

F620

(Rev)

§483.15(a) Admissions policy.

§483.15(a)(1) The facility must establish and implement an admissions policy.

§483.15(a)(2) The facility must—

- (i) Not request or require residents or potential residents to waive their rights as set forth in this subpart and in applicable state, federal or local licensing or certification laws, including but not limited to their rights to Medicare or Medicaid; and Not request or require oral or written assurance that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits.**
- (ii) Not request or require residents or potential residents to waive potential facility liability for losses of personal property.**

§483.15(a)(3) The facility must not request or require a third party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may request and require a resident representative who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources.

§483.15(a)(4) In the case of a person eligible for Medicaid, a nursing facility must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan, any gift, money, donation, or other consideration as a precondition of admission, expedited admission or continued stay in the facility. However,—

- (i) A nursing facility may charge a resident who is eligible for Medicaid for items and services the resident has requested and received, and that are not specified in the State plan as included in the term “nursing facility services” so long as the facility gives proper notice of the availability and cost of these services to residents and does not condition the resident's admission or continued stay on the request for and receipt of such additional services; and**
- (ii) A nursing facility may solicit, accept, or receive a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to a Medicaid eligible resident or potential resident, but only to the extent that the contribution is not a condition of admission, expedited admission, or continued stay in the facility for a Medicaid eligible resident.**

§483.15(a)(5) States or political subdivisions may apply stricter admissions standards under State or local laws than are specified in this section, to prohibit discrimination against individuals entitled to Medicaid.

§483.15(a)(6) A nursing facility must disclose and provide to a resident or potential resident prior to time of admission, notice of special characteristics or service limitations of the facility.

§483.15(a)(7) A nursing facility that is a composite distinct part as defined in §483.5 must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under paragraph (c)(9) of this section.

DEFINITIONS/ACRONYMS

“Composite distinct part”: A composite distinct part is a distinct part consisting of two or more noncontiguous components that are not located within the same campus, as that term is defined in §413.65(a)(2) of this chapter. Additional requirements specific to SNF/NF composite distinct parts are found at §483.5.

“Campus”: Campus is defined in §413.65(a)(2) and means the physical area immediately adjacent to the provider’s main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis, by the CMS *location*, to be part of the provider’s campus.

“Distinct part”: A distinct part SNF or NF is physically distinguishable from the larger institution or institutional complex that houses it, meets the requirements of this paragraph and of paragraph (b)(2) of this section, and meets the applicable statutory requirements for SNFs or NFs in sections 1819 or 1919 of the Act, respectively. A distinct part SNF or NF may be comprised of one or more buildings or designated parts of buildings (that is, wings, wards, or floors) that are: In the same physical area immediately adjacent to the institution's main buildings; other areas and structures that are not strictly contiguous to the main buildings but are located within close proximity of the main buildings; and any other areas that CMS determines on an individual basis, to be part of the institution's campus. A distinct part must include all of the beds within the designated area, and cannot consist of a random collection of individual rooms or beds that are scattered throughout the physical plant. The term “distinct part” also includes a composite distinct part that meets the additional requirements of paragraph (c) of this section. Additional requirements specific to SNF/NF distinct parts are found at 483.5.

GUIDANCE

§483.15(a)(1) and (2) Admissions Policy/Preconditions of Admission

All facilities must establish and implement a policy or policies addressing resident admission to the facility. First, the admissions policy must comply with the provisions at §483.15(c)(1) which stipulate the limited conditions for transfer or discharge. The provisions at §483.15 (a)(2) –(5), further prohibit the waiver of certain rights and preconditions for admission to, and continued stay in the facility. Additionally, under §483.15(a)(6) – (7), the admissions policy must identify information that must be disclosed to residents and potential residents, such as notice of special facility characteristics, any service limitations of the facility, if applicable. Additionally, it requires that the facility’s admission agreement disclose its physical composition, including any composite distinct part locations, and must specify the policies that apply to room changes in a composite distinct part (see additional guidance below). The facility must also have a process for how it will disclose required information to residents and potential residents.

The provisions at §483.15(a)(2)(i) and (ii) prohibit both direct and indirect requests to

residents or potential residents to waive any rights under the LTC requirements and under applicable federal, state, local licensing or certification laws, including but not limited to the waiver of rights to Medicare or Medicaid. A direct request for waiver, for example, would require residents to sign admissions documents explicitly promising or agreeing not to apply for Medicare or Medicaid. An indirect request for waiver would include, for example, requiring the resident to pay private rates for a specified period of time, such as two years (e.g., “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 or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits.

Lastly, residents must not be asked to waive facility responsibility for the loss of their personal property or be unable to use personal property because it is only permitted in the facility if safeguarded by the facility in a manner that makes the property essentially inaccessible to the resident. These waivers effectively take away the residents’ right to use personal possessions and relieve facilities from their responsibility to exercise due care with respect to residents’ personal property. Compliance requires facilities to develop policies and procedures to safeguard residents’ personal possessions without effectively prohibiting a resident’s use of personal possessions. This provision is not intended to make facilities automatically liable for every loss regardless of whether or not the facility is aware of the extent of personal property brought into the facility. Examples of reasonable facility policies may include 1) establishing a process to document high value personal property (particularly cash, valuables, and medical/assistive devices) brought in by residents; and 2) establishing a process to work with residents and their representatives/family to ensure safety as well as availability to the resident of cash and/or items over a certain dollar value, including medical/assistive devices. For concerns related to whether the facility takes reasonable care to protect each resident’s property from loss or theft or the resident’s right to be free from misappropriation of property, see F584, §483.10(i) Safe Environment and F602, §483.12 Misappropriation of Resident Property.

§483.15(a)(3) Third Party Guarantee of Payment

The facility must not request or require a third party to accept personal responsibility for paying the facility bill out of his or her own funds as a condition of admission, expedited admission, or continued stay in the facility. However, the facility may request and require a resident representative with legal access to the resident’s funds available to pay for facility care to access and use the resident’s money or other assets to pay for care, as authorized by law. The facility may request and require this representative to sign a contract, without incurring personal liability, to provide the facility with payment from the resident’s income or assets. *If an individual does not actually have legal access to the resident’s funds, the facility may not request or require the individual to pay the facility.* A third party guarantee is not the same as a third party payor, e.g., an insurance company; and this provision does not preclude the facility from obtaining information about Medicare or Medicaid eligibility or the availability of private insurance. The prohibition against third-party guarantees applies to all residents and prospective residents in all certified long term care facilities, regardless of payment source.

Thus, language that specifically requests a third party to personally guarantee payment to a facility is noncompliant. Also, language can be noncompliant even if it does not specifically reference a “guarantee” by a third party. Any language contained in an agreement that seeks to hold a third party personally responsible for paying the facility would violate this requirement. Examples of noncompliant language include, but are not limited to:

- Language that holds both (1) the resident and (2) the representative or other individual jointly responsible for any sums due to the facility (however, language that holds the resident solely responsible without joining the representative is allowable).*
- Language that holds the representative or other third-party individual personally liable for breach of an obligation in the agreement, such as (1) failing to apply for Medicaid in a timely and complete manner or (2) allowing someone other than a signatory to the agreement to spend the resident’s resources that would be used to pay the nursing home.*
- Language that does not specifically mention a third-party guarantee but that implies the resident could be discharged if the representative does not voluntarily agree to personally pay to prevent the discharge.*
- Language that holds the representative or other individual personally liable for any amounts not paid to the facility in a timely manner because the representative or other individual did not provide accurate financial information or notify the facility of changes in the resident’s financial information.*

Admission agreements containing language like the examples above, or which contain other language which confers personal liability upon a third party, represent noncompliance with this provision. Such language is noncompliant if it appears in the main document that a facility uses as its admission agreement or in other documents that are signed at admission. In addition, after a resident is admitted, the facility cannot use such language in agreements regarding a resident’s continued stay in the facility.

§483.15(a)(4)(i) and (ii), Medicaid – Preconditions for Admission

The requirements at §483.15(a)(4)(i) and (ii) apply only to individuals eligible for Medicaid and therefore to Medicaid certified nursing facilities (NFs) or dually-certified SNF/NFs.

Facilities may not charge for any service that is included in the definition of “nursing facility services” which are required to be provided as part of the daily rate (See also §483.10(f)(11)(i)). Facilities may not accept additional payment from residents or their families as a prerequisite to admission or to continued stay in the facility. Additional payment includes, but is not limited to, deposits from residents who are eligible for Medicaid or their families, or any promise to pay private rates for a specified period of time.

NOTE: This regulation does not preclude a facility from charging a deposit fee to, or requiring a promissory note from, an individual whose stay is not covered by Medicaid. In instances where the deposit fee is refundable and remains as funds of the resident, the facility must have a surety bond that covers the deposit amount-- (See also §483.10(f)(10)(vi)).

A nursing facility is permitted to charge an applicant or resident for services, while his or her Medicaid eligibility is pending. This charge may be in the form of a deposit prior to

admission and/or payment after admission. Subject to the rules of the State in which the facility is located, Medicaid eligibility will be made retroactive up to 3 months before the month of application if the applicant would have been eligible had he or she applied in any of the retroactive months.

NOTE: A resident cannot be discharged for nonpayment while their Medicaid eligibility is pending (See F627 , *Inappropriate* Transfer and Discharge).

In addition, the nursing facility must accept as payment in full the amounts determined by the state for all dates the resident was both Medicaid eligible and a nursing facility resident. Therefore, a nursing facility that charged a recipient for services between the first month of eligibility established by the state and the date notice of eligibility was received is obligated to refund, within 30 days from receipt of funds from a third party payor, any payments received for that period less the state's determination of any resident's share of the nursing facility's costs for that same period. A nursing facility must prominently display written information in the facility and provide explanation to applicants or residents in a manner they can understand about applying for Medicaid, including how to use Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

Under the post-eligibility process, if the resident who is eligible for Medicaid has income and is required to make a monthly payment to the nursing facility (which is a portion of the Medicaid payment amount), then the nursing facility is permitted to retain the amount it is legally owed. However, the nursing facility must not charge any administrative fees.

A nursing facility may charge a beneficiary who receives Medicaid for a service the beneficiary has requested and received, only if:

- That service is not defined in the State plan as a “nursing facility” service;
- The facility informs the resident and the resident's representative in advance that this is not a covered service to allow them to make an informed choice regarding the fee; and
- The resident's admission or continued stay is not conditioned on the resident's requesting and receiving that service.

§483.15(a)(5) State/Local Jurisdiction Admission Standards

Surveyors are expected to refer to state and/or local laws and regulations on admissions standards to prohibit discrimination against individuals entitled to Medicaid as applicable.

§483.15(a)(6) Facility Special Characteristics

Facilities may choose to offer specialized care or services, such as a rehabilitation, dementia, or a mechanical ventilation unit. To enable potential residents and resident representatives to make informed decisions in choosing a facility for admission, facilities must inform residents and resident representatives and potential residents or representatives of any special characteristics or service limitations the facility may have prior to admission. For example, a facility may have a religious affiliation that guides its practices and routines which must be communicated to any potential resident.

Likewise, if a facility has limitations in the type of medical care it can provide, this information must be communicated prior to admission. For example, if the need for a

specific type of care or service becomes necessary, knowledge of service limitations may make the need for transfer or discharge more predictable and understandable for the resident and/or his or her representative.

Disclosure of facility special characteristics does not relieve a facility of its responsibility to provide required nursing and other services for which it is licensed and certified to provide. To see the required services, refer to sections 1819(a) and 1819(b)(4)(A), and sections 1919(a) and 1919(b)(4)(A) of the Act.

§483.15(a)(7) Composite Distinct Part

If a facility does not have a composite distinct part, this provision does not apply. If there are concerns as to whether or not a facility meets the requirements for a composite distinct part according to §483.5(c), consult with the CMS *location* for clarification.

Prior to admission, facilities that have areas that meet the definition of a composite distinct part must disclose in their admission agreements to residents:

- A description of the facility's physical configuration, including the locations for each part that comprise the composite distinct part.
- Policies governing room changes between its different locations.

NOTE: If there is a deficiency specific to the requirement at §483.10(g)(15), do not cite at §483.10(g)(15), F580, but cite here at F620, regarding admission policies.

INVESTIGATIVE PROTOCOL

Objectives

The objectives of this protocol are to determine whether the facility has failed to comply with the regulations at §483.15(a)(1) – (7) above, regarding admission policies and payment.

Use

Use this protocol when concerns regarding admissions procedures arise during record review, interviews and/or in response to complaints.

PROCEDURES

Record Reviews

Review the facility admissions package, including admissions policies, and contracts to determine if they contain any of, but not limited to, the following:

- Requirements or requests for residents to waive:
 - their rights to current or future enrollment in Medicare or Medicaid
 - claims of liability against the facility for loss of personal property
- Requirements or requests for a third party guarantee of payment as a condition of admission or expedited admission.
- Requirements for payment for services which are covered under Medicaid as a condition of admission, or continued stay.

In addition, if the facility has any special characteristics or service limitations, review the admissions package to determine if they are and have been disclosed to residents and their representative prior to admission. For composite distinct part facilities, determine if the facility discloses and has disclosed its various locations that make up the composite distinct parts and its policies for room changes between its different locations.

For concerns regarding a facility charging for services that may be covered by the State Medicaid plan, surveyors are expected to review State covered services. Compare with the list of items for which the facility charges to determine if the facility is charging for covered services.

Interviews

Ask resident and/or their representative if there were any preconditions or requirements for admission, such as a third party guarantee of payment, or requests for gifts, money, donations or other considerations.

Ask resident and/or their representative if there were any other preconditions or requirements, or limitations in care that they did not expect or know about prior to admission.

Ask resident and/or their representative if they were required to waive:

- Their rights to Medicare or Medicaid, or future enrollment in either; and/or
- Claims of liability against the facility for loss of personal property.

Interview staff about information that is provided to potential residents to help them make informed decisions.