This document serves as an overview of the transition to long term placement process, offering guidance on steps a facility must take regarding a member's eligibility for long term placement and the documents it must timely submit to the LDSS/HRA and NY State of Health in conjunction with facilitating Medicaid application by the member. Additionally, it offers resources regarding where the facility can submit claims, appeals, and requests for administrative reviews as well as nursing home demographic changes to MetroPlusHealth.

NURSING HOME TRANSITION ELIGIBILITY CRITERIA:

- All recipients over age 21 in need of long-term care/permanent placement in a **nursing home (NH)** who are not yet residing in one are required to join a Medicaid Managed Care Plan (MMCP) or a Managed Long Term Care Plan (MLTCP).
- All current long term/permanent custodial care beneficiaries in a Medicaid-certified NH prior to the phase-in date (2/1/2015-NYC) will remain in Fee-for-Service (FFS) Medicaid.
- Voluntary enrollment is available to Medicaid Managed Care individuals residing in nursing homes who are in fee-for-service Medicaid.
- You may visit the following website for more information on the transition of Nursing Home populations and benefits to Medicaid Managed Care: https://www.health.ny.gov/health_care/medicaid/redesign/2016-jan_rev_nh_transition_faqs.htm or you may contact the Nursing Home Eligibility Division Provider Relations Unit at 718-557-1368.

***Members are not required to change nursing homes as a result of this requirement.*

STAY DEFINITION*:*

- A **short-term stay** is a temporary admission following a surgery, injury, illness, or other medical condition that is expected to improve. Services can last several weeks or a few months or sometimes longer depending on the severity of the condition being treated.
- A **long-term stay** may be required if the member is admitted to the facility and there is a significant delay in the discharge plan such as a need for a home modification prior to discharge or if the member needs permanent placement but is actively enrolled in a HARP plan which prevents them from converting to a permanent placement status. Long-term stays are not considered permanent placements unless the member is officially converted to a permanent placement status and is given an N-code designation.
- **Permanent Placement** is the term used to refer to an individual who will permanently reside in a Residential Health Care Facility (RHCF) and the Plan determines that the individual is not expected to return home or to a community setting based on medical evidence affirming the individual's need for RHCF level of care on an ongoing basis. This designation is made by the local district (HRA) based on medical evidence, affirming the individual's need for long-term RHCF placement.

MEMBERS TRANSITIONING TO PERMANENT PLACEMENT:

- If a member is in a NH for a short-term stay and it is determined they are unable to be safely discharged to the community and they will instead be transitioning to permanent placement, the NH must notify the Local Department of Social Services (LDSS), known as the Human Resources Administration (HRA) in New York City, of the change in status.

- Per NYS Department of Health (DOH), for any changes in status, the NH must transmit the 2159i (NYC) form to HRA as notification of a change in status. This transmittal must also include authorization from the plan for consumers who are enrolled in managed care. Paper copies of the form may be mailed to:

  Medical Assistance Program
  Nursing Home Eligibility Division
  P.O. Box 24210
  Brooklyn, New York 11202-9810

  In order for the form to be considered complete, the 2159i Form must be signed by the individual's managed care plan and the residential health care facility in order for HRA"s Nursing Home Eligibility Division (NHED) to review and make a determination regarding the N-code designation. The NH must check the appropriate placement/bed type for the consumer. Below is the list of codes and the description:

  N1 - Regular SNF Rate – MC Enrollee
  N2 - SNF AIDS – MC Enrollee
  N3 - NF Neuro-Behavioral – MC Enrollee
  N4 - SNF TBI – MC Enrollee
  N5 - SNF Ventilator Dependent – MC Enrollee
  N6 - MLTC Enrollee Placed in SNF

- If the member is pending transition to permanent placement but is actively enrolled in HARP, they will need to be disenrolled from HARP prior to being permanently placed as permanent placement is not a covered benefit under the HARP benefit package. To request a HARP disenrollment for permanent placement, the NH must transmit the 2159w form (NYC-specific) to HRA for processing. Paper copies of the form may be mailed to:

  Medical Assistance Program
  Nursing Home Eligibility Division
  P.O. Box 24210
  Brooklyn, New York 11202-9810

- While a member is pending disenrollment from HARP, the plan will approve services for room and board until the disenrollment is effective. However, to ensure continued approval of room and board, the nursing home facility **must** provide a copy of the signed 2159w that was submitted to HRA to the UM department as part of the continued stay utilization review process. Failure to submit the necessary documentation will result in a denial.

ENROLLED IN LONG TERM PLACEMENT – ELIGIBILITY CRITERIA (Eligible MetroPlusHealth Members):

- MetroPlusHealth members to be permanently placed must reside in an in-network facility.
- MetroPlusHealth members wishing to be permanently placed in an out-of-network nursing home must choose another managed care organization (MCO) which is contracted with the facility where they will reside.

- If the member wishes to go to an out-of-network nursing home, they will need to have their NYC case closed and open a new case in the county in which the out-of-network facility is located.

- The recommendation for long-term care placement is made by the NH physician or clinical peer and is submitted to MetroPlusHealth for review and approval. When requesting initial permanently placed authorizations the following must be received:
  - Copy of the signed 2159i
  - Letter of attestation signed by the member with consent to long term custodial/permanent placement.
- NH will request for transition from the status, ie., such as - Rehabilitation or Custodial stay for conversion to long-term permanent placement in writing via fax.
- NH will be advised by the plan within the standard timeframe (14 days) for authorization determination.
- MetroPlusHealth will notify the NH in writing via Approval Letter of the approved length of stay.
- Upon MetroPlusHealth approval of the permanent placement, the facility must provide written proof that the appropriate documentation was sent timely to the LDSS/HRA. This proof should be submitted via facsimile to **212-908-3023.**

  Please Note: ***This Fax is only for submitting proof of documentation submission to LDSS/HRA – Clinical Documentation should not be sent to this fax number. Failure to submit the required documentation to the LDSS/HRA and provide sufficient proof to MetroPlusHealth may result in the retraction and/or non-payment of claims.***
- The NH will assist the Enrollee in submitting documentation for Medicaid coverage of the long-term placement to the Local Department of Social Services (LDSS) within 90 days of the date of long-term permanent placement in a New York State facility.
- NH will continue to receive reimbursement during this process; however, if the member is deemed to be ineligible or fails to complete the Chronic Care application for NH Medicaid, payments may be recouped.
- If the provider is acting as the member's representative payee, the provider is responsible for submitting the NAMI to the Plan. Medicaid recipients in nursing homes are responsible for paying a certain amount of their nursing home costs each month. This amount, which is termed the recipient's *Net Available Monthly Income (NAMI),* is calculated by the recipient's local social services district.

H78 Code

- Individuals with NY State of Health coverage (identified in ePACES with the "Office Field" code of H78) who need permanent nursing home placement must have their case administration transferred from NY State of Health to their LDSS to determine nursing home Medicaid eligibility. Long-term care providers can notify either the LDSS or NY State of Health of the need to transition the case.
- The additional paperwork that needs to be completed is needed to transition the case to the NYC HRA for case administration. Then HRA will determine the member's nursing home Medicaid eligibility.

Here are the steps the nursing facility needs to conduct:

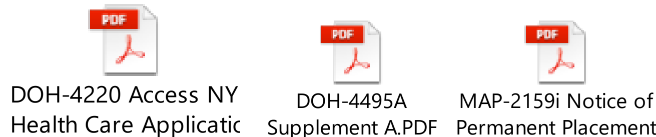
1) Fill out 3 forms:
   a. DOH-4220 (Medicaid application)
   b. DOH-4495A (Supplement A to the Medicaid application)
   c. MAP-2159i (A Residential Health Care Facility Reoprt of Medicaid Recipient Admission/Discharge/Readmission/Change in Status" form)

   Note: MetroPlusHealth will sign-off on the MAP-2159i based on a determination of medical necessity.

2) Submit them to NY State of Health (hxfacility@Health.nyc.gov) which will then notify HRA and mail a Medicaid application packet to the member

3) Assist member to complete and submit the Medicaid application packet back to HRA

- Please click the icons below to access copies of the aforementioned forms.



- Please call the NY Health Benefit Exchange (855)-355-5777 If you have any questions or inquiries.
- Once the facility has submitted the documents to NY State of Health, proof of submission must be promptly provided to MetroplusHealth.
- Since eligibility for coverage of nursing home care may be authorized for up to 90 days retroactive from the date of application, the member will have 90 days from the date of admission to the nursing home to submit an application for coverage of the permanent placement.
- If Medicaid application is not submitted within 90 days of admission, the plan may deny coverage as the member is not eligible for the benefit; the member would have appeal and fair hearing rights. Since Medicaid can be authorized only up to 90 days retroactive from the month of application, there may be months that cannot be covered.

CLAIMS:

- NH claims submission process: Electronic claims are received via the 837-file using Change Health as the clearing house. Providers are to submit claims in a timely manner. Par Providers have 120 days to avoid late filing denials. Non-Par Providers have 180 days.

Paper Claims are mailed to:

MetroPlusHealth
P.O. Box 830480
Birmingham, AL 35283-0480

- NH Providers are to follow DOH billing guidelines when submitting claims for reimbursement. Coding will be decided upon by the provider, which depends on the type of service provided.

APPEALS AND REQUESTS FOR ADMINISTRATIVE REVIEWS:

- Medical Necessity - Standard Clinical Appeals must be received within 60 business days of the initial adverse determination and should be mailed to:

  Attn: Appeals Department
  MetroPlusHealth
  50 Water Street
  7th Floor
  New York, NY 10004

- Claims reconsiderations must be submitted within 60 calendar days of the date of the remittance advice and can be faxed to the following number: **212-908-8824.**

DEMOGRAPHIC CHANGES FOR NH:

Submit your demographic changes online through MetroPlusHealth's Provider Portal – https://providers.metroplus.org/ – and select the Your Directory Information menu option on the home page. Or you can fax or mail data maintenance changes to the Provider Relations Department in your area at least thirty (30) days prior to the effective date of the change (i.e., office hours, address, telephone number, and panel status). You can fax your changes to 212-908-3316.

Failure to submit changes in a timely manner may result in claim denials.