



State of New Jersey

DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

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MEDICAID COMMUNICATION NO. 16-09

DATE: November 17, 2016

TO: County Welfare Agency Directors
Institutional Services Section (ISS) Area Supervisors
Eligibility Determining Agencies
Medicaid Participating Providers

SUBJECT: Assisted Living (AL), Nursing Facility (NF), and Special Care Nursing Facility (SCNF) Provider Communication: Clinical Eligibility Standards and Timeframes

Background:

N.J.A.C. 8:85-1.2 defines the clinical eligibility assessment as the Pre Admission Screening (PAS). "Pre admission screening (PAS) means the process by which all Medicaid eligible beneficiaries seeking admission to a Medicaid certified NF and individuals who may become Medicaid eligible within six months following admission to a Medicaid certified NF receive a comprehensive needs assessment by professional staff designated by the Department to determine their long term care needs and the most appropriate setting for those needs to be met."

N.J.A.C. 8:85-1.8(e) "The following procedure is to be used by a referent when seeking Medicaid authorization of NF placement through PAS prior to the admission of individuals who are financially eligible for Medicaid or individuals residing in a NF paying from private funds who may become eligible for Medicaid within 180 days. If the referent is a NF, the referent shall refer an individual no later than 180 days prior to the individual's anticipated date of Medicaid eligibility by submitting the completed Notification from Long Term Care Facility of Admission or Termination of a Medicaid Patient form, also known as the LTC-2 form...to the LTCFO for PAS and by submitting a copy of the form to the CWA for a determination of financial eligibility."

It is the responsibility of Medicaid providers to confirm eligibility and payer source, on a monthly basis, and to ensure that clinical eligibility is established and valid. The County Welfare Agencies (CWAs) are the entities responsible for establishing financial eligibility for individuals seeking Medicaid services through a waiver program.

The Division of Aging Services Office of Community Choice Options (DoAS OCCO) is the entity responsible for establishing clinical eligibility for individuals seeking Medicaid services through a waiver program. This has historically been known as the Pre-Admission Screening (PAS) process. At Risk Criteria Pre-Admission Screen (ARC-PAS) and subsequent Enhanced At Risk Criteria Pre-Admission Screen (EARC-PAS) were implemented for the acute care hospital settings. The intent of the EARC-PAS screen is to provide acute care hospital staff the expertise to conduct an abbreviated screen to reduce hospital stay and facilitate discharge to nursing facility settings for individuals currently Medicaid-eligible (without managed care enrollment) or potentially Medicaid-eligible within 180 days of admission.

Medicaid-enrolled individuals who were in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF) prior to July 1, 2014 were identified as Medicaid Fee-for-Service Exempted (FFS Exempt). These individuals have had clinical eligibility established and are not subject to an annual clinical assessment. Additionally, effective February 2015, the EARC-PAS is no longer recognized as clinical eligibility determination for long-term services and supports. The Department's Managed Long Term Services and Supports (MLTSS) program establishes a requirement for clinical eligibility to be determined at least annually. FFS Exempt Medicaid enrolled individuals with established clinical eligibility, EARC or PAS, prior to July 1, 2014 are not subject to an annual clinical assessment.

The EARC Authorization for individuals being discharged from an acute care hospital setting to a nursing facility serves as an initial 90-day authorization. Individuals newly seeking Medicaid who are above 100% FPL and require Medicaid as a payer source to the nursing facility are referred for a full clinical assessment to establish Medicaid eligibility.

Historically, the PAS has been requested far in advance of 180 days of potential Medicaid eligibility. The intent of the PAS processes is to provide an assessment and determination of clinical eligibility for individuals who are:

1. Medicaid-enrolled without MCO enrollment
2. Potentially eligible for Medicaid within 180 days.

Individuals enrolled in an MCO are not eligible for EARC-PAS or PAS through DoAS OCCO. MCO-enrolled individuals are subject to prior authorization processes which are specific to each MCO. The MCO authorizes or denies services and conducts assessments for MLTSS in accordance with their policies and procedures.

Policy:

Medicaid is the payer of last resort. This is regardless of whether the Medicaid is FFS or managed care. Individuals who require Medicaid payment for services in an assisted living, community residential facility, nursing facility, or special care nursing facility are required to have clinical eligibility established for enrollment. Clinical assessment may be conducted by the individual's MCO, DoAS, or other state designated entity (i.e. ADRC, PACE). The clinical eligibility is valid for one year from the date of completion to facilitate Medicaid enrollment. Once Medicaid enrollment

occurs, clinical eligibility is re-established at least annually. The only exception to the annual redetermination of clinical eligibility is Medicaid FFS Exempted individuals.

The County Welfare Agency will not recognize clinical eligibility for individuals pending Medicaid eligibility, unless the clinical eligibility date is within one year of the financial eligibility date. This includes individuals who lose eligibility and are determined new applicants. This one year period allows for a sufficient spend-down and eligibility determination period when the guidelines are followed. For individuals newly seeking Medicaid eligibility, it is both the Provider and individual responsibility to identify when the 180th day of stay is approaching and request a clinical eligibility assessment at that time. Providers are responsible for informing individuals on the requirements and to determine when the 180 day period should be initiated. Providers who do not determine the 180 day period to the best of their ability and request clinical eligibility in advance of the 180 day period are at risk of having the clinical eligibility expire before financial eligibility can become effective. If the Medicaid eligibility is not determined within one year of the clinical assessment, the clinical assessment is no longer valid.

When the DoAS OCCO receives a referral for clinical eligibility of an individual pending Medicaid who is residing in an assisted living (AL), nursing facility (NF), or special care nursing facility (SCNF), the DoAS has a specific number of days in which to complete the assessment. An assisted living (AL) and special care nursing facility (SCNF) has 14 days and a nursing facility has 30 days. It is the Provider responsibility to request the clinical eligibility determination at least 30, and up to 180 days, in advance of financial eligibility. If DoAS OCCO does not conduct the assessment within the specified 14 or 30 days of referral, DoAS OCCO has the ability to back-date the clinical eligibility to begin on the 15th day for AL/SCNF or 31st day for NF after the referral receipt date. This allows for payment to the provider without penalty as a result of DoAS OCCO failure to conduct the assessment timely. DoAS OCCO back-dating is only permitted for individuals eligible for Medicaid FFS billing and when the following requirements have been met:

1. The individual resides in an AL, NF, or SCNF at the time of referral to DoAS OCCO
2. The provider has complied with all notification policies in N.J.A.C. 8:85
3. The DoAS OCCO determination was not timely.

If you have any questions regarding this Medicaid Communication, please contact the Division's Office of Eligibility field staff for your agency at 609-588-2556.

MD:eb

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