Commonwealth of Massachusetts
Executive Office of Health and Human Services
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MassHealth
Nursing Facility Bulletin 125
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TO: Nursing Facilities Participating in MassHealth

FROM: Beth Waldman, Medicaid Director BW

RE: **Revisions to the Nursing Facility Preadmission Process**

Introduction

This bulletin provides a detailed description of procedural changes concerning the roles and responsibilities of nursing facilities as they relate to the nursing-facility clinical-eligibility screening process for MassHealth members and applicants. These revisions are effective **June 1, 2004**.

Current Process

Nursing-facility clinical eligibility for MassHealth-only members, MassHealth applicants, and the dually eligible population (those with Medicare and Medicaid) are determined by acute inpatient hospitals (AIHs) or the Aging Service Access Points (ASAPs). The clinical-eligibility authorizations are short term, for up to 90 days, or, under limited circumstances, long term. The nursing facility receives a preadmission eligibility authorization from the AIH and from the ASAP on all other preadmissions. The nursing facility is required to submit the required documentation when residents convert to Medicaid from another payment source, and when a short-term review is due after an initial short-term approval.

What Is Changing

The AIH will continue to determine clinical eligibility for nursing-facility services for the following populations: MassHealth only, MassHealth applicants with no other primary payer source for nursing-facility services (that is, the uninsured), and for MassHealth applicants and dually eligible individuals when there is a nonqualifying Medicare hospital stay (less than three days). However, under this new process, short-term approvals granted by AIHs will be for only 45 days of nursing-facility services, rather than for up to 90 days. AIHs will continue to grant long-term approvals under the limited circumstances described in the current guidelines.

Psychiatric inpatient and chronic disease and rehabilitation inpatient hospitals will continue to assess clinical eligibility for nursing-facility services for the same populations noted above.

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What Is Changing (cont.)

Hospitals will no longer determine or assess nursing-facility clinical eligibility for MassHealth applicants or dually eligible members. These populations will receive Medicare reimbursement or another primary insurer's reimbursement for nursing-facility services on admission to the nursing facility.

Hospitals will transfer these individuals to nursing facilities without clinical screenings or notices of clinical eligibility from MassHealth. For those MassHealth members who are dually eligible, MassHealth will continue to cover the appropriate nursing-facility coinsurance and deductibles. The nursing-facility coinsurance and deductible payments from MassHealth do not require clinical eligibility.

What Is Not Changing

Hospitals will continue to determine or assess nursing-facility clinical eligibility for Medicaid-only MassHealth members, and individuals who at the time of hospital discharge have no nursing-facility payer source and for whom Medicaid will be the sole source of payment for the nursing facility from the first day of admission.

The OBRA/PASARR screening for all individuals seeking admission to a nursing facility remains the same. All individuals, regardless of payment source, seeking admission to a nursing facility must be reviewed for the need of a Level II PAS before admission. If an individual requires a Level II PAS, DMR or DMH/HES must be notified. The Level II PAS must be completed, and the individual determined clinically eligible, for nursing-facility services before admission. Where applicable, attach the findings to the Notice of Eligibility.

Dually Eligible Members: Payment of Coinsurance and Deductibles

In circumstances where a MassHealth member enters a nursing facility under the Medicare benefit, MassHealth will pay for coinsurance and deductibles for these individuals. Facilities **are not** required to submit an SC-1 and a level of care to receive these payments. Facilities will receive payment by billing for coinsurance and deductibles via the Explanation of Medicare Benefits (EOMB).

Dually Eligible Members: Time Frame for SC-1 Submission

Nursing facilities should submit an SC-1 and level of care only at the point at which the primary insurer's coverage is scheduled to expire. The request date on the form should be the first day following the expiration of the primary insurer's coverage.

Questions

If you have any questions about the information in this bulletin, please contact MassHealth Provider Services at 617-628-4141 or 1-800-325-5231.