TO: Local District Commissioners, Medicaid Directors

FROM: Jason A. Helgerson, Medicaid Director and Deputy Commissioner, Office of Health Insurance Programs

SUBJECT: Prior Authorization and Payment Requirements for Admission to Out-of-State Non-Specialized Skilled Nursing Facilities

EFFECTIVE DATE: October 1, 2011

CONTACT PERSON: Prior Authorization:
OHIP Medical PA (800)342-3005 Option 1

Local District Liaison (518)474-5888

This GIS message is to advise local departments of social services of the processes required for implementation of prior authorization (PA) for admission to out-of-state non-specialized skilled nursing facilities (OOS N/S SNFs), and the post authorization process to determine whether continued payment to the OOS N/S SNF is to be authorized.

The PA requirement for OOS N/S SNF admissions was developed to ensure that New York State Medicaid beneficiaries are provided every opportunity to remain in and receive health care services from providers within the borders of New York State. The PA process will prevent unnecessary admissions in out-of-state facilities.

Previously, when a Medicaid beneficiary was admitted to an OOS N/S SNF, the local district was contacted and the principal provider file was updated, linking the beneficiary with the provider and facilitating payment. Effective October 1, 2011, the NYS Department of Health’s Office of Health Insurance Programs (OHIP) in Albany must determine whether it is appropriate to authorize admission to an OOS N/S SNF.

If OHIP determines it is appropriate for the NYS Medicaid program to prior authorize nursing home care in an OOS N/S SNF, an approval letter will be sent to the Medicaid beneficiary, ordering practitioner, case manager/discharge planner and the local department of social services. The local district is required to update the principal provider file for a Medicaid beneficiary only after the approval letter is received from OHIP and only for an effective period of 120 days from the date the beneficiary is admitted to the OOS N/S SNF. OHIP will be monitoring compliance with this directive to ensure that payment is only made for authorized admissions. To facilitate timely notification, each local district must inform OHIP Medical PA at the telephone number above of the contact information for staff responsible for updating the principal provider file.

As with all admissions to a skilled nursing facility, the discharge planner/case manager must complete an H/C PRI and SCREEN form. If the screener's recommendation is for SNF level of care, a Level I Evaluation must be completed. If the individual is identified as having serious mental illness and/or mental retardation the discharge planner/case manager should continue with the PASRR process as defined in federal regulations. If the individual requires SNF level of care, admission to an OOS N/S SNF will only be authorized under the following conditions:

- the individual has been denied admission to all in-state SNFs within 50-75 miles of their residence, or

- the individual will be temporarily absent from the State and residents of the individual's district customarily obtain care at the proposed facility.

The discharge planner/case manager must maintain the above documentation and provide it upon request.

A new prior authorization form and submission instructions for admission to an OOS N/S SNF will be posted on the eMedNY website: https://www.emedny.org/ProviderManuals/ResidentialHealth/. Requirements and instructions for OOS High/Specialized Level of Care SNF admissions are also available on this website.

Additionally, a new Post Authorization Process has been developed to monitor the necessity for continued payment to the out-of-state facility for Medicaid beneficiaries for whom initial admission was prior authorized. Within 120 days of the admission, the OOS N/S SNF must evaluate the individual's potential for repatriation to New York State. The facility must provide documentation to the local district that the recipient has been declined admission to all New York State facilities within 50–75 miles of the recipient's New York State residence. Denial must be based upon a recently completed, not to exceed fourteen days, PRI and SCREEN. This information is required for the local district to extend authorization for payment through the principal provider file. The initial PA approval letter to the recipient will include the required notice that SNF services will not be reimbursed unless these Post Authorization requirements are met.

Both the Prior Authorization and Post Authorization Processes will provide an opportunity for New York State to further analyze the service needs of Medicaid beneficiaries against the services currently available within the State. This will provide an opportunity to more effectively and efficiently plan for the medical and clinical needs of our New York State residents.