Chapter 27

Long-Term Care (LTC)

Long-term care facilities (LTC Facilities) provide medical and supportive services for residents who meet both of the following criteria:

- Have lost some capacity for self-care due to chronic illness or condition
- Are expected to need care for a temporary or prolonged period of time

Questions about LTC Facilities, policy, and services can be directed to the IMCare 1-800-843-9536 (toll free).

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) are eligible to provide LTC services. Swing Bed hospital provider eligibility information is specified in the *Swing Bed* section of this chapter.

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

Exemption: An SNF or ICF that is operated, listed, and certified as a Christian Science sanatorium by the First Church of Christ, Scientist, of Boston, Massachusetts, is not subject to the Federal regulations for utilization control in order to receive IMCare payments for the cost of member care.

MN Stat. sec. 256B.48, subd. 1 provides that a nursing home is not eligible to receive Medical Assistance (Medicaid) payments unless it refrains from requiring any resident of the nursing facility (NF) to utilize a vendor of health care services chosen by the NF.

MN Stat. sec. 256B.48, subd. 1 addresses payment agreements between nursing homes and providers of ancillary medical care. It provides that a nursing home is not eligible to receive Medical Assistance (Medicaid) payments unless it refrains from requiring any vendor of medical care (as defined by MN Stat. sec. 256B.02, subd. 7), who is reimbursed by Medical Assistance (Medicaid) under a separate fee schedule, to pay any portion of the provider's fee to the nursing home except as payment for renting or leasing space or equipment or purchasing support services from the NF as limited by MN Stat. sec. 256B.433.

MN Stat. sec. 256B.48, subd. 1 addresses payment rates and special services for nursing homes and its private pay residents. It provides that a nursing home is not eligible to receive Medical Assistance (Medicaid) payments unless it refrains from requiring its residents to pay more than its Medical Assistance (Medicaid) rate for similar services. Exceptions are made for the following:

- Private paying residents in private/single bedrooms; and
- Special services not included in the daily rate, if Medical Assistance (Medicaid) residents are charged the same rate for the same service.

In addition, an NF participating in the demonstration project under MN Stat. sec. 256B.434 may charge private pay residents up to the Medicare rate for the first 100 days after admission only if the private pay resident's stay is less than 101 days. Refer to this Statute for additional details of these provisions. Legal references are also included at the end of this chapter.

Eligible Members

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

IMCare eligible recipients must reside in a certified bed that matches their certified level of care.

IMCare will cover the cost of care for a recipient who resides in a certified NF or certified BCH, if the following requirements are met:

- Certified Nursing and Certified Boarding Care Facility
- The care is ordered by a physician
- The nursing facility is in compliance with state and federal regulations
- The care provided in an NF or BCH is required as determined through the preadmission screening process completed by the county prior to admission to the facility
- Swing bed hospital, see the specifications in the Swing Bed section

IMCare Minnesota Senior Care Plus (MSC+), and IMCare Classic (HMO SNP) eligible members must reside in a certified bed that matches their certified level of care.

Nursing facility level of care can be determined through a face-to-face assessment conducted by a lead agency (county, tribe, or managed care organization) with the authority to determine eligibility for the programs listed as specified under Minnesota Stat. sec. 256B.0911 governing Long Term Care Consultation Services (LTCCS). Nursing facility level of care is also determined through preadmission screening as described in Minnesota Stat. sec. 256.975. The Nursing Facility Level of Care Criteria document can also be used to assist in determining eligibility for long-term care.

Physician Certification

A physician must certify the need for a certified nursing facility or certified boarding care facility. A Physician Certification DHS-1503 form must be completed in all of the following instances:

- Upon initial admission or upon readmission following discharge
- When a member transfers from one nursing facility to another
- When a member transfers within a nursing facility from one level of care to another
- When a member returns from an unauthorized leave exceeding 24 hours
- When a member returns from hospitalization, if their level of care changes

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 DHS-1503 form.

The DHS-1503 form must be completed by the 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 DHS-1503, or the actual admission date, whichever is later.

Physician Visits for Nursing Facility and Boarding Care Members

Under State Rule, a certified nursing facility or boarding care resident must be examined by a physician within five days prior to or 72 hours after admission. After the admitting examination, the resident must be seen by a physician at least every 30 days for the first 90 days after admission and at least every 60 days thereafter.

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 (PA), certified nurse practitioner (CNP), or Clinical Nurse Specialist (CNS). The PA, CNP, or CNS must not be an employee of the NF. Refer to Chapter 6, Physician and Professional Services, for supervision requirements for physician extenders.

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 LTC 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.

Resident Classification

The Minnesota case-mix system uses an existing Federally mandated assessment instrument for all nursing facility residents.

The facility must conduct the following resident assessments in accordance with the most current CMS guidelines, and use them 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
- 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.

Request for Reconsideration of Resident Classification

The resident, resident's representative, or the nursing facility or BCH may request that MDH reconsider the assigned reimbursement classification. Residents or their representatives have the right to review the minimum data set (MDS) and other documentation in the medical record. Facility staff should help explain the assessment process and discuss any MDS items in question. If the resident, resident's representative, or facility staff wish to pursue reconsideration, the request must be submitted in writing to MDH within 30 days of the day the resident or the resident's representative receives the resident classification notice.

For additional information about Minnesota case-mix or to request a reconsideration, contact:

Minnesota Department of Human Services
Case Mix Review Section
PO Box 64938
Saint Paul, MN 55164-0938

Phone: **1-651-201-4301**
Fax: **1-651-215-9691**
Email: **Health.FPC-CMR@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 Registry

Nursing Assistant Training and Competency Evaluation

A LTC 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
- Has been deemed or determined competent as provided by MDH.

A LTC 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:

- 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
- Has been deemed or determined competent as provided by the MDH

A LTC 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 LTC Facility will receive immediate verbal verification of the individual's status on the Registry. If the nursing assistant 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 nursing assistant 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, Ste 300
PO Box 64501
Saint Paul, MN 55164-0501
Phone: **1-651-215-8705** or **1-800-397-6124** (toll free)
Email: **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
Phone: **1-651-431-2282**
Email: **DHS.LTCpolicycenter@state.mn.us**

Preadmission 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 receive PAS, regardless of the length of stay or payer source for facility services.

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). 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.

Minnesota Department of Human Services (DHS) Approval Required for All Individuals Age 21 and Under and/or for All Individuals with a Developmental Disability

DHS must approve all admissions for individuals age 21 and under and all admissions of individuals with developmental disabilities, regardless of the exemptions outlined below or responsibilities of the Senior LinkAge Line®/local agency outlined above. DHS approval is required regardless of the source of admission or payer for facility services.

Preadmission Screening for Mental Illness or Developmental Disability

All applicants to certified nursing and boarding care facilities, as well as hospital "swing" beds, must be screened **prior to admission**, regardless of income, assets or funding sources, and except as outlined below. A person who has a diagnosis or possible diagnosis of mental illness or developmental disability must receive a PAS before admission, regardless of the exemptions related to level of care determinations outlined below, to identify the need for further evaluation or specialized services. There is an exception if the admission prior to screening is authorized by the local mental health authority or the local developmental disabilities case manager, or unless authorized by the county agency according to Public Law Number 100-508.

The local agency will use qualified professionals, and forms and criteria developed by the commissioner to identify people who require referral for further evaluation and determination of the need for specialized services.

The local county mental health authority or the state developmental disability authority under Public Law Numbers 100-203 and 101-508 may prohibit admission to a nursing facility if the individual does not meet the nursing facility level of care criteria or needs specialized services as defined in Public Law Numbers 100-203 and 101-508.

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

- A person who, having 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 inpatient care at the hospital
- The person requires NF services for the same condition for which they received care in the hospital
- The attending physician has certified before admission that the individual is likely to receive less than 30 days of NF services

Preadmission Screening for NF Level of Care Determination

The determination of the need for nursing facility level of care will be made according to criteria developed by the commissioner. In assessing a person's needs, screeners will have a physician available for consultation and will consider the assessment of the individual's attending physician, if any. The individual's physician will be included if the physician chooses to participate. Other personnel may be included on the team as deemed appropriate by the county agencies.

Exemptions: Persons who are exempt from preadmission screening for purposes of level of care determination include:

- Persons exempt under the federal requirements related to screening for mental illness or developmental disability as outlined above
- An individual who has a contractual right to have nursing facility care paid for indefinitely by the veteran's administration
- An individual who is enrolled in the Ebenezer/Group Health social health maintenance organization project, or enrolled in a demonstration project under Minnesota Statutes 256B.69, subd. 8, at the time of application to a nursing facility
- An individual currently being served under the alternative care program or under a home and community-based services waiver authorized under section 1915(c) of the Social Security Act

An individual admitted to a certified nursing facility for a short-term stay, which, based upon a physician's certification, is expected to be 14 days or less in duration, and who have been screened and approved for nursing facility admission within the previous six months. This exemption applies only if the screener determines at the time of the initial screening of the six-month period that it is appropriate to use the nursing facility for short-term stays and that there is an adequate plan of care for return to the home or community-based setting. If a stay exceeds 14 days, the individual must be referred no later than the first county working day following the 14th resident day for a screening, which must be completed within five working days of the referral. Payment limitations listed below will apply to an individual found at screening to not meet the level of care criteria for admission to a certified nursing facility.

Individuals Under 21 Years of Age

Exemptions outlined above DO NOT apply to people under age 21. 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, their 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 (Medicaid) Reimbursement

Medical Assistance (Medicaid) reimbursement for certified nursing facilities, hospital Swing Beds, or certified boarding care facilities shall be authorized for an IMCare member only if a PAS has been conducted prior to admission or the local county agency has authorized an exemption. IMCare 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 mental 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 an IMCare 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 prior to 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:

- The physician has determined that delaying admission until the PAS is completed would adversely affect the person's health and safety
- 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
- The attending physician must authorize the emergency placement and document the reason that emergency placement is recommended

The provider must contact the county screener on the first working day following the emergency admission.

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) or care in an emergency room without hospital admission. If these criteria are not met, the date of the actual screening will be used.

PAS Summary

The table below summarizes timelines and other requirements for preadmission screening as well as some follow-up activity performed by county long-term care consultation (LTCC) staff.

TIMELINES FOR PAS and ASSESSMENTS FOR NURSING FACILITY ADMISSIONS	**Preadmission Screening**	
	Under 65	**Over 65**
Hospital discharge: NF admission meets criteria for a 30-Day exemption	No PAS required	No PAS required
Inter-facility transfer (NF-NF or NF-acute hospital-NF)	No PAS required	No PAS required
Initial admission under a qualifying 30-day exemption but stay exceeds 30 days	By 40th day of admission: Face-to-face LTCC visit, OBRA Level 1, any needed OBRA Level 2	By 40th day of admission: Telephone screening or face-to-face; OBRA Level 1 and any needed OBRA Level 2
Acute hospital discharge to NF: Stay projected to be 30 days or longer, or admission doesn't meet other 30-day delay criteria	Before admission, may be telephone or face-to-face. If telephone: LTCC face-to-face visit must occur within 40 working days of admission.	Before admission: Telephone or face-to-face
Admission from an acute hospital to NF on non-working county day	Next work day after admission. LTCC visit within 40 working days of admission if telephone screen.	Next work day after admission
Initial screening after emergency NF admission	Next work day after admission. LTCC visit within 40 working days of admission if telephone screen.	Next work day after admission
Age 20 and under	Face-to-face LTCC & DHS approval required for any admission to NF	
Required face-to-face assessment for persons age 21 to 64 admitted to NF if admitted by telephone	Within 40 work days of admission	

screening		

If a person received the PAS either online or through a face-to-face assessment, that PAS is valid for 60 calendar days. Sometimes, a person's admission is delayed after the PAS is completed and documented in MMIS. If the screener determined NF level of care was needed, OBRA Level I was completed, and the screening document was entered, re-screening is not needed if the date of nursing facility admission occurs within 60 calendar days of the PAS. Nursing facilities may contact the Senior LinkAge Line® to receive a copy of the PAS. If the individual is on a home and community based waiver or alternative care, the nursing facility should contact the county to obtain a copy.

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 recipients 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.

Nursing Facility and Boarding Care Facility Responsibility

Certified nursing facilities' responsibilities under the PAS program include the following:

- Determining if the applicant has been screened
- Informing applicants of PAS program requirements and background
- Obtain consent for PAS and notify the county
- Providing the screener with pertinent information obtained from the applicant or family

For further details on PAS, contact the Senior Care Coordinator at IMCare at **1-800-843-9536** (toll free)

The nursing facility should retain the following documents:

- PAS notice to resident that they have been screened
- Statement of applicant's choice for placement
- A copy of the Level I form signed by the screener

Covered Services

IMCare covers room and board care for an IMCare member in a certified nursing facility or certified BCF. 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 and 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.)
- Over-the-counter drugs or supplies used on an occasional, as needed basis (e.g. aspirin, acetaminophen, antacids, cough syrups, etc.)

Items and services not included in the per diem (not an all-inclusive list):
MA covers the majority of costs incurred while in a nursing facility. However, a resident may be responsible for some noncovered MA services, such as:

- Special services
- Other services not covered by MA
- Spenddown amounts

180-Day Benefit

IMCare is responsible for a total of 180 days of nursing home room and board. After the initial 180 days, billing for nursing home care should be submitted to DHS.

If an IMCare member is residing in a nursing home at the time they enroll in IMCare Classic, they are **not** entitled to the 180-day benefit. **Continue to submit claims for room and board to DHS.**

If an IMCare member is in the middle of their 180-day benefit and enrolls in IMCare Classic, this benefit ends. DHS is responsible for the member's nursing care.

Respite days **do not** count toward the benefit.

180-Day Separation Period

The member must reside in the community for 180 days after discharge from the SNF in order for the member to be eligible for a new 180-day benefit.

After the member is in the community for 180 days, IMCare would be responsible for a new, distinct 180-day SNF benefit period for a member who is still community based.

If the member becomes institutionalized prior to the end of the separation period, no new SNF benefit period applies.

100 Medicare Days

IMCare Classic members are entitled to up to 100 days of Medicare coverage if the Medicare qualifications have been met.

IMCare waives the three-day qualifying hospital stay for members in IMCare Classic.

The nursing facility should notify IMCare when the resident enters a Medicare skilled level of care.

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

Claims for the Medicare days for IMCare Classic members are sent to IMCare.

A member is entitled to the 100 Medicare days no matter how long they have been a resident at the nursing facility, as long as they meet the requirements of a skilled level of care.

IMCare follows Medicare skilled coverage criteria.

The Centers for Medicare & Medicaid Services (CMS) provides a list for consolidated billing items and services included in the per diem.

Ensure Medicare denials are issued in a timely manner.

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. In order to qualify as a special service, the following conditions must be satisfied for Medical Assistance (Medicaid) 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 they desire 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)

Questions regarding nursing facility services may be directed to the IMCare 1-800-843-9536 (toll free).

Rehabilitative Services

LTC 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-language pathology (SLP) if it is not a part of the facility's per diem. IMCare will not make separate reimbursement for therapy services for residents of an LTC Facility that includes therapy as part of the per diem rate. The party designated to do the billing shall bill for all rehabilitative services. Refer to Chapter 17, Rehabilitative Services, for covered services.

Leave Days (Skilled Nursing Facility [SNF]/Nursing Facility/Boarding Care Home [BCH])

Leave days are eligible for MSC+/IMCare Classic payment. A leave day must be for hospital leave or therapeutic leave of a member who has not been discharged from an LTC Facility. A reserved bed must be held for a member on hospital leave or therapeutic leave. Payment for leave days in an SNF or nursing facility is limited to 30 percent of the applicable payment rate.

To be eligible for MSC+/IMCare Classic payment, the following criteria must apply:

Hospital Leaves

- The member must have been transferred from an LTC 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 LTC Facility
- The hospital leave days must be reported on the claim submitted by the LTC Facility with the appropriate hospital leave revenue code

Therapeutic Leaves

- The member's record must document the date and time the member leaves the LTC 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 LTC Facility, hospital, or other entity eligible to receive Federal, State, or county funds for their maintenance
- The therapeutic leave days must be reported on the claim submitted by the LTC 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:

- 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
- 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

MSC+/IMCare Classic payment for therapeutic leave days is limited to 36 leave days per calendar year for recipients in an SNF or NF or certified boarding care facility.

MSC+/IMCare Classic payment for 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 LTC Facility to hold the bed beyond the MSC+/IMCare Classic 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. MSC+/IMCare Classic 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 MN Stat. sec. 144.652, subd. 29.

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 the following occupancy rates:

- LTC 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
- LTC 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.)
- The LTC 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
- Divide by the number of licensed beds to determine the occupancy rate for the month.

For questions on SNF/nursing facility/BCH bed hold and leave day policy, call IMCare at 1-800-843-9536

Private (Single Bed) Rooms in Nursing Facilities

To receive payment from IMCare for a single bedroom for an MSC+/IMCare Classic member, the following requirements must be met:

- The single bed room must be located in a nursing facility that has chosen to assign a greater proportion of their costs to single bed rooms
- The bed in the single bed room must be certified for Medical Assistance (Medicaid) by MDH
- The member's attending physician must determine and certify that a single bed room is necessary because of a medical or behavioral condition that affects the health of the member or other residents (the estimated length of time the private room is needed must also be indicated)
- The facility must estimate the length of time the private room is needed
- The Quality Assessment and Assurance Committee (QAAC) must recommend the single bed room and document the member's condition necessitating the single bed room
- The attending physician's statement, the QAAC's statement, and any additional relevant documentation from the member's medical record, must be submitted to IMCare for review.

If member has exhausted their 180- or 100-day liability benefit with IMCare, use the DHS Private Room Request form and send to:

Minnesota Department of Human Services
Nursing Facility Rates and Policy—Private Room Request

Fax: **1-651-431-7466**

Swing Bed Hospital Services (Nursing Facilities/Swing Beds)

State law allows Medical Assistance (Medicaid) payments for Swing Bed services provided by a designated licensed hospital, if the following criteria are met:

- The hospital is the sole community provider, or is a public hospital owned by a government entity with 15 or fewer acute care beds
- The IMCare member requires skilled nursing care per Medicaid guidelines
- A nursing home bed is not available within 25 miles of the facility
- The patient is transferred from an acute care hospital bed and acute care is no longer needed
- The person must receive a PAS prior to placement as specified in the *Preadmission Screening* section of this chapter

The hospital enrollment criteria, specified in Chapter 1, Requirements for Providers, are met

Eligible Providers

To be eligible as a Swing Bed provider in the Medical Assistance (Medicaid) program, a provider must accomplish the following:

- Receive Medicare certification as a Medicare Swing Bed provider. Medicare certification requires a survey by MDH. Certification information may be obtained from:

  Minnesota Department of Health Facility and Providers Compliance Division
  85 E 7th Place
  PO Box 64900
  Saint Paul, MN 55164
  Phone: **1-651-215-8701**

- Sign a Swing Bed Provider Agreement with DHS. Provider agreement information may be obtained from:
  Minnesota Department of Human Services
  Nursing Home Rates and Policy
  PO Box 64973
  Saint Paul, MN 55164-0973

Exceptions: Swing Bed services may be billed by a hospital not enrolled in the Medical Assistance (Medicaid) program only in the case of a Qualified Medicare Beneficiary (QMB) receiving IMCare Classic services. Coinsurance and deductible on QMB claims will be paid for the length of the IMCare stay. IMCare also covers up to 10 days of nursing care provided to a member in a Swing Bed if:

- The member's physician certifies that the member has a terminal illness or condition that is likely to result in death within 30 days and moving the member would not be in the best interests of the member and the member's family
- A nursing home bed is not available within 25 miles of the facility
- An open bed is not available in any Medicare hospice program within 50 miles of the facility

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 IMCare payment. A copy of the preadmission document must be attached to the claim.

Preadmission Screening (PAS)

All persons 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 (PAS) section of this chapter. Exceptions to PAS in swing bed placement are:

- Persons admitted from the community on a physician certified emergency basis or persons 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

Limitations

In accordance with State law, payment for Swing Bed services for a IMCare member is limited to 40 days, unless the Commissioner of MDH grants an extension. Approval for services in excess of 40 days must be requested in writing from MDH at least 10 days before the end of the maximum 40-day stay. The extension approval must be attached to claims, which include service dates beyond the initial 40-day period. 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 IMCare. 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

- Room and board services must be billed in the 8371 format using the facility's National Provider Identifier (NPI). The type of bill must be 281.
- The daily room and board payment rate for Swing Bed services is set by law as the statewide average payment rate of all Medical Assistance (Medicaid) nursing facilities' per diem. This rate is computed annually, effective each July 1.
- Only non-OTC IMCare 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 IMCare Classic-eligible members must be billed to IMCare. If the services are not covered by Medicare, IMCare may be billed under the member's Medicaid benefit.
- Ancillary services for Medicare-eligible members not on an IMCare Medicare Advantage Plan must be billed to Medicare. If the services are not covered by Medicare, IMCare may be billed under the member's Medicaid benefit.

Equalization

State law prohibits LTC Facilities from charging private-pay residents higher rates than those approved by DHS for Medicaid recipients. The law also allows residents to be awarded three times the payments that result from a violation. For more information on equalization and special services, refer to the *Additional Charges for Special Services* section in this chapter.

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 bed rooms, depending on the cost allocation method for single bed rooms chosen by the facility on their annual cost report

Conditions of Participation

Termination of Provider Agreement

An LTC 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 program (contact Nursing Home Rates and Policy at **1-651-431-2281** for more information). If discharge of residents is necessary, discharge planning and relocation must be done in accordance with all provisions of State and Federal Resident Rights and the State Resident Relocation Law.

Segregation of Medicaid Residents

Partial certification or de-certification of a distinct part of a nursing facility may result in the segregation of Medical Assistance (Medicaid) 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. LTC Facilities that intend to or have segregated Medical Assistance (Medicaid) residents will be investigated by DHS.

Solicitation of Contributions

Federal law prohibits soliciting contributions, donations, or gifts directly from Medical Assistance (Medicaid) residents or family members. General public appeals for contributions are not considered direct solicitation of Medical Assistance (Medicaid) residents or families. If a Medical Assistance (Medicaid) 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 an LTC Facility to promptly report any organizational or ownership changes to MDH to maintain enrollment with IMCare.

MDH will determine if the LTC Facility continues to meet minimal State and Federal standards under new ownership. MDH will submit copies of the certification to the LTC Facility, IMCare, and the county.

If IMCare receives notification that an entity has changed ownership, IMCare will follow up with the provider to see if the provider wants to continue to be part of the IMCare network. If the provider does, IMCare will send them the appropriate documents to reflect the change. Once IMCare has received the appropriate documents, it

will inactivate the old "owner" and make a new entry in Provider Management Application (PMA) with the new/updated information with the effective date of the change.

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

Resident Trust Account

Administration of Resident Fund Accounts

An LTC Facility resident may deposit their funds, including the personal needs allowance established under Minnesota Statutes, in a resident fund account administered by the facility. An LTC Facility must comply with MDH regulations concerning resident funds in addition to the following provisions:

- Credit to the account all funds attributable to the account including interest and other forms of income
- Do not co-mingle resident funds with the funds of the facility
- Keep a written record of the recipient's resident fund account, including the date, amount, and source of deposit or withdrawal recorded within five working days of the account activity
- Require a recipient who withdraws $10.00 or more at one time to sign a receipt for the withdrawal. A withdrawal of $10.00 or more that is not documented by a receipt must be credited to the recipient's account. Receipts for the actual item purchased for the recipient's use may substitute for a receipt signed by the recipient.
- Do not charge the recipient a fee for administering their account
- Do not solicit donations or borrow from a resident fund account
- Report and document to the county a recipient's donation of money to the facility when the donation equals or exceeds the statewide average Medical Assistance (Medicaid) payment for SNF care
- Do not use resident funds as collateral for or payment of any obligations of the facility
- Treat funds remaining in a recipient's account upon death or discharge as required by MDH regulations

Limitations on Use of Trust Funds

Funds in the member's resident fund account must **not** be used to purchase the following items or services generally reported in the facility's cost report:

- Medical transportation
- Initial purchase or replacement purchase of furnishings or equipment required as a condition of certification as an LTC Facility
- Laundering the member's clothing
- Furnishings or equipment not requested by the member for personal convenience
- Personal hygiene items necessary for daily personal care (e.g., bath soap, shampoo, toothpaste, toothbrushes, dental floss, shaving cream, razor, facial tissues)
- OTC drugs or supplies used by the member on an occasional, as needed basis, not prescribed for long-term therapy of a medical condition (e.g., aspirin, acetaminophen, antacids, anti-diarrheas, cough syrups, rubbing alcohol, talcum powder, body lotion, petroleum jelly, mild antiseptic solutions, etc.)

These limitations do not prohibit the member from using their funds to purchase a brand name supply or other furnishings not routinely supplied by the LTC Facility.

Questions on LTC policy and services may be directed to the IMCare at 1-800-843-9536 (toll free).

Definitions

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

Certified Nursing Facility: A facility or part of a facility that is licensed to provide nursing care for people who are unable to care for themselves properly.

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

Facility with Distinct Part Certification: Sections of the facility certified as psychiatric, nursing facility, or Intermediate Care Facility for the Developmentally Disabled (ICF/DD) must admit and care for those Medical Assistance (Medicaid) members certified as requiring the same level of care as the bed certification.

Long-Term Care Facility (LTC Facility): A residential facility certified by the Minnesota Department of Health (MDH) as a Skilled Nursing Facility (SNF) or as an Intermediate Care Facility (ICF), 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: 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 they occupied before the leave. Commonly referred to as "bed hold."

Residential Facility: Facility in which residents live in a group setting at a location that is not a single-family home or medical institution.

Skilled Nursing Facility (SNF): A licensed facility that provides skilled nursing care for acute and chronic conditions as well as additional help for activities of daily living (ADL).

Swing Bed: A hospital bed that has been granted a license under MN Stat. sec. 144.562 and which has been certified to participate in the Federal Medicare program under Title 42 United States Code (USC) 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.

Legal References

MN Stat. sec. 144.562 – Swing Bed Approval; Issuance of License Conditions
MN Stat. sec. 144.562, subd. 2 – Swing Bed Approval; Issuance of License Conditions: Eligibility for license condition
MN Stat. sec. 144.562, subd. 3 – Swing Bed Approval; Issuance of License Conditions: Approval of license condition
MN Stat. sec. 144A.161 – Nursing Home and Boarding Care Home Resident Relocation
MN Stat. sec. 256B.27, subd. 1 – Medical Assistance; Cost Reports: Reports and audits
MN Stat. sec. 256B.0625, subd. 2 – Covered Services: Skilled and intermediate nursing care
MN Stat. sec. 256B.0911 – Long-Term Care Consultation Services
MN Stat. sec. 256B.48 – Conditions for Participation:
MN Stat. sec. 256B.501, subd. 8 – Rates for Community-Based Services for Disabled: Payment for persons with special needs
MN Stat. sec. 256B.501, subd. 8a – Rates for Community-Based Services for Disabled: Payment for persons with special needs for crisis intervention services
MN Stat. sec. 256B.69, subd. 8 – Prepaid Health Plans: Preadmission screening waiver
MN Rules parts 9505.2390 – 9505.2500
MN Rules parts 9510.1020 – 9510.1140 – Special Needs Rate Exception for Very Dependent Persons with Special Needs
MN Rules part 9549.0060, subp. 11 – Determination of the Property Related Payment Rate: Capacity days
MN Rules part 9549.0070, subp. 3 – Computation of Total Payment Rate
Public Law 100-203: OBRA 1987 – Extension of Reductions under Sequester Order
Public Law 101-508: OBRA 1990 – Payments for Medical Costs
42 USC 1395 – Health Insurance for Aged and Disabled