✓MetroPlusHealth

This document outlines the steps and responsibilities for Nursing Home (NH) providers when transitioning a member from short-term to long-term placement. It includes:

- Eligibility criteria for long-term placement
- Required documentation and submission timelines
- Medicaid application coordination
- Claims, appeals, and administrative review procedures
- How to report NH demographic changes to MetroPlusHealth

DEFINITION of Stay Types*:*

- A **short-term stay** is a temporary admission following a surgery, injury, illness, or other medical condition that is expected to improve or stabilize allowing the individual to return to the community.
- A **long-term stay** is when a member requires placement in a nursing home for 120 days or more and the individual is not expected to return to the community. LTNHP benefit requires the individual to be eligible to receive an N-code designation.

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 has an H78 code, timely completion of additional paperwork is required. Please see the "H78" section below.
- 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

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

- MetroPlusHealth members to be permanently placed must reside in a New York State facility.
- 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 /permanent placement.
- NH will request for transition from the status, i.e., 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 fax 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 of the authorization 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.
- Per NYS guidance, the plan will give approval for LTNHP, but billing must only take place once the N code is designated.
- If the provider is acting as the member's representative payee, the provider is responsible

for submitting the Net Available Monthly Income (NAMI) to the Plan. The NAMI refers to the amount of the monthly nursing home costs that Medicaid recipients in nursing homes are responsible for paying each month. This amount 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.
- It is necessary to complete additional paperwork 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 to complete this additional paperwork:

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 Report 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.

DOH-4220 Access NY Health Care Application

DOH-4495A Supplement A.PDF

MAP-2159i Notice of Permanent Placement

MAP-3044a Facility Submission of Application

- 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 still 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: Providers should submit claims using a clearing house connected to MetroPlusHealth and should 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 email changes to Provider Relations at ProviderRelationsOps@metroplus.org.

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