# Transition of New Benefits into Managed Care

June 10, 2013

# New Benefits Effective 8/1/2013

- **Adult Day Health Care (ADHC)**

  1,193 Recipients

- **AIDS Adult Day Health Care (AADHC)**

  1,450 Recipients

- **Directly Observed Therapy for Tuberculosis (TB/DOT)**

  308 Recipients

(2012 Data)

# TB DOT Managed Care Payment Policy

- Plans must provide service effective August 1, 2013.
- This is a service provided under the authority of the local government and must be reimbursed if provided by the LPHU or designated site (NYC) .
- Plan will pay the FFS rate if it does not have a contract with an appropriate provider.
- The FFS rate is $82.58 upstate and $95.90 downstate (Westchester and points south).
  - This is a weekly rate - regardless of the frequency of treatment (daily, twice weekly, three times a week).
  - The rate does not include TB drugs, which are also the responsibility of the plan.

# TB Directly Observed Therapy (TB DOT)

## Non-Dual, Plan-Enrolled Recipients by Provider for CY 2012

| Provider Name | Total Recipients |
|---|---|
| ALBANY COUNTY HEALTH DEPT | 1 |
| ELMHURST HOSPITAL CENTER | 24 |
| ERIE COUNTY HEALTH DEPT | 11 |
| KINGS COUNTY HOSPITAL CENTER | 17 |
| MONROE CNTY DEPT HLTH CLINIC | 10 |
| NYCDOH-ASTORIA/CORONA | 70 |
| NYCDOH-BEDFORD | 43 |
| NYCDOH-FT GREEN | 78 |
| NYCDOH-LOWER MANHATTAN | 10 |
| NYCDOH-RICHMOND | 8 |
| NYCDOH-SOUTH BRONX-MORRISANIA | 80 |
| NYCDOH-UPPER WESTSIDE-WASHING | 37 |
| ORANGE CNTY DEPT OF HEALTH | 1 |
| TOMPKINS CNTY HLTH DEPT CLINI | 1 |
| WAYNE CTY PUBLIC HLTH SERVICE | 1 |
| WESTCHESTER CNTY DOH | 11 |
| Grand Total | 403 |

Note: The unduplicated recipient count was 308, but the recip count here is overstated due to the method used in the data extraction.

# Managed Care and Local Health Departments

- Medicaid contract requires payment for DOT services
- Plans may amend contracts or enter into new contracts for these services
- LHD must follow plan submission guidelines for claims
- Participating LHD must follow requirements for notification

# Managed Care and ADHC/AADHC

- Health plans are responsible for ensuring services are medically necessary
- Plans will contract with ADHC/AADHC for their members
- Plans will be partner, approve care plan and authorize services
- May conduct concurrent review and/or review patient status between assessments
- May develop performance standards

# Transitional Care:

## Adult Day Health Care and AIDS Adult Day Health Care

- Members will receive 90 days transitional care with the current care plan, or until the MCO has conducted a new assessment, whichever is later.
- The member will continue with the current provider for 1 year.
- Plans will pay the Medicaid rate during this transition period for all members in need of ADHC and AADHC, regardless of contract amounts. After 1 year, plans may negotiate payment rate.

# FFS AIDS ADHC and ADHC Rates

- The current AIDS ADHC rate for all programs sponsored by a long term care provider is apx. $185.67 per day.
- The current AIDS ADHC rate for programs sponsored by a D&TC is apx. $180 per day.
- The current ADHC rates average $107, but vary greatly by provider.
- A complete listing of AIDS ADHC and ADHC rates by provider has been distributed to all plans.
- For both services, the plan must mirror the provider's current FFS rate for one year from the date of implementation.

# ADHC and AIDS ADHC Transportation

- The ADHC rates exclude transportation, which will continue to be paid through FFS.
- The AIDS ADHC rates include transportation.
  - As previously noted, plans will pay the full AIDS ADHC FFS rate (including the transportation) for one year after the carve in.
  - During that year, plans will not be responsible for any transportation costs beyond those that are included in the current rate.
  - The AIDS ADHC providers will continue to be responsible for providing transportation, none of which will be billable to FFS.
  - At the end of the one year period, the AIDS ADHC providers and the health plans will negotiate rates that exclude transportation. AIDS ADHC transportation will then become a FFS benefit under a state-contracted transportation vendor.

# ADHC and AADHC County Network Requirements

- **Upstate:**
  - Adult Day Health Care - A minimum of two providers
  - AIDS Adult Day Health Care – One provider, where available

- **Metropolitan Region:**

  **(NYC, Nassau, Suffolk, and Westchester Counties)**
  - Adult Day Health Care - A minimum of three providers
  - AIDS Adult Day Health Care - Two providers, where available

- **MCOs must enter into single case agreements with providers providing services to less than 5 members.**

# ADHC/AADHC Provider Action

- For existing registrants:
  - Check eligibility 1st and 15th of every month to ensure health plan has not changed
  - Notify health plan as soon as possible that enrollee is receiving services
  - Share last assessment and care plan. If the patient's condition has not changed, plans will use the most current assessment to authorize a care plan for 91st day. If the patient's condition has changed since the last assessment completed, plans may require a reassessment.
  - Work with PCP and/or plan if member needs referral for off-site services to par providers
  - Follow health plan contract/provider manual for prior authorization and billing requirements

# ADHC/AADHC Provider Action

- New registrants:
  - Check eligibility prior to admission/assessment.
  - Physician referral needed and member may go to participating ADHC or AADHC for assessment.
  - Health plan will cover up to 2 visits for the assessment to be conducted.
  - Once completed, the assessment must be shared with the health plan for authorization of services at the ADHC or AADHC.
  - Comprehensive care plan must be developed within 5 visits or 30 days.
  - Ongoing days per week authorized by health plan, refer off-site services to par providers

# Managed Care Authorizations

- Time frames for review of service authorization request
  - Prior Authorization for new registrants
    - Decided on expedited basis, within 3 business days of the request (receipt of the assessment)
  - Concurrent, existing registrants
    - Decided within 1 business day of all information, but no more than 3 business days of request
  - Both may be extended if in enrollee's best interest for up to 14 more days

# Managed Care Notice Requirements

- Anytime a service authorization request is denied or approved for less than requested
- Health plan issues Notice of Action, verbally and in writing, to provider and member
  - Clinical rationale or benefit denial
  - Enrollee appeal rights
  - Enrollee right to fair hearing
  - Enrollee right to external appeal for medical necessity denials.
- Provider may represent enrollee
- This may be issued in addition to a claim denial

# Managed Care Provider Rights

- Once authorized, authorization may not be changed without receipt of new information,  fraud or loss of coverage
- Independent right to external appeal of medical necessity denial for concurrent and retrospective denials
- Plan must have process to resolve provider payment disputes
- Plan may not have policy or contract that prohibits provider from filing complaint with the State
- Contracted provider may not be terminated for filing complaint to State

# Managed Care Provider Rights

- At least 90 days to submit claims, plan may extend time via contract; non-pars have up to 15 months
- Insurance Prompt Pay Law
  - Clean e-claims processed in 30 days, or receive specific written notice with reason for denial
  - Insurer pays interest for late claims
  - Untimely filing dispute resolution process
- See also http://www.dfs.ny.gov/insurance/hprovrght.htm

# Managed Care Common Pitfalls

- Eligibility not checked
- Authorization not obtained
- Claim processing
  - Untimely claims
  - Coding issues
  - No appeal filed
  - Plan process not followed

# AIDS ADHC, ADHC and TB

## (Optional/Suggested Claims Coding)

| Service | HCPCS/ICD-9 | HCPCS/ICD-9 Description | Modifier | Units | Provider Specialty Code | MEDS COS | FFS Rate Codes |
|---|---|---|---|---|---|---|---|
| Adult Day Health Care | S5102 | Day care services, adult; per diem | NA | 1 | 664 | 12 or 15 | 2800, 3800 |
| AIDS Adult Day Health Care | S5102 | Day care services, adult; per diem | U1 | 1 | 355 | 12 or 15 | 1850 |
| TB DOT (see notes below) | H0033 | Oral medication administration, direct observation | U1 | 1 | Varies | Varies | 5312, 5313, 5317, 5318 |
| Inpatient TB Therapy (ordered by LDSS) | ICD-9 Dx 01000 - 01286 | Various TB diagnoses. The codes shown all group to APR-DRG 137, but other Dxs and DRGs are possible for TB and may apply. The full range of codes extend up to ICD-9 Dx code 01896. | | | Varies | 11 | |

The first-line medications, used as part of directly observed therapy (DOT) to treat TB, are isoniazid (INH), rifampin, ethambutol and pyrazinamide. They are all oral meds. There are other oral meds that can be used, but they are prescribed on a less frequent basis.

In some cases (again, less common), patients may require injectable/infused meds. The standard injectable meds for TB are Streptomycin (J3000), Kanamycin (J1850), Amikacin (J0278) or Capreomycin (J3490). They are administered and billed to Medicaid by a CHHA or by the LCHD. The NDC that should be reported is the NDC listed on the package label.

# Department of Health Complaints

- Enrollees and providers may file a complaint regarding managed care plans to DOH
  - 1-800-206-8125
  - managedcarecomplaint@health.state.ny.us
- When filing:
  - Identify plan and enrollee
  - Provide all documents from/to plan
  - Medical record not necessary
- Issues not within DOH jurisdiction may be referred.
- DOH is unable to arbitrate or resolve contractual disputes in the absence of a specific governing law.
- File prompt pay complaints with Department of Financial Services (www.dfs.ny.gov)