Institutionalized Care Program

Nursing Facility Transition of Members to Long Term Care

Purpose of Training

To provide an understanding of the following:

- The Agency for Healthcare Administration (AHCA) contract requirement for the provision and reimbursement of a nursing facility (NF) stay for up to 120 days
- The process for expediting LTC enrollment for eligible members admitted to nursing facilities
- LTC eligibility forms used for the member enrollment process

History

- Nursing Facility services are covered under Long Term Care (LTC).
- AHCA's new contract requires Sunshine Health to pay for medically necessary nursing facility admissions for up to 120 days from the date of admission when the member is not eligible for LTC.
- Sunshine Health must pay for the services provided by the nursing facilities that are considered custodial (non-skilled) care while the member is in the process of qualifying for an LTC plan.

Goals

- To comply with AHCA's contract requirement to cover nursing facility stays for up to 120 days
- To collaborate with nursing facility social workers to assist in:
  - Securing LTC enrollment for a new nursing home member
  - Coordination of the CARES application process

Institutionalized Care Program (ICP) Work Process

C.A.R.E.S

Comprehensive Assessment and Review for Long Term Care Services

- Federally mandated pre-admission screening program for nursing home applicants in FL
- A comprehensive assessment of each individual who requests Medicaid reimbursement for nursing facility placement
- Required to determine medical eligibility for the Medicaid Institutional Care Program (ICP)
- Reviewed by physician or RN to determine:
  - Most appropriate level of care

C.A.R.E.S

- CARES assessment may be initiated by any person or family member by applying for the Medicaid Institutional Care Program (ICP)
- Assessment:
  - Establishes appropriate level of care
  - Identifies long-term needs
  - Recommends least restrictive and most appropriate placement

Skilled Nursing Facility (SNF)

Covered SNF Services:

- Skilled nursing care is necessary only when the needed services are of such complexity that the skills of a registered nurse (RN) or a licensed practical nurse (LPN) are required to furnish the services
- Treatment goals are based on individualized assessment or evaluation
- Skills are necessary to maintain the current condition and slow further deterioration
- Healthcare providers continually evaluate the member's need for skilled care
- Meets Medicare requirement for reasonable and necessary to diagnoses or treat the condition
- Ongoing determinations for continued care are based on the goals and treatment plan

Non-Covered Skilled Nursing Facility Services

- Non-skilled or custodial care
- Assessment of the clinical condition does not demonstrate a need for skilled care
- Services needed can effectively be performed by the member or unskilled caregivers

Medicare Coverage: Therapy Services

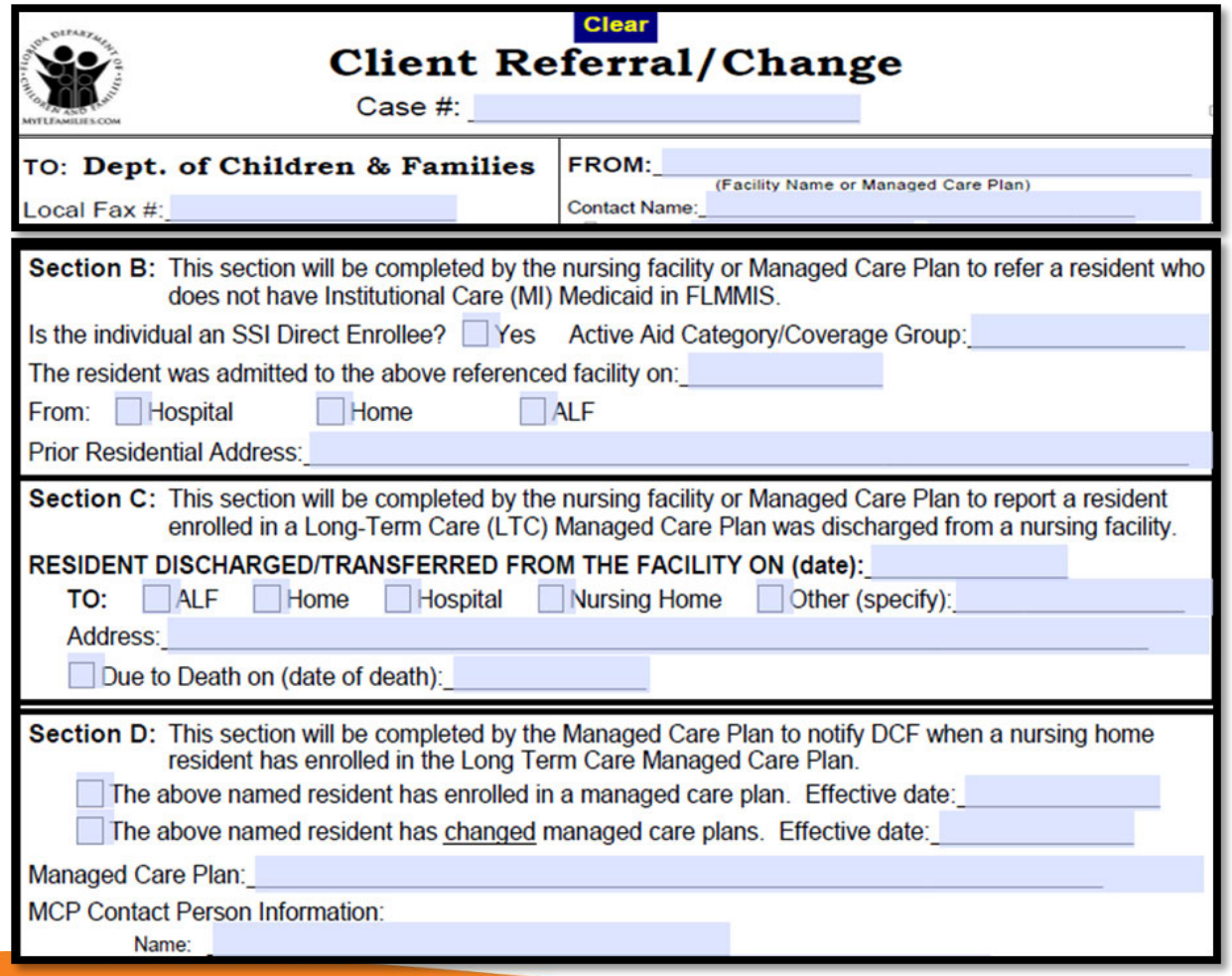
Skilled therapy services are covered when:

- Assessment of the member's clinical condition demonstrates therapy is necessary for the performance of a safe and effective maintenance program
- Therapy may prevent or slow further deterioration

ICP Process

- ❑ Nursing Facility will identify potentially impacted members and complete the ICP application (date of admittance and length of stay).
- ❑ Nursing Facility will complete and file the 3008 form to CARES for determination of Long Term Care eligibility and Level of Care within 10 days of resident admission.
- ❑ Nursing Facility will complete PASSR form and send to CARES for review.
- ❑ Nursing Facility needs to forward copy of PASSR and completed 2506A from to Sunshine Health to obtain authorization for services.
- ❑ Nursing Facility will complete application with the Department of Children and Family Services (DCF) for Medicaid eligibility determination.
- ❑ CARES will complete an onsite visit to the Skilled Nursing Facility.
- ❑ Nursing Facility will complete financial packet for resident to be submitted to DCF.
- ❑ Eligibility for Long Term Care and Medicaid will be determined within 30 days.
- ❑ AHCA will notify Sunshine Health of resident's LTC enrollment.

Required Forms: CF-ES 2506A



Clear

Client Referral/Change

Case #: _____

TO: **Dept. of Children & Families**

Local Fax #: _____

FROM: _____
(Facility Name or Managed Care Plan)

Contact Name: _____

Section B: This section will be completed by the nursing facility or Managed Care Plan to refer a resident who does not have Institutional Care (MI) Medicaid in FLMMIS.

Is the individual an SSI Direct Enrollee? ☐ Yes Active Aid Category/Coverage Group: _____

The resident was admitted to the above referenced facility on: _____

From: ☐ Hospital ☐ Home ☐ ALF

Prior Residential Address: _____

Section C: This section will be completed by the nursing facility or Managed Care Plan to report a resident enrolled in a Long-Term Care (LTC) Managed Care Plan was discharged from a nursing facility.

RESIDENT DISCHARGED/TRANSFERRED FROM THE FACILITY ON (date): _____

TO: ☐ ALF ☐ Home ☐ Hospital ☐ Nursing Home ☐ Other (specify): _____

Address: _____

☐ Due to Death on (date of death): _____

Section D: This section will be completed by the Managed Care Plan to notify DCF when a nursing home resident has enrolled in the Long Term Care Managed Care Plan.

☐ The above named resident has enrolled in a managed care plan. Effective date: _____

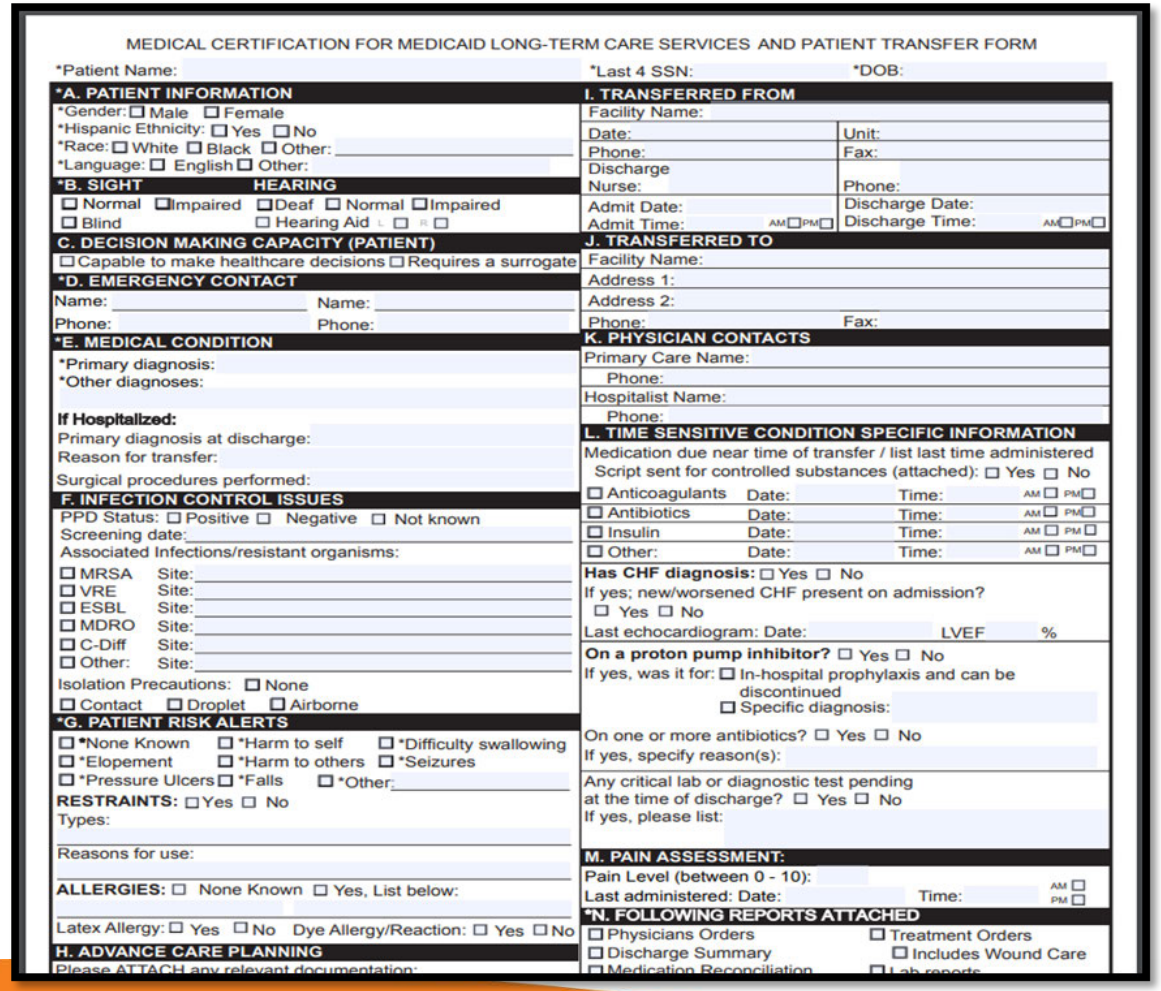
☐ The above named resident has changed managed care plans. Effective date: _____

Managed Care Plan: _____

MCP Contact Person Information:

Name: _____

Required Forms: AHCA 3008



MEDICAL CERTIFICATION FOR MEDICAID LONG-TERM CARE SERVICES AND PATIENT TRANSFER FORM

*Patient Name: *Last 4 SSN: *DOB:

***A. PATIENT INFORMATION**
*Gender: ☐ Male ☐ Female
*Hispanic Ethnicity: ☐ Yes ☐ No
*Race: ☐ White ☐ Black ☐ Other:
*Language: ☐ English ☐ Other:

***B. SIGHT** **HEARING**
☐ Normal ☐ Impaired ☐ Deaf ☐ Normal ☐ Impaired
☐ Blind ☐ Hearing Aid L ☐ R ☐

C. DECISION MAKING CAPACITY (PATIENT)
☐ Capable to make healthcare decisions ☐ Requires a surrogate

***D. EMERGENCY CONTACT**
Name: Name:
Phone: Phone:

***E. MEDICAL CONDITION**
*Primary diagnosis:
*Other diagnoses:

If Hospitalized:
Primary diagnosis at discharge:
Reason for transfer:
Surgical procedures performed:

F. INFECTION CONTROL ISSUES
PPD Status: ☐ Positive ☐ Negative ☐ Not known
Screening date:
Associated Infections/resistant organisms:
☐ MRSA Site:
☐ VRE Site:
☐ ESBL Site:
☐ MDRO Site:
☐ C-Diff Site:
☐ Other: Site:
Isolation Precautions: ☐ None
☐ Contact ☐ Droplet ☐ Airborne

***G. PATIENT RISK ALERTS**
☐ *None Known ☐ *Harm to self ☐ *Difficulty swallowing
☐ *Elopement ☐ *Harm to others ☐ *Seizures
☐ *Pressure Ulcers ☐ *Falls ☐ *Other:
RESTRAINTS: ☐ Yes ☐ No
Types:
Reasons for use:
ALLERGIES: ☐ None Known ☐ Yes, List below:
Latex Allergy: ☐ Yes ☐ No Dye Allergy/Reaction: ☐ Yes ☐ No

H. ADVANCE CARE PLANNING
Please ATTACH any relevant documentation:

I. TRANSFERRED FROM
Facility Name:
Date: Unit:
Phone: Fax:
Discharge Nurse: Phone:
Admit Date: Discharge Date:
Admit Time: AM ☐ PM ☐ Discharge Time: AM ☐ PM ☐

J. TRANSFERRED TO
Facility Name:
Address 1:
Address 2:
Phone: Fax:

K. PHYSICIAN CONTACTS
Primary Care Name:
Phone:
Hospitalist Name:
Phone:

L. TIME SENSITIVE CONDITION SPECIFIC INFORMATION
Medication due near time of transfer / list last time administered
Script sent for controlled substances (attached): ☐ Yes ☐ No

☐ Anticoagulants	Date:	Time:	AM ☐ PM ☐
☐ Antibiotics	Date:	Time:	AM ☐ PM ☐
☐ Insulin	Date:	Time:	AM ☐ PM ☐
☐ Other:	Date:	Time:	AM ☐ PM ☐

Has CHF diagnosis: ☐ Yes ☐ No
If yes; new/worsened CHF present on admission?
☐ Yes ☐ No
Last echocardiogram: Date: LVEF %

On a proton pump inhibitor? ☐ Yes ☐ No
If yes, was it for: ☐ In-hospital prophylaxis and can be discontinued
☐ Specific diagnosis:

On one or more antibiotics? ☐ Yes ☐ No
If yes, specify reason(s):

Any critical lab or diagnostic test pending at the time of discharge? ☐ Yes ☐ No
If yes, please list:

M. PAIN ASSESSMENT:
Pain Level (between 0 - 10):
Last administered: Date: Time: AM ☐ PM ☐

***N. FOLLOWING REPORTS ATTACHED**
☐ Physicians Orders ☐ Treatment Orders
☐ Discharge Summary ☐ Includes Wound Care
☐ Medication Reconciliation ☐ Lab reports

Required Forms: AHCA PASSR

State of Florida Agency for Health Care Administration
Preadmission Screening and Resident Review (PASRR)

LEVEL I SCREEN

For Serious Mental Illness (SMI) and/or Intellectual Disability or Related Conditions (ID)

For Medicaid Certified Nursing Facility (NF) Only

Name of Individual Being Evaluated (print) | Social Security Number* | Date of Birth

☐ Male ☐ Female | Age | Individual's or Residency Phone Number

Present Location of Individual Being Evaluated | Street Address, City | State, Zip

☐ NF ☐ Hospital ☐ Home ☐ Assisted Living Facility ☐ Group Home ☐ Other

Legal Representative's Name (if applicable) | Street Address, City | State, Zip

Representative's Phone Number

Medicaid Identification Number if Applicable | Other Health Insurance Name and Number if Applicable

☐ Private Pay

Requesting Admission to:
(May document up to three facilities)

NF Name	Street Address	City, State, Zip Code	Phone

Contact Us

Sunshine Health

Provider Services 1-844-477-8313

TTY/TDD: 1-800-955-8770

SunshineHealth.com