State of Tennessee
Department of Finance and Administration
Bureau of TennCare
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Phil Bredesen
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URGENT MEMO

Date: May 25, 2007

To: Intermediate Care Nursing Facilities (Level 1)
Skilled Care Facilities (Level 2)

From: Patti Killingsworth, Assistant Commissioner
Chief of Long Term Care Operations

Subject: Elimination of retroactive eligibility for Nursing Facility care

The purpose of this memo is to advise you regarding: 1) a change in eligibility policy for individuals applying for Medicaid reimbursement of Nursing Facility care; and 2) steps you can take to assist individuals seeking admission to your facility in applying timely for Medicaid eligibility in order to avoid a gap in coverage for Nursing Facility care.

As explained in the attached DHS Policy Bulletin, effective June 1, 2007, DHS will no longer provide retroactive Medicaid coverage and vendor payments for individuals who qualify for Medicaid in an institutional category.

Accordingly, starting June 1, 2007, it will be important that persons seeking Medicaid coverage of Nursing Facility care **file a Medicaid application *on or before* the date of admission to the Nursing Facility.**

Current Nursing Facility residents seeking Medicaid coverage of Nursing Facility care **should file a Medicaid application *prior to* June 1, 2007**.

- Applications filed *on or before May* 31, 2007 will be processed in accordance with current policy which permits 90 days retroactive Medicaid coverage in an institutional category.
- Applications filed *on or after* June 1, 2007 will be processed in accordance with new policy, which provides that the earliest date of eligibility will be the date the application is *received by* DHS.

Medicaid applications are available online at:
http://www.tennessee.gov/humanserv/forms/hs-0169.pdf

The information that must be provided in the filed application includes such things as name, address, SSN, date of birth, etc. Financial information regarding income, resources, etc. will be gathered during the interview process *after* the application is filed.

Federal regulations specify that **the Medicaid application must be signed** by the person seeking Medicaid eligibility or his/her authorized representative (generally, but not always a family member). An application that is not signed is incomplete and will not be deemed by DHS to be "filed" until such date that the required signature is provided. In rare circumstances, e.g., when an applicant is physically and/or mentally incapable of signing the application and there is no family member or other authorized representative who can sign on his/her behalf, the application may be signed by the social worker, hospital or nursing facility administrator on the applicant's behalf. The social worker or administrator must include a statement on the bottom of the application just below the signature line indicating why the applicant was unable to sign the application; e.g. applicant is comatose or mentally/physically unable to sign and there are no family members or other responsible parties present to sign.

A Nursing Facility may **not** require a person to apply for Medicaid coverage and may not file an application on behalf of a resident or potential resident if that resident or potential resident has refused to apply for Medicaid. However, any individual who chooses not to apply for Medicaid coverage or who applies but is not eligible for Medicaid coverage will be responsible for payment of all appropriate care and services provided by the facility.

In addition to mail or hand delivery, **Medicaid applications may be filed with the local DHS office by fax 24 hours a day, 7 days a week.** If otherwise eligible, TennCare Medicaid coverage may begin the date the faxed application is received by DHS (including holidays and weekends). The fax numbers of each of the area DHS offices are available online at http://www.tennessee.gov/humanserv/st_map.htm. On the Tennessee state map, click on any county to obtain the fax number and other information for the applicable county DHS office.

When filing a Medicaid application by fax, please:
1) **Ensure that the top page of the fax is page 1 of the Medicaid application.** If you use a fax cover sheet, please transmit the cover sheet as the last (rather than first) page of the fax in order to ensure that when printed, the fax confirmation page includes the applicant's name and SSN in the event proof of filing is needed.
2) **Keep a copy of the application and the fax confirmation page.**

If you hand-deliver applications to the DHS office, you may ask for a receipt. Receipts are not mailed if an application is received by DHS via mail, and the date of application is the date of *receipt* of the application by DHS, not the post-mark date. Accordingly, hand-delivery and/or fax may be the preferred filing method in order to ensure timely filing and to obtain written confirmation of receipt.

While DHS cannot apply institutional income standards to establish financial eligibility until a person has been a Nursing Facility resident for at least 30 days, **the Medicaid application can (and starting June 1, 2007 *should*) be filed *on or before* admission to the facility** in order to preserve the application date (i.e., effective date of eligibility). However, particularly in metropolitan areas where individuals and their families may be engaged in discussions with a number of Nursing Facilities, DHS would *prefer* that Nursing Facilities wait until the date the person is *actually admitted* to the Nursing Facility to file the Medicaid application in order to prevent multiple applications from being filed by multiple Nursing Facilities. Obviously, there may be circumstances even in metropolitan areas where a Facility is confident of the upcoming admission, and in such case, proceeding with application *prior to* admission may be appropriate.

This policy change affects *only* the Medicaid (i.e., financial) eligibility determination. Medical eligibility (i.e., the level of care determination) established pursuant to a PreAdmission Evaluation may continue to be retroactively applied up to thirty (30) days when TennCare receives an approvable PreAdmission Evaluation within thirty (30) calendar days of the PAE Request Date or the physician certification date, whichever is earlier. In summary, in order to obtain Medicaid coverage for Nursing Facility care from the date of admission:

- **An approvable Medicaid application must be filed *on or before* the date of admission to the Nursing Facility; and**
- **An approvable PreAdmission Evaluation must be filed within thirty (30) days *after* the date of admission to the Nursing Facility.**

Attached is an information page entitled, "Paying for Long-Term Care" that you can share with Nursing Facility applicants/residents to help explain eligibility requirements.

If you have any questions regarding the implementation of these changes, please contact Pat Santel, Director of TennCare Long Term Care Elderly and Disabled Services.

Thank you.

C: Darin J. Gordon
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May 25, 2007 **Bulletin No. 24**
MA-07-16

To: **All District, County and Area Offices**
Division of Appeals and Hearings
Family Assistance Service Centers

From: **Virginia T. Lodge, Commissioner**

Subject: **Elimination of Retroactive Medicaid Eligibility and Vendor Payments For Nursing Home and HCBS Coverage**

Effective June 1, 2007, DHS will no longer provide retroactive Medicaid coverage and vendor payments for individuals applying for institutional coverage. The TennCare Bureau has provided clarification that the TennCare waiver eliminated retroactive coverage for **all** Medicaid coverage groups.

DHS eliminated retroactive coverage for all non-institutional categories effective January 1, 1994, but continued to offer up to three (3) months retroactive Medicaid and vendor payments for institutionalized groups. Effective June 1, 2007, DHS will eliminate providing retroactive coverage to the institutionalized groups as well.

Any Medicaid applications filed on or after June 1, 2007 will have eligibility for Medicaid and vendor payments determined beginning with the date of application or date determined otherwise eligible (i.e. QIT date, PAE approval date, or the date that Home and Community Based Services (HCBS) Lead Agency determines an individual is likely to need HCBS services), whichever is later.

NOTE: Individuals in a nursing facility may be eligible, as of the application date, when thirty (30) days of continuous confinement and all other eligibility requirements are met.

EXAMPLE: Individual enters nursing home on June 1, 2007 and applies for Medicaid on June 27, 2007. She meets continuous confinement on June 30, 2007. She met all other eligibility requirements beginning June 27, 2007 and her application will be approved effective June 27, 2007.

Applying for Nursing Home or HCBS Coverage

- A written application signed by the applicant or his/her responsible party is required. A faxed application meets this requirement.
- When there is a good reason why an applicant in a hospital or nursing facility cannot sign an application, DHS may accept an application signed by the social worker, hospital or nursing facility administrator. The social worker or administrator must include a statement on the bottom of the application just below the signature line indicating why the applicant was unable to sign the application; i.e. applicant is comatose, in emergency surgery, or physically unable to sign and there are no family members or other responsible party present to sign.
- Applications may be faxed to DHS. An application received in any DHS office should be date stamped and forwarded to the correct county office. If otherwise eligible, TennCare Medicaid coverage may begin the date the faxed application is received by DHS (including holidays and weekends).
- The application may be filed before the nursing facility admissions date, however thirty (30) days continuous confinement must be met before the application is authorized.

QMB, SLMB, and QDWI:

The elimination of the Retroactive Coverage for Medicaid and Vendor Payments **also applies** to Qualified Medicare Beneficiaries (QMB), Specified Low-Income Medicare Beneficiaries (SLMB), and Qualified Disabled Working Individuals (QDWI) processing. DHS will no longer provide retroactive coverage to QMB, SLMB and QDWI individuals.

In certain situations, retroactive QMB eligibility was given beginning with the 65th birthday, up to 3 months prior to the application month, and policy also allowed retroactive coverage for QDWI and SLMB. Effective June 1, 2007, there will be no retroactive coverage for these groups. All references to retroactive coverage for QMB, QDWI and SLMB have been removed from the TennCare Medicaid and TennCare Standard Manual (pages 209, 348, and 353).

There has never been a retroactive provision for Qualifying Individuals (QI1) and that policy remains the same.

The revised pages (209, 326, 328, 348, 353, 400, 401, and 403) of the TennCare Medicaid and TennCare Standard Policy Manual are attached. Also attached is a letter from the TennCare Bureau to the nursing facilities. It informs the facilities of the elimination of retroactive coverage and also advises that Medicaid applications can be faxed to DHS.

Additional questions or concerns are to be routed through the Medicaid-TennCare Field Support Unit by e-mail at Medicaid-TennCare.FieldSupport.DHS@state.tn.us or by phone at 1-866-482-3886.

Information in this bulletin does not affect the Food Stamp or Families First programs.

VTL/MG/cn

Paying for Long-Term Care in TennCare

What is long-term care?

Long-term care includes medical and non-medical care to people who have a chronic illness or disability. It includes help with activities of daily living like dressing, bathing, and using the bathroom. Long-term care can be provided at home, in the community, or in nursing homes.

Does TennCare pay for long-term care?

Yes, TennCare helps pay for some kinds of long-term care for people who qualify. This includes nursing home care. **In order for TennCare to pay for nursing home care:**

1. You must qualify for Medicaid. To qualify:

- For 2007, **your monthly income must be less than $1,869**. The federal government increases this amount in January of each year.
- AND, **the total value of things you own** (like bank accounts, stocks and bonds, etc.) **must be less than $2,000** ($3,000 if you have a spouse). These are your "resources." What if you have more than $2,000 in resources? You can use some of what you own to pay for your long-term care or other expenses until you're under the $2,000 limit to qualify for Medicaid. If you do that soon enough, DHS may be able to approve your application. If your application is denied because you have too many resources, you will need to apply again after you've spent some of those resources down. You can't just give your resources away. You must spend them on long term care or other things you need. Some things don't count as resources like the house you live in, the car you drive to medical appointments, or a pre-paid burial plan. Even before you apply, DHS can take a look at the things you own and tell you what will count. It's called a "resource assessment." This will help you plan, so you will know when you may be able to qualify for Medicaid. Be sure you apply for Medicaid **before** your resources run out so you don't have Nursing Facility bills that you can't pay.

You can apply for Medicaid at your local DHS (Department of Human Services) office. The nursing home can help you apply. If you qualify, the earliest date that TennCare can start paying for your care is the date you applied for Medicaid. We can't pay for care you got before that date. If you think you'll need help paying for long-term care, apply for Medicaid right away.

2. AND, you must show that you have health problems or disabilities that require the level of care that is provided in a nursing home.

That means that one or more of these things is true for you:

- You can't transfer to and from bed, chair, or toilet without help from someone.

- You can't walk or get around (even with a wheelchair, walker, or cane) without help from someone.
- You can't eat unless someone actually feeds you or gives you a drink.
- You can't use the bathroom or take care of toileting needs without help from someone.
- You can't communicate basic needs and wants, or understand and follow simple instructions.
- You don't know your name, can't recognize family members or don't know where you are.
- You can't take your medicine even with limited help from another person.
- You need ongoing help for serious behavior problems that could hurt you or someone else.
- You need skilled nursing care or rehab services.

To see if you qualify for a nursing home "level of care," you must apply to TennCare.
It's called a PreAdmission Evaluation or PAE. The nursing home can help you apply.

<u>Will you have to pay TennCare back for your Long Term Care?</u>
Federal law says that TennCare must recover the costs of long term care services from your estate after your death. Your "estate" includes your home and other things you own. But, this won't happen until *after* your death. TennCare will also wait until *after*:
- A surviving spouse has died.
- A minor child turns age 18.
- A disabled child (who became disabled before age 18) has died.