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TRANSITION OF NURSING HOME POPULATIONS AND BENEFITS TO MEDICAID MANAGED CARE

Frequently Asked Questions

March 2015

For purposes of this Frequently Asked Questions document, the term "managed care" includes Medicaid Managed Care (MMC) and Managed Long Term Care (MLTC). The term "Medicaid Managed Care Plan" (MMCP) includes mainstream Medicaid Managed Care and HIV SpeciaI Needs Plan products. The term "Managed Long Term Care Plan" includes Partial Capitation and Medicaid Advantage Plus (MAP) products.

Physician Services and Credentialing

1. What happens when a PCP in the community is not credentialed to see an enrollee in the Nursing Home? What is the NH's responsibility to allow the consumer to see their community PCP while a resident in the NH?

   Enrollees may retain their PCP when they transition from the community into a Nursing Home. The Nursing Home is responsible for credentialing or granting privileges for providers that come in to the Nursing Home to provide services, including PCPs. If the Nursing Home is not willing to credential or grant privileges to the PCP, the enrollee may continue with the PCP at the PCP's office in the community.

2. Who is responsible for credentialing the community PCP, the plan or the NH provider?

   MCOs are required to credential all providers participating in the plan.

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

   As indicated above, plans are responsible for credentialing network providers. If the NH is not willing to credential or grant privileges to the PCP, or the PCP is unwilling to go to NH, the enrollee may be allowed to continue seeing the PCP in the community.

4. A mainstream 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 MMCP enrollees must have a PCP, and enrollees may retain their community PCP when transitioning from the community to a NH for long term services. MMC plans may use the NH physician as the PCP for an enrollee, but must inform DOH and ensure that the NH physician maintains the responsibilities similar to those of other network PCPs, including but not limited to: disease management, referrals, and overall coordination of services.

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

   Yes, if an enrollee is transitioning from the community into a Nursing Home for long term services, and the community PCP does not participate in the plan of choice, the enrollee may be allowed to retain his or her community PCP for a transitional care period of 60 days. Please note: PCP designations in the NH must be negotiated with the plan.

Benefit

6. 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.

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

   Non-emergency transportation for a MMCP enrollee may be arranged through the State vendor (Logisticare for NYC) and paid by Medicaid Fee-for-Service (FFS), other than in Nassau and Suffolk counties, in which case the plan would arrange transportation.

8. 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.

9. 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.

Pharmacy

10. 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.

11. 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.

12. 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.

Rates and Billing

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 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.

15. 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.

16. 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.

Discharge and Care Planning

17. 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.

18. 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.

19. 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.

20. What are the requirements for the sharing of care plan information between the MCO and the Nursing Home for an enrollee?

    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 MCO must implement a written care plan and assist the member in accessing the services authorized under the person centered services plan.

Eligibility

21. 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.

22. How long does the NH have to submit the request to the LDSS for increased coverage for long term placement at a NH?

    The NH should 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.

23. 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.

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

    For consumers in a NH for whom long term 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.

25. 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.

26. 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.

27. 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.

28. 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 long term placement.

29. 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.

30. 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.

31. 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.

32. 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.

33. 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.

34. 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.

Enrollment

35. 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 if he or she is determined to be exempt or excluded.

36. If a consumer is in a NH for a short term rehabilitation stay and requires long term placement after the transition date, must the consumer enroll in a MCO?

    Consumers requiring long term 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.

37. Who is the enrollment broker for NYS?

    The enrollment broker is New York Medicaid Choice (NYMC).

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

    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.

39. 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.

40. 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 long term NH care, is s/he required to enroll in MMC?

    Consumers in need of long term NH services after the transition date must enroll in a plan to receive this benefit.

41. 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 or the LDSS to transfer to a new plan. Enrollment is effective prospectively on the first of the month following pull down.

42. 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) will be able 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.

43. If a consumer is currently in the nursing home for long term 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?

Consumers whose long term placement is established prior to the transition date would not be required to enroll in a Medicaid managed care plan.

44. How will the NH be made aware of an enrollee switching MCOs?

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

45. 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 long term placement in a Nursing Home prior to February 1, 2015 and is also Medicaid eligible for Nursing Home care, 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.

46. Following the October 2015 voluntary enrollment period, 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 long term placement who are residing in a NH prior to the applicable transition date will not be required to enroll in a managed care plan but will be allowed to enroll if they so choose.

47. Will a resident of a NH with FFS Medicaid who is discharged to a hospital and is readmitted to the facility, and who was previously determined eligible for long term care, be required to enroll in managed care?

    Consumers who are admitted to the NH for a short term or rehab stay are not required to enroll in managed care. Consumers in receipt of fee for service Medicaid and in long term 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.

48. 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 receiving long term services in a Nursing Home prior to the applicable transition date will remain in FFS Medicaid and will not be required to enroll in a plan.

Complaints and Appeals

49. When a current enrollee in MMC is admitted to a NH for long term care, can the MMCP deny coverage, stating the patient requires LTSS greater than 120 days? Must the MMCP cover the enrollee until he/she is enrolled in MLTC?

    Both the population and the benefit are transitioning into MMC. MMC enrollees requiring long term NH services will be provided these services as a covered benefit by the MMCP and would not be required to enroll in a MLTCP unless they begin receiving Medicare and become dually eligible.

Contracting and Network

50. How will 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.

51. How will plans receive Nursing Home reports?

    The managed care plans will 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 long term placement; and (4) exception code. NHs will continue to receive their FFS roster in the current method of delivery.

Assessments

52. 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.

53. 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.

54. 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 considered when the plan is authorizing services, equipment and supplies for the member. The care plan, UAS-NY, MDS, medical record and input from the care management team provides the MCO with the necessary information for the authorization of services both in the NH and upon discharge from the NH. Plans and NH may compare the UAS-NY assessed needs with the MDS assessments conducted by the NH, so both may be considered when authorizing services, equipment and supplies for the member.

55. 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.

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

Authorizations

57. What are the criteria for the MCO when determining whether an enrollee is in need of long term care placement?

    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. The MCO makes a determination for long term placement based on the plan's written medical necessity criteria, informed by the clinician's recommendation, the assessment and person centered care plan. See above question relating to plan authorization.

58. 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.

Communications

59. Will standing meetings with DOH be scheduled for this initiative?

Bi-weekly meetings are 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 as long as they are needed.

60. 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.

61. Is there a date when the transition will begin in central New York counties?

The transition in these counties is scheduled for July 1, 2015.

Miscellaneous

62. 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.