

Administrator Alert

*Policy updates & rule clarifications for Assisted Living,
Residential Care & Nursing Facilities*

Office of Licensing & Quality — Oregon Department of Human Services

February 28, 2011

Skilled Nursing Facility Coinsurance Claims – Payment Clarification

Dear Administrator,

Please share this Administrator Alert with the person(s) responsible for billing the Department of Human Services for Medicaid nursing facility services.

Several inquiries have been made around payment practices for Skilled Nursing Facility (SNF) days 1-20. The purpose of this administrator alert is to reiterate long-standing policy on SNF co-insurance via questions that are routinely submitted to Central Offices of both the Division of Medical Assistance Programs (DMAP) and Seniors and People with Disabilities Division (SPD).

Question: *What are the basic policies for payment of coinsurance for Medicare-covered skilled nursing facility stays?*

Answer: The State pays nothing for days 1-20. Coinsurance amounts due, up to Medicare's allowable amount, are typically reimbursed for days 21-100.

Question: *May nursing facilities charge Medicaid for skilled nursing facility days 1-20 provided to dual eligible (Medicare/Medicaid) beneficiaries?*

Answer: No.

OAR 411-070-0125 states "SPD shall pay on behalf of eligible individuals the coinsurance rate established under Medicare, Part A, Hospital Care, for care rendered from the 21st day



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through the 100th day of care in a Medicare certified nursing facility. SPD shall pay the appropriate rate as described in these rules for care beyond the 100th day.”

Question: *Some Medicare Advantage plans model their nursing facility benefit in line with the original Medicare plan. May nursing facilities bill Medicaid for co-insurance due in days 21-100 for clients enrolled in Medicare Advantage plans?*

Answer: Yes.

This situation is no different than the original Medicare plan.

Question: *Some Medicare Advantage plans have opted to cover Medicare Skilled Nursing Facility payments in a different manner. Many have co-payments for days 1-20, and may also decrease/eliminate the beneficiary co-insurance liability on days 21-100. May nursing facilities bill Medicaid for days 1-20 for clients enrolled in Medicare Advantage plans with these types of payment practices?*

Answer: No.

The State developed its SNF coinsurance policy based upon the original Medicare plan. Since the original Medicare plan covers days 1-20 in full, no co-insurance will be made for days 1-20.

Question: *May nursing facilities bill a client with dual (Medicare/ Medicaid) eligibility if the client is enrolled in a Medicare Advantage Plan that either has co-payments for or does not cover days 1-20?*

Answer: No.

OAR 410-120-1230 (3) states: “The following Clients are exempt from co-payments:



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(c) Any Client receiving services under the Home and Community based waiver and Developmental Disability waiver, or is an inpatient in a hospital, Nursing Facility (NF), Intermediate Care Facility for the Mentally Retarded (ICF/MR);”

Additionally, OAR 410-120-1210 (3) (B) states: “Providers may bill QMB Clients for services that are not covered by Medicare. Providers may not bill QMB-only Clients for the deductible and coinsurance amounts due for services that are covered by Medicare.”

Finally, 42 U.S.C. 1395w-22(a) (7) was amended January 1, 2010 to state: “In the case of an individual who is a full-benefit dual eligible individual (as defined in section 1935(c)(6)) or a qualified Medicare beneficiary (as defined in section 1905(p)(1)) and who is enrolled in a specialized Medicare Advantage plan for special needs individuals described in section 1859(b)(6)(B)(ii), the plan may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such plan.”

Question: *If a nursing facility has contracted with a Medicare Advantage Plan that pays in full for days 21-100, may nursing facilities still bill for the daily coinsurance rate?*

Answer: No.

410-120-1340 (11) (a) states: “DMAP limits payment to the Medicaid allowed amount less the Medicare payment up to the Medicare co-insurance and deductible, whichever is less. DMAP payment cannot exceed the co-insurance and deductible amounts due;” Since no coinsurance was due, no billing shall be made to DMAP.

Question: *Is there an expectation for Nursing Facilities and/ or case managers to review past billings for compliance with this policy clarification?*

Answer: No.



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If you have further questions about payment policy for SNF coinsurance, please submit them to Mike McCormick at mike.r.mccormick@state.or.us

