Senate Counsel & Research
SUITE G-17, CAPITOL
(612) 296-4791

Short Subjects

TITLE: Medicare Payments for Nursing Home Care DATE: 11-4-87

AUTHOR: David Giel, Legislative Analyst PHONE: 296-7178

The 1985 Legislature mandated that all Minnesota nursing homes participating in the Medical Assistance (MA) program also become certified for the Medicare program. This mandate was designed to reduce state expenditures. The state pays over 40 percent of MA costs, but the federal government pays 100 percent of Medicare expenses. Legislators were concerned that MA was paying for care that was reimbursable through Medicare.

In conjunction with mandatory Medicare certification, the Department of Human Services (DHS) negotiated a contract with the Medicare Advocacy Project (MAP), a nonprofit legal services corporation, to provide legal services to nursing home residents who are denied Medicare coverage. That contract was effective July 1, 1985.

The purpose of this report is to describe the progress made to date in certifying nursing homes for the Medicare program, to review MAP's accomplishments, and to provide background information on further state action that may be necessary to fully maximize Medicare payments for nursing home services.

I. Nursing Home Medicare Certification. In March, 1985, only 118 Minnesota skilled nursing homes participated in the Medicare program. Those facilities had 6,615 beds certified by the federal government as meeting Medicare standards and therefore eligible for Medicare reimbursement. As of October, 1987, 338 skilled facilities are participating in Medicare, and 17,833 beds in those homes are eligible for Medicare reimbursement. The percentage of skilled nursing home beds certified by Medicare has risen during this period from about 20 percent to almost 50 percent. Only about 35 skilled nursing homes, with 3,091 beds, have no Medicare-certified beds. All of those facilities have certification applications pending with the federal government. It appears that in the near future every skilled nursing home in Minnesota that accepts MA clients will also be participating in Medicare.

It has taken longer than anticipated to enroll all skilled facilities in the Medicare program. There are several reasons

for this. Some facilities objected to the mandatory certification requirement. They expressed concerns that the administrative burden of participating in Medicare was not justified, given the strict limits on Medicare nursing home coverage and the small percentage of residents likely to qualify. Some of these facilities delayed making a request for Medicare certification. In addition, the Chicago regional office of the federal Department of Health and Human Services apparently was not adequately staffed to process the large number of applications coming from Minnesota as a result of the certification mandate.

II. Medicare Advocacy Project. The Medicare program sets stringent requirements for nursing home benefits. In order to qualify for Medicare reimbursement, a nursing home stay must follow a hospital stay of at least three days, and the applicant must need care for a condition that was treated in the hospital. The resident must be admitted to the nursing home within a short time of leaving the hospital. The nursing home stay must be for rehabilitative purposes rather than maintenance care only. Initial determinations of Medicare eligibility are made by the nursing home furnishing the care. These decisions are reviewed by fiscal intermediaries under contract with the federal government. Nursing homes may become financially liable for care they provide if their percentage of approved claims later denied by the fiscal intermediary exceeds a federal threshold. Many Medicare claims are denied by the nursing home or the fiscal intermediary on the grounds the nursing home stay does not meet one or more of the Medicare eligibility criteria. Prior to the MAP contract, the state was not making a concerted effort to challenge these denials. Participation in MAP is now mandatory for nursing home residents who are recipients of MA. Private pay residents may voluntarily request MAP assistance with their claims. MAP staff request reconsideration of claim denials in appropriate cases. MAP also requests administrative hearings, which are the next level of appeal, in cases where there is a good likelihood of success. In unusual cases MAP could pursue cases through a federal appeals council or in federal district court.

It has taken some time for MAP to produce significant results. The Medicare program is slow to respond to reconsideration requests, with decisions often taking up to nine months. MAP opened over 1,000 cases the first year but received decisions on very few.

However, recent program results have been encouraging. For June through September, 1987, MAP obtained Medicare coverage in 46 percent of the cases for which reconsideration was requested. In addition, MAP prevailed in 85 percent of the cases it appealed to the administrative hearing level. The approximate value of the 6,600 additional days of Medicare coverage obtained through

these efforts is $358,000, according to MAP. The state savings is the state MA share of that amount, or about $150,000. The cost for providing MAP's services in these cases was $73,600, of which the state paid half, or $36,800. The federal government paid the other half. The ratio of savings to costs for this period was 4 to 1, and MAP projects that this ratio will eventually be 5.5 to 1. The 6,600 days of added Medicare coverage for MA recipients won during this three-month period exceed the 6,171 days of coverage won by MAP during the year ending June 30, 1987. (Additional days of coverage were also obtained for private pay residents.)

Medicare-covered skilled nursing home days for MA recipients, including coverage provided as a result of routine claims submission and coverage obtained through the efforts of MAP, totalled 70,466 in the year ending September 30, 1986.

III. Issues.

1. Availability of certified beds. Some skilled nursing facilities have not certified all of their beds for Medicare participation. Some have certified very few beds. Consequently, if those beds are occupied and a resident who could qualify for Medicare reimbursement is admitted to a different bed, there is no opportunity to claim Medicare reimbursement.

   Legislation under consideration in Congress may make this issue more critical. The legislation would remove the requirement that a covered nursing home stay must follow a hospital stay, and it would increase to 150 days from 100 the limit on Medicare reimbursement for skilled nursing home care. This legislation would enable more people to qualify for Medicare coverage, increasing the savings the state could generate by having adequate numbers of Medicare certified beds available. This situation could be addressed by mandating Medicare certification for all MA beds; for a certain percentage of MA beds; or for a minimum number of beds in each facility.

2. Therapy coverage. Medicare also pays for the costs of rehabilitative therapy provided by Medicare certified nursing homes and therapists. DHS has not made a concerted effort to maximize this reimbursement source. Medicare payment for therapy services could probably be increased by expanding the MAP contract to include therapy services or by requiring DHS to pursue Medicare claims more vigorously.