STATE OF CALIFORNIA--HEALTH AND WELFARE AGENCY

GEORGE DEUKMEJIAN, *Governor*

DEPARTMENT OF HEALTH SERVICES
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November 13, 1989
Letter No: 89-94

TO: All County Welfare Directors
All County Administrative Officers

SUBJECT: MEDI-CAL PERSONS IN LTC ELIGIBLE FOR 150 DAYS OF MEDICARE COVERAGE UNDER THE MEDICARE CATASTROPHIC COVERAGE ACT (MCCA)

The MCCA provides certain Medicare beneficiaries who reside in long term care (LTC) facilities with expanded Medicare coverage for the first 150 days of LTC care each calendar year. At this time we are not certain how many patients will qualify to receive the expanded coverage since it is dependent on the level of care required by the LTC patients. Medicare does not cover custodial care, or care that is not reasonable and necessary under Medicare program standards. Until we receive federal clarification on how this expanded coverage will impact our Medi-Cal LTC population, no change to the current LTC share of cost system is planned.

SHARE OF COST TREATMENT

Existing Medi-Cal regulations require that LTC beneficiaries with a share of cost less than or equal to the Medi-Cal payment rate be issued a Medi-Cal card on the first of each month. LTC beneficiaries with a Share of Cost (SOC) higher than the Medi-Cal payment rate must be issued a form MC 177S, Record of Health Care Costs, as if the individual were not an LTC patient. These regulations were designed to facilitate Medi-Cal card issuance to LTC patients with severe medical conditions, and to streamline the administrative process and provide expeditious payment to LTC facilities.

Until further instruction is received, any LTC beneficiary reported to be covered by Medicare is to continue to receive an LTC Medi-Cal card on the first of each month, as long as the property limit is not exceeded and all other eligibility criteria are met. During the Medicare eligibility determination process, and while the LTC patient is covered by Medicare, <u>it is imperative that the beneficiary and provider be advised not to use that card until and unless Medicare payment is denied</u>. The LTC facility is responsible for making the initial Medicare eligibility determination based on the patient's medical condition and the type of care needed. Denial of Medicare eligibility is subject to the Social Security Administration's (SSA) appeal process which can result in a reversal of the initial eligibility determination.

PROPERTY TREATMENT

During the Medicare eligibility determination period and/or while the LTC patient is covered by Medicare, the LTC Medi-Cal beneficiaries will not be using their income to meet their Medi-Cal share of cost each month. As a result, their income may build up in a patient trust or other account until it exceeds the property limit. In order to avoid discontinuance due to excess property and Medi-Cal reapplication once Medicare coverage ends, LTC beneficiaries reported as Medicare patients should be advised of the following:

1. The patient must be at or below the property limit for at least one day each month to avoid Medi-Cal ineligibility due to excess property.

2. Excess property funds may be reduced by purchasing exempt property for his/her own benefit, e.g., purchasing clothing or personal effects or making payments to satisfy legal debts. Excess property may not be reduced by transferring property without adequate consideration.

3. The beneficiary may also reduce his/her excess property by utilizing the state Voluntary Repayment System described in Medi-Cal Eligibility Manual Procedures Section 16E. Note that monies voluntarily repaid are not refundable unless they exceed the amount expended by Medi-Cal.

UNPAID SHARE OF COST

The question has come up on whether an LTC facility could subsequently charge residents the unpaid SOC which occurred during the Medicare eligibility determination process is the resident is found ineligible for coverage. We referred this question to the Social Security Administration (SSA). They responded that skilled nursing facilities (SNF) are expected to be knowledgeable about Medicare coverage requirements since they are responsible for making initial Medicare eligibility determination based on the patient's diagnosis and required level of care. At the point of admission or change in condition, the SNF makes this determination and gives the patient written notification. If the SNF determines that the patient qualifies, a claim is submitted to Medicare. Medicare's fiscal intermediary then reviews the claim and determines Medicare coverage eligibility. If the SNF determines that the patient does not qualify, the SNF advises the patient in writing of the decision and his/her appeal rights.

SSA's Medicare eligibility determination system relies on the SNFs to make appropriate initial Medicare eligibility determinations. Since their decisions are not subject to review by Medicare until <u>after</u> services have been rendered, a patient could be harmed by an inaccurate SNF decision. Therefore, the Social Security Act provides relief to beneficiaries who acted in good

faith in accepting LTC services that were later found not to qualify for Medicare. In such situations, the beneficiary is not liable for the costs of these services. The SNF is liable if it is determined that "the SNF knew, or could reasonably have been expected to know", that the items or services provided were not covered under Medicare. The Medicare program accepts liability for the uncovered services if neither the SNF nor the beneficiary knew, or could reasonably be expected to have known, that the services were uncovered.

Once we obtain further information and experience with the Medicare 150 day LTC program, Medi-Cal LTC procedures and regulations will be reviewed and, if warranted, revised.

If you have any further questions, please call Sandy Poindexter at (916) 324-4953.

Sincerely,

Original signed by

Frank Martucci, Chief
Medi-Cal Eligibility Branch

cc: Medi-Cal Liaisons
Medi-Cal Program Consultants

Expiration Date: October 1, 1990