Chapter 30

Long-Term Care (LTC)

NOTE: *Please review the following detail for specific processes and expectations with South Country Health Alliance (South Country). South Country may vary from the MHCP Manual and Minnesota Department of Human Services Guidelines. For additional detail on this chapter, please go to the Minnesota Health Care Programs Provider Manual at* MHCP Provider Manual.

Billing Information – Please review the South Country Provider Manual Chapter 4 Provider Billing for general billing processes and procedures.

Nursing Facility (NF) Communication Form (DHS-4461) is required. The form is required within one (1) business day for admission and discharge and for each updated reason code as indicated on the form. Fax completed form to 1-888-633-4052.

Day count of custodial and Medicare days available: providers may call to verify benefit day count by contacting utilization management at 1-888-633-4051.

Daily Rates

Claims for nursing facilities are paid based upon the case mix rates in effect for the specific date(s) of service, not based upon the rates in effect when the claim is submitted or processed by South Country Health Alliance. Rates from a previous calendar year are required when processing a claim in 2024 for dates of service in 2023. South Country Health Alliance uses Minnesota Department of Health (MDH) Nursing Home Report Card facility daily rates when processing long-term care claims. Rates for previous calendar years are removed from the Nursing Home Report Card website and no longer available after the first of each year. To prevent claims with dates of service in 2023 from denying due to missing Medical Assistance (Medicaid) resource utilization group (RUG)/Casemix rates please fax the 2023 RUG rates to 1-888-633-4052. Providers may access their historical rates at nfportal.dhs.state.mn.us.

If you have questions, please call the Provider Contact Center at 1-866-633-4055.

Definitions

Certified Bed: A bed certified under Title XIX of the Social Security Act.

Certified Nursing Facility (NF): A facility or part of a facility which is licensed to provide nursing care for persons who are unable to properly care for themselves.

Discharge: Termination of place placement in the NF that is documented in the discharge summary and signed by the physician.

Facility with Distinct Part Certification: Sections of the facility certified as psychiatric, NF, or ICF/DD; must admit and care for those MA members certified as requiring the same level of care as the bed certification.

LTC Facility: A residential facility certified by the MDH as a skilled nursing facility or as an intermediate care facility, including an ICF/DD.

Leave Day: An overnight absence of more than 23 hours. After the first 23 hours, additional leave days are accumulated each time the clock passes midnight. Absence must be for hospital or therapeutic cause.

Reserved Bed/Bed Hold: The same bed that a member occupied before leaving the facility for hospital leave or therapeutic leave, or an appropriately certified bed if the member's physical

condition upon returning to the facility prohibits access to the bed he/she occupied before the leave.

Short-term Stay: Nursing facility admission expected to be less than 14 days.

Swing Bed: A hospital bed that has been granted a license under MN Statutes 144.562 and which has been certified to participate in the federal Medicare program under US code title 42, section 1395. Refer to the Swing Bed section of this chapter.

Transfer: The movement of a member after admission from one facility directly to another facility with a different provider number, or to or from a unit of a hospital to another unit recognized as a rehabilitation-distinct part by Medicare. Transfer also includes members who move to or from extended inpatient psychiatric services capacity under contract with the Minnesota Department of Human Services (DHS). Moving a member from a medical or surgical service to the acute psychiatric unit within the same hospital is not considered a transfer and must be billed as one continuous hospitalization.

Eligible Providers

Skilled nursing facilities (SNF), nursing facilities (NF), or boarding care homes (BCH), licensed as nursing facility providers by the Minnesota Department of Health (MDH). Swing bed hospital provider eligibility information is specified in the swing bed section.

Facilities with distinct part certification must admit and care only for those MA members certified as requiring the same level of care as the bed certification.

Eligible Members

Minnesota Senior Care Plus (MSC+)

Minnesota Senior Health Options (MSHO): SeniorCare Complete (SCC)

Special Needs Basic Care (SNBC): SingleCare, SharedCare and AbilityCare

Nursing facilities provide services to individuals who have been screened and determined to need a nursing facility level of care.

South Country Health Alliance eligible members must reside in a certified bed that matches their certified level of care.

South Country Health Alliance will cover the cost of care for a member who resides in a certified nursing facility or certified BCH if all of the following requirements are met:

- Certified nursing and certified board care facility
- The care is ordered by a physician;
- The care is provided in compliance with State and Federal regulations; and
- The care provided in a nursing facility or BCH is required because of physical or mental limitations determined through the Preadmission Screening (PAS) process or Long-Term Care Consultation (LTCC) process completed by the county prior to admission to the facility, with certain exceptions defined below.

Swing Bed Hospital:

Specifications are in the *Swing Bed* section of this chapter.

Physician Certification

A physician must certify the need for a certified nursing facility or certified boarding care facility. The Physician Certification (eDoc DHS 1503) form must be completed in the following instances:

- Upon initial admission or upon readmission following discharge.
- When a member transfers from one nursing facility to another.

Telephone orders cannot be used for physician certification purposes. Written orders signed and dated by a physician are permissible for this purpose, or a physician may sign and date the Physician Certification form.

The Physician Certification (eDoc DHS 1503) form must be completed by the following:

- **Facility:** Within 30 days prior to the admission date, or on the date of admission. Payment will begin on the date the physician signs and dates orders for admission or the Physician Certification form or the actual admission date, whichever is later.

Physician Visits for Nursing Facility and Boarding Care Members

Under state rule, a resident must have a current admission medical history and complete physical examination performed and recorded by a physician, physician assistant or nurse practitioner within five days before or within seven days after admission. After the admitting examination, the physician must see the resident at least every 30 days for the first 90 days after admission and then whenever necessary. A physician visit is considered timely if it occurs within 10 days after the date the visit was required.

When a member on a 60-day schedule of visits is transferred to a hospital and returns to the same nursing facility, it is not necessary to begin a new 30-day schedule of visits for 90 days. The next required routine physician visit would occur 60 days after the member returns from the hospital.

At the discretion of the physician, and in accordance with facility policy, required visits after the initial visit may alternate between personal visits by the physician and visits by a physician assistant, certified nurse practitioner, or clinical nurse specialist. The physician assistant, certified nurse practitioner or clinical nurse specialist must not be an employee of the nursing facility.

Residents who would otherwise be on a 60-day visit schedule, but refuse to see their physician this often, may waive this requirement. Under State law, physicians must see nursing home residents at least every six months and boarding care home residents at least once per year. Each refusal must be documented in the member's medical record and signed by the resident and the physician.

Discharge and Transfer

When a resident is *discharged*, they are terminated from a residential treatment period of care through the formal release or death of the resident. The record must contain a discharge summary signed by a physician, and the facility must notify the county. Payment is not made for reserving a bed after discharge. If the resident returns to the facility, all admission record requirements must be completed.

When a resident is *transferred*, they are temporarily placed into an inpatient hospital (not including regional treatment centers or other nursing facilities) and the facility holds the bed for the resident. The medical record must indicate the resident was absent from the facility and, upon return, must be updated with any changes. A transfer does not prohibit a facility from thinning the medical record.

In addition, any transfer, discharge, or relocation of residents must comply with all applicable federal or state laws, including the State Resident Relocation law, found in MN Stat. sec. 144A.161.

Same Day Transfers

When a member transfers from on SNF to another; there is no charge for date of discharge. The first SNF will not bill for date of DC; the incoming SNF will be allowed to charge for date of admit.

Transfers and PAS:

A new PAS is not required if an individual is transferring from:

Nursing facility to nursing facility;

Hospital swing bed to hospital swing bed; or

Nursing facility to acute hospital to nursing facility.

This PAS exemption applies only if the individual does not return to the community during these transfers. See also PAS Summary in MHCP Provider manual for timelines and other requirements for PAS: Nursing Facilities (state.mn.us).

A PAS may be considered valid for up to 60 days prior to admission. If an individual discharges to the community, but the PAS was completed within 60 days of the second admission, a new PAS would not be needed, even if the individual returned to the community.

In addition, any transfer, discharge, or relocation of residents must comply with all applicable federal or state laws, including the state Resident Relocation law, found in M.S.144A.161.

Resident Classification

The case mix system utilized for Minnesota nursing facilities (NFs) certified for Medicaid (MA or Medical Assistance) is based on the federally required minimum data set (MDS). . The RUGS-III 34 group model was modified to 36 groupings and used to establish Minnesota case mix classifications. These case mix classifications, in part, determine the per diem (daily) rates for residents residing in Minnesota nursing facilities.

The following resident assessments must be conducted by the facility in accordance with the most current CMS guidelines and are used in determining a resident's case mix classification for reimbursement purposes.

- Admission assessment;
- Annual assessment;
- Significant change assessment;
- Quarterly assessments;
- Significant correction to prior comprehensive assessment; and
- Significant correction to prior quarterly assessment.

Nursing facilities conduct the MDS assessment on each resident and transmit that data to the Minnesota Department of Health (MDH). MDH then determines the resident's case mix classification based on the MDS data and notifies the facility, who in turn notifies the resident. MDH also transmits this data to the Department of Human Services (DHS), for use in determining the facility's reimbursement (per diem) rates. MDH also conducts regular audits of the MDS data submitted by NFs to ensure the data is accurate. Audits conducted by the MDH may result in changes to the resident's case mix classification and therefore the per diem rate.

The nursing facility or the resident may request a reconsideration of the case mix classification from MDH. Case-mix related functions are conducted by the MDH on behalf of the Medicaid program under contract to the DHS (the Medicaid agency).

For more information on Minnesota case-mix for nursing facilities, review Minnesota Case Mix Review Program - MN Dept. of Health (state.mn.us)

Penalty for late or non-submission of resident assessment

A facility that fails to complete or submit an assessment for a case-mix classification within seven days of the time required is subject to a reduced rate for that resident. The reduced rate will be the lowest rate for that facility. The reduced rate is effective on the day of admission for new admission assessments, or on the day that the assessment was due, for all other assessments. The reduced rate continues in effect until the first day of the month following the date of submission of the resident's assessment.

Nursing Assistant (NA) Registry

Nursing Assistant Training and Competency Evaluation

A nursing facility may employ an individual working in the facility as a nursing assistant for more than four months, if the individual:

- Is a permanent employee, competent to provide nursing and nursing related services;
- Has successfully completed an approved training and competency evaluation program or a competency evaluation program approved by the state; and
- Has been deemed or determined competent as provided by the MDH.

A nursing facility may employ an individual working in the facility as a nursing assistant for less than four months, if the individual meets one of the following criteria:

- Is a permanent employee enrolled in an approved training and competency evaluation program;
- Has demonstrated competence through satisfactory participation in a state approved training and competency evaluation program or competency evaluation; or
- Has been deemed or determined competent as provided by the MDH.

A nursing facility may employ a non-permanent (temporary or contract) employee working in the facility as a nursing assistant, if the individual:

- Is competent to provide nursing and nursing-related services.
- Has successfully completed a training and competency evaluation program or a competency evaluation program approved by the state.

Nursing facilities may employ an individual to work as a nursing assistant if the individual meets any of the requirements outlined above, but the facility must also seek and obtain a copy of the Nursing Assistant Registry verification for the permanent employment file. In the case of non-permanent (temporary or contract) staff, the nursing facility remains the responsible party to ensure that staff employed in their facility meet all requirements.

Information in Registry

The Nursing Assistant Registry includes substantiated findings of resident abuse, neglect, or misappropriation of resident property involving an individual listed in the registry. It may also include a brief statement by the individual disputing the findings.

Contacting the Registry

When the Nursing Assistant Registry is contacted by telephone, the nursing facility will receive immediate verbal verification of the individual's status on the registry. If the NA is active on the registry, the facility can request an inquiry letter be mailed or faxed verifying the nursing assistant's status. The facility will be instructed to speak to a registry representative if the NA is inactive, not on the registry, or has abuse allegations or findings on record.

Contact the registry at:

Minnesota Department of Health
Nursing Assistant Registry
85 East 7th Place, Suite 300
P.O. Box 64501
St. Paul, MN 55164-0501
651-215-8705 or 1-800-397-6124
health.FPC-NAR@state.mn.us

Information on Nurse Aide Reimbursement

For questions related to nurse aide reimbursement policies, contact:

Long-Term Care Policy Center
651-431-2282
DHS.LTCpolicycenter@state.mn.us

Pre-Admission Screening (PAS) Under State and Federal Statutes

Minnesota statutes and federal law require that all individuals entering a Medical Assistance (Medicaid) certified nursing facility, hospital swing bed, or certified boarding care facility be screened by the county before admission. Refer to the Minnesota Senior Linkage Line for state policy information on preadmission screening for nursing facility admission.

The purpose of the PAS process is to avoid unnecessary facility admissions by identifying individuals whose needs might be met in the community and who can be connected with community-based services. PAS helps determine and document the need for certified nursing facility, hospital Swing Bed, or certified boarding care facility services in Medicaid Management Information System (MMIS) for the purpose of Medical Assistance (Medicaid) payment for services and to provide assistance after facility admission to support the transition back to community life. PAS also serves to screen people for mental illness or developmental disabilities (OBRA Level I). In addition, nursing facility members on MA must have their level of care established at admission and 90 days after admission. The screening is completed to identify and refer individuals to other professionals for additional diagnosis and evaluation (OBRA Level II) of the need for specialized mental health or developmental disability services as required under federal law. An OBRA Level II evaluation is needed when a person is suspected to have or has a confirmed diagnosis of a serious mental illness or a developmental disability or related condition and is seeking admission to a nursing facility. The county must complete the OBRA Level II prior to nursing facility admission.

The Senior LinkAge Line® is responsible to perform PAS for all individuals except those enrolled in the following Minnesota Health Care Programs (MHCP):

- Minnesota Senior Health Options (MSHO);
- Minnesota Senior Care Plus (MSC+); and
- Special Needs BasicCare (SNBC).

Exemptions: Exemptions from the federal requirements for screening people for mental illness or developmental disability (and subsequent referrals for more complicated evaluation as needed) are limited to:

- A person, who has entered an acute care facility from a certified nursing facility, is returning to a certified nursing facility.
- A person transferring from one certified nursing facility in Minnesota to another certified nursing facility in Minnesota.

Certain hospital discharges when all of these conditions are met:

- The person is entering a certified nursing facility directly from an acute care hospital after receiving acute impatient care at the hospital;
- The person requires NF services for the same condition for which he or she received care in the hospital; and
- The attending physician has certified before admission that the individual is likely to receive less than 30 days of NF services.

All PAS referrals must be submitted online by a qualified health care professional at www.sllreferral.org. The qualified health care professional must have sufficient information to complete the online screening tool.

- South Country Health Alliance serves as the entry point for all PAS referrals from the Senior LinkAge Line® for individuals enrolled in Senior Care Complete, MSC+, AbilityCare, Shared Care and Single Care. South Country has delegated completion of PAS activities to our county partners. If the county staff is unable to determine the need for nursing facility level of care or complete the OBRA Level I based on the information provided via online referral, a face-to-face assessment must be completed in order to determine the need for nursing facility level of care and complete OBRA Level I. The face-to-face assessment must be completed within 20 calendar days of the initial request for screening and prior to admission.

County staff will forward a copy of the most recent OBRA Level I screening form to the facility when an individual participating in one of the HCBS programs listed is admitted to a certified nursing facility, hospital Swing Bed, or certified boarding care facility.

County Responsibility

The county responsibilities under the PAS program include the following:

- Under certain circumstances, counties have the option to complete a PAS face-to-face or by telephone. A public health nurse or social worker must complete a PAS.
- The nursing facility must notify all applicants who request admission, and their families, that a PAS is required before admission. The nursing facility must also notify the county PAS screener of all new applicants.
- Under most circumstances, the "county of location" is responsible for PAS for members requesting admission to a certified nursing facility or certified boarding care facility.
- If the person leaves a correctional facility (on medical release) to enter a NF, the person must be screened by the county in which the prison is located.
- If the person is being discharged from the hospital to the nursing facility, contact the county in which the hospital is located.

See DHS MHCP provider manual for PAS timelines and other requirements for preadmission screening. Exemption from Level of Care Determination and OBRA Level I Screening.

Individuals Under 21 Years of Age

For all individuals under age 21, a face-to-face assessment must occur before admission to a certified nursing facility, hospital swing bed, or certified boarding care facility, regardless of expected length of stay or admission source. This requirement is intended to prevent admission of this population whenever possible by developing community-based support and care plans that will meet the individual's needs in a less restrictive environment.

At the face-to-face assessment, all community alternatives must be explored and presented to the person, his/her family, and/or the person's representative. If a certified nursing facility, hospital swing bed, or certified boarding care facility admission cannot be prevented, the admission must be approved by DHS by calling **1-651-431-4300**.

Preadmission Screening (PAS) and Medical Assistance Reimbursement

Medical Assistance (Medicaid) reimbursement for certified nursing facilities, hospital swing beds, or certified boarding care facilities shall be authorized for a South Country Health Alliance member only if a PAS has been conducted prior to admission or the local county agency has authorized an exemption. South Country Health Alliance reimbursement for certified nursing facilities, hospital swing beds, or certified boarding care facilities shall not be provided for any member whom the local screener has determined does not meet the level of care criteria for certified nursing facilities, hospital swing beds, or certified boarding care facilities placement or, if indicated, has not had an evaluation completed unless an admission for a member with mental illness is approved by the local mental health authority or an admission for a member with developmental disability or related condition is approved by the state mental disability authority.

The certified nursing facility, hospital swing bed, or certified boarding care facility shall not bill a person who is not a South Country Health Alliance member for resident days that preceded the date of completion of screening activities as required under state and federal law. The certified nursing facility, hospital swing bed, or certified boarding care facility must include an un-reimbursed resident day in the certified nursing facility, hospital swing bed, or certified boarding care facility resident day totals reported to DHS.

Emergency Admissions

Persons admitted to the Medicaid certified nursing facility from the community on an emergency basis, or from an acute care facility on a nonworking day, must be screened the first working day after admission.

Emergency admission to a nursing facility before screening is permitted when a person is admitted from the community to a certified nursing or certified boarding care facility during county nonworking hours and:

1. The physician has determined that delaying admission until the PAS is completed would adversely affect the person's health and safety.
2. There is a recent precipitating event that no longer enables the person to live safely in the community, such as sustaining an injury, sudden onset of acute illness, or a caregiver is unable to continue to provide care.
3. The attending physician must authorize the emergency placement and document the reason that emergency placement is recommended.

The Senior LinkAge Line® must be contacted on the first working day following the emergency admission. However, PAS referrals can be made online 24 hours a day, including holidays. The Senior LinkAge Line® will retrieve the form on the next working day.

Transfer of a patient from an acute care hospital to an NF is not considered an emergency except for a person who has received hospital services in the following situations: hospital admission for observation (i.e., stabilization of medications) care in an emergency room without hospital admission or following hospital 24-hour bed care. The admission date will be used as the screening date for qualified emergency admissions when the above criteria are met. If these criteria are not met, the date of the actual screening will be used.

Nursing facility, swing bed and certified boarding care home responsibility

Nursing Facilities and boarding care facilities' responsibilities under the preadmission screening program include the following:

- Determining if applicant has been screened.
- Informing applicants of preadmission screening program requirements and background.
    - Providing the screener with pertinent information obtained from the applicant or family.

For further details on PAS, contact the Senior LinkAge Line® at **1-800-333-2433**.

The nursing facility should retain the following documents:

- Preadmission screening notice to resident that he/she has been screened.
- Statement of applicant's choice for placement.
- A copy of the Level I form signed by the screener.

Covered Services

South Country Health Alliance covers room and board care for a South Country Health Alliance member in a certified nursing facility or certified boarding care facility. The care and monthly room and board services (per diem) cannot be billed until the beginning of the following month (e.g., January services cannot be billed until February 1).

Items/services usually included in the per diem (not an all-inclusive list):

- Nursing services;
- Laundry and linen services;
- Dietary services;
- Personal hygiene items necessary for daily personal care (e.g., soap, shampoo, toothpaste, toothbrush, shaving cream, etc.); and
- Over-the-counter drugs or supplies used on an occasional, as needed basis (e.g., aspirin, acetaminophen, antacids, cough syrups, etc.).

Noncovered Services

Items/services not included in the per diem (not an all-inclusive list):

South Country Health Alliance covers the majority of costs incurred while in a nursing facility. However, a resident may be responsible for some non-covered MA services, such as the following:

- Special services;

- Other services not covered by Medical Assistance;
- Spenddown amounts; and
- Private room.

Additional Charges for Special Services

- State law allows a facility to charge residents for special services that are not included in the per diem. Special services must be available to all residents in all areas of the facility and charged separately at the same rate for the same services. To qualify as a special service, the following conditions must be satisfied for MA and private-pay residents:
- The facility must provide a detailed explanation of what is included in the case-mix rate;
- The facility must provide a detailed explanation of the special service and the additional charge;
- The cost of the special service must not have been included in the facility's historical cost in the cost report for the prior reporting year;
- The service cannot be a licensure or certification requirement;
- Each resident or potential admission must be free to choose whether or not he or she desires to purchase the special service from the facility;
- The facility must allocate and report the cost and charges associated with the provision of special services under unallowable costs in the facility's annual cost report (for those required to file); and

Nursing Facility Services for PMAP/MNCare are not covered by this MCO unless a special substitute arrangement is agreed upon. Contact DHS Fee for Services for coverage. For questions MN DHS Help Desk Ph# 800-366-5411.

Swing Bed – Critical Access Hospital (CAH)

South Country Health Alliance allows Medical Assistance (Medicaid) payments for members admission to a critical access hospital swing bed. Services are provided by a designated licensed hospital, if the following criteria are met:

- Member elects swing bed level of care post-acute care;
- The member requires skilled nursing care per Medicaid/Medicare guidelines;
- The member is discharged from an acute care hospital to a swing bed or remains in the CAH but transitions to swing bed level of care;
- The member must receive a preadmission screening prior to placement as specified in the Preadmission Screening section of this chapter; and
- CAH Swing Bed notification from # 4495 must be submitted to South Country Fax 1-888-633-4052 within one (1) business day of admission and discharge.

180-Day Benefit – SeniorCare Complete (MSHO) and MSC+

South Country Health Alliance is responsible for a total of 180 cumulative days of nursing home room and board for SeniorCare Complete (MSHO) and MSC+ members. After the initial 180 days, billing for nursing home care should be submitted to DHS.

If a South Country Health Alliance member is residing in a nursing home at the time they enroll in South Country Health Alliance SeniorCare Complete (MSHO), they are **not** entitled to the 180-day benefit. If a member elects hospice service during their benefit period; hospice days do not count towards the 180-day benefit period; State MA FFS pays room and board during

hospice election. In the event hospice services are discontinued the facility shall notify South Country within 24 hours to resume health plan responsibility days. (See notification requirements on page 12)

100-Day Benefit – Special Needs Basic Care (SNBC) – AbilityCare, SingleCare and SharedCare

South Country Health Alliance is responsible for a total of 100 cumulative days of nursing home room and board for Special Needs Basic Care (SNBC) – AbilityCare, SingleCare and SharedCare members. After the initial 100 days, billing for nursing home care should be submitted to DHS.

If a South Country Health Alliance member is residing in a nursing home at the time they enroll in South Country Health Alliance Special Needs Basic Care (SNBC) – AbilityCare, SingleCare and SharedCare he/she is **not** entitled to the 100-day benefit.

180-Day/100-Day Benefit requires 180 day Separation Period

For a member to be eligible for a new distinct180-day benefit period for MSHO or the 100 day benefit period for SNBC, the member would have first need to have exhausted the 180/100 day benefit of nursing facility services, and then the member would discharge from the nursing facility for 180 consecutive days. This separation period is defined as being out of the nursing facility for 180 consecutive institutional or community days in order for member to be eligible for a new 180/100-day benefit period. For members who do not reach the 180-day separation or who do not exhaust the initial benefit days upon readmission the day count will resume with last covered day from previous stay. For example, a member has used 110 custodial benefit days, discharges to the community even with a full 180 day separation period upon readmission day count will be 111th day of 180 day benefit period For members who exhaust their initial benefit upon readmission after a 180-day separation in the community will return on day 1 of their MCO benefit period.

A member who is in their 180-day separation period that is placed in a hospital or nursing facility that is 30 days or less shall still be considered as residing in the community and these days shall be counted toward the 180-day separation period.

After the member is in the community for 180 days, South Country Health Alliance would be responsible for a new, distinct 180-day nursing facility benefit period for a SeniorCare Complete (MSHO)/ MSC+ member or a new, distinct 100-day nursing facility benefit for a Special Needs Basic Care (SNBC) – AbilityCare, SingleCare, and SharedCare member who is still community based.

If the member becomes institutionalized prior to the end of the 180-day separation period, no new nursing facility benefit period applies to South Country members.

100 Medicare Skilled Nursing Days

South Country Health Alliance SeniorCare Complete (MSHO) and AbilityCare (SNBC) members are entitled to up to 100 days of Medicare coverage if the Medicare qualifications have been met.

The nursing facility is required to notify South Country Health Alliance when the resident enters a Medicare skilled level of care using the Nursing Home Communication Form (DHS-4461).

Once the 100 days of Medicare coverage are used, the person is **not entitled** to another 100 days Medicare skilled days, unless there has been a 60-day break from the Medicare skilled level of care.

A member is entitled to the 100 Medicare days no matter how long he/she has been a resident at the nursing facility, as long as he/she meets the requirements of a skilled level of care. South Country Health Alliance follows Medicare skilled coverage criteria.

Notification is required for Custodial and Skilled Stays

Nursing facilities are required to track Medicare Benefit days and inform South Country when the facility determines members Medicare eligibility start and end dates.

1. A notification within one business day of all member tracking reason codes identified on the form **is required**. The SNF must fax the following to South Country: Nursing Facility (NF) Communication Form (DHS-4461) Form under Notifications.
2. Skilled care (SNF) and custodial care (NF) do not require health plan prior authorization of medical necessity.

South Country Health Alliance does NOT require a prior three (3) day hospitalization for skilled (SNF) care coverage for members. Nursing facilities must assure that members have available Medicare Part A days, meet SNF coverage/eligibility criteria, and must meet one of the following:

- Present to a clinic, emergency department or urgent care setting and require ongoing skilled care, observation, monitoring, or rehabilitation therapy that cannot be appropriately provided in the home setting.
- The member is a long-term care resident and experiencing an acute illness or exacerbation of a chronic condition that would meet criteria for an inpatient admission, and care can safely be provided in the nursing facility. Coverage will only be authorized for the period of time that the member requires skilled services that meet coverage criteria.

Critical access hospitals providing Medicare coverage in swing bed are required to submit form #4495 to 1-888-633-4052.

For details regarding co-insurance payment calculation see also DHS MHCP Provider Manual/provider basics/billing policy/payment methodology- non-hospital. Also noted below:

Skilled Nursing Patient Driven Payment Model (PDPM) / Co-Insurance payment methodology

Patient Driven Payment Model (PDPM) case-mix classification model is used under the skilled nursing facility (SNF) Prospective Payment System (PPS) for classifying SNF patients in a covered Part A stay. South Country follows CMS methodology for reimbursement of Medicare covered SNF stays. Refer to the CMS Patient Driven Payment Model web page for more information on the PDPM.

South Country follows DHS payment methodology for MSC+ and SharedCare co-insurance days. It is imperative the NF Communication Form (DHS - 4461) (See Billing Section) for those products contain the PDPM rate and the DHS rate level for the calculation of co-insurance skilled days. South Country will pay the lesser of:

- The actual coinsurance amount.
- The amount by which the MA RUGS III case mix payment rate exceeds the Medicare rate less the coinsurance amount. For coinsurance days occurring during a 30-day enhanced rate period for new admits, the enhanced MA rate is used.

Nursing facilities may not apply unpaid coinsurance amounts to a member's resources. The MA allowed amount for the coinsurance must be considered payment in full, even if it is a zero payment. Nursing facilities may consider coinsurance amounts that are not paid in full by MA to

be a bad debt for Medicare purposes. Use the DHS RA for information to claim the bad debt from the Medicare intermediary.

Co-Insurance amount for SeniorCare Complete (MSHO) and AbilityCare are reimbursed at 100% of the Medicare co-insurance established daily rate for skilled days.

Requirements of the rate equalization law do not limit the amount of the Medicare copay that a nursing facility may collect from a private pay resident.

Rehabilitative Services

Nursing facilities may provide rehabilitative services to their residents and members of the community, utilizing either their own staff or by contracting with an outside service vendor (rehab agency). Services must be provided on the premises.

The billing party may only bill physical therapy (PT), occupational therapy (OT), and speech therapy (ST) if it is not a part of the facilities per diem. South Country Health Alliance will not make separate reimbursement for therapy services for residents of a nursing facility that includes therapy as part of the per diem rate. The party designated to do the billing shall bill for all rehabilitative services.

Note: The provider that bills for and receives payment for services is responsible for the accuracy of the claims and for maintaining patient records that fully disclose the extent of the benefits provided. Also, if SeniorCare Complete (MSHO)/AbilityCare (SNBC) requires the nursing facility to do the billing for SeniorCare Complete (MSHO)/AbilityCare (SNBC) covered rehabilitative services for dually eligible members, you must follow the programs requirements until SeniorCare Complete (MSHO)/AbilityCare (SNBC) benefits are exhausted.

Leave Days (nursing facility/nursing facility/boarding care facility)

Leave days are eligible for payment. A leave day must be for hospital leave or therapeutic leave of a member who has not been discharged from a nursing facility. A reserved bed must be held for a member on hospital leave or therapeutic leave. Payment for leave days in a skilled nursing facility or nursing facility is limited to 30% of the applicable payment rate.

To be eligible for payment, the following criteria must apply:

Hospital leaves:

- The member must have been transferred from a nursing facility to the hospital;
- The member's record must document the date the member was transferred to the hospital and the date the member returned to the nursing facility; and
- The hospital leave days must be reported on the claim submitted by the nursing facility with the appropriate hospital leave revenue code.

Therapeutic leaves:

- The member's record must document the date and time the member leaves the nursing facility and the date and time of return;
- The member may go on a home visit or vacation, to a camp that meets MDH licensure requirements, or to another residential setting **except** another nursing facility, hospital, or other entity eligible to receive federal, state, or county funds for his/her maintenance; and
- The therapeutic leave days must be reported on the claim submitted by the nursing facility with the appropriate therapeutic leave revenue code.

Leave day limitations:

Payment for hospital leave days is limited to 18 consecutive days for each separate and distinct episode of medically necessary hospitalization. Separate and distinct episode means one of the following:

- The occurrence of a health condition that is an emergency;
- The occurrence of a health condition that requires inpatient hospital services, but is not related to a condition that required previous hospitalization and was not evident at the time of discharge; or
- The repeat occurrence of a health condition that is not an emergency, but requires inpatient hospitalization at least two calendar days after the member's most recent discharge from the hospital.

Payment for therapeutic leave days is limited to the number of days listed below:

- Members in a nursing facility or skilled nursing facility or certified BCF are entitled up to 36 leave days per calendar year.

Leave days beyond the 18- or 36-day limit is prohibited, regardless of the occupancy rate. However, the resident or family may opt to pay the nursing facility to hold the bed beyond the benefit period if the facility offers this special service. If a resident is on leave day status, under most circumstances the facility may not discharge the resident or fill the bed with another resident until after the 18- or 36-day leave period has elapsed, and not at all if the resident has elected to self-pay for days beyond the 18- or 36-day leave period. This policy applies regardless of the facility's occupancy rate. Residents who exhaust their hospital leave days and are subsequently discharged from the facility are entitled to be readmitted to the facility to the next available bed.

Note: A 30-day notice may be required before a resident can be discharged due to leave days being exhausted, as provided in MS 144.652, subd.29.

For SeniorCare Complete (MSHO) and AbilityCare (SNBC) members, leave of absence days are shown on the bill with revenue code 018X and leave of absence days as units. However, charges for leave of absence days are shown as zero on the bill, and the nursing facility cannot bill the beneficiary for them. Occurrence span code 74 is used to report the leave of absence from and through dates. The electronic data elements are shown in the following chart. Refer to the Medicare Claims Processing manual, Chapter 25, "Completing and Processing the UB-04 (CMS 1450) Data Set," for further information about billing, including UB-04 data elements and the corresponding fields in electronic billing records.

The following data elements are required for reporting leave of absences:

- Revenue code 018X;
- Revenue code units and charges;
- Occurrence span code 74 and associated dates; and
- Patient status code.

Note: When the patient does not return from a leave of absence, regardless of the reason, the nursing facility must submit a discharge bill showing the date of discharge as the date the individual actually left. If the patient status was reported as "30" (still patient) on an interim bill and the patient failed to return from a leave of absence within 30 days, including the day leave began, or has been admitted to another institution at any time during the leave of absence, the nursing facility must submit an adjustment request to correctly indicate the day the patient left as the date of discharge. (A member cannot be an inpatient in two institutions at the same time.) This closes the open admission of the patient's utilization record.

Determining the Number of Leave Days

According to the definition of "leave day," an overnight absence of more than 23 hours is considered a leave day that must be reported. An absence of less than 23 hours on the first day is not a leave day. After the first 23 hours, each time the clock passes midnight counts as an additional leave day. Examples:

LEAVE	RETURN	NUMBER OF LEAVE DAYS
4:30 p.m. Friday	11:30 a.m. Saturday	0 (Less than 23 hours)
4:30 p.m. Friday	5:00 p.m. Saturday	1 (More than 23 hours)
4:30 p.m. Friday	8:00 p.m. Sunday	2 (More than 23 hours; past midnight once)
4:30 p.m. Friday	7:30 a.m. Monday	3 (More than 23 hours; past midnight twice)

Occupancy Rate

Payment for hospital leave and therapeutic leave days are subject to accurate completion and timely submission of the Nursing Facility (FC) Communication Form (DHS-4461) under Notifications as well as the following occupancy rates:

- Nursing facilities with 25 or more licensed beds will not receive payment if the average occupancy rate was less than 96 percent during the month of leave;
- Nursing facilities with 24 or fewer licensed beds will not receive payment if a licensed bed has been vacant for 60 consecutive days prior to the first leave day (Date of death or discharge will be considered day one when counting consecutive days.); and
- Nursing facility charge for a leave day must not exceed the charge for a leave day for a private paying resident in the same type of bed.

The occupancy rate may be calculated separately for each level of care in the facility as follows:

- Determine the number of days each licensed bed was occupied during the month. (**Note:** A reserved bed is to be considered an occupied bed for this purpose);
- Total to determine the number of occupied bed days for the month;
- Divide by the number of days in the current month; and
- Divide by the number of licensed beds to determine the occupancy rate for the month.

Private (Single Bed) Rooms in Nursing Facilities

Nursing facilities would complete form #4496 on South Country website and fax request to utilization management at 1-888-633-4052. To receive MA payment for a single bedroom for a MA member, the following requirements must be met:

- The bed in the single bedroom must be certified for MA by MDH;
- The member's attending physician must determine and certify that a single bedroom is necessary because of a medical or behavioral condition that affects the health of the member or other residents; and
- The facility must estimate the length of time the private room is needed.

The Nursing Facility Private Room Request form must be completed in its entirety including the facility's Quality Assessment and Assurance Committee (QAAC) must recommend and sign to acknowledge the necessity for the single bedroom.

Swing Bed Hospital Services (nursing facility/swing beds)

Eligible Members

To be eligible for swing bed payment, there must be documentation that the member requires a level of skilled nursing care consistent with admission to an LTC facility and no longer requires acute care hospital services. If the need for skilled nursing care cannot be documented, the services are not eligible for South Country Health Alliance payment. A copy of the preadmission document must be attached to the claim.

Preadmission Screening (PAS)

All people seeking placement in a swing bed must be screened either through a community screening or through a telephone screening prior to admittance to a swing bed in accordance with the policy described in the *Preadmission Screening* section of this chapter. Exceptions to PAS in Swing Bed placement are for the following: PAS

- Persons admitted from the community on a physician certified emergency basis or people admitted on a county non-working day must be screened on the first county working day after admission;
- Persons returning to a Swing Bed who entered an acute care facility from a swing bed;
- Persons in a swing bed who are transferring to another swing bed in another facility;
- Persons who have a contractual right to have their swing bed services paid for by the veterans administration; and
- Persons who are enrolled in the Ebenezer/Group Health Social HMO Project at the time of application to the swing bed.

Limitations

In accordance with state law, payment for swing bed services for a South Country Health Alliance member is limited to 40 days. Eligible hospitals are allowed a total of 1,460 days of swing bed use per the state's fiscal year (July 1 – June 30), provided that no more than 10 hospital beds are used as swing beds at any one time.

Ancillary Services

Routine care and services, similar to those provided in a nursing facility, are included in the daily swing bed payment rate. All other covered services may be billed to South Country Health Alliance. All ancillary services must be billed in accordance with the respective guidelines for the service, as outlined in the appropriate chapters of this manual.

Billing Guidelines

- Providers are required to fax the Nursing Home Communication form to utilization management at 1-888-633-4052. This form must be received prior to claims submission. Providers are required to submit the notification form promptly and accurately for member tracking. The following changes should be submitted: initial admission, bed hold (covered/noncovered) PDPM or DHS rug rate changes, discharge to home/hospital, readmission to facility, end of benefit for skilled or health plan days reached, changes in Medicare skilled stay, hospice enrollment and death, etc.
- For MSC + and SharedCare members, the form must contain the PDPM rate and the DHS rate level for co-insurance payment calculations. Providers should use required form DHS-4461-Eng found at Forms Page on the notifications tab.

- Room and board services must be billed in the 837I format using the facility's National Provider Identifier (NPI). The type of bill must be 281.
- The care and monthly room and board services (per diem) cannot be billed until the beginning of the following month (e.g., January services cannot be billed until February 1).
- The daily room and board payment rate for swing bed services is set by law as the statewide average payment rate of all MA nursing facilities per diem. This rate is computed annually, effective each July 1. A copy of the PAS must be attached to the claim.
- Only non-over-the-counter (OTC) South Country Health Alliance formulary pharmacy services can be billed outside the room and board per diem. Stock medications and OTC products are not separately reimbursable.
- Ancillary services for SeniorCare Complete (MSHO)/AbilityCare (SNBC) eligible members must be billed to South Country Health Alliance. If the services are not covered by Medicare, South Country Health Alliance may be billed under the member's Medicaid benefit.

If members receive their Medicare benefits from either original Medicare or another Medicare Advantage program, the ancillary services must be billed to the other Medicare plan. If the services are not covered by Medicare, South Country Health Alliance may be billed under the member's Medicaid benefit with a copy of Medicare's denied EOB. Medicare and other insurance are considered primary to Medical Assistance. South Country expects to be notified of all admissions even when other insurance is primary payor including Medicare fee for service.

Equalization

State law prohibits nursing facilities from charging private-pay resident's higher rates than those approved by DHS for Medicaid members. The law also allows residents to be awarded three times the payments that result from a violation.

Exceptions

- The Equalization Law does not apply to third party payers.
- The Equalization Law may or may not apply to private paying residents in single bedrooms, depending on the cost allocation method for single bedrooms chosen by the facility on their annual cost report.

Prohibited Practices

Certain practices, including, but not limited to the following, are considered prohibited practices and violations could result in penalties to the provider:

- financial exploitation
- restricting resident choice of vendors of medical services
- differential treatment
- discrimination
- kickbacks
- refusing admission to the nursing facility

  Refer to Minnesota Statutes, 256R.04 for more details.

Spenddown Refund Requests

- Members residing in a nursing facility who have an LTC spenddown are obligated to pay the nursing facility their LTC spenddown amount.
- When a member is also covered by Medicare Part A, the member may receive a refund for a portion of the LTC spenddown amount due to Medicare payments the nursing facility receives after the member has already paid the LTC spenddown. The nursing facility may retain the refund amount for payment of a past due obligation but only with the agreement of the member. Follow the Instructions for spenddown refund request for Long-term Care (DHS-4277A) (PDF) to apply for a spenddown refund.

Conditions of Participation

Termination of Provider Agreement

A nursing facility that chooses not to comply with the Equalization Law may voluntarily withdraw or involuntarily be withdrawn from the Medicaid program. Under most of these circumstances, the provider becomes ineligible to receive payment under other State and county programs. Special laws apply to nursing facility providers that withdraw from the Medicaid programs (contact the LTC Policy Center at 1-651-431-2282 for more information). If discharge of residents is necessary, discharge planning and relocation must be done in accordance with all provision of state and federal resident rights and the State Resident Relocation Law.

Segregation of MA Residents

Partial certification or de-certification of a distinct part of an NF may result in the segregation of MA residents. These practices discriminate against residents based on their source of funding and may violate both the Equalization Law and anti-discrimination laws. DHS will not enroll facilities that stigmatize residents receiving public assistance or practice other forms of resident discrimination. DHS will investigate nursing facilities that intend to or have segregated MA residents.

Solicitation of Contributions

Federal law prohibits soliciting contributions, donations, or gifts directly from MA residents or family members. Public appeals for contributions are not considered direct solicitation of MA residents or families. If an MA resident or family member makes a free-will contribution, the LTC provider is required to execute a statement for signature by the contributor and the LTC administrator, stating services provided in the LTC facility are not predicated upon contributions or donations and the gifts are free-will contributions.

Change of Ownership

The Social Security Act requires a nursing facility to promptly report any organizational or ownership changes to the MDH to maintain enrollment with South Country Health Alliance. MDH will determine if the nursing facility continues to meet minimal state and federal standards under new ownership.

If South Country Health Alliance receives notification that an entity has changed ownership, South Country Health Alliance will follow up with the provider to see if the provider wants to continue to be part of the South Country Health Alliance network. If the provider does, South Country Health Alliance will send them the appropriate documents to reflect the change. Once South Country Health Alliance has received the appropriate documents, it will inactivate the old “owner” and make a new entry in PMA with the new/updated information with the effective date of the change.

According to state law, the owner of the nursing facility is liable for any overpayment amount owed by a former owner for any facility sold, transferred, or reorganized.

Legal References

- MS 144.562, subd. 2 & 3 – Swing bed approval
- MS 256B.27, subd.1 - Medical Assistance; Cost Reports
- MS 256B.0625, subd.2 - Covered Services
- MS 256B.0911, - Long-Term Care Consultation Services

MS 256B.48 (Conditions for Participation)

- Minnesota Rules 9505.0410 to 9505.0420, - TC; Rehabilitative and Therapeutic Services
- Minnesota Rules 9549.0010 to 9549.0080, - Nursing Facility Payment Rates
- MS 256B.48, - Conditions for Participation

MS 256B.48 (Conditions for Participation)

- MS 256B.501, - Rates for Community-Based Services for Disabled
- Minnesota Rules 9549.0060, subp.11 - Determination of the Property Related Payment Rate
- Minnesota Rules 9549.0070, subp.3 - Computation of Total Payment Rate

Minnesota Rules, 4658.0710, subpart 4 (Physician visits)

Code of Federal Regulations, 483.30(c) (Physician services; Frequency of physician visits)