INFORMATIONAL LETTER	TRANSMITTAL: 90 INF-42
	DIVISION: Medical Assistance
TO: Commissioners of Social Services	
	DATE: August 24, l990
SUBJECT: Medicare Optimization for Care Provided in Skilled Nursing Facilities.	
SUGGESTED DISTRIBUTION: Medical Assistance Staff Staff Development Coordinators Data Entry Staff	
CONTACT PERSON: Alfred Roberts 1-800-342-3715, extension 3-5539	

ATTACHMENTS:

Attachment I - Medicare Optimization - RHCF Certification of Technical Ineligibility for Medicare Benefits (not available on-line)

Attachment II - Medicare Part A Technical Eligibility Criteria Form (not available on-line)

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
		505.9 540.5	367-a		90 LCM-02

DSS-329EL (Rev. 9/89)

I. PURPOSE

This letter has been prepared in response to a variety of questions raised by local social services staff and provider representatives regarding the current requirements for maximizing Medicare's participation in the provision of skilled nursing facility care.

II. BACKGROUND

In response to major reductions in the number of skilled nursing facility patient days covered by Medicare, the Department issued policy (Medicare Maximization) in 1976 which was designed to ensure that adequate consideration be given to the availability of Medicare coverage for Medicaid patients.

At the heart of the initial and all subsequent Medicare maximization or optimization policy is the requirement that skilled nursing facility staff document their efforts to obtain Medicare coverage as a condition of participation in the Medicaid Program.

The 1990 Medicare Optimization effort differs mainly in its use of information gathered from the residential health care facility case mix reimbursement process to identify those Resource Utilization Groups (RUGS) most likely to qualify for Medicare coverage.

In the interst of making reasonable demands upon both providers and local districts, the current Medicare Optimization effort focuses upon the five RUGS categories which are considered most representative of the kinds of cases covered by Medicare:

Rehabilitation A
Rehabilitation B
Special Care A
Special Care B
Clinically Complex D

Medicare applications must be made for technically eligible individuals falling in these five RUGS categories. We shall not, however, jeopardize provider waiver of liability status by expecting them to submit to the Medicare fiscal intermediary as covered when they do not believe the patient should be covered for Medicare.

III. PROGRAM IMPLICATIONS

To assist local districts and provider staff in their efforts to comply with requirements related to obtaining Medicare coverage for care in skilled nursing facilities, we have assembled the following list of questions raised by local social services staff and provider representatives and the answers prepared by this division:

1) Question: Are the five RUGS categories (Rehab A and B, Special Care A and B, and Clinically Complex D) the only categories subject to Medicare Optimization (pursuant to 90 LCM-2)?

   Answer: The system has been set to control against inappropriate Medicaid payments, prior to Medicare optimization, for those five RUGS categories, which are expected to include the vast majority of eligible individuals. We require that Medicare applications be made for all technically eligible individuals falling within these categories. Though not subject to the same system controls, we will expect that facilities would apply on behalf of individuals not falling in these categories, but for whom the aggregate of services provided suggests the probable availability of Medicare coverage.

2) Question: How will the local department of social services (LDSS) be notifed of the RUGS category for a particular client?

   Answer: The admitting skilled nursing facility shall submit to the responsible LDSS a copy of the face sheet of the Patient Review Instrument (PRI) which the facility must complete within five days of admission. The RUGS category appears at the top left side of the face sheet.

3) Question: At what point does the LDSS initially enter a RHCF client's name on the principal provider system?

   Answer: The LDSS should accept the PRI page submitted by the admitting RHCF as the notification which triggers entry to the principal provider system.

4) Question: Is the RHCF required to seek reconsideration of Medicare discontinuances as part of the Medicare Optimization effort?

   Answer: No. The current Medicare Optimization effort is focused upon initial admissions and readmissions, and upon the initial effort to obtain Medicare coverage. In order to ensure that RHCFs may bill Medicaid promptly upon discontinuance of Medicare coverage, the LDSS must be certain to enter a payment code of 2 upon receipt of notice of Medicare coverage. The effective date for the code 2 entry would be the end date of full Medicare coverage contained in the notice, despite the fact that the Fiscal Intermediary (FI) may subsequently extend that coverage.

5) Question: Can RHCFs exclude technically ineligible individuals from the Medicare Optimization process?

   Answer: Yes. Facilities are not expected to pursue Medicare coverage for individuals clearly not technically eligible for the program (e.g., no preceding three-day hospital stay; already exhausted lifetime covered days).

6) Question: How should RHCFs indicate to the LDSS that clients are technically ineligible?

Answer: RHCFs should staple a brief cover memo to the face sheet of the PRI which indicates technical ineligibility and the reason for ineligibility (e.g., no qualifying hospital stay; lifetime days exhausted). Attached, as examples of the kind of cover memo which might be used, are forms developed by New York City's Human Resources Administration, and by the New York Association of Homes and Services for the Aging.

7) Question: RHCFs have expressed concern that Medicare Optimization may result in a risk to their Medicare waiver of liability (presumptive status). What does this mean?

Answer: The Medicare fiscal intermediary reviews the paper work and coverage decisions made by individual RHCFs each quarter. Those facilities meeting standards of documentation and coverage accuracy (by FI criteria) are granted authority to make their own decisions about Medicare coverage. As long as a percentage of accuracy is maintained, Medicare will cover individual cases even when it feels the RHCF has erred (waiver of liability).

8) Question: How does a RHCF's functioning in presumptive status under Medicare waiver of liability affect the Medicare Optimization process?

Answer: As long as the individual RHCF is in presumptive status, we will accept its coverage decision. However, if the patient demands reconsideration, the facility must submit a request for coverage to the fiscal intermediary. The facility would then submit either notice of coverage granted or the denial of the reconsideration to the LDSS.

9) Question: Who is responsible, and what is the process, for verifying that an individual RHCF actually is functioning in presumptive provider status?

Answer: Districts should assume that a notice of coverage or denial originating with a RHCF indicates that the facility is in presumptive provider status. The New York State Department of Social Services' Office of Audit and Quality Control will be instructed to verify presumptive provider status for any RHCF audit performed. A RHCF's failure to follow Medicare Optimization requirements during a period when it was not in presumptive status will result in recoveries of all monies paid for the first twenty days of RHCF care provided to technically eligible client falling in one of the five RUGS categories.

10) Question: Exactly what forms are RHCFs expected to submit to document their having properly applied for Medicare payment?

Answer: Since the current effort focuses on the initial coverage following an admission or readmission, any one of the three following documents will suffice to change the Principal Provider System (PPS) indicator and initiate Medicaid coverage: 1) a copy of the explanation of coverage granted, from either the fiscal intermediary or a presumptive provider; 2) a copy of the presumptive provider's notice to the patient of initial coverage denial; or, 3) a copy of the denied request for reconsideration of a denial made by the fiscal intermediary.

11) Question: What degree of standardization can be expected of the fiscal intermediary and presumptive provider notices to patients in regard to not being covered by Medicare?

Answer: We assume the notifications from the fiscal intermediaries, for both coverage and denial, will be on forms standard to the individual FI. Since relatively few fiscal intermediaries will be involved, this should not be a major problem.

We assume also that most RHCFs will follow the denial form letters contained in "Medicare Skilled Nursing Facility Manual" transmittal No. 280, dated May 1989.

12) Question: Does this process apply to out-of-state facilities?

Answer: Yes. The major difference would be in the use of the PRI, which we cannot mandate for out-of-state facilities. The notification requirements, to the extent it is possible to identify individuals falling within the five RUGS categories, are identical. Receipt of the facilities' admission notification will trigger entry of Payment Exception Type 1. Receipt of copies of either an explanation of coverage or a denial of the reconsideration request, from the out-of-state facility, will change the Payment Exception Type to a 2.

13) Question: Even when covered by Medicare, a point is reached (after 20 days of full Medicare coverage) where Medicaid is obligated to pay the co-insurance. Will RHCFs be permitted to bill for co-insurance on the twenty-first day following an admission or readmission?

Answer: Currently, the payment system cannot accommodate Medicaid payment of the Medicare co-insurance. However, we are developing the necessary systems modifications to allow co-insurance payment, which includes modifications which will permit retroactive payment to facilities. Additional information will be forthcoming.

14) Question: Though rare, patients falling within the five RUGS categories do occasionally gain admission to Health Related Facilities. Must we pursue Medicare coverage for those patients?

Answer: No. Medicare does not cover care in a Health Related Facility, regardless of the patient's level of disability. While in the HRF, the client must be viewed as being technically ineligible for Medicare.

15) Question: How is the Net Available Monthly Income (NAMI) of a nursing home resident applied while waiting for a determination of eligibility for Medicare payment for their cost of care?

Answer: It is not the local department of social services responsibility to collect or preserve the client's NAMI. This responsibility rests with the facility in which the client has been placed. While we understand the problems associated with the inability to collect the client's anticipated income/NAMI the month it is received, we cannot hold the client liable for a NAMI which in fact may never be established should Medicare pay all or part of the individual's cost of care.

Therefore, we recommend that facilities establish procedures to safeguard against the potential loss of NAMI which protect the client from liability for the cost of care that has or will be paid for by either the Medicare or Medicaid Programs.

The assumption that once a presumptive provider has made an eligibility determination the provider is allowed to collect the patient's NAMI is correct. For non-presumptive providers, the collection of the NAMI should begin once the FI has made an eligibility determination. Note however, if the FI makes a negative determination, NAMI collection cannot begin until the FI issues a decision regarding a reconsideration.

16) Question: Should the client's NAMI be entered in Principal Provider?

Answer: Yes, the client's anticipated NAMI should be entered into Principal Provider, along with the proper Payment Exception Type code. The Payment Exception Type code should be changed once a determination is received from the Medicare fiscal intermediary. Once the Payment Exception Type code is changed, the nursing home may bill for co-insurance and deductible, and the appropriate number of days of care.

17) Question: Should the client's NAMI be used to pay the co-insurance and deductible amounts?

Answer: Yes. However, as noted above, the nursing home is not entitled to collect this money (NAMI) until a Medicare determination is made by the fiscal intermediary.

18) Question: What if the NAMI is more than the deductible and co-pay amounts?

Answer: The nursing home should charge the client only the amount of the deductible and co-insurance. In instances where the client's NAMI exceeds these charges, the client is entitled to retain the money in excess of the charges. This money would be added to their other countable resources for MA purposes. We do not anticipate problems in this area due to the high co-insurance and deductible.

19) Question: What if the NAMI is less than the deductible and co-insurance amounts?

Answer: The nursing home will be entitled to payment from Medicaid once Medicare has been maximized and the NAMI collected. This will be accomplished through the Principal Provider System. When the MA rate is less than the total Medicare, no MA is paid; however, when the MA rate is greater, MA will supplement to provide full co-insurance and deductible payment.

20) Question: What if Medicare takes more than the required 30 days to process the client's claim?

Answer: As described in the above answers, the nursing home is not entitled to bill Medicaid or collect the client's NAMI until a Medicare eligibility determination has been made.

IV. RECOMMENDED ACTION

Districts and skilled nursing facilities were advised of the Medicare Optimization process which went into effect on January 1, 1990 via a Local Commissioner's Memorandum and on MMIS Provider Letter issued at that time. The questions and answers supplied in this release are intended to assist districts in their implementation of that process.

V. ADDITIONAL INFORMATION

Attached for your information are copies of the Local Commissioner's Memorandum and MMIS Provider Letter describing the process for seeking Medicare coverage of skilled nursing facility care. Attached also is a copy of the Medicare denial letter required of RHCFs upon admission of a patient.

Jo-Ann A. Costantino
Deputy Commissioner
Division of Medical Assistance