan for telemedicine services?

Coverage of telemedicine services by Medicaid managed care (MMC) plans is optional. Providers should check with the enrollee's MMC plan to determine whether telemedicine services are covered and, if so, for medical necessity criteria and plan-specific billing instructions.

33) Are plans able to bill for stop-loss for enrollees transitioning from a rehab or short term stay to permanent 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.

34) Until CMS approves nursing home 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

35) Are revenue codes required on the claims submitted to MC plans?

Revenue codes are submitted to plans by the provider when billing.

36) Is it expected that plans use the billing code sets previously discussed?

Most plans have agreed to work with 2 sets of billing codes. NYSDOH is working on a survey to gather more specific detail from plans on the billing codes they will use.

37) 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.

38) How can nursing homes execute contracts with MMCPs absent clear billing guidance? How can a NH guarantee submission of a clean claim if there is no billing standard?

Plans are required to provide billing guidance to providers.

RATES:

1) What is the NH "benchmark" rate and what does it include?

The NH benchmark rate is equivalent to each facility's FFS Medicaid rate, and is intended to represent a "benchmark" for rate negotiations between NHs and managed care plans. The benchmark rate includes the direct, indirect, non-comparable and capital components; statewide pricing phase-in adjustments through Dec. 2017; the Medicaid-only CMI adjustment and other adjustments and add-ons to the FFS rate; the 6 percent cash receipts assessment add-on; NH quality pool adjustments; and any universal settlement amounts if an agreement is reached and

payments are made through the rates. DOH has posted a listing of benchmark rates by facility at: http://www.health.ny.gov/facilities/long_term_care/reimbursement/nhr/.

2) What is included in the benchmark rate? Does the benchmark rate include physician ancillary services and assessments?

Medical Staff Services is cost center 44 of the NH cost report, as part of the benchmark a per diem has been calculated and is displayed for Medical Staff Services. This is a non-comparable cost center and is reimbursed 'as reported' by the facility in the base year report, that is, no 'price' was determined for the non-comparable component.

3) Must a NH accept the benchmark rate (i.e., FFS rate) in a contract?

No. A home may negotiate an alternative rate or reimbursement methodology as long as it is acceptable to both provider and managed care plan and represents a non-FFS alternative rate. However, a home may not "force" a plan to pay a higher rate than the benchmark. If the homes in a county are unwilling to contract with a plan at the benchmark rate, the plan will not be penalized if it does not meet the network requirements in that county.

4) What indicator is used to show the services included in the benchmark rate?

There is no 'marker' on the rates or in the benchmark.

5) Are benchmark rates site-specific? Are they based on Case Mix Index (CMI)?

Yes, the benchmark rate is site (facility) specific. The benchmark rate does include the latest processed case mix.

6) At what rate must plans pay NHs in their network during the transition period?

During the rate transition period, i.e., for 3 years after a county is deemed mandatory for NH population enrollment, MLTC and MMC plans must pay their contracted NHs either the benchmark rate or a negotiated rate, i.e., based on an alternative payment methodology other than FFS such as episodic, tiered, etc. as long as it is acceptable to both the NH and managed care plan. The negotiated rate option is not intended to be an amount tied directly to the benchmark rate (e.g., benchmark rate 17 minus 10%, etc.); rather, it is supposed to be based on an alternative payment arrangement.

7) There is some confusion among plans and providers as to the per diem benchmark rate the plans are required to pay during the transition. The multiple columns/ data elements in the Excel worksheet on DOH's website are confusing. It should highlight the final Medicare eligible and non-Medicare eligible per diems the plans should be paying in addition to providing the detailed breakout.

The Department is currently working to update the benchmark rate file on the website to provide clearer information in detail and in total.

8) Will DOH still continue to set and pay FFS rates after the transition begins?

Yes. The transition of the NH population from FFS to Medicaid managed care is expected to take at least 3 years to complete. Furthermore, Medicaid FFS will remain the payer for nursing home resident beneficiaries who are not required to enroll in a managed care plan.

9) Will the roster contain the new rate code or will plans use the R/E code to derive the correct rate code for billing and reconciliation?

The plans use the R/E codes N1-N5 to derive the correct rate for NH billing and reconciliation.

10) At what rate must plans pay NHs for out of network services?

MLTC and MMC plans are required to pay non-participating NHs at 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.

11) How will CMI adjustments be made to Medicaid rates after the transition begins?

The current FFS rates are based on the CMI for all Medicaid patients in each facility. As the Medicaid population in NHs is gradually transitioned into managed care, the CMI in the FFS/benchmark rates will continue to be based on the entire population of Medicaid beneficiaries identified on the census roster. This includes both FFS and Medicaid managed care enrollees. The Department is committed to minimizing retroactive rate adjustments and will continue to work toward eliminating as many of the retroactive rate adjustments as possible.

12) Subsequent to the transition, will CMI audits include residents enrolled in MMC plans or will they be limited to residents covered under the FFS program?

It is anticipated that the audit plan will audit all Medicaid recipients, both MMC and FFS, as this represents the NH case mix adjustment.

13) During the transitional period, will rate adjustments be applied to the Medicaid FFS rate to account for the Case Mix Index (CMI)?

Yes, the benchmark rate is updated every 6 months to account for CMI. The Department is committed to minimizing retroactive rate adjustments and will continue to work toward eliminating as many of the retroactive rate adjustments as possible.

14) Will the case mix process be discontinued moving forward, and if so, when will it be discontinued?

FFS regulations require that nursing facility rates be adjusted for case mix twice per year.

15) Will NHs be reimbursed by managed care plans for retroactive adjustments to the benchmark rates (e.g., CMI updates, cash receipts assessment reconciliations, adjudicated rate appeals, etc.)?

Yes. Plans will be responsible for paying these retroactive rate adjustments to NHs in their network and for services provided out of network.

16) Considering the benchmark rate does not include levels, how should plans reimburse rehabilitative services after a hospital admission?

The benchmark is based directly on the promulgated nursing facility rate. These rates include an average Medicaid only case mix for the facility based upon a census submitted by the facility. This average rate is paid to nursing facilities for six months and then revised based upon the next census. The nursing facility rate is not adjusted on a patient specific basis.

17) 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 patients and is to be included for payment.

18) How does the plan pay for the cash assessment, since this is not included in the benchmark rate? Is it billable separately, and are there separate rate codes?

The current benchmark currently includes Cash Receipts Assessment.

19) Are there special rules around reimbursement of the capital component of the Medicaid rates?

Yes. After the 3-year transition period, MLTC and MMC plans must continue to pay NHs (both in network and out of network) the capital component of the benchmark (i.e., FFS) 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.

20) Do managed care plans receive additional reimbursement from the State for contracting with a facility with a high property in its rate?

There is a Nursing Home Price Mitigation Pool to provide additional funding to high cost Nursing Homes.

21) Will MLTC and MMC plans be responsible to pay Medicare coinsurance and deductible amounts for dual eligible residents who receive Medicare Part A/Part B covered services?

Medicaid is responsible for payment on behalf of enrolled NH residents. The FIDA program does not have any coinsurance or deductibles.

22) 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.

23) When will Plans be notified of the premium rate add-on for administering the long term NH benefit?

The Department is currently developing the PMPM with its actuary, Mercer and it will be made available as soon as possible.

24) 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.

25) What is the rate for pediatric nursing homes under this transition?

This transition applies only to consumers age 21 and older.

26) Are plans expected to map to the new rate codes from the R/E code? Or will the equivalent rate code be furnished on the roster?

Rate codes will be furnished on the roster.

27) 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.

28) Since there is no adjustment embedded in MLTC premiums and no distinct specialty rate codes for MLTC to bill, DOH indicated there will be a \$10 million risk mitigation pool. How will this pool be funded and how will it operate? How was the \$10 million amount determined, and will it be sufficient to compensate plans for all variations from the regional average rate (including specialty services, which have considerably higher rates) that they must pay for in network and OON services? As progressively more Medicaid beneficiaries

move into managed care in each year of the transition, will the \$10 million be increased each year?

The Department would like to discuss this in more detail with the plans and provider representatives. DOH continues to address these questions with CMS and looks forward to continued feedback from both plans and providers, and anticipates arranging for these discussions in the near future.

29) We understand that some current contracts contain COB provisions that may preclude NHs from billing and retaining amounts they would otherwise be entitled to. There was no Department response to the issue of cross-over claims.

For Medicare covered services that are provided in the NH, the facility is required to continue billing as it currently does. The MLTCP rate takes into account Medicare reimbursement. The NH may retain Medicare reimbursement to which it is entitled for covered services.

30) Payments by plan if resident invokes rights under nursing home transfer/discharge regulations to appeal a transfer/discharge [10 NYCRR § 415.3(h)]

Under current transfer/discharge regulations, the individual is responsible for payment to the facility for a continued stay during a pending appeal. However, if an enrollee is in disagreement with the plan's determination, the enrollee may also exercise his or her due process rights by requesting a fair hearing and aid to continue. Fair Hearing determinations are binding. In the FIDA program, an individual may appeal through the integrated appeals process and continue to receive services pending the appeal. If an individual has availed him or herself of continuing aid, the individual would not be responsible for payment to the facility.

31) 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.

COMPLAINTS

1) How do a plan and provider obtain resolution when there is not agreement regarding a plan of care? What if the NH and/or resident disagree with a managed care plan's recommendation to transition the resident out of the NH?

The enrollee and/or provider should follow the standard appeals process currently in place or request a fair hearing. This process may be expedited if circumstances warrant. The plan is responsible for the cost of services during the time prior to the decision. However, if the plan's adverse determination is made at a time when the NH decides the discharge plan is not safe and the enrollee must remain in the nursing home, the plan continues to be responsible for the ALC nursing home payments. The plan may require an authorization request for ALC. If the determination confirms a safe discharge to the community, the plan may deny payment for continued stay. If the enrollee timely requests a fair hearing and aid continuing, and there is a provider order for the stay, the plan would pay for the stay until issuance of the fair hearing decision, as directed by the Office of Administrative Hearings.

2) A plan enrollee is permanently placed from the community and found ineligible for Medicaid chronic care coverage for financial reasons. If a fair hearing is requested, will the plan have to continue to pay the facility until a decision is made?

If the enrollee requests, and the Office of Administrative Hearings directs the State and plan to provide aid continuing, the plan will pay for the stay until the fair hearing decision.

3) Is there someone who will act as liaison between facilities and the health plans as issues arise?

The NH and the Plan should work cooperatively to resolve issues. If unable to reach a resolution, plans and providers may contact DOH for assistance.

4) What is the protocol for plans not approving a continued NH stay? MCOs may not provide advance notice for a denial of continued coverage.

Plans must provide timely notice to the provider of any denial of service. Providers would follow the current complaints and appeals process if there is not agreement between plan and provider.

5) What can providers do if they encounter problems or delays in getting authorization for services or in the appeals process?

Providers encountering such issues should call the DOH hotline. For MLTC call 1- 866-712-7197; for MMC plans call 1-800-206-8125.

6) The rules and regulations of the Commissioner of Health place ultimate responsibility for patient care on the NH board. If the MCO makes a determination regarding patient care, does the NH still bear the ultimate responsibility?

The NH remains responsible for care provided, and the plan authorizes the care plan based upon medical necessity criteria. MCO may make a determination regarding the medical necessity of patient care. However, if there is a disagreement, the NH and enrollee should exercise appeal rights and aid to continue, if applicable.

7) How is "fraud and abuse" defined for contract termination purposes?

How is "imminent harm" defined?

10 NYCRR Parts 98-1.21 (1) and (2) define fraud and abuse. Fraud means any type of intentional deception or misinterpretation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person in a managed care setting, including any act that constitutes fraud under applicable federal or state law, committed by an MCO, contractor, subcontractor, provider, beneficiary, or enrollee or other person(s). Abuse means provider practices that are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the state or federal government or MCO, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care in a managed care setting, committed by an MCO, contractor, subcontractor, or provider. There is no statutory definition of "imminent patient harm". Providers may elect to define this term in their contracts.

SYSTEMS

1) Will plans receive any of the new R/E values (N1-N7) on the rosters prior to the implementation date? If not, when can plans expect to begin receiving the new N codes?

The N1-N7 R/E codes will appear in the system and on the roster once the local districts receive notice and complete an eligibility determination for permanent placement in a nursing facility for a Medicaid/Medicaid managed care recipient.

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

The NH is responsible for notifying the LDSS regarding the bed or facility type for the recipient. LDSS must refer to 15 OHIP/ADm-01 for direction from DOH regarding correct use of the N1-N7 codes. DOH is also in the process of revising form LDSS-3559, which is in the final approval process, and will indicate the bed type and appropriate RE code. DOH will issue a GIS with instructions for using the new form at the time the form is released.

3) 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 based upon status/severity of the individual’s care, meaning a vent should trump other types. Each rate will be paid distinctly based upon N code.

4) How is a Medicaid beneficiary who is enrolled in a managed care plan be coded in the system?

Nursing Home Transition Rate Code Billing Matrix						
			Managed Care Program			
R/E Code	Equivalent Rate Code	Description	MMC	HIV/SNP	MLTC	FIDA
N1	1821	Regular SNF Rate - MC Enrollee	X	X		
N2	1822	SNF AIDS - MC Enrollee	X	X		
N3	1823	SNF Neuro-Behavioral - MC Enrollee	X	X		
N4	1825	SNF Traumatic Brain Injury-MC Enrollee	X	X		
N5	1826	SNF Ventilator Dependent - MC Enrollee	X	X		
N6	3479	Partial Cap 21+Nursing Home Certifiable(valid through 3/31/15)			X	
	3478	MLTC Partial Cap Age 18+(effective 4/1/15)			X	
	3489	Primary FIDA, Age 21+, Dual Eligible				X
N7	N/A	NH Budgeting Approved- Awaiting M/C Enrollment				

NOTES:

- Rate derivation billing logic will be implemented for MMC only. All other Managed Care program plans will follow program specific billing guidance
- PACE, MAP, and MA plans will not be impacted by the transition

5) If a case is coded with N7, does this mean an enrollee is NOT to be moved to the NH program on the plan’s system?

If a case is coded with N7, it means the LDSS has determined the consumer to be fully eligible for long term nursing home benefits and they are awaiting managed care enrollment. Once

enrolled, the local district must enter the end date for the N7 code and enter the applicable N1-N6 R/E code. The local district must be contacted to correct the coding if necessary.

6) When a consumer in a NH dies, does the N code need to be end dated or removed?

No action needs to be taken with the N codes when a consumer dies in a NH. The case is closed.

7) Is R/E code N6 used for clients who are currently enrolled in Managed Long Term Care, and subsequently enter a NH?

The N6 code is used only for Managed Long Term Care (MLTC). A consumer may be enrolled in MLTC prior to entering a Nursing Home. The LDSS would enter the N6 code on this case when the consumer entered the NH.

Another example could be a MMC enrollee who gained Medicare coverage while in the NH, becoming excluded from MMC enrollment. This consumer would be required to enroll in MLTC. The LDSS would change the N code to N6, reflecting the new enrollment in the MLTC plan.

8) For PACE MLTC enrollees who are in permanent placement in NHs, the LDSS must enter R/E N6. What start date does the district use on the cases that have resided in facilities with active PACE since prior to the 7/1/15 start date? Does the district enter the N6 codes on all cases now, or as it touches the cases at recertification or next contact?

The LDSS would not enter the N code on existing cases for consumers in permanent placement in a NH prior to the transition date for the county. The N code is used for actions taking place on or after the transition date.

For new enrollments in permanent placement on or after the transition date, the LDSS would enter the N-6 once notified of the enrollment via the monthly Enrollment Report. The Begin Date of the N-6 is equal to the first day of plan enrollment.

For current MLTC enrollees entering the NH for permanent placement on or after the transition date, the LDSS would enter the N-6 with a Begin Date equal to the date of permanent placement.

9) A Nursing Home Resident is transferring from one facility to another. The MLTC Plan in which they were enrolled originally does not contract with the second home. Does the LDSS need to change the provider associated with the N6 code in eMedNY? If so, what date is used?

Yes, the Nursing Home provider has changed and the LDSS is responsible for updating the system to reflect this change. For MMC and MLTC enrollments, the LDSS must update the NH Medicaid Provider ID number associated with R/E N code to reflect the new Nursing Home Medicaid Provider ID number. The LDSS must end date the original Provider ID, effective the last day of the month of transfer. The LDSS must then enter a line for the new Provider, with an effective date equal to the first day of the month following transfer. The original plan must cover the NH stay until the new plan enrollment becomes effective. The new plan will be able to bill for the effective months of enrollment in that plan.

10) If a client is not Medicaid eligible at recertification, what does the LDSS do about the N codes?

When a client is determined to be no longer eligible at recertification, the LDSS does not need to take action with the N code. Once the case is closed the N code will sunset after 90 days when eligibility is lost.

11) If there is a line entered in the Principal Provider (PP) screen and Maximus processes an enrollment, will an error be generated for the transaction if the PP line is not ended? Will the facility be able to continue to bill FFS even though it should be billing the plan?

Currently, if the PP data exists, enrollments will be processed only if the R/E N-7 code also exists. Once the enrollment line is in place, FFS claims will be rejected since payment would be made through the managed care plan.

12) There is mention of a new R/E report via HCS and BICS that contain the N codes. Does 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 yet 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.

13) 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.

14) 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.

15) Will the NH file contain retroactive dates in the RE-FROM DATE field?

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

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

Yes.

17) 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 (WMS) 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.

18) How will this information be shared for Medicaid members who enrolled through the Exchange?

There will be no New York State Department of Health insurance Exchange cases reflecting permanent placement in a Nursing Home. If a consumer whose case resides on the NYSoH Exchange is in need of permanent placement, his/her case will be referred back to the local district for NH eligibility determination.

19) 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.

20) How can providers clearly identify the type of plan into which a consumer is enrolled, i.e., MMC vs. MLTC? Online 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.

21) How will plans receive Nursing Home reports?

The managed care plans receive pertinent enrollee information via the Roster system. Included on the roster are: (1) the managed care rate code; (2) the NH Provider ID; (3) effective date of permanent placement; and (4) exception code. NHs will continue to receive their FFS roster in the current method of delivery.

22) How do managed care plans and NHs receive roster information?

The managed care plans receive pertinent enrollee information via the Roster system. Included on the roster will be: (1) the managed care rate code; (2) the NH Provider ID; (3) effective date of permanent placement; and (4) exception code. NHs continue to receive their FFS roster in the current method of delivery.

23) Why do MCO Roster and NH Roster contain different information?

The roster and Nursing Home enrollment reports are used for different purposes by different entities, so they do not have the same data fields.

24) R/E codes are appearing incorrectly on roster. Is this due to NH submission inaccuracy and Non HRA counties not having a field available on the form to input a code? Nursing Homes are using N6 for all cases regardless of plan type?

The Nursing Home is not responsible for appropriate data entry at the local district. DOH is providing additional training and desk aids to LDSS staff regarding "N" codes, and reviewing NH enrollment reports to contact districts to make corrections to cases in the system. NYS DOH is also in the process of revising the LDSS-3559 to contain additional fields to capture information required by the local district and reflecting N code utilization.

25) How are NH's made aware of an enrollee switching MCOs?

The provider is required to verify eligibility and enrollment status at the time of service delivery, or at least weekly for nursing home services, for billing purposes.

26) How will a nursing home find out in a timely way if one of its patients changes managed care plans?

The provider must verify eligibility and enrollment status at the time of service, or weekly for nursing home services, for billing purposes.

MISC:

1) 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.

2) What is the timeframe to post the presentation given in January 2015 to the NYS DOH website?

The January 22, 2015 presentation is currently available on the NYS DOH website.

3) Will standing meetings with DOH be scheduled for this initiative?

Bi-weekly meetings were scheduled as a forum for plans and providers to meet with DOH to address questions arising during the transition phase. The Department will continue these meetings on a monthly basis as long as they are needed.

4) Will DOH have a meeting with NYC nursing homes to assist with understanding the process once they have some experience and case examples?

Nursing homes would also be interested in information regarding how the cash flow is impacted and/or working.

DOH had a series of standing meetings with plans and providers. If warranted, the DOH would be willing to have a meeting with NYC nursing homes.

5) Is there a DOH webpage that identifies contact information and phone numbers for each plan?

The DOH website has a MCO directory with Provider Services phone number for each plan. However, DOH encourages providers to work with each contracted plan to develop the most efficient contact and process to communicate and address issues.

6) Will DOH enforce the availability of a contact person at each plan for the NH transition?

Plans and providers are encouraged to participate in workgroups and meetings designed by DOH to promote collaboration.