Mandatory Enrollment

- Date is now February 1st for NYC
- April 1st for Nassau, Suffolk and Westchester
- July 1st for remaining counties
- Nothing changes for current NH residents
Mandatory Enrollment

- Current residents may voluntarily enroll in MLTC or FIDA starting October 1, 2015
- Medicaid only – Enroll in Mainstream Managed Care Plans
- If not in Plan at time of enrollment may select any NH
FIDA

- Dually eligible residents will be auto enrolled in FIDA if they do not opt out.
- MLTC is a package of all Medicaid services while FIDA includes Medicaid and Medicare.
- Demonstration project only in 8 downstate counties.
FIDA

- Participants have access to all providers, all authorized services, and preexisting service plans including prescription drugs for 90 days or until the Person Centered Service Plan is finalized and implemented, which is later. Participants can maintain their existing Nursing Home provider for the duration of the demonstration.
FIDA

- All FIDA Plans must have contracts or payment arrangements with all nursing homes such that nursing home residents who are passively enrolled are afforded access to that nursing home for the duration of the demonstration.
Some Good News

- Residents can change MCOs to be in a network that includes your NH
- No residents will be required to change NHs
- MCOs will be required to pay you for residents who voluntarily enroll and elect to stay in your Facility
During Transition

- Includes all aspects of NH FFS rate, including but not limited to Operating, Capital, Per Diems, Cash Assessment and Quality

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- Can negotiate a rate acceptable to all parties and approved by DOH (risk sharing arrangement)

- Contracted rate must be increased by the Plan if it falls below the current market Bench Mark rate at any time
During Transition

- Bedhold
- Policy remains the same, although prior authorization may be required
- Pharmacy
- Current NH pharmacy arrangements must be honored during 3 year transition period unless another arrangement is negotiated
• Calculated by DOH
• Passed through from Plans to Providers
• “Guaranteed” after 3 year transition
• NH Capital Workgroup will identify changes needed
• Capital Pool
Eligibility

- NH or hospital must assist the member in applying for long term eligibility with LDSS

- Nursing Home transmits LDSS-3559 and Plan authorization if patient already enrolled in managed care

- LDSS continues to determine financial eligibility based on chronic care budgeting rules (60 month lookback, annual re-certification)

- LDSS notifies NH (and Plan) of the NAMI amount

- LDSS not involved in plan selection

- Enrollment Broker – New York Medicaid Choice (aka MAXIMUS)
Eligibility

Pending – Not in a plan

- The State will not pay for the pending period prior to determination – NO CHANGE

- If eligibility approved, State will pay the NH minus the NAMI amount until they are enrolled in a plan, then the Plan will pay.

- If ineligible, the patient will be private and the NH responsible for collecting from the patient. - NO CHANGE
Pending Eligibility

Pending Eligibility – Enrolled in a plan

- The plan will pay the NH while the chronic care re-budgeting is pending.
- If eligibility approved, the plan will collect any applicable NAMI amounts from the member.
- If not approved, the plan can recoup funds from the NH for the period eligibility was pending and coordinate a safe discharge to the community with supports.
- Patient would be private pay and the NH would collect directly from the member.
Transition from Hospital to NH

- Most dual eligibles leaving the hospital enter a NH temporarily for rehab
- Their MLTC Plan may not restrict them to NHs in their network
- Once Medicare ends, not clear if MLTC has to pay
- No Lock-In for either MLTC or FIDA
Discharge Planning

- Plan must work with NH to ensure members are receiving care in the least restrictive setting. The decision should not be based on finance.
- Plan should be notified of all discharges.
- The NH, Plan, and member or representative must all be involved in discharge planning.
- The NH is responsible for creating and executing the care plan while in the facility.
- Plan may authorize and review care plans.
- Plan must authorize all community supports needed to retain the member in the community, if appropriate.
Overarching goal – Avoid Unnecessary Hospitalizations

- Demonstrate a strong track record of keeping residents out of hospitals
- Avoid ER use
- Return residents to the community
Contracting Issues

- MCOs have little flexibility with contract
- Contracts approved by DOH
- Material changes require additional approval
- NYS Mandatory Provisions prevail and cannot be modified
Improving Your Bargaining Position

- Demonstrate quality through NHQP data and CMS ratings
- Medical Director with specialty in gerontology
- 24° coverage by physician or NP
- Integration with Major Hospitals/PPS
- EMR capability
Your Rights

- NY’s Prompt Pay Law - Payment for “clean claims” within prescribed period
- Payment of undisputed portion of claim cannot be delayed
- DOH will be monitoring
- Due process rights
Billing

- Make sure you know what is required for a clean claim
- MCO does not have to pay claims submitted after 90 days
- MCO should allow billing after 90 days in isolated circumstances
Due Process Rights

- Opportunity to remedy any problems before MCO can terminate agreement unless there is evidence of imminent patient harm, fraud or abuse.
Due Process Rights

- If contract is terminated MCO may not require member to transfer to a different NH.
- Must continue placement or out of network provider at fee for service rate in effect prior to transfer.
- Member may transfer voluntarily.
Credentialing

- DOH recommends MCOs delegate credentialing to NHs
- Requires formal agreement approved by DOH
- Less administrative burden.
Delegated Credentialing Agreement

- Requires DOH Approval
- Sets forth credentialing procedures
- Staffing
- Reports to MCO
General MCO Contract Issues

- Concept of Medical Necessity
- Authorization for services (Exception for Emergencies)
- No billing of enrollees, LDSS or DOH
  - Exception: can bill enrollee for non-covered services if enrollee agrees in writing
Contract Issues

- Coordination of Care Planning
- Liaison between NH and MCO
- Claims processing
- Authorization procedures
- Indemnification
Indemnification

- MCO assumes no responsibility for patient care
- SNF is ultimately responsible for providing medically appropriate services
- If MCO denies authorization but SNF feels service is necessary, provide service and appeal
MCO’s Responsibilities

- Care Management
- Informing provider of pertinent P+P’s and billing procedures
- Appointing Liaison
- Nurse Navigator Concept
Overlap of MCO and SNF’s Responsibilities

- Care planning and care coordination
- Quality Improvement
- Credentialing
- Compliance with Law and Regulations
Care Management Administrative Services Agreement (CMAS)

- MCO may delegate care management to NH:
  - Requires a contract approved by DOH
  - NH would perform the required MCO Assessments and Reassessments
  - NH would develop care plan to meet both MCO and NH requirements
MCO Plan of Care

- Mental status
- Clinical status
- Types of services and equipment required
- Prognosis
Care Plan, Cont’d

- Nutritional requirements/Fluid intake
- Medications and treatments
- Safety measures to protect against injury
- Goals, specific to Member needs
- Care Manager works with Multi-Disciplinary Team
Challenges

- Disagreement on care plan/placement
  - Enrollee contests decision or specific placement
  - Provider recommendation denied by MCO
  - MCO appeal, external appeal and fair hearing rights
  - Enrollee may change plans
  - ALC coverage in place until safe discharge
- No available community service/bed
  - Coverage in place until safe discharge
  - Out of network options
- Dispute over process/roles/billing
Other Contract Issues

- Provider Appeals
- Obligation to continue Treatment in case of MCO insolvency
- MCO Escrow and Capital Reserve Requirements
Litigation

- Breach of Contractual Payment Obligations
- Breach of Prompt Pay Laws
- Antitrust suits – Refusal to Contract
Litigation, cont’d.

- Class Action Suits Address Core HMO Abuses
- Interference with Care Delivery
- Placing Profits over People
- Bundling and Downcoding
Litigation by Members

- Refusal to Cover Treatment, especially when outcomes are poor

- Juries have awarded large verdicts when people died after HMO refused to authorize treatment
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