



**Department
of Health**

Medicaid
Redesign Team

Transition of Nursing Home Populations and Benefits to Medicaid Managed Care

Webinar August 18, 2015

Nursing Home Transition Phase-In Schedule

Month	County
February 1, 2015 Phase 1	New York City – Bronx, Kings, New York, Queens and Richmond
April 1, 2015 Phase 2	Nassau, Suffolk and Westchester
July 1, 2015 Phase 3	Albany, Allegany, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Dutchess, Erie, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Montgomery, Niagara, Oneida, Onondaga, Ontario, Orange, Orleans, Oswego, Otsego, Putnam, Rensselaer, Rockland, St. Lawrence, Saratoga, Schenectady, Schoharie, Schuyler, Seneca, Steuben, Sullivan, Tioga, Tompkins, Ulster, Warren, Washington, Wayne, Wyoming, Yates
October 1, 2015	Voluntary enrollment in Medicaid managed care becomes available to individuals residing in nursing homes who are in fee-for-service Medicaid.

Transition Policy

- All eligible recipients age 21 and over in need of Long Term/Custodial Placement will be required to enroll in MMCP or MLTCP.
- Existing MMCP enrollees will NOT be dis-enrolled if they require long term custodial placement.
- No individual will be required to change nursing homes resulting from this transition.
- Consumers enrolled in a plan will select a NH based on their needs and the plan's network of providers.
- Plans must ensure that placement is in the most integrated, least restrictive setting available to meet the enrollee's needs.

Reserved Beds - Bed Holds

- MCOs are required to continue following the current methodology during the transition period unless an alternative is negotiated and agreed to.
- Three types of reserved bed days are eligible for payment:
 - Temporary Hospitalizations-reimbursed at 50% of the Medicaid FFS rate.
 - Professional Therapeutic-reimbursed at 95% of the Medicaid FFS rate.
 - 14 days in a 12 month period, (combined aggregate of temporary hospitalizations and professional therapeutic leave days)
 - Reserved beds hold for an absence not related to a professional therapeutic leave or temporary hospitalization shall be made at 95% of the Medicaid rate.
 - 10 days in a 12 month period
- LDSS-3559 is being revised to include an indication of bed hold,(DOH-5182).

Long Term Placement

- Nursing home physician or a clinical peer makes the recommendation for permanent placement.
- Nursing home transmits the recommendation and supporting documentation to the MCO for review and approval.
- NH sends LDSS-3559 form, with authorization from the MCO, to the local district.

Long Term Medicaid Eligibility Process

- The nursing home and the MCO work together to assist the member in gathering documentation required by the LDSS to perform the eligibility determination.
- Once an application is received, LDSS has 45 days to complete the eligibility determination for long term placement.

Eligibility Determination

- Consumers in need of long term placement will have eligibility determined using institutional rules, including a review of assets for the 60 months look-back period and the transfer of assets rules.
- Post eligibility budgeting rules are used to determine the net available monthly income (NAMI) that must be contributed toward the cost of nursing home care for consumers who are otherwise eligible and are not subject to a transfer penalty.

Eligibility Determination

- For consumers who are Medicaid eligible under MAGI, the same look-back and transfer of assets rules are used, but there is no resource test and post eligibility budgeting rules do not apply.
- If LDSS determines there are uncompensated transfers during the look-back period, a transfer penalty is imposed and the individual is ineligible for coverage of nursing home care until the completion of the penalty period.

Restriction/Exception Codes

- Once re-budgeting and long term eligibility is approved, the LDSS will enter specific Restriction/Exception (R/E) codes into WMS to identify the type of long term placement for managed care enrollees.
- These R/E codes will appear on rosters.
- ePACES will also reflect this information.
- R/E codes will drive MMC premium rate payment.
- For new applicants, N7 is entered once the eligibility determination is complete, and any penalty period has lapsed to begin the outreach and enrollment process.

Nursing Home Transition Rate Code Billing Matrix and R/E Codes

R/E Code	Description	Managed Care Program	
		MMC	MLTC
N1	Regular SNF Rate - MC Enrollee	X	
N2	SNF AIDS - MC Enrollee	X	
N3	SNF Neuro-Behavioral - MC Enrollee	X	
N4	SNF Traumatic Brain Injury-MC Enrollee	X	
N5	SNF Ventilator Dependent - MC Enrollee	X	
N6	Any MLTC enrollee		X
N7	NH Budgeting Approved-Awaiting MC Enrollment	X	X

N1 – N6:
For current MMC or MLTC Enrollees

N7:
Entered once eligibility is established if no plan enrollment

Rosters

- **MCOs** will receive pertinent enrollee information via the Roster system and a Nursing Home report. Included on the distinct report will be:
 - District
 - CIN and Case Number
 - Restriction Exception (R/E) Code (N series)
 - NH Provider ID
 - Effective Date of Long Term placement
 - NAMI amount
- **Nursing Homes** will continue to receive their FFS roster in the current method of delivery.

Plan Selection and Enrollment:

- Consumers who must enroll in MMC or MLTC have 60 days to select a plan for enrollment.
- Consumer will select from plans contracting with the nursing home in which the individual resides.
- If a plan is not selected within 60 days, a plan that contracts with the nursing home will be assigned.
- New York Medicaid CHOICE will be available to assist consumers with education and plan selection (in enrollment broker counties only).

Net Available Monthly Income (NAMI)

- Plans are responsible for NAMI collection and may delegate this to the NH.
- If not enrolled, LDSS will continue to notify NH of NAMI amount and any changes in NAMI.
- Once enrolled or for current enrollees, the Local District will notify the Plan of the NAMI amount once eligibility determination is complete.
- Local districts are responsible for notifying the Plan via the notice process of any NAMI changes not appearing in the budget.
- Distribution of the Personal Needs Allowance should be coordinated between Plans and providers during the contracting process.

Nursing Home Transition Information

- 15 OHIP/ADM-01

available on-line:

http://www.health.ny.gov/health_care/medicaid/redesign/mrt_1458.htm

- NH Policy Paper
- Frequently Asked Questions
- Today's Power Point Presentation
- Questions - MRUpdates@health.ny.gov
- OHIP Local District Support