

## NURSING FACILITY ELIGIBILITY AND ENROLLMENT PROCESS

### SECTION 4 – BENEFICIARY ELIGIBILITY AND ADMISSION PROCESS

#### 4.1 NURSING FACILITY ELIGIBILITY

There are five components for determining eligibility for Medicaid nursing facility reimbursement.

##### 4.1.A. Verification of Medicaid Eligibility

Medicaid payment for nursing facility services for an individual requires a determination of Medicaid eligibility for that individual by the Michigan Department of Human Services (MDHS). When a Medicaid-eligible or potentially-eligible individual is admitted to a nursing facility, or when a resident becomes Medicaid eligible while in the facility, the nursing facility must submit the Facility Admission Notice (MSA-2565C) to the local MDHS office to establish/confirm the individual's eligibility for Medicaid benefits. A copy of the form is available on the MDCH website and in the Forms Appendix of the Medicaid Provider Manual.

A facility is considered officially notified of an individual's Medicaid eligibility when they have received the completed MSA-2565-C.

**In order for Medicaid to reimburse for nursing facility services, the beneficiary must be in a Medicaid-certified bed.**

Federal regulations require annual recertification that residents meet Medicaid financial eligibility requirements. The annual recertification process is performed by the Michigan Department of Human Services.

##### 4.1.B. Correct/Timely Preadmission Screening/Annual Resident Review (PASARR)

The Preadmission Screening/Annual Resident Review (PASARR) process must be performed prior to admission as described in the PASARR Process Section of the Nursing Facilities chapter of the Medicaid Provider Manual.

A Level I Preadmission Screen must be performed for all individuals admitted to a Medicaid-certified nursing facility regardless of payer source. When a Level II evaluation is required, placement options are determined through the federal PASARR screening process requirements. The Level I screening form (Preadmission Screening [PAS]/Annual Resident Review [ARR]; DCH-3877) may be found on the MDCH web site. (Refer to the Directory Appendix of the Medicaid Provider Manual for website information.)

MDCH performs retrospective reviews, randomly and when indicated, to determine that the nursing facility has complied with federal PASARR requirements.

The nursing facility is required to ensure that the PASARR Level I screening has been completed and passed by the individual prior to admission. MDCH reviews retrospectively to determine that the Level I screening was performed, and that the Level II evaluation was performed when indicated.

MDCH is required to recover any payments made to nursing facilities for the period that a participant may have been admitted to a nursing facility when the PASARR screening process was not completed.

#### **4.1.C. Physician Order for Nursing Facility Services**

A physician-written order for nursing facility admission is required. By renewing orders, the physician certifies the need for continuous nursing facility care. The order must be dated and the physician's degree must appear with the signature. The physician must initial a rubber-stamped signature.

With the exception of beneficiaries 21 years of age or under residing in a psychiatric facility, a physician (MD or DO) must approve a beneficiary's need for long-term care not more than 30 calendar days prior to the beneficiary's admission to a nursing facility.

For an individual who applies for Medicaid while a resident in a nursing facility, the physician must reaffirm the need for long-term care not more than 30 calendar days prior to the submission of the application for Medicaid eligibility.

#### **4.1.D. Appropriate Placement Based on Michigan Medicaid Nursing Facility Level of Care Determination**

##### **4.1.D.1 MICHIGAN MEDICAID NURSING FACILITY LEVEL OF CARE DETERMINATION**

For nursing facility admissions and readmissions on and after November 1, 2004, nursing facilities must verify beneficiary appropriateness for nursing facility services by completing an electronic web-based version of the Michigan Medicaid Nursing Facility Level of Care (LOC) Determination form. A nursing facility may not bill Medicaid for services provided if the beneficiary does not meet the established criteria identified through the Michigan Medicaid Nursing Facility LOC Determination or Nursing Facility LOC Exception Process, and may not bill the beneficiary unless the beneficiary has been advised of the denial and elects, in advance, to pay privately for services.

Services will only be reimbursed if the determination demonstrates functional/medical eligibility through the electronic web-based tool. Providers must submit the information via the web no later than 14 calendar days following the start of service.

**Applicants must be evaluated prior to the start of Medicaid-reimbursable services.**

The electronic web-based tool, a copy of the Michigan Medicaid Nursing Facility LOC Determination form, Field Definition Guidelines, and other information referenced in this section are on this MDCH website. The website also contains contact information for technical support to:

- register to utilize the web-based tool
- complete the LOC Determination form
- complete the exception process
- complete the immediate review process
- transition beneficiaries

The Michigan Medicaid Nursing Facility LOC Determination must be used by a health professional (physician, registered nurse, licensed practical nurse, clinical social worker [BSW or MSW], or physician assistant) representing the proposed provider. Non-clinical staff may perform the evaluation with clinical oversight by a professional. The nursing facility must bill Medicaid for only those residents who meet the criteria.

For residents admitted to the facility prior to November 1, 2004, the Michigan Medicaid Nursing Facility LOC Determination must be applied no earlier than the next anniversary date of their admission to the facility. All residents admitted prior to November 1, 2004 must be evaluated no later than October 31, 2005.

Residents who are assessed at their admission anniversary date, and who qualify under only Door 7, must be offered the opportunity and assistance to transition to the community, but may not be required to do so. In applying the criteria for Door 7, it is assumed that current services provided to residents are necessary to maintain function.

When the nursing facility determines that the resident who has been in the facility for less than 12 months is not eligible for services based on functional/medical criteria, the resident must be provided an adverse action notice and referred to appropriate service programs.

The Michigan Medicaid Nursing Facility LOC Determination must be completed using the electronic web-based tool for:

- All new admissions of Medicaid-eligible applicants where reimbursement is requested beyond co-insurance and deductible amounts.
- All readmissions of Medicaid-eligible applicants where Medicaid reimbursement, is requested beyond co-insurance and deductible amounts, and a LOC Determination was not previously completed for the original admission.

Readmissions in general do not require resubmission of the tool; this applies only if a tool was previously submitted for the resident.

Example: If a nursing facility resident was transferred to the hospital on November 28, 2004, then readmitted to the nursing facility on December 4, 2004, the LOC Determination must be applied to that resident if he has not been previously screened.

This protocol must be followed for readmissions from November 1, 2004 through October 31, 2005.

- Non-emergency transfer of Medicaid-eligible residents to another nursing facility, including transfers originating from a nursing facility that is undergoing a voluntary facility closure.
- Disenrollment of a beneficiary from a Medicaid Health Plan which has been paying for nursing facility services.
- Private-pay residents already residing in a nursing facility who are applying for Medicaid as the payer for nursing facility services.
- Dually eligible beneficiaries who wish to return to their Medicaid nursing facility bed and refuse their Medicare SNF benefit following a qualifying Medicare hospital stay.
- Any transfer of a Medicaid-eligible resident from a nursing facility that is undergoing an involuntary facility closure due to federal or state regulatory enforcement action.

Nursing facilities do not need to complete the entire Michigan Medicaid Nursing Facility LOC Determination criteria, but must submit the information requested on the on-line Emergency/Involuntary Transfer form by selecting "Emergency/Involuntary Transfer" from the bottom of the LOC Determination welcome screen.

Once admitted into the facility, however, the resident must meet the functional/medical eligibility criteria on an ongoing basis, as with all other residents covered under Medicaid fee-for-service as the primary payer. A proactive discharge plan must be provided to persons who fail to qualify, and an adverse action notice must be issued if appropriate. Retrospective review of transferred residents will still apply.

- Emergency transfer of a Medicaid-eligible resident from a nursing facility experiencing a hazardous condition (e.g., fire, flood, loss of heat) that could cause harm to residents when such transfers have been approved by the State Survey Agency.

Nursing facilities do not need to complete the entire Michigan Medicaid Nursing Facility LOC Determination criteria, but must submit the information requested on the on-line Emergency/Involuntary Transfer form by selecting "Emergency/Involuntary Transfer" from the bottom of the LOC Determination welcome screen.

Once admitted into the new facility, however, the resident must meet the functional/medical eligibility criteria on an ongoing basis, as with all other residents covered under Medicaid fee-for-service as the primary payer. A proactive discharge plan must be provided to persons who fail to qualify, and an adverse action notice must be issued if appropriate. Retrospective review of transferred residents will still apply.

Completion of the Michigan Medicaid Nursing Facility LOC Determination is not required for:

- Hospice beneficiaries who are being admitted to the nursing facility for any services.
- Nursing facility readmissions where a Michigan Medicaid Nursing Facility LOC Determination was previously completed for the original admission and the beneficiary met the nursing facility criteria.
- Cases where Medicare is the primary payer of the claim and the facility is only billing Medicaid for hospital leave days.
- Cases where Medicaid reimbursement is requested for coinsurance days.

Process Guidelines define required process steps for use of the electronic web-based tool and application of the criteria, informed choice, and specific discharge planning requirements. The Process Guidelines are available on this MDCH website.

The functional/medical criteria include seven domains of need:

- Activities of Daily Living
- Cognitive Performance
- Physician Involvement
- Treatments and Conditions
- Skilled Rehabilitation Therapies
- Behavior
- Service Dependency

For residents who qualify under one of three of these domains (Physician Involvement, Treatments and Conditions, and Skilled Rehabilitation Therapies), specific restorative nursing plans and assertive discharge planning must be evident and documented within the medical record (except for end-of-life care). These requirements are specified in the Process Guidelines.

**The electronic web-based Michigan Medicaid Nursing Facility Level of Care Determination must be completed only once for each admission per individual provider.**

#### **4.1.D.2 NURSING FACILITY LEVEL OF CARE EXCEPTION PROCESS**

An exception process is available for those applicants who have demonstrated a significant level of long term care need but do not meet the Michigan Medicaid Nursing Facility LOC Determination criteria. The Nursing Facility LOC Exception Process is initiated when the nursing facility telephones the MDCH designee and requests review after the applicant has been determined ineligible using the electronic web-based tool. The Nursing Facility LOC Exception Criteria is available on this MDCH website. An applicant need trigger only one element to be considered for an exception.

#### **4.1.D.3 TELEPHONE INTAKE GUIDELINES**

The Telephone Intake Guidelines are questions that identify potential nursing facility residents. The Telephone Intake Guidelines do not determine program eligibility. Use of the Telephone Intake Guidelines is at the discretion of the nursing facility. This document is available on the MDCH website.

#### **4.1.D.4 ONGOING ASSESSMENTS**

The nursing facility must ensure that residents meet the Michigan Medicaid Nursing Facility LOC Determination criteria on an ongoing basis in order for services to be reimbursed by Medicaid. Quarterly and annual Minimum Data Set (MDS) assessments and progress notes must demonstrate that the resident has met the criteria on an ongoing basis.

#### **4.1.D.5 RETROSPECTIVE REVIEW AND MEDICAID RECOVERY**

At random and whenever indicated, the MDCH designee will perform retrospective review to validate the Michigan Medicaid Nursing Facility LOC Determination and the quality of Medicaid MDS data overall. If the resident is found to be ineligible for nursing facility services, MDCH will recover all Medicaid payments made for nursing facility services rendered during the period of ineligibility.

#### **4.1.D.6 ADVERSE ACTION NOTICE**

When the provider determines that the beneficiary does not qualify for services based on the Michigan Medicaid Nursing Facility LOC Determination, the provider must immediately issue an adverse action notice to the beneficiary or his authorized representative. The provider must also offer the beneficiary referral information about services that may help meet his needs. The action notice must include all of the language of the sample letters for long term care. These letters may be found on this MDCH website.

The beneficiary may request an administrative hearing for a benefit denial. The Administrative Tribunal Policies and Procedures Manual explains the process by which each different case is brought to completion. The manual is available for review on the MDCH website. (Refer to the Directory Appendix of the Medicaid Provider Manual for contact information for the Administrative Tribunal.)

When a beneficiary appeals an adverse action notice to the MDCH Administrative Tribunal, the facility must notify MDCH LTC Services of the hearing. (Refer to the Directory Appendix of the Medicaid Provider Manual for contact information.) Both a facility representative and an MDCH LTC Services representative must be present at the hearing.

#### **Immediate Review-Adverse Action Notices**

The MDCH designee will review all preadmission or continued stay adverse action notices upon request by a beneficiary (or representative). When a beneficiary requests an immediate review before noon of the first working day after the date of receipt of the notice the:

- MDCH designee will request that the nursing facility provide pertinent information by close of business of the first working day after the date the beneficiary (or representative) requests an immediate review.
- MDCH designee will review the records, obtain information from the beneficiary (or representative) and notify the beneficiary (or representative) and the provider of the determination by the first full working day after the date of receipt of the beneficiary request and the required medical records.
- Beneficiary (or representative) may still request an MDCH appeal of the Level of Care Determination.

Beneficiaries may contact the MDCH designee to request an immediate review. (Refer to the Directory Appendix of the Medicaid Provider Manual for contact information.)

#### **4.1.E. Freedom of Choice**

When an applicant has qualified for services under the nursing facility level of care criteria, they must be informed of their benefit options and elect to receive services in a specific program. This election must take place prior to initiating nursing facility services under Medicaid.

The applicant (or representative) must be informed of services available through:

- Medicaid-reimbursed nursing facilities
- The MI Choice program
- The Program of All-Inclusive Care for the Elderly (PACE) program, where available.

If applicants are interested in community-based care, the nursing facility must provide appropriate referral information as identified in the Access Guidelines to Medicaid Services for Persons with Long Term Care Needs. The guidelines are available on this MDCH website. Applicants who prefer a community long term care option, but are admitted to a nursing facility because of unavailable slots or other considerations, must also have an active discharge plan documented for at least the first year of care.

Applicants must acknowledge that they have been informed of their program options in writing by signing the Freedom of Choice form that is witnessed by the applicant's

representative, when appropriate. A copy of the completed form for non-admissions must be retained for a period of three years. The completed form must be kept in the medical record if the applicant chooses to receive nursing facility services. The Freedom of Choice form is available on this MDCH website.

## **4.2 APPEALS**

### **4.2.A. Individual Appeals**

#### **4.2.A.1 FINANCIAL ELIGIBILITY**

A determination that a beneficiary is not financially eligible for Medicaid is an adverse action. Beneficiaries may appeal such an action to MDHS.

#### **4.2.A.2 FUNCTIONAL/MEDICAL ELIGIBILITY**

A determination that a beneficiary is not functionally/medically eligible for nursing facility services is an adverse action. If the beneficiary (or representative) disagrees with the determination, he has the right to request an administrative hearing before an administrative law judge. Information regarding the appeal process may be found on the MDCH website. (Refer to the Directory Appendix of the Medicaid Provider Manual for website information.)

### **4.2.B. Provider Appeals**

A retrospective determination that a beneficiary is ineligible for nursing facility services based on review of the functional/medical screening is an adverse action for a nursing facility if MDCH proposes to recover payments made. If the facility disagrees with this determination, an appeal may be filed with MDCH. Information regarding the MDCH appeal process may be found on the MDCH website. (Refer to the Directory Appendix of the Medicaid Provider Manual for website information.)

## **4.3 ADMISSION PROCESS**

Prior to or upon admission, the nursing facility must provide residents and their representatives the following information. The information must be provided both orally and in a written language that the beneficiary understands. Beneficiaries must be provided copies of those items noted with asterisk (\*).

- Rights as identified in federal regulations;
- All rules and regulations governing beneficiary conduct and responsibilities during their stay in the facility; \*
- Rights as a Medicaid beneficiary and a list of Medicaid-covered services (services for which the resident may not be charged) as published in the Medicaid "Know your Rights" booklet; \*
- Noncovered items and services, as well as the costs, for which the beneficiary may be charged (admission to a facility cannot be denied because the beneficiary is unable to pay in advance for noncovered services); \*
- Facility policies regarding protection and maintenance of personal funds; \*
- A description of the facility's policies to implement advance directives; \*
- Facility policies regarding the availability of hospice care; \*
- The name, specialty and contact information of the physician responsible for their care;
- Information about how to apply for Medicare and Medicaid; \* and

- How to file a complaint.

Facilities must notify residents and their representatives (both orally and in a written language that the beneficiary understands) of any changes to the information listed above.

Receipt of the above information and any amendments must be acknowledged, in writing, by the beneficiary or his representative. Individual facilities may develop their own documentation for this process.

#### **4.4 PREADMISSION CONTRACTS**

Nursing facilities must abide by all state and federal regulations regarding preadmission contracts.

Nursing facilities are prohibited from requiring a Medicaid-eligible person or a Medicaid beneficiary, his family, or his representative to pay the private-pay rate for a specified time before accepting Medicaid payment as payment in full. Nursing facilities violating this prohibition are subject to the appropriate penalties (i.e., revocation of their Medicaid provider agreement).