
Office of Health Insurance Programs

**Transition of Nursing Home
Benefit and Population into
Managed Care**

**February 2015
Implementation**

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Effective February 1, 2015**

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Office of Health Insurance Programs

Transition of Nursing Home Benefit and Population into Managed Care

Overview of Transition

Effective February 1, 2015, in NYC (Bronx, Kings, New York, Queens and Richmond counties) all eligible beneficiaries age 21 and over, in need of long term placement in a nursing facility, as defined by §1919(a)(1)(C) or 42 U.S.C. 1396r, requirements for nursing facilities, will be required to join a Medicaid Managed Care Plan (MMCP) or a Managed Long Term Care Plan (MLTCP). In April 1, 2015, the counties of Nassau, Suffolk, and Westchester will be phased in, and the rest of State is scheduled to transition beginning July 2015 for both dual and non-dual eligible populations. The phase-in for the transition of the nursing home benefit and population is reflected in Table 1. As you can see from Table 1, the transition will occur in phases and no upstate county will start before July 1, 2015. All current long term placed beneficiaries in a Medicaid certified skilled nursing facility (NH) prior to February 1, 2015 for Phase 1, April 1, 2015 for Phase 2, and July 1, 2015 for the upstate phase-in will remain in fee-for-service Medicaid and will not be required to enroll in a Managed Care Organization (MCO)¹.

As of October 1, 2015, the State will allow any eligible individual residing in a nursing home to enroll in a MCO on a voluntary basis. This population will no longer be excluded, but exempt from mandatory enrollment into mainstream Medicaid managed care and MLTC.

In addition, beneficiaries currently enrolled in a MMCP will not be disenrolled if they need long term placement. Effective February 1, 2015, the MMCP will be responsible for covering this benefit in the Phase I counties. MLTCs are currently responsible for covering this benefit and will continue to do so. No individual will be required to change nursing homes resulting from this transition; however, new placements will be based upon the MCO's contractual arrangements and the needs of the individual. MCOs must evaluate and ensure that individuals are placed in the least restrictive setting with needed community supports.

¹ When the term "MCO" is used it applies to both the mainstream managed care plan and the managed long term care program

Table I

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

MCOs are required to pay the NH the current fee-for service (Benchmark) rate or a negotiated rate, acceptable to both plans and nursing homes, for 3 years after a county has been phased in. If the MCO had previously negotiated agreements with NHs which reflect a different level of reimbursement, the MCO is required to pay the benchmark rate during this transition unless another arrangement is agreed to for this specific transition period. As a result, for Phase 1, the transition period for payment will extend from February 1, 2015 through January 31, 2018, for Phase 2, the transition period will be from April 1, 2015 through March 31, 2018, and for the rest of the State, the transition period will extend from July 1, 2015 through June 30, 2018. After the transition period, NHs and MCOs will negotiate a rate of payment for services.

The steps toward this transition require that each party: MCOs, providers and the state assure that individuals in need of long term care services receive care in the most integrated and least restrictive setting. The ultimate goal is to foster a care delivery model that promotes transitional planning across the health care delivery system with the focus on providing services in the community whenever possible.

I. Eligibility and Enrollment

1. Recommendation for long term placement in a Nursing Home

- a) The recommendation for long term 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.
- b) When an individual moves to long term placement in a nursing home from a community setting or rehabilitative stay, the process must be a consumer oriented transition. The criteria used to determine whether the consumer is in need of long term placement will be coordinated among the multiple parties involved to ensure a smooth transition. This includes the nursing home, managed care plan, hospital discharge planner, and local department of social services (LDSS), in conjunction with the consumer and his or her family or designee.
- c) The PASRR process, the Patient Review Instrument (PRI) and other mandated review processes and evaluation criteria will remain in place, and will not be altered due to a change in payer source. The PASRR and PRI will be performed, as it is today, providing a tool to ensure the consumer is placed in the least restrictive setting with appropriate supports that meets his or her needs.
- d) All mandated processes and evaluation criteria will continue under Medicaid managed care 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.
- e) Following the appropriate assessments, the MCO in which the individual is enrolled is responsible for reviewing all documentation and approving or adjusting the care plan to ensure the needs of the consumer are appropriately met.
- f) Once the decision for long term placement is made, a recommendation for approval must be made to the MCO, with supporting documentation.
- g) The MCO will identify a clinician or other appropriate representative who will work with the NHs and hospitals on discharge planning

activities for members. The liaison will assist in coordinating the roles of the hospital and nursing home staff, ensure the beneficiary and his or her family are consulted, and facilitate communications between all interested parties.

- h) For members of an MCO, the plan must authorize all levels of care and ensure that it is in the best interest of the patient. The individual or enrollee and his or her family must all be in communication with the other responsible parties to ensure an appropriate transition to placement in a nursing home.

2. Determination of Eligibility for Long Term Nursing Home Care

For Medicaid eligibility purposes, individuals in need of coverage for long term placement in a nursing home will have eligibility determined using institutional rules, including a review of assets for the 60 months look-back period and the transfer of assets rules. Since individuals in long term placement in a nursing home are considered to be in permanent absence status for Medicaid eligibility purposes, individuals who are resource eligible and are not subject to a transfer penalty, will have income eligibility determined using chronic care budgeting. This budgeting methodology is utilized to determine the amount of monthly income that a permanently institutionalized individual must contribute toward the cost of nursing home care. Eligibility determinations are performed by the local department of social services under fee for service Medicaid and this responsibility will continue with the transition to Medicaid managed care.

Under chronic care budgeting, post-eligibility rules, including spousal impoverishment, if applicable, are applied to determine the net available monthly income (NAMI) that an institutionalized individual must contribute toward the cost of nursing home care. These rules provide for a disregard of certain types of income and allow certain deductions from the monthly income of the institutionalized individual or institutionalized spouse, if applicable. Any remaining income is applied toward the cost of care on a monthly basis.

If the local district determines that there are uncompensated transfers during the look-back period, a transfer penalty is imposed and the individual is ineligible for coverage of nursing home care until the penalty period expires. The period of ineligibility begins on the 1st day of the month in which the individual is institutionalized and otherwise eligible for coverage of nursing home care. During the period of ineligibility for

coverage of nursing home care, the nursing home resident may only be eligible for community Medicaid coverage.

For MCO enrollees, if long term eligibility is not approved or if a penalty period is identified, the MCO may recoup payment from the nursing home for the long term placement and coordinate a safe discharge into the community, with supports, for the member.

- a) Enrollees already in a plan: MCOs must authorize all long term placements in nursing homes, and will pay the nursing home while long term eligibility is being conducted by the local district.
 - i) The nursing home and MCO will assist the enrollee in submitting documentation for Medicaid coverage of the long term placement to the local district in a timely manner.
 - ii) The member will have 90 days from the date long term placement is determined to submit the application for coverage of the long term custodial placement to the local district.
 - iii) Once the eligibility determination is made by the local district, they will notify the MCO, enrollee and NH.
 - iv) If the enrollee is eligible, the MCO will continue to pay the NH, collect any associated NAMI from the member if applicable, and the MCO will receive the premium associated with NH placement from the State.
 - v) If the member is ineligible, the MCO may recoup payment from the nursing home for long term placement and coordinate a safe discharge into the community, with appropriate supports for the member, if appropriate. The member would remain enrolled in the MMCP as the plan would be responsible for a comprehensive set of services, however, for MLTCP, the State will recoup the premium from the plan for any period of ineligibility since the premium is mainly to support the provision of home and community based services.

- b) Beneficiaries or individuals not enrolled in an MCO or newly eligible: Individuals in need of NH care not enrolled in an MCO will obtain a long term care eligibility determination from the local district prior to enrollment. As per current eligibility rules, local departments of social services have 45 days from the date the application is received to complete the determination for long term Medicaid eligibility. Nursing homes will continue to be allowed to retroactively bill FFS for care provided by the nursing home for any period prior to managed care enrollment as long as the beneficiary was determined to have long term Medicaid eligibility during such period.
 - i) Once long term eligibility is approved and any penalty period has elapsed, if applicable and the NAMI amount is identified, the

member will have 60 days to choose an MCO if the eligibility is approved.

- ii) The beneficiary will be educated to pick an MCO which contracts with the NH where the individual is residing or they can choose a different MCO if they wish to change NHs.
- iii) As the State's contracted enrollment broker, New York Medicaid Choice will work with the beneficiary to assist with education, the plan selection process and enrollment. The enrollment broker will assist the beneficiary or designee in selecting from the plans contracting with the nursing home in which the beneficiary resides.
- iv) If the beneficiary does not pick an MCO, s/he will be enrolled in an MCO which contracts with the NH where the beneficiary resides.

3. Auto-assignment and lock-in

- a) After long term eligibility is approved, the beneficiary will be required to pick an MCO. The beneficiary will be contacted by New York Medicaid Choice to assist with enrollment in order for the beneficiary to stay at the current NH. Once a member of a plan, s/he may choose an alternate MCO if they also contract with the NH or if s/he wishes to change NHs.
- b) If the recipient does not choose an MCO within the 60 days allotted, the beneficiary will be auto-enrolled into an MCO which contracts with the NH where the member resides.
- c) There will be no lock-in for this population. An enrollee will always have the opportunity to change MCOs with enrollment occurring on the first day of the following month, if enrollments are received by the 15th of the month.
- d) As the State's contracted enrollment broker, New York Medicaid Choice is required to provide a report of all auto-assignments on a monthly basis. DOH reviews these reports as they are received and responds to any trends identified.

4. The roles of the local department of social services, the MCO and the nursing home post transition

- a) Post transition, the role of the LDSS will be limited to determining whether an individual is Medicaid eligible for community or institutional based services. Once a clinical determination is made by the MCO, provider team and member, the LDSS will conduct the eligibility review, as applicable. The local district must inform the MCO, consumer and NH of the determination.

- b) The MCO's role is to review the request for services and to make coverage decisions based on the identified needs of the enrollee.
- c) All parties must consider and to the extent possible arrange for services in the most integrated, least restrictive environment as expressed by the enrollee.
- d) The enrollee's due process rights remain unchanged.

II. Access to Care and Quality

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

The initial recommendation for permanent placement in a nursing home 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. Following the appropriate assessments, the MCO in which the individual is enrolled is responsible for reviewing all documentation and approving or adjusting the care plan to ensure the needs of the consumer are appropriately met.

The decision to enter into a nursing facility is one that primarily involves the individual themselves, as well as family members, and skilled professionals. This plan, developed by the individual in collaboration with others, should focus on the needs and desires of the individual and their goals. All family members, community supports and professionals must understand that the plan must support the value of the individual and their objectives.

The MCO is responsible for assessing the long term care needs of the individual using the state required assessment tools (Uniform Assessment System). The plan's assessments are in addition to any assessment required of the hospital, nursing home or other providers. The assessment and the medical provider's order become the basis for determining the needs of the member. During the assessment process and the care planning process, the member is made aware of all services available through the plan. They are also made aware of services that are not included in the benefit package but are Medicaid services under the fee for service program. The MCO must implement a written care plan

and assist the member in accessing the services authorized under the person centered services plan.

1. Transition Planning

There may be several transitional steps in planning for individuals in receipt of long term care services. A member may move from community to an inpatient setting, to a rehabilitation setting back to the community and then to long term placement. There may be several transitions between these settings before the final transition to long term placement in a nursing home. Transitioning a member from one setting to another requires formal discharge planning with the member, the family, providers and the MCO. To assure that the MCO is an active participant in the discharge planning process requires that prior to discharge:

- The MCO will arrange for a comprehensive assessment or update assessment per the UAS-NY.
- Assure there is an identified person at the MCO who is in communication with the discharging facility, member, family and accepting provider.
- The MCO will review the request for services, equipment and supplies with consideration to the most appropriate setting, assessed level of care, and with input from the discharging facility, physician(s) and the member.
- When a member is being discharged from a hospital to a skilled nursing facility, the SNF selected must have the capability to meet the special needs of the member. The member's choice of SNF must be considered by the MCO except where the member's choice would result in an unsafe discharge, or is an out of network SNF and an in-network SNF that meets the member's needs has an available bed.
- The MCO will authorize out-of-network SNF placement when there is no participating facility with an available bed that meets the member's needs.

When an enrollee is transitioning from the hospital to the nursing home; or the nursing home to the community; or the nursing home to the hospital; it is critical that the enrollee, the enrollee's family, where appropriate, providers and the MCO all be in communication to assure that all of the enrollee's needs are met and is receiving care in the least restrictive setting. For this to occur requires:

- a) The MCO should be notified of all discharges and the MCO must ensure that all parties are involved in the discharge planning.
- b) Discharge planning must be patient centered and should focus on the needs of the enrollee. Creating incentives to NHs and MCOs in

arranging for the least restrictive setting based upon the enrollee's health care needs would help to assure this occurs.

- c) Before discharging an enrollee from a nursing home to a hospital; or from the hospital to a nursing home or community; or from a nursing home to the community, the needs of the enrollee must be accurately communicated to the MCO.
- d) The treating facility is responsible for caring for the member and determining patient care needs while in the care setting. The MCO is expected to take an active role in assessing, authorizing and arranging for needed services in the least restrictive setting.
- e) The principles below must be defined formally clarified between all parties in order to operationalize and promote appropriate discharge planning and care management.
 - i) The MCO will make a coverage and medical necessity determination for requested services, equipment and supplies for the member taking into consideration the results of the full UAS-NY assessment and other assessments conducted by the NH. The UAS-NY assessed needs are compared with the MDS assessments conducted by the SNF and considered when authorizing services, equipment and supplies for the member. The care plan, MDS, UASNY, medical record and input from the care management team provides the MCO with the necessary information for the authorization of services both in the SNF and upon discharge from the SNF.
 - ii) The discharging facility whether hospital or nursing home will notify the MCO within a sufficient period of time so the MCO can assess the member, make arrangements for needed services, equipment and supplies and whether the proposed disposition is the most integrated and least restrictive setting for the member when discharge is expected to a nursing home or community and the procedure and tools used by the Hospital, MCO and member/family to determine the least restrictive setting for discharge.
 - iii) The MCO and network hospitals will develop an agreed upon procedure for the notification by the hospital to the MCO about the anticipated needs of the member. The hospital may recommend to the MCO a SNF with the capability to meet the member's needs. A best practice already identified by the group is a standardized capability matrix. The nursing home identifies the specialty

services and populations it provides to assist the hospital, MCO and member in determining discharge to the most appropriate setting. Nursing homes will update the capability matrix periodically for accuracy. The MCO will work with the member or their designee to determine which of the SNFs in the MCO's network have the necessary services to meet the needs of the member and whether there are beds available to accept the member.

- iv) In all transition planning the MCO will inform the member and family about the community and nursing home options available and how to determine which may be the most appropriate setting prior to choosing placement.
- v) As part of the care plan development, or afterward, the MCO may review the proposed care for service coverage and medical necessity. The time to review a request for long term placement begins with the provider's recommendation for placement and request to the MCO for transfer to a SNF. The MCO will make medical necessity determination as fast as the enrollee's condition requires and within the timeframe mandated by the MCO contract with the State.

The MCO may determine that a transition to another facility or to the community is appropriate to meet the enrollee's needs. The member and/or the facility may not agree with the MCO's determination and may appeal through internal process at the plan, by independent external appeal, or by requesting a fair hearing, all of which may be expedited if circumstances warrant.

- f) MMCPs must mirror the MLTC practice associated with coverage for members until an appropriate setting for discharge is identified. Reimbursement may be at a rate associated with an alternate level of care until a decision about discharge is reached.
- g) The nursing home, hospital and the MCO will respond to an enrollee's request for services in a less restrictive location in a timely manner; and decisions regarding the enrollee's care should not be based on financial incentives for the nursing home and/or hospital.
- h) Special consideration must be given for enrollees who are homeless during discharge planning. The MCO and nursing home need to

engage the LDSS in arranging a safe location for the homeless person post discharge.

2. MCO Authorizations for Care

The NH and the MCO will follow authorization procedures as outlined in the provider agreement and generally follows existing procedures.

- a) No prior authorization needed for transfer for emergency care (911 calls).
- b) For urgent care, when a nursing home determines they cannot provide care to meet the patient's needs, the nursing home may transfer the patient to a hospital.
 - i) No prior authorization is needed if member is transferred to a network hospital.
 - ii) Prior authorization is needed if seeking transfer 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.
 - iii) If a transfer requiring prior authorization is requested during non-business hours and the MCO does not process authorizations on a 24/7 basis, the nursing home must request authorization with all necessary documentation the next business day and MCO will be required to cover urgent hospital services provided and applicable bed holds, as applicable, while authorization is pending.
- c) Nursing home will notify the MCO that the enrollee was transferred to a hospital and which hospital.
- d) Once the patient reaches the hospital, the responsibility for evaluating the patient rests with the hospital. The hospital will seek authorization as required by MCO for admission.
- e) The nursing home must follow authorization policies and procedures specified in the contract or accompanying provider manual for routine or elective care.
- f) Educating NHs and MCOs about each other's responsibility to the Patient/Member is important to promote a smooth transition.

To assist both the NHs and the MCOs with information about NH operations and MCO operations, education programs will be developed to ease the transition. The educational materials will include examples of

best practices currently in use by nursing homes and MCOs with contractual arrangements for residential care. An example would be how Medicare Institutional SNPs have a nurse navigator on site at the nursing home to facilitate review of service requests. The education program would:

- a) Describe nursing home/MCO statutory/regulatory requirements that must be considered when contracting.
- b) Describe the roles and responsibilities of the MCO and nursing home in care plan development and discharge plan development.

3. Pharmacy Services

Absent a negotiated agreement between the NH and MCO, the following policy will prevail. 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. In addition, 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.

4. Primary Care Provider (PCP)

All managed care enrollees must have a primary care provider to facilitate and manage the provision of health care services. 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 PCPs. Those responsibilities include, but are not limited to, disease management, referrals, and hours of availability. In any event, all enrolled recipients must have an assigned PCP.

5. Reserved Beds – Bed Holds

Federal and State Medicaid bed hold/bed reservation regulations (CFR 483.12 and 10YCRR 415.8 and 18NYCRR 505.9, respectively) identify the circumstances in which Medicaid reimburses a nursing facility to hold a bed for a patient who is temporarily absent from the facility. Absent a negotiated policy relating to bed holds, MCO's are required to continue following the current methodology during the transition period. After the three year transition period, MCOs should negotiate a bed hold policy with contracted nursing homes.

- a) Payments for reserved bed days related to leaves of absence for temporary hospitalizations shall be made at fifty percent (50%) of the Medicaid rate, unless an alternative bed hold arrangement is negotiated among the contracted parties.
- b) Payments for reserved bed days related to non-hospitalization leaves of absence, including health care professional therapeutic visits, shall be made at ninety five percent (95%) of the Medicaid rate unless an alternative bed hold arrangement is negotiated among the contracted parties.
- c) Payment to a facility for reserved bed days for both temporary hospitalizations and health care professional therapeutic visits may not exceed a combined aggregate of fourteen days in any twelve month period.
- d) Payment to a facility for reserved bed days for other therapeutic leaves of absence, including leaves of absence other than temporary hospitalizations and health care professional therapeutic visits, may not exceed ten days in any twelve month period.
- e) The beneficiary must have been a resident of the facility seeking reserved bed day reimbursement for at least 30 days, regardless of reimbursement, and the unit to which the recipient will return has a vacancy rate of no more than five percent (5%).

MCO's may find additional information regarding bed hold/bed reservations at the following link:

III. Network and Contracting

1. Network Adequacy

Due to the variability between counties of the number of nursing homes, the number of MCOs, and the number of members in need of long term residential, the network requirements were adjusted for this transition. NH placement associated with each county; the impact bed availability has on access to NH services; and the potential for NHs to be excluded from the managed care system if network requirements are set too low were all issues that directly impacted the final recommendation. The following policy has been developed to address network adequacy as it relates to this transition.

- a) Non-dual and dual MA eligible individuals already enrolled in an MCO and subsequently determined to be eligible for long term residential nursing home placement will be permitted to change MCO in order to have access to their preferred NH (i.e. suspension of lock-in requirements in MMCP for these individuals).
- b) MCO network requirement for Specialty Nursing Home care will be a minimum of two participating Specialty Nursing Homes of each type in each county of MCO operation, where the availability of specialty NHs permits. (A spreadsheet listing the number of specialty homes and proposed requirements, by specialty type and county, is attached.)
- c) MCO network requirement for standard nursing homes services will be as follows:

Counties	Minimum number of participating NHs required per county
Kings, Queens, Bronx, Suffolk, Nassau, Westchester, Erie, Monroe	8
New York, Richmond	5
Oneida, Dutchess, Onondaga, Albany,	4
Broome, Niagara, Orange, Rockland, Rensselaer, Chautauqua, Schenectady, Ulster	3
All other Counties	2 where available

(Note: “Contracts with “specialty” nursing homes that are also certified to provide “regular” nursing home services, i.e. RHCF services/beds, may be used to meet this requirement provided the contract includes the provision of RHCF services/beds to members.)

An MMCP’s NH network will be considered inadequate in instances where the network does not meet the above requirements or meets the above requirements, but the number of participating NHs with available beds is insufficient to meet the needs of the enrolled population. In order to meet the needs of members, the network must provide members with a choice of two participating NHs with available beds. MMC Plans with inadequate NH networks will be required to augment their NH networks by contracting with additional providers. If the NHs in a county are unwilling to contract with the MCO at the benchmark rate, MCOs will not be penalized if they do not meet the network requirements in that county. The MCO must show evidence of their willingness to pay the benchmark rate to the Department.

- d) Plans whose NH networks are inadequate, whether due to an insufficient number of contracts or an insufficient number of contracted NHs with available beds, will be required, upon member request, to permit members eligible for NH placement to receive services at a non-participating NH.
- e) MMC 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.
- f) MMC Plans will be required to contract with at least one veterans’ NH that operates in their service area. If the MMCP 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 MMCP that has a veteran’s home in their network. While the member’s request to change plans is pending, the MMCP 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.

2. Credentialing

In order to minimize administrative burden on NHs and MCOs, it was decided that NHs must adhere to Federal and State laws as it relates to credentialing staff. Therefore, it was recommended that MMCPs MCOs should strongly consider delegating credentialing to the NHs. If

credentialing is delegated, the MCO must have a process to verify that the NH has completed the required credentialing. It was decided that MCOs should minimize additional credentialing requirements. It should be noted that pursuant to the model contract between the MCO and the State MCOs are required to have in place a formal credentialing process for credentialing Participating Providers on a periodic basis (not less than once every three (3) years) and for monitoring participating provider's performance. The Department is strongly recommending that MMC Plans add only minimal additional requirements.

3. Contracts

- a) All provider contracts must have appended and fully incorporated into the agreement the "New York State Department of Health Standard Clauses for Managed Care Provider/IPA Contracts. The language in the standard clauses cannot be modified by the contracting parties.
- b) All MCO contracts must include due process rights for providers that allow the provider to appeal any determination concern identified by the MCO. The Agreements must also allow the provider to remedy any issues or problems identified prior to the imposition of penalties or termination of the agreement unless there is evidence of imminent patient harm or fraud or abuse.
- c) In the event a contract between an MCO and NH is terminated, for reasons other than imminent patient harm or a finding of fraud, the MCO may not require members residing at the terminated NH to transfer to a participating NH. The MCO must continue the member's placement as an out of network (OON) placement. The rate of payment for OON placements will be at the fee for service rate in effect at the time of service, and comply with all MCO policies and procedures. Members may voluntarily choose to transfer to a participating NH.
- d) Members must be provided with the MCOs available for selection, along with each MCO's network of participating NHs.
- e) MCO will create a process to train contracted providers regarding the claim adjudication process to promote understanding and improve the submission and payment of claims.
- f) Each MCO and nursing home must negotiate provider contracts in good faith.

IV. Quality Metrics and Incentives

1. Nursing Home Quality Pool

DOH remains committed to rewarding facilities that demonstrate a high quality of care. Incentive dollars will remain at current levels, but as the NH populations shift into MMCP, MLTC and FIDA, Nursing Home quality measures and dollars will be proportionately moved from the Nursing Home Quality Pool (NHQP) to other quality incentive programs.

2. Quality Metrics

The Uniform Assessment System for New York (UAS-NY) is a standardized, comprehensive assessment system that can evaluate individual's functional needs and abilities. The UAS-NY will allow us to evaluate quality performance measures across health plans and programs. The UAS is already in use in MLTC and is slated for use in MMCP's in the last quarter of 2014.

3. Utilization

a) Two measures derived from the UAS-NY that will assess the use of emergent care are:

- The Prevalence of Inpatient Acute Hospitalizations and
- The Prevalence of Emergency Department Visits

Both measures will be assessing an inpatient stay or an emergency department visit in the last 90 days and both will be risk-adjusted by New York State.

b) Nursing Home Utilization

The Department of Health (DOH) will also calculate the percent of plan members who are currently in a nursing home or who have had a nursing home admission since their last assessment and the percent for which that admission was a permanent placement in the Nursing Home.

4. Quality and Patient Safety

a) The prevalence of members who received the influenza vaccination in the last year.

Influenza is a highly contagious illness and it is estimated by the Centers for Disease Control and Prevention that 90 percent of seasonal flu-related deaths and more than 60 percent of seasonal flu-related hospitalizations occur in people 65 years and older. Receiving an annual influenza vaccination is a public health priority for nursing home population. Using UAS-NY data, DOH will calculate this measure.

b) **The Prevalence of Falls Resulting in Medical Intervention**

Among older adults, falls are the leading cause of both fatal and nonfatal injuries. The Department will calculate risk adjusted fall measures from the UAS-NY data.

5. Transitions in Care

One of the most critical junctures in a person's health care is the transition from Nursing Home to the community. To assess if adequate supports and safety measures for the member were in place during this transition, the DOH will calculate the following measures for members who had a baseline assessment in the Nursing Home and a follow-up assessment in the community.

- The Prevalence of Inpatient Acute Hospitalizations and
- The Prevalence of Emergency Department Visits
- The Prevalence of Falls Resulting in Medical Intervention

V. Finance and Reimbursement

1. Rate Transition

- a) For 3 years after a county is deemed mandatory for nursing home population enrollment, plans will be required to pay contracted nursing homes either:
- i) **Benchmark Rate (FFS)**, which would include all existing scheduled pricing/transition phase-in adjustments (including Universal Settlement if agreement is reached); **or**
 - ii) **Negotiated Rate**, which will allow the Nursing Home and Plan to engage in other financing arrangements, such as sub-capitation.
- b) Many NHs currently submit claims weekly to the State to promote cash flow for the facility. As a result, during this transition, MCOs have indicated a willingness to allow the submission of clean claims from NHs at least every two weeks (bi-weekly) or twice a month.

- c) The State will continue to monitor the contractual agreements between the Nursing Home (provider) and the Managed Care Plans. The Negotiated Rate will only apply to alternative payment arrangements. If an existing contracted rate falls below the current market Benchmark Rate at any point, the Plan must increase the contracted rates to at least this threshold.
- d) After the first full year of the transition, the State will assess the impact of the transition policies and determine whether the transition payments should be extended beyond the three year requirement.

2. Nursing Home Capital Component

After the 3 year transition period NHs will continue to receive the capital component of the rate as a “guarantee”. Under this process, the Department will calculate the capital component of the rate and will require via contractual agreement with the Plans that they in turn pay this rate to nursing homes within their network. This will provide NHs and mortgage holders with financial stability on a going forward basis. Modifications, which may result from the NH Capital Work Group, will be reflected in the capital rate and incorporated into plan premiums.

If it is deemed to be needed, a capital pool could be established to ensure that plans are not disproportionately impacted by contracting with Nursing Homes with large capital per-diems.

3. Shared Savings Proposal

The State will facilitate and develop strategies and/or financial incentives for Plans and providers to share savings, in association with their level of assumed risk. DOH is working with the State’s actuary, Mercer and 3M to define baseline performance and efficiency measures, within regions. DOH will continue working on development of Shared Savings policy and guidance with the implementation of FIDA. Possible Shared Savings Models could include, but are not limited to: Sub-Capitation, Managed FFS/ACO, and Bundling Payments.

4. Premium Development – Mainstream/MLTC

- a) ***Mainstream:*** DOH along with Mercer will establish new premium group(s) and actuarially sound premiums for Mainstream Managed Care Programs. Mainstream rates will include a new premium group(s) to appropriately reflect the disproportionately higher cost of this population. Population reviews illustrate a separate rate cell is needed for Mainstream Managed Care in order to provide fair payment for the

wide variation in costs (i.e. \$300 pmpm vs. \$6,750 pmpm). Further discussion and data review is required between DOH and Mercer to determine if the development of specialty premium groups is warranted. Historical fee for service expenditures will be trended forward to the rate period and the benchmark premium will be used in premium development. Having separate rate cells for the Nursing Home population will allow the recipients to be tracked as they transition from fee for service into Mainstream MMCP.

- b) **MLTC**: A blended rate cell will be utilized in the MLTC program to help transition the NH population into a managed care environment. The nursing home residents eligible for managed care enrollment as outlined above will be blended into the current MLTC mandatory transition rate cell. This cell was established to help phase in MRT 90 transition populations.

5. Net Available Monthly Income (NAMI)

- a) The initial implementation will shift the responsibility for NAMI collection to the MCO. The MCO may delegate the collection of NAMI to the NH or other entity. The handling of NAMI with the provider should be outlined and agreed to during the contracting process. Once re-budgeting is complete, the local district must inform the plan and nursing home of the NAMI amount to be collected from the member.
- b) Long Term, the State (or designee) will assume financial and organizational responsibility to distribute NAMI information, as well as collect NAMI income from all Medicaid recipients residing in a Nursing Home. This recommendation will be linked to the 1115 waiver, which will be used as the avenue to effectuate the transition of NAMI responsibility. The State and oversight administration can establish a new point-of-entry system in correlation with Medicaid's overall effort to redesign entry into the program. This system will collect NAMI more efficiently and will potentially secure resources up front.

6. Risk Mitigation

In conjunction with the blended Rate Cell for the MLTC program the State will establish a High Need Pool for Individuals being served in the community. This pool will be used to help mitigate the risk of the individuals in the community who are deemed to be High Need patients. This will include community based ventilator dependent individuals as well as high need individuals such as continuous or live in personal care cases.

