

## SECTION S: STATE SPECIFIC ITEMS (New York)

**Intent:** The intent of this section is to support the semi-annual determination of each RHCf’s Medicaid payment rate.

**Effective:** The version of Section S to use for a particular assessment is determined by the *assessment date*. The *assessment date* is one of three dates in Section A. The specific date used is based on the Entry/Discharge Reporting code (A0310F).

If the Entry/Discharge Reporting (A0310F) is coded:

- [01] (entry), then the *assessment date* is equal to **A1600** (entry date).
- [10, 11, or 12] (discharge or death in facility), then the *assessment date* is equal to **A2000** (discharge date).
- [99] (not entry/discharge), then the *assessment date* is equal to **A2300** (assessment reference date).

After determining the *assessment date* as described above, select from the table below the correct version of Section S to use for the assessment.

Section S Version	Effective for <i>Assessments Dated</i> (A1600 or A2000 or A2300)	
	Start Date	End Date
01/31/2011	04/01/2011	09/30/2017
10/01/2017	10-01-2017	none

### Instructions:

- Complete Section S for all nursing home assessments, except the Tracking (NT) Item Set:
  - NC Nursing Home Comprehensive
  - NQ Nursing Home Quarterly
  - NP Nursing Home PPS
  - ND Nursing Home Discharge
  - NS Nursing Home OMRA – Start of Therapy
  - NSD Nursing Home OMRA – Start of Therapy and Discharge
  - NO Nursing Home OMRA
  - NOD Nursing Home OMRA – Discharge
- Section S is not required for swing-bed program assessments.

**S0160. Specialty Unit/Facility Reimbursement, or Resident Eligible for Enhanced Reimbursement (Add-On) for AIDS or TBI Conditions**

<b>S0160. Specialty Unit/Facility Reimbursement, or Resident Eligible for Enhanced Reimbursement (Add-On) for AIDS or TBI Conditions</b>	
Enter Code <input type="text"/>	<b>01</b> Discrete AIDS Unit
	<b>02</b> Ventilator Dependent Unit
	<b>03</b> Traumatic Brain (TBI) Unit
	<b>04</b> Behavioral Intervention Unit
	<b>05</b> Behavioral Intervention Step-Down Unit
	<b>06</b> Pediatric Specialty Unit / Facility
	<b>07</b> AIDS Scatter Beds
	<b>08</b> Traumatic Brain (TBI) Extended Care
	<b>09</b> Neurodegenerative Unit
	<b>99</b> None of the Above

**Item Rationale:**

- To identify whether the resident:
  - Resides in a discrete specialty unit or facility that is eligible for a discrete specialty Medicaid reimbursement rate in accordance with the applicable regulation or statute,
 OR
  - is eligible for enhanced Medicaid reimbursement (Add-On) for an approved specialty program in accordance with the applicable regulation or statute.

**Definitions and Coding Instructions:**

Enter the single code that applies.

To be eligible for a discrete specialty unit/facility rate the resident must reside in a unit or facility that is approved by the Commissioner of Health in accordance with the cited regulation(s) and/or statute(s).

- **Code 01, Discrete AIDS Unit/Facility** - Approved pursuant to 10 NYCRR Part 86-2.10 (p) and Part 710 or any successor regulation and/or statute.
- **Code 02, Ventilator Dependent Unit** - Approved pursuant to 10 NYCRR Part 86-2.10 (q) and Section 415.38 or any successor regulation and/or statute.
- **Code 03, Traumatic Brain-Injured (TBI) Unit** - Approved pursuant to 10 NYCRR Part 86-2.10 (n) and Section 415.36 or any successor regulation and/or statute.
- **Code 04, Behavioral Intervention Unit** - Approved pursuant to 10 NYCRR Part 86-2.10 (w) and Section 415.39 or any successor regulation and/or statute.
- **Code 05, Behavioral Intervention Step-Down Unit** – This code does not apply to any NY facilities.
- **Code 06, Pediatric Specialty Unit / Facility** – Approved pursuant to 10 NYCRR Part 86-2.10 (i) or any successor regulation and/or statute. Department of Health policy ONLY recognizes pediatric residents up to age 21 for purposes of specialty reimbursement.
- **Code 09, Neurodegenerative Unit** - Approved pursuant to 10 NYCRR Part 86-2.10 (x) and Section 415.41 or any successor regulation and/or statute.

OR

To be eligible for an enhanced Medicaid reimbursement rate (Add-On) the resident must be enrolled in a specialty program that is approved by the Commissioner of Health in accordance with the regulation(s) and/or statute(s) cited below.

- **Code 07, AIDS Scatter Bed** - Approved pursuant to 10 NYCRR Part 86-2.10 (p) (3) and Part 710 or any successor regulation and/or statute.
- **Code 08, Traumatic Brain-Injury (TBI) Extended Care** - Approved pursuant to 10 NYCRR Part 86-2.10 (v) and Section 415.40 or any successor regulation and/or statute.

OR

- **Code 99, None of the Above** - if the resident does not reside in a unit or facility that is approved by the Commissioner of Health in accordance with the above-cited regulation(s) and/or statute(s), and the resident is not enrolled in a specialty program

that is approved by the Commissioner of Health in accordance with the above-cited regulation(s) and/or statute(s).

## **S0185. Discharge to Hospital: Health Care Proxy Involvement**

### **Item Rationale:**

- To identify residents who are sent to the hospital at the request of someone who has authority to make health care decisions for the resident, although the facility staff do not believe the hospitalization to be medically necessary.

### **Definitions and Coding Instructions:**

Enter the single code that applies.

Under Article 29-CC of the New York Public Health Law, the Family Health Care Decisions Act enables a surrogate to make health care decisions on behalf of the patient in the absence of a health care proxy. Surrogates (e.g., legal guardians) under Article 29-CC should be considered when completing item S0185.

More information about health care agents and surrogates (e.g., legal guardians) can be found at <https://www.health.ny.gov/publications/1503/>.

- **Code 0, No** - the resident is not being discharged to an acute hospital against the opinion of the nursing home.
- **Code 1, Yes** - the resident is being discharged to an acute hospital against the opinion of the nursing home.
- For non-discharge assessment and/or the resident is not being discharged to an acute hospital, the facility should use a dash to indicate that the question is not applicable.

## **S6500. Comfort Care Provided in the Last 14 Days**

### **Item Rationale:**

- To identify residents who are receiving comfort care without curative intent. These residents are those who are not receiving care from a state-licensed and/or Medicare-certified hospice provider as defined in MDS Item O0100K. To meet the criteria of this item, the primary goal of comfort care must be to reduce suffering.

### **Definitions and Coding Instructions:**

Enter the single code that applies.

- **Code 0, No** - the resident has not received comfort care in the last 14 days.
- **Code 1, Yes** - the resident has received comfort care in the last 14 days.

## S7000. Dental Care

### Item Rationale:

- To capture the type and frequency of dental care provided to residents.

### Definitions and Coding Instructions:

Enter the single code that applies.

Routine dental care is planned or scheduled care. Emergent dental care is unplanned or unscheduled care provided for the purposes described in 10 NYCRR Section 415.17 and any successor regulation.

- **Code 1, Routine dental care since last assessment** - the resident received planned or scheduled dental care.
- **Code 2, Emergent dental care since last assessment** - the resident received unplanned or unscheduled dental care.
- **Code 9, None of the above** - the resident did not receive routine or emergent dental care since the last assessment.

## S8015. MMIS Identification Number

### Item Rationale:

- To identify the Managed Long-Term Care (MLTC) or Medicaid Managed Care ("Mainstream") plan the resident is enrolled in at the time of assessment.

### Definitions and Coding Instructions:

Enter the Medicaid Management Information System (MMIS) identification number for the Managed Long-Term Care or Mainstream Medicaid Managed Care plan in which the resident was enrolled for this assessment, regardless of whether the plan is also the primary payor at the time of assessment (Question S8055). Please click on link below for Managed Care Information. If the resident was not enrolled in either type of managed care plan, enter a dash in the first box.

A listing of current MMIS identification numbers for Managed Long-Term Care and Mainstream Medicaid Managed Care plans can be found at:

[https://www.emedny.org/ProviderManuals/AllProviders/PDFS/Information\\_for\\_All\\_Providers\\_Managed\\_Care\\_Information.pdf](https://www.emedny.org/ProviderManuals/AllProviders/PDFS/Information_for_All_Providers_Managed_Care_Information.pdf)

Please note that the MMIS identification number for a managed care plan is its 8-digit plan identification number. MMIS identification numbers (i.e., plan ID numbers) may also be obtained directly from managed care plan representatives.

**S8055. Primary Payor**

<b>S8055. Primary Payor</b>	
<input type="text"/> Enter Code	<b>1</b> Medicare
	<b>2</b> Medicaid
	<b>3</b> Medicaid Pending
	<b>4.</b> Medicaid Managed Care
	<b>5.</b> Managed Long-term Care
	<b>9</b> None of the Above

**Item Rationale:**

- To determine the primary payment source as of the MDS Assessment Reference Date (A2300).

**Steps for Assessment:**

- Check with the billing office to review current payment source(s). Do not rely exclusively on information recorded in the resident's clinical record.

**Definitions and Coding Instructions:**

Enter the Code of the **one** source of coverage that has primary responsibility for and pays for most of the resident’s current nursing home stay on the Assessment Reference Date (A2300).

- **Code 1. Medicare** – Medicare Part A (traditional) or Medicare Part C (Medicare Choice/HMO) is the primary payor. Medicaid may pay for the Medicare co-insurance and/or deductibles.

- **Code 2. Medicaid\*** – Medicaid fee-for-service is the primary payor. Residents with Medicaid coverage supplemented by Medicare Part B should be recorded as Medicaid payor.
- **Code 3. Medicaid Pending\*** - There is no other primary third-party coverage being used for the resident's present stay, **and** the facility has sought, or intends to seek, establishment of Medicaid eligibility for coverage as of the Assessment Reference Date (A2300).
- **Code 4. Medicaid Managed Care\*** - A Medicaid managed care program is the primary payor. Medicaid Managed Care (“Mainstream” managed care) covers acute, primary, specialty, long term care and behavioral health through managed care organizations (MCOs) for residents who are not Medicare eligible.
- **Code 5. Managed Long Term Care\*** - A Medicaid Managed Long Term Care (MLTC) plan is the primary payor. MLTC assists chronically ill or disabled individuals who require health and long-term care services. Full Medicaid eligibility and most often but not always Medicare eligible. MLTC plan types include FIDA, Partial Capitation Plans, Program of All-Inclusive Care for the Elderly (PACE), Medicaid Advantage Plus and Medicaid Advantage.
- **Code 9. None of the Above** - The primary third-party payor is not Medicare Part A or Medicaid, and Medicaid is not pending. A resident who pays privately, or has long-term care insurance or Veteran’s Administration benefits, or one who receives charity care.

**\*Payor category is included in the nursing home Medicaid-Only CMI.**

## For Further Information

- For questions on Items S0185, S6500 and S7000 please send an email to: [nhqp@health.ny.gov](mailto:nhqp@health.ny.gov).
- For questions on Item S8015 please send an email to: [doh.sm.MLTC.System.issues@health.ny.gov](mailto:doh.sm.MLTC.System.issues@health.ny.gov).
- For questions on Items S0160 or S8055 please send an email to: [PRImail@health.ny.gov](mailto:PRImail@health.ny.gov).