DEPARTMENT OF HEALTH & HUMAN SERVICES

Financing Administration

Refer to: CO7

Region V
105 West Adams Street
15th Floor
Chicago, Illinois 60603

SEP 0 1 1992

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MICH. DEPT. OF PUBLIC HEALTH
BUREAU OF HEALTH FACILITIES

Richard Yerian, D.O.
Chief Medical Consultant
Bureau of Health Systems
Michigan Department of Public Health
3423 North Logan
P.O. Box 30195
Lansing, Michigan 48909

Dear Dr. Yerian:

This is in reply to your letter of July 21, 1992 regarding the possible noncompliance of certain Medicaid nursing facilities (NF) with Federal admissions rights requirements. These issues were brought to your attention by Citizens for Better Care (CBC), whose letter you enclosed. You submitted material from two facilities; we reviewed the material and have the following comments.

Oakbrook Common Health Center, Dearborn, Michigan

This facility's June 24, 1992 letter to you sets forth its admissions practices including this statement, from the letter's second page:

> If there is no issue respecting medical care needs, and if it appears that the applicant's resources (either private or via insurance) are reasonably adequate to cover the cost of the applicant's projected stay at the Health Center (o approximately 18 month's charges if this is shorter), then the applicant wi ordinarily be admitted if a bed is available.

Relevant here are the requirements of Section 1919(c)(5)(A)(i)(I) and (II) of th Social Security Act (the parallel regulation is 42 CFR 483.12(d)(1)(ii)) which reads

> (A) Admissions.--With respect to admissions practices, a nursing facility must- (i)(I) not require individuals applying to reside or residing in the facility to waiv their rights to benefits under this title or title XVIII, (II) not require oral or writte assurance that such individuals are not eligible for, or will not apply for, benefit under this title or title XVIII...

The NF survey guidelines say the following (on SOM page P-73, tag F211) in regard to the requirements quoted just above.

> This provision is intended to prohibit direct and indirect requests for waiver of rights to Medicare or Medicaid. A direct request for waiver, for example, requires residents to sign admissions documents explicitly promising or agreeing not to apply for Medicare or Medicaid. An indirect request for waiver means, for example, requiring the resident to pay private rates for a specified period of time, such as two years ("private pay duration of stay contract") before Medicaid will be accepted as a payment source for the resident. Facilities must not seek or receive any kind of assurances that residents are not eligible for, or will not apply for, Medicare or Medicaid benefits. (Underlining added.)

Oakbrook Common points out that it does not require anyone to actually pay for 18 months of care out of their own resources; this allows them to remain in compliance with 1919(c)(5)(A)(i)(I), since they do not require the signing of a private pay duration of stay contract. Nevertheless, their means test for admission is clearly a requirement for an assurance that the applicant is not eligible for Medicaid and will not be for some time, and therefore is a violation of 1919(c)(5)(A)(i)(II).

Regarding an applicant discovered to be close to Medicaid eligibility, they say the following (on the second page of the letter).

> If the Health Center's analysis of an applicant's resources during the admission application process suggests that the applicant might be able to become a Medicaid beneficiary immediately or in the near future, the Health Center suggests that the applicant may wish to apply for Medicaid and re-submit a residency application to the Health Center upon receipt of verified Medicaid enrollment.

Of course, an applicant who might be able to become a Medicaid beneficiary immediately or in the near future would not meet the admission rule requiring personal resources equal to 18 months' charges. Such applicants are, in effect, told to come back when they are on the Medicaid rolls, at which point, if no Medicaid bed is available, they will be placed on a waiting list for one of the 38 beds in the Medicaid section of the facility (which has a total of 200 beds). As Oakbrook Common's letter says (in the first paragraph of the second page),

> If the applicant is still a verified Medicaid beneficiary and still desires admission when his or her name reaches the top of the waiting list and a vacancy occurs in a Medicaid certified bed, he or she will be admitted at that time.

The effect of all this is to steer Medicaid-eligible applicants, and those soon to be eligible, elsewhere. (This could allow the facility to maintain its Medicaid beds primarily for the residents admitted through its private pay admissions process who have exhausted their private resources.) Overall, Oakbrook Common's admissions system functions to do exactly what the law seeks to avoid, namely, discriminate on the basis of Medicaid eligibility.

The facility's letter (fourth page) defends its practice by referring to page 48841 of the September 26, 1991 Federal Register, which published the final long term care regulations and HCFA's responses to comments submitted on the interim final regulations. Oakbrook Manor says this page "... makes it quite clear that HCFA has no intention of prohibiting NFs or SNFs from satisfying themselves of appropriate sources of payment." However, this is not an accurate characterization of HCFA's response on page 48841 (third column), quoted below.

> We do not believe Congress intended to limit in any other way the facility's right to obtain information necessary for collecting payment from third party payors (not guarantors). Therefore, we will explain in the interpretive guidelines that a "third party guarantee" is not the same thing as a "third party payor" and that this provision does not preclude the facility from obtaining information about Medicare or Medicaid eligibility or the availability of private insurance.

This Federal Register statement is made in the context of the law's and regulation's prohibition of requiring guarantees of payment from a third party (such as a spouse or relative), not in the context of the prohibition of requiring assurance that an applicant is not or will not be eligible for Medicaid. Contrary to Oakwood Common's characterization of this passage as a blanket approval of a facility's right to gather all manner of financial information from applicants, the quoted section is strictly limited to allowing a facility to request information regarding third party payors only.

The law allows a facility to ask an applicant if she or he is eligible for Medicare, is eligible for Medicaid or has private insurance which will be applicable to the facility's charges. This makes practical sense. However, the next step, asking for personal financial information which has the effect of assuring that the applicant is not eligible for Medicaid benefits and will not apply for Medicaid benefits in the near future, is prohibited by the law, as discussed above.

While the practice of requiring a deposit prior to admission was not mentioned by CBC, it is relevant to address it here. Regional Program Letter No. 92-26 (July, 1992) (copy enclosed) contains our Central Office's answers to this and other questions regarding admissions and bed-hold fees. The Program Letter says private pay applicants may be charged application fees and advance deposits (providing they are given, per 42 CFR 483.10(b)(6), information regarding services available in the facility and charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate).

To summarize the issues discussed to this point, a NF (or a facility with a NF distinct part) may ask an applicant if he or she is eligible for Medicare or Medicaid or has private insurance, but may not collect financial information, in writing or orally, which would assure the facility that the applicant is not eligible for Medicaid or will not apply for Medicaid benefits in the future. Once the facility determines that an applicant is a private pay applicant, it may charge an application fee and require an advance deposit. (The advance deposit cannot be so large as to become, in effect, a "private pay duration of stay contract," which is an indirect request to the applicant that he or she waive his or her rights to Medicare or Medicaid, as discussed above. Our judgement is that a deposit covering more than two months of care would be excessively large.)

Sisters of Bon Secours Nursing Care Center, St. Clair Shores, Michigan
Based on the submitted letter from this facility, its practices are virtually identical to those of Oakbrook Common, and all the comments made in regard to Oakbrook also apply to this facility.

CBC's letter to you decries the practice of facilities certifying for Medicaid only a limited number of beds. However, the Social Security Act allows distinct parts of facilities to participate in Medicaid. This can be changed only by amending the Act itself or by amending Michigan's Medicaid State Plan to prohibit distinct part participation. Another practice allowed by the Act but opposed by CBC is requiring a resident who becomes eligible for Medicaid while in a facility to leave the facility if no certified Medicaid bed is available in the facility's NF distinct part. Again, changing the Medicaid State plan would be necessary to forbid this practice.

Since each of the above named facilities is out of compliance with Medicaid regulations, you should cite a deficiency to each of them using data tag F211 and request a plan of correction. After you have received an acceptable plan of correction from each facility, please forward them to this office for our information.

If you have any questions regarding this, please contact Mark Dykstra at (312) 886-5217.

Sincerely,

Walter V. Kummer
Associate Regional Administrator
Division of Health Standards and Quality

Enclosure

cc: M. L. Lundgren, Michigan Department of Public Health
Michigan Department of Social Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

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Refer to: FQA-811

Date JAN 22 1993

From Director
Bureau of Policy Development

Subject Financial Screening of Applicants for Admission to Nursing Facilities (NFs)--INFORMATION

To Regional Offices

I am writing to inform you of developments concerning a controversy over admissions policies in long-term care facilities (LTCFs).

Recently, an advocacy group in Michigan challenged the admissions policy of two LTCFs with Medicaid distinct part NFs. This policy required individuals to have sufficient funds to pay for their expected lengths of stay as a prerequisite for admission to the non-Medicaid part of the facility. The only residents in the Medicaid distinct part were individuals who had spent down private funds in the participating part and were able to qualify for Medicaid. The Chicago Regional Office, in response to a letter from the Michigan Department of Public Health, stated that it believed the facility was in violation of current law and regulations governing NF admissions practices related to Medicaid eligibles.

BPD is currently reviewing the NF policies as they are applied by the Michigan facilities and the extent to which the facilities may violate current law or regulations. Until resolved, regional offices should not try to develop their own interpretations of the Michigan NFs' policies or to use the Region V interpretation as a basis for issuing new guidance to NFs.

The current statutory language that addresses admissions practices is summarized below:

- Under section 1919(c)(5)(A)(i) of the Social Security Act (the Act), a NF must
  - + not require individuals who reside or are applying to reside in the facility to waive their rights to Medicare or Medicaid and
  - + not require oral or written assurances that such individuals are not eligible for (or will not apply for) benefits under Medicare or Medicaid.

- Under section 1919(c)(5)(A)(iii) of the Act, NFs may not require Medicaid recipients to provide gifts, money, donations, or other considerations as a condition of admission, expedited admission, or continued stay in the facility.

Until we have completed our review of this issue and consult with the Office of General Counsel, we ask that you not go beyond the strict wording of the statute in evaluating facility practices. We hope to respond to the issues that have been raised in the near future.

Questions may be addressed to Martha Kuespert of my staff at (410) 966-1782.

Kathleen A. Buto

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