

January 4, 2017

<Provider Name>
<Provider Address 1>
<Provider Address 2>
<Provider City> <State> <zipcode5-zipcode4>

Dear Nursing Facility Administrator and Billing Office:

RE: Accepting and Refunding Monies to a Potentially Eligible Medicaid Beneficiary or Eligible Medicaid Beneficiary

This letter is to clarify the application of Medicaid policy to certain conditions in which a resident pays the nursing facility and the Medicaid application is pending. It has been noted that some residents whose Medicaid eligibility is pending are paying facilities for their care and not informing the local case worker of this payment. Once the resident becomes Medicaid-eligible the facility refunds the resident and bills Medicaid for the months paid by the resident. This practice violates Medicaid policy and presents risks for the resident. Providers should follow the guidance in this letter and inform families of their responsibilities and risks.

- Retroactive Medicaid eligibility is granted if there are *unpaid* medical expenses. If a resident has paid the nursing facility for a month, those nursing facility charges are not covered by retroactive eligibility. A nursing facility cannot refund a resident's payment for services provided and then bill Medicaid for the same services.
- If the resident has made *partial* payments to the nursing facility, and the resident has retroactive eligibility for the same time period, the nursing facility can bill Medicaid for the difference between the resident's partial payment and the nursing facility's Medicaid rate.
- Nursing facilities must report any resident payments for nursing facility services to the resident's eligibility case worker at the local Michigan Department of Health and Human Services (MDHHS) office. The local office will determine if there are implications for the resident's Medicaid eligibility.

- Nursing facilities must also report resident payments in their Community Health Automated Medicaid Processing System (CHAMPS) claims using Value Code 22. The “Note” portion of the claim must include a description of the money received, including the date that the nursing facility contacted the resident’s eligibility case worker. This requirement was also addressed in Medicaid letter L 16-12, issued in March 2016.
- A pre-payment for nursing facility services not yet received is considered a countable asset and could affect the resident’s Medicaid eligibility determination. Therefore, the nursing facility must report any pre-payment to the local eligibility case worker and on their claims, as described above.
- Failure to report these monies on the Medicaid claim and to the local office may constitute Medicaid fraud as published in the General Information for Providers chapter of the Medicaid Provider Manual, Section 16 – “Billing Without Reporting Other Resources.” The Medicaid Provider Manual is available on the MDHHS website at www.michigan.gov/medicaidproviders >> Policy and Forms.
- If a resident receives a refund for services provided and those services are then billed to Medicaid, it could constitute divestment and impact eligibility.

Any questions regarding this letter should be directed to Provider Inquiry, Department of Health and Human Services, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. An e-mail submission must include your name, affiliation, and phone number so contact can be made if necessary. Providers may phone toll-free 1-800-292-2550.

Sincerely,



Chris Priest, Director
Medical Services Administration