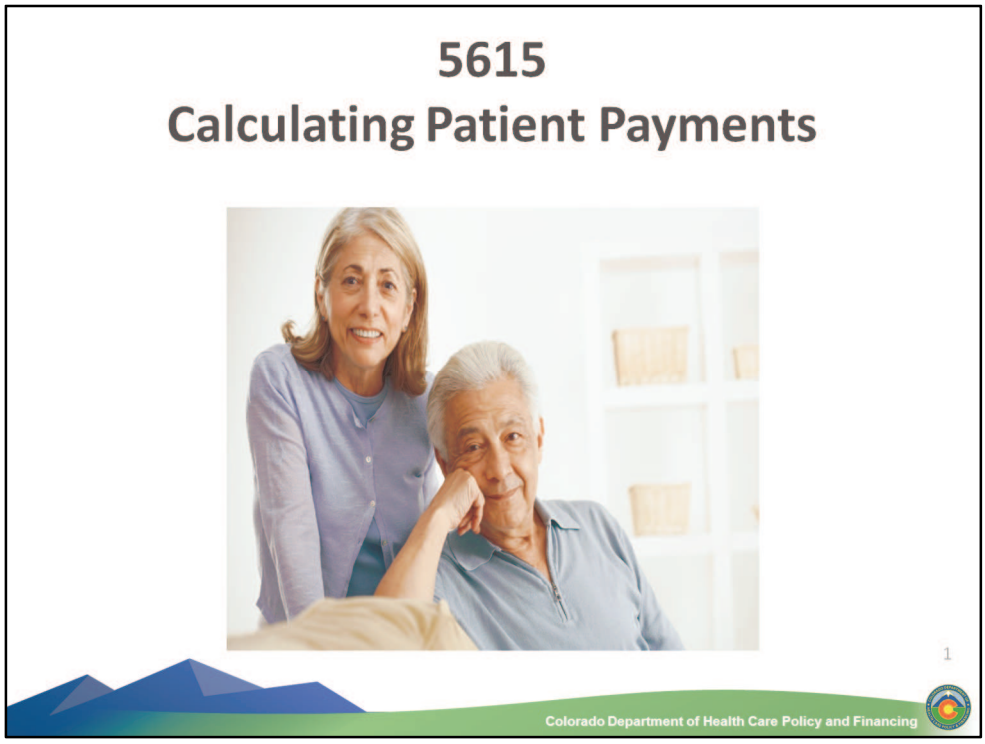
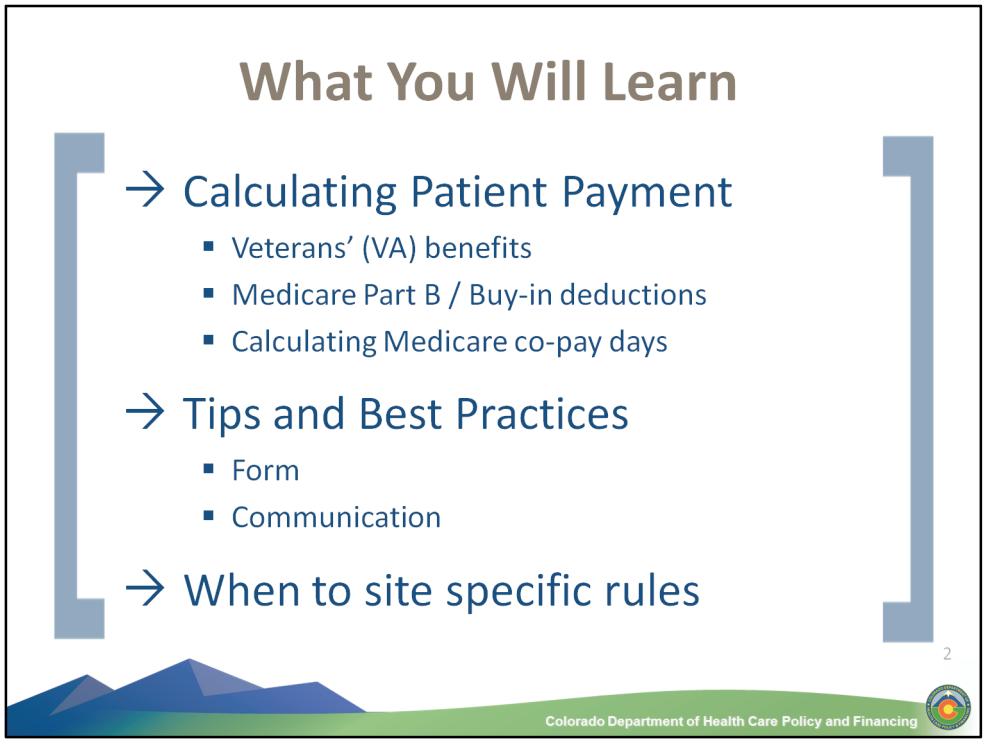


Introductions/polling

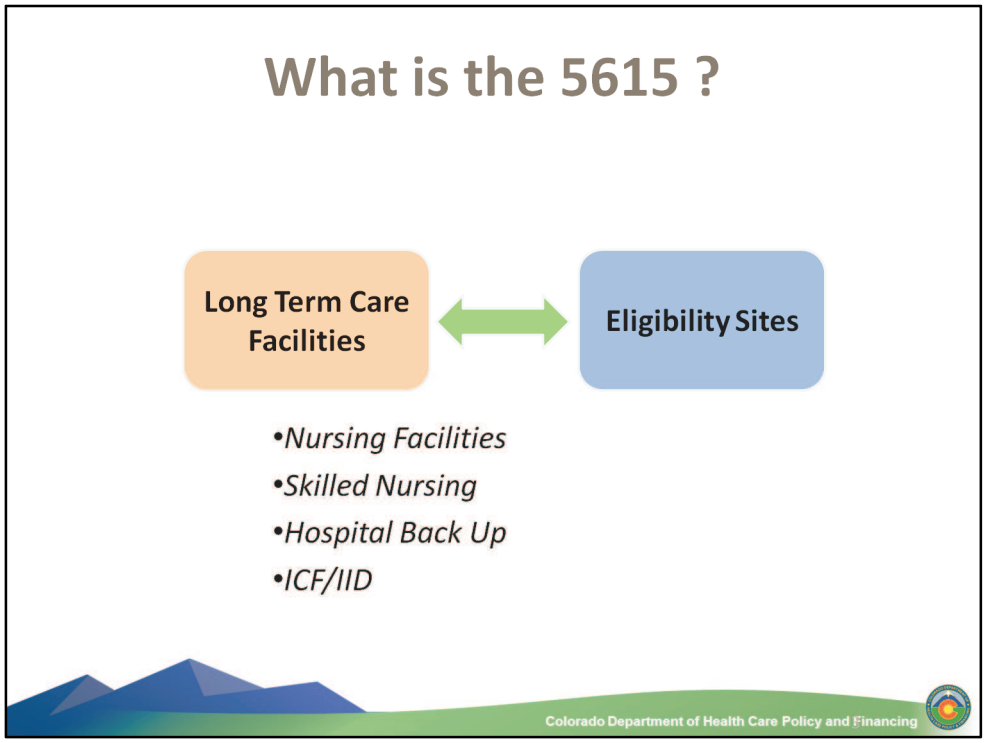
Packet of information includes – action ideas page, best practices and rules guide, scenarios that we'll work on later.

* = *Click for animation*



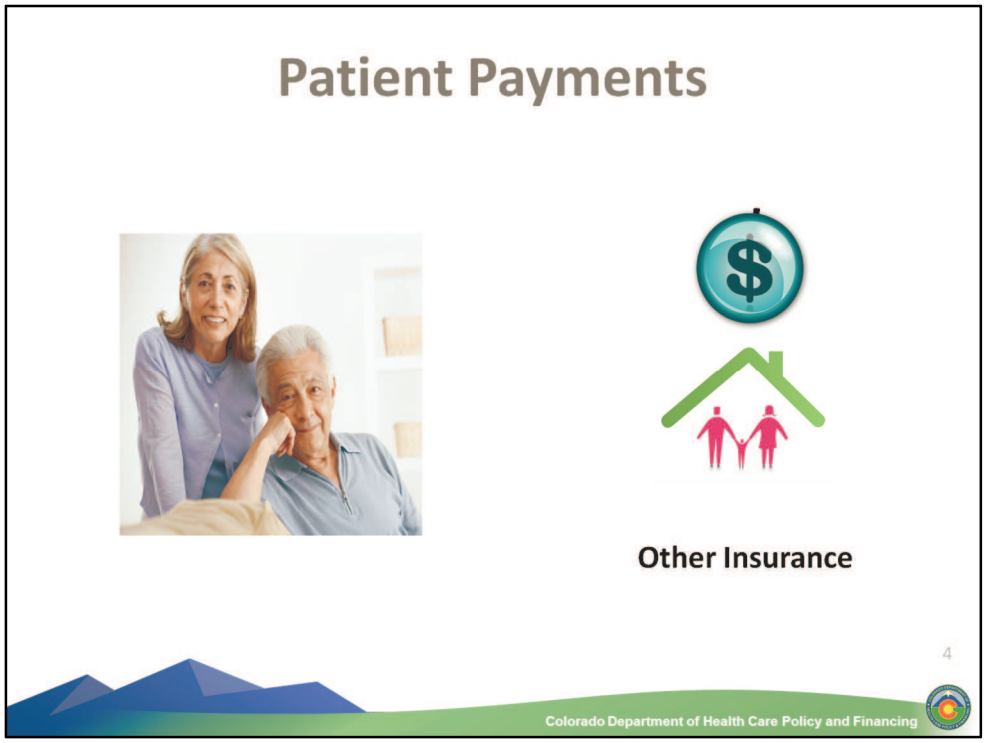
Today we are going to spend a little time walking through the form itself and giving you some exercises to do from the eligibility perspective of the form and process. We will discuss issues that can arise with
- Veterans benefits,
- Medicare Part B, and
- Medicare co-pay days.

We'll also talk about some tips and best practices for filling out the form, handling different situations, when to site specific rules.



The 5615 is a form developed to help facilitate the ***communication** between ***Long** term care facilities and ***eligibility** sites. Today we will use the general term Long term care facility, which will ***include** Nursing facilities and skilled nursing, hospital back up and ICFIID's or Intermediate Care Facilities for Individuals with Intellectual Disabilities. Note that this does not include Assisted Living Facilities because they do not use this form.

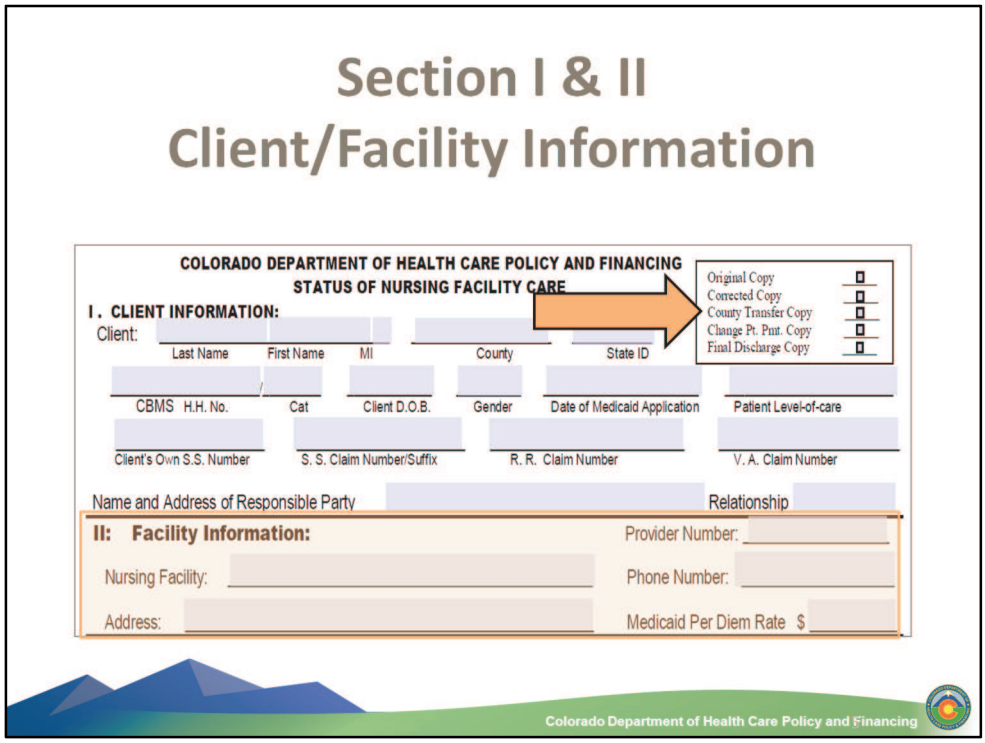
The purpose of the form is to help Long term care facilities know how to determine patient payments for Medicaid clients and it allows the Long Term Care Facility to begin billing.



When a Patient enters a **Long term care** facility there is a portion of **Long Term Care Facility charges** that the patient must cover

The amount that they pay varies from client to client. Depending on their
- ***Income**
- ***If** they have a Spouse or Dependents in the community, or
- ***Other** Insurance

All of these will factor into the patient payment



Let's start looking at the top half of the form – sections 1 and 2. We're not going to spend a lot of time here because the fields are pretty self-explanatory. However, there are a couple of things that I want to call your attention to.

First – these two sections should be filled out by the **entity who is initiating the form**. For example, **Long Term Care facilities** are often initiating the form for a client entering their facility or moving from private pay to Medicaid.

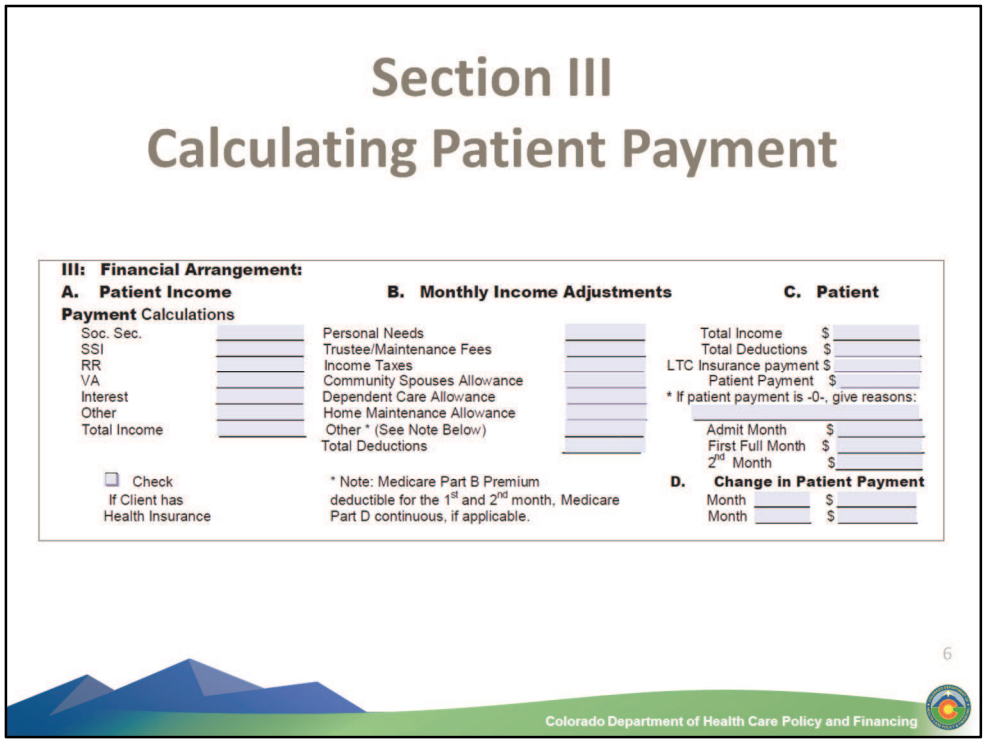
On the other hand, if a change or a correction is needed often **the eligibility site** will be initiating the form.

Are there other instances you can think of when an eligibility site is initiating this form?

The second thing I wanted to call your attention to is this ***status checkbox** at the top-right.
- this checkbox comes in very handy when trying to determine which form is the original and which form reflects a change or modification. But it also can be helpful for you when managing your files, and the Department auditors find it very helpful as well.

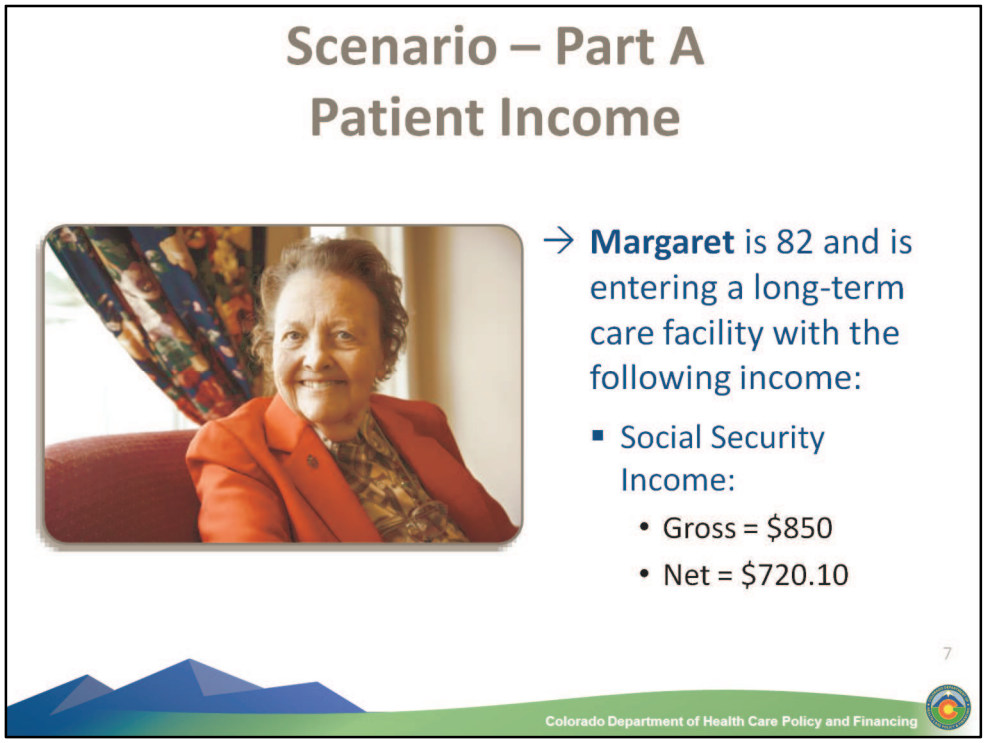
***The last thing** is I wanted to give you a resource for section 2. If you receive a form that is missing any information in this section, contacting the business office at LTC facility is going to be your best resource for that.

Questions about that before we move on?



Section 3 is the responsibility of the eligibility site to fill out and/or verify any information listed here.

We will focus quite a bit of attention on this section and help walk you through some calculations, as well as give you some tips and resources.

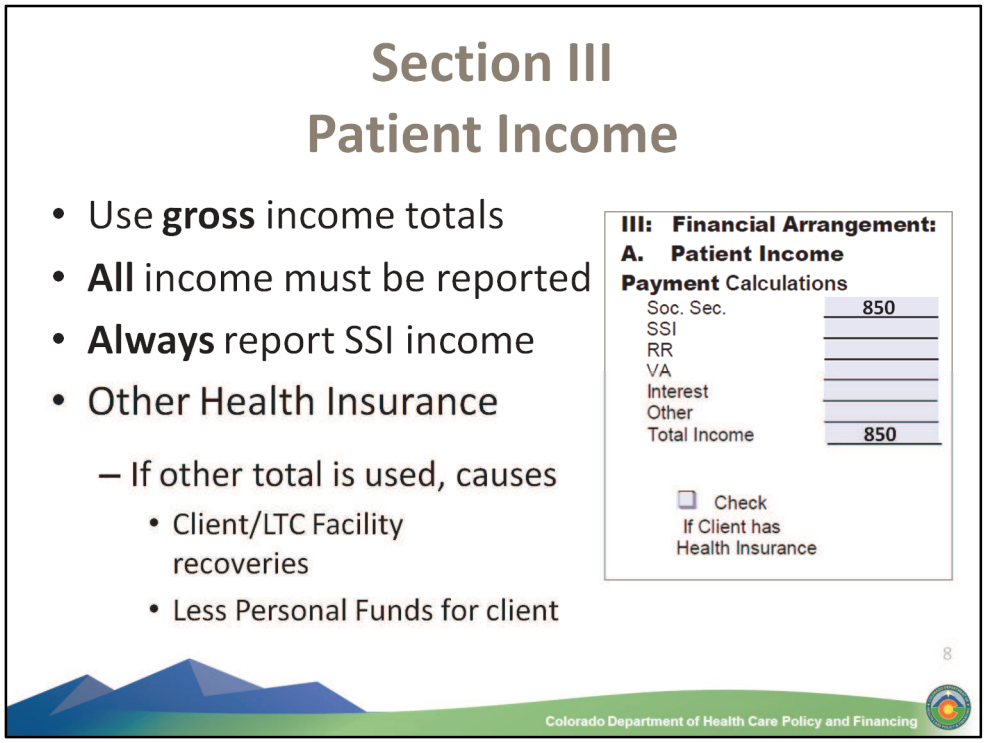


Scenario Part A – we see some income figures here for Margaret.

Only focusing on the first section of Section 3 – A. Patient Income – I'll give you a minute to discuss with your neighbor how you would fill out this section of the form with Margaret's income

What did you come up with in that first column?

Let's look at the answers…



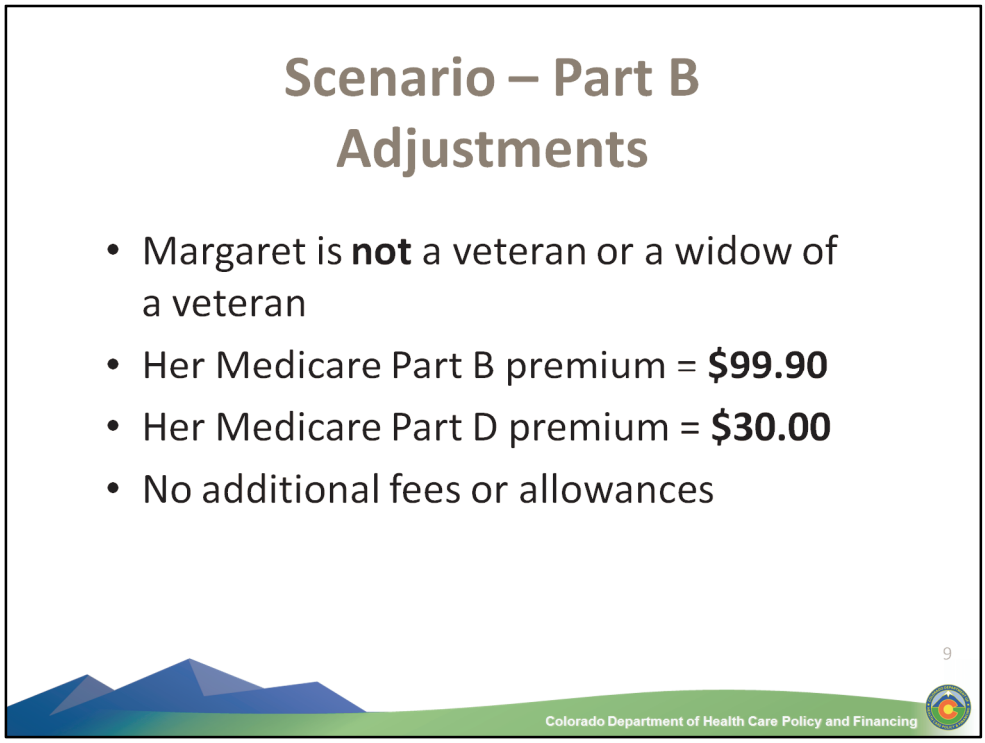
Using the **Gross amount** is the most important – Why?
- using net amount or some other amount causes issues down the line
- causes more calls, form corrections, takes up a lot of your time fixing it later
- causes Long Term Care Facilities recoveries

Good Business practice – report **all income** – lay it all out on the table

Always report SSI amount here even though you will deduct it later – why?
- good record keeping
- we want the LTC facility to be aware that the client is receiving SSI money so it can be reduced after 3 months
- we realize that some of you were trained not to put the SSI on the form. However, this is one of the things that we're hoping can bring a little more consistency to this process across counties. So that when you're working with other counties, you're all doing it the same.

- if the SSI is not recorded the **client may receive that money** or a family member of the client and it may be spent in other ways, which causes Social Security to come back to the client and ask for **reimbursement**
- it could cause the client to have **less personal funds**
- often times if unreported for many months, the LTC facility may be **unable to recover** that money if the patient passes away

The last thing to point out in this section is the **Health Insurance Checkbox**, checking that when the client has other health insurance will alert the LTC facility to apply for **PETI** – no adjustment for it.



Keeping in mind the information we've already given you about Margaret

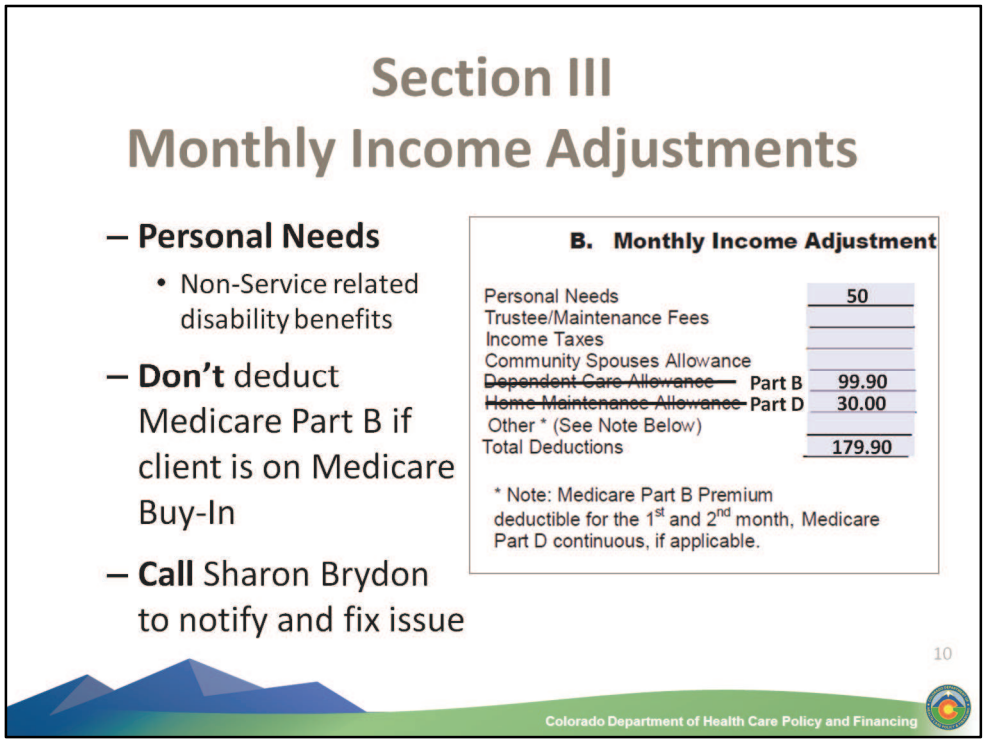
Work with your neighbor or group to determine what adjustments to make in the next piece of section 3

What adjustments did you include?

Why was it important that we know that she is not a veteran or a widow of a veteran?
- affects personal needs allowance – but only for those with a specific veterans benefit – not all veterans

What other information is important to know?
- Know whether she is on the buy-in to know whether to adjust for her premiums or not

Let's look at the answers



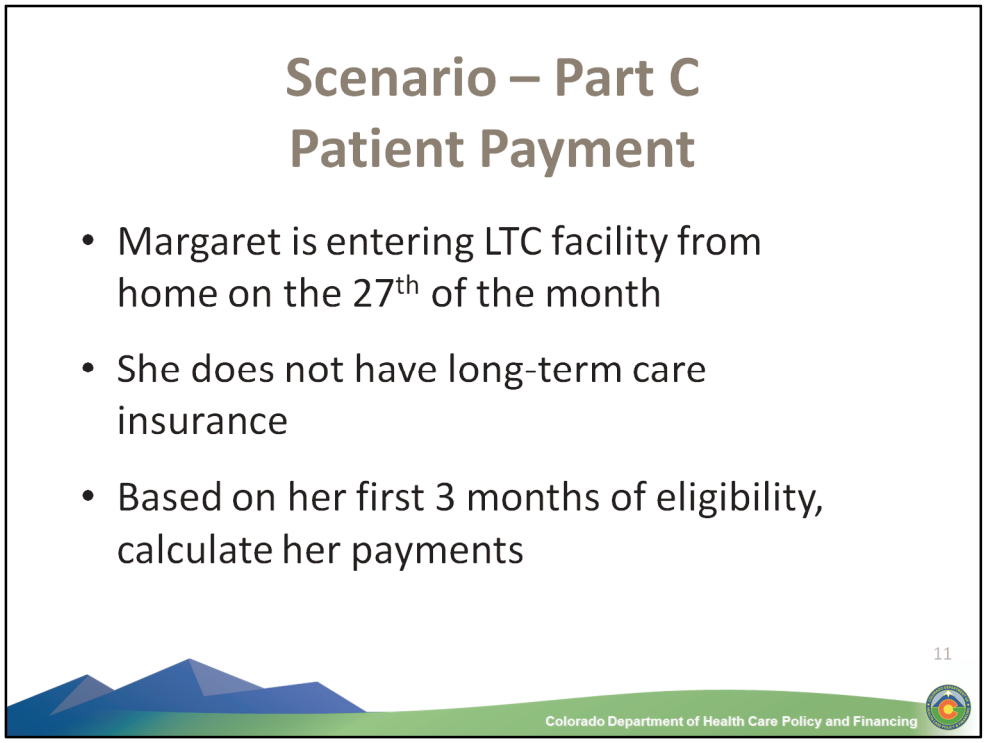
Monthly income adjustments are the dollars that need to be kept aside for other expenses the client may have. So in **section A**., we've told the LTC facility here is **all** of the income the client has, but in **section B** we're saying – but wait, you can't have it all, **the client needs some** of it for these things.

Personal needs – usually $50 for most – only get $90 if the client is a veteran with non-service related disability benefits. VA benefits take some special consideration **Tip** - when verifying VA income – ask for the **initial eligibility income**, which will help you determine what type of benefit it is.

Here, we assumed Margaret was **not** on the Medicare Buy-In program yet which helps pay the clients Medicare premiums for part B. However, if she was on the buy-in – DO NOT include the part B adjustment. Because they are already being paid for by Medicaid – not the client. Keep in mind – buy-in is only once in a lifetime, so if the client is transferring from another facility, it's a good chance that they've already used it.

Buy-In usually occurs automatically based on information you enter in CBMS that then connects with the SSA system. Typically it takes 2 months for SSA to recognize that this client needs to be on the Buy-In and stops charging the client the Part B premium. If during the 3rd month the client is still being charged the premium often the facility or the family will call the eligibility site saying the check that the client received is not the right amount and suggest that the 5615 be amended by the eligibility site to reflect the correct income.
Red Flag - Instead of taking the time to play with the numbers to make it work, tell the LTC facility that you will contact Sharon Brydon at the Department to find out what is happening with the buy-in for this client. Often she can get it fixed pretty quickly and the change will occur the next month.

Questions before we move on?

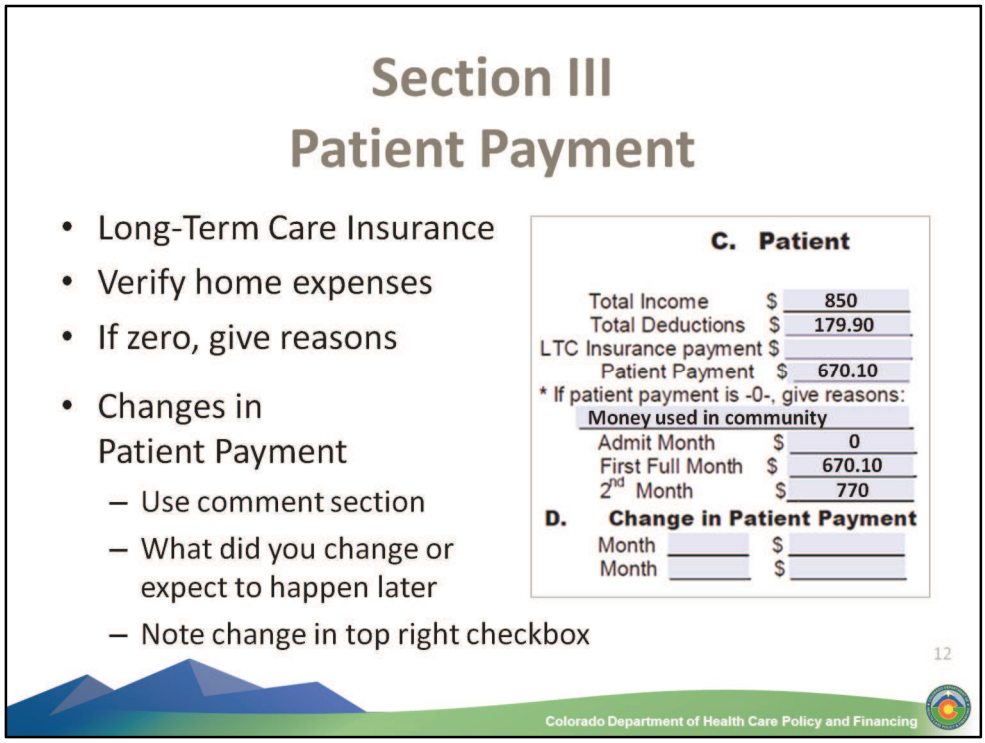


Ok – so let's wrap up Margaret's calculation

I'll give you another couple of minutes to work together to finish up the calculations

What did you come up with?

Let's look at the answers…



So again we are assuming Margaret is not on the buy-in yet

The **first** full month could be the clients **second** month of eligibility. **Buy-in only covers the first two months** of eligibility whether there is a patient payment or not. The 2nd month line on this form would then really reflect the 3rd month of eligibility. Eligibility and admittance are two different things.

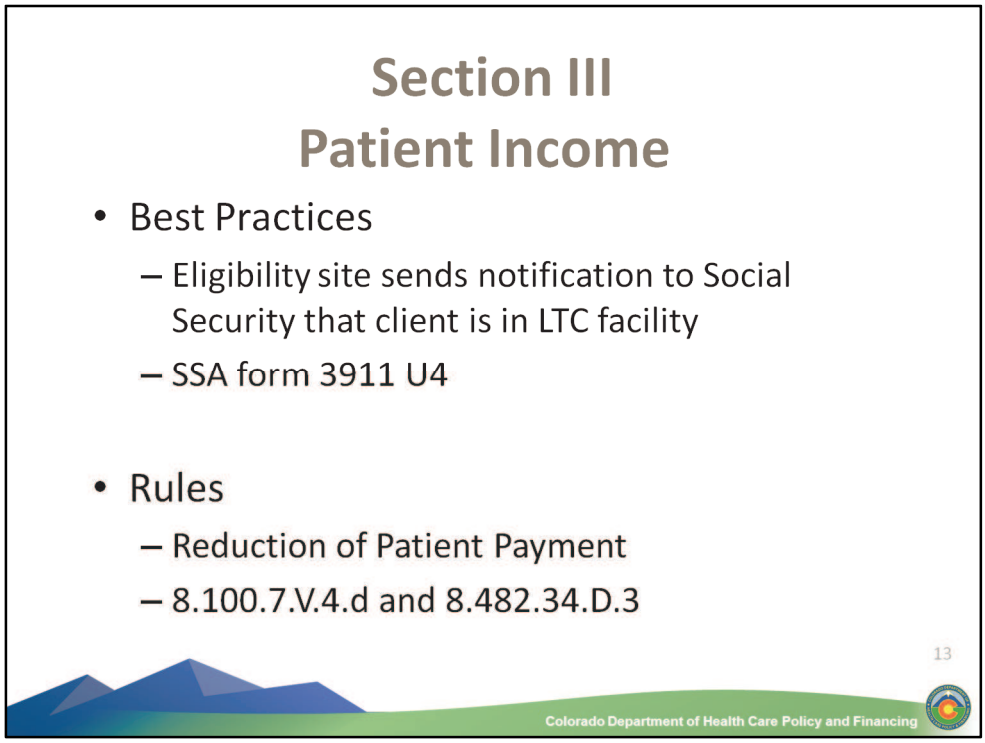
Very important for the eligibility site to **verify** that there are home expenses in the community first, and get documentation – here we are assuming that there were, so we've put zero for the first payment.

If the patient payment ever equals zero – you need to **note why** on this middle line. For instance – "money used in community" is one we see often

What other reasons might you have for the patient payment being zero?
- money already applied toward previous LTC facility
- SSI income only – does not apply to patient payment
- income used toward private pay
- spousal allowance

Can use comment section as well for this notation

Then if there are changes in the patient payment – you would use section D for that, or perhaps make other corrections, revisions
Use the comment section at the bottom of the form to note what you changed or expect to happen at a later date. The more of this type of documentation you can include, the better it is for everyone, because it explains your thought process.



Best practices for handling SSI clients
- Some eligibility sites send a notification letter or other form of communication to Social Security Administration (SSA) notifying them that client is in a LTC facility
- There is a **Report of Change form** for SSI that Social Security provides that some counties use, it is in your packet. Adams county created an electronic version of this form and graciously shared it with us. You don't have to use this form, it's just a suggested tool to use to communicate with the SSA

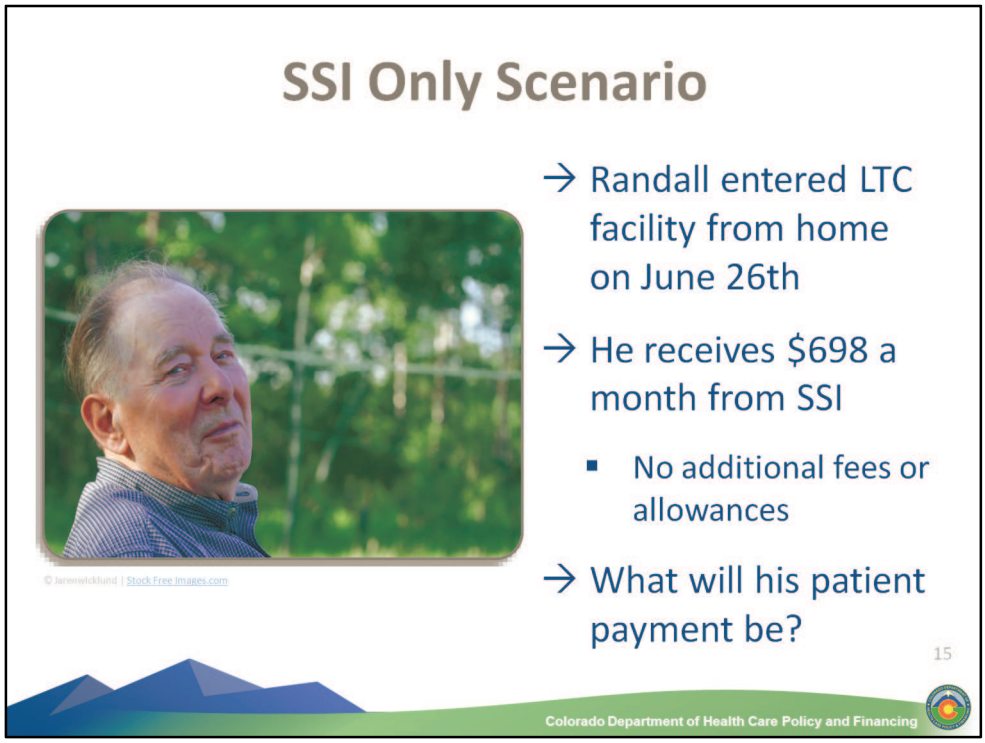
Rules
- the exact same passage about SSI payments not counting against the patient payment exists in both of these rules

Questions before we move on?

We've gone through a lot here, so I'll give you a minute to digest.

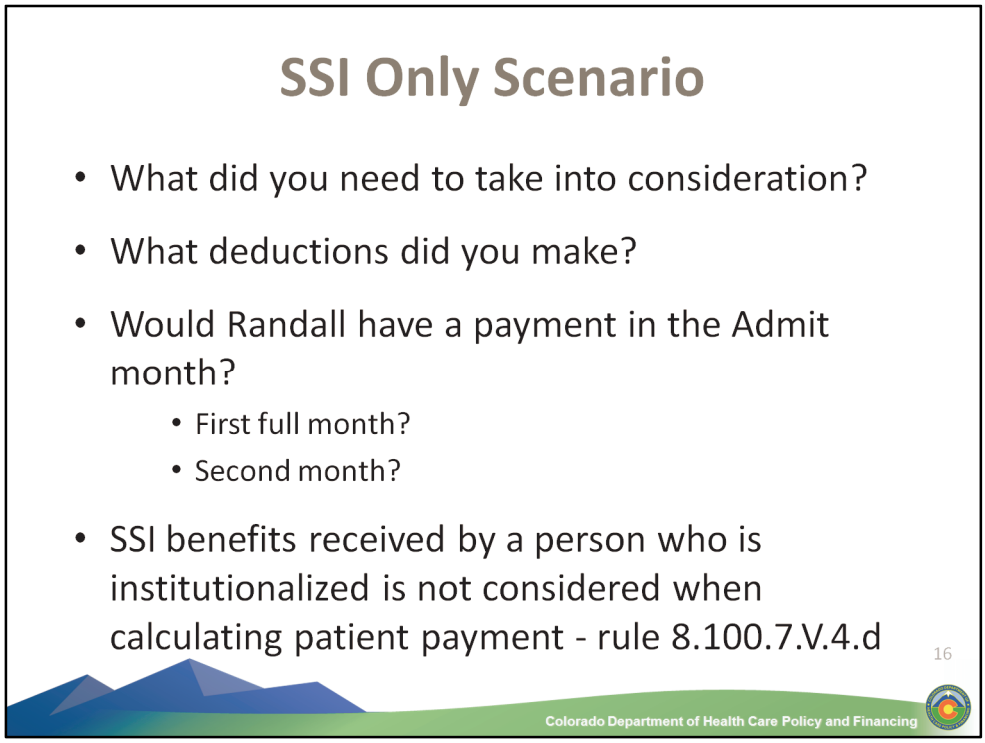
Write down an action idea, or a best practice that you want to try to use when you get back to the office or desk

These notes are just for you, I'm not going to collect them. It's a way to help you remind yourself about the training and gives you a list of things that you wanted to try or remind yourself about the 5615 process when you get back to your desk.



Now that I've walked you through the process step by step, let's try one with a client who only has SSI

I'll give you a few minutes to work through the whole process with your neighbor or people at your table

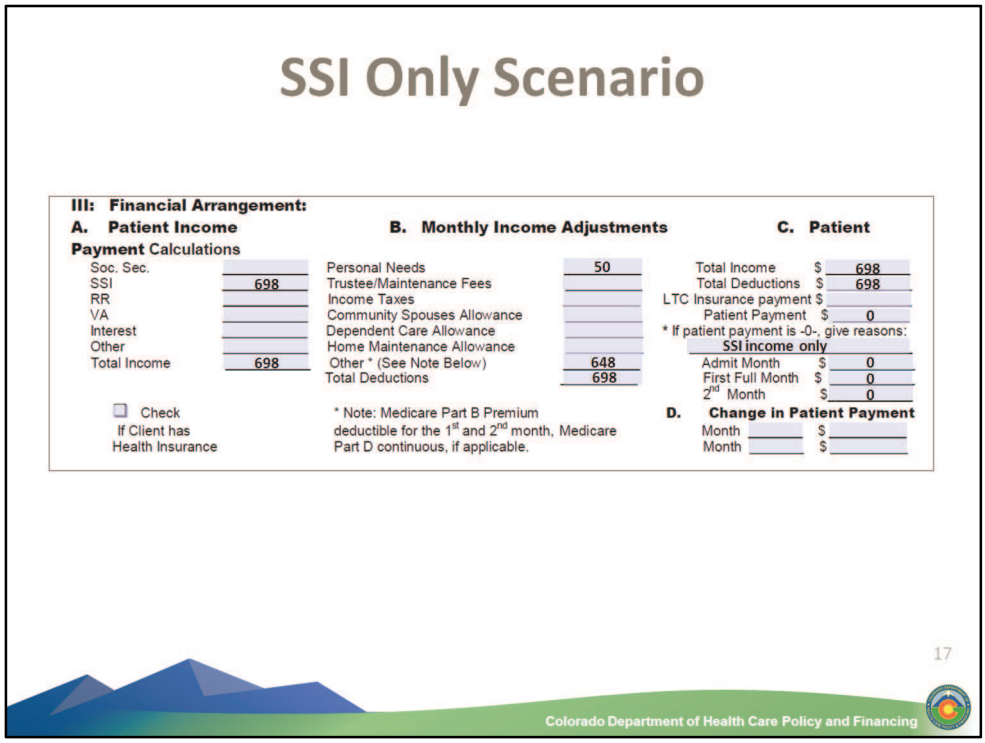


One of the things to take into consideration –
- SSI does not apply to patient payment

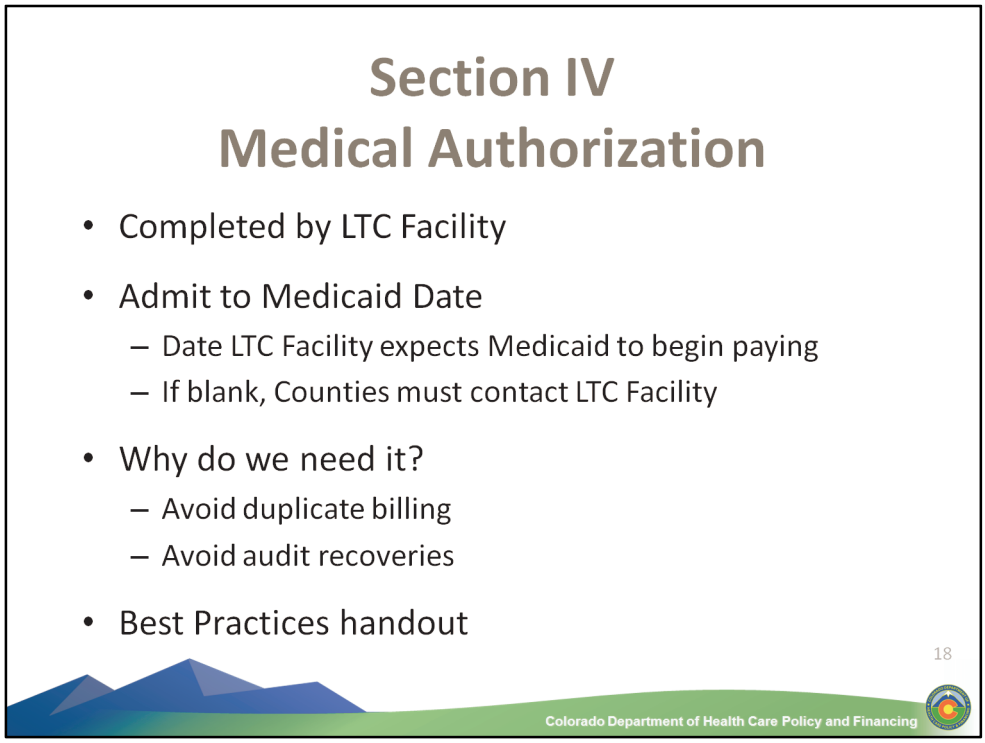
Deductions –
- $50 personal needs allowance

Patient Payment
- admit month – $0
- first month – $0
- second month – $0

It is best practice to redo the 5615 when the SSI benefits are reduced to reflect the current income.



Here is what that would look like - Now we will talk about the next section of the form, and then we will come back and do some more calculations.



Section 4 is completed by the LTC facility

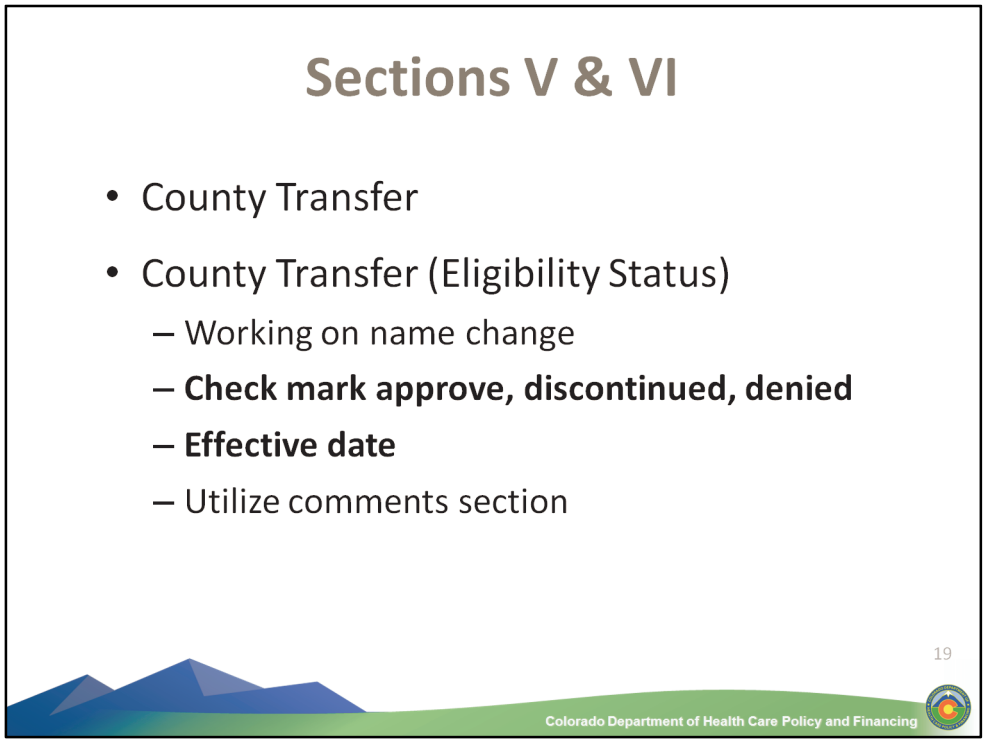
However, as I understand it, often times the **Admit to Medicaid** date is left blank. I'm assuming there is some confusion with the language used on the form for the LTC facilities, so they leave it **blank.**

The important thing to keep in mind is that this date is not related to eligibility – it is the date that the LTC Facility expects to **begin billing Medicaid**.

Getting this date correct is **important to the eligibility sites** – because it reflects the **date that Medicaid** needs to pick up where private pay or other insurance left off. Using the **incorrect** date could cause the LTC facility to get funds from both the client (or other income sources) and Medicaid at the same time for the same services.

That's why getting this date correct is **important to the LTC facilities** too – because Medicaid will eventually come to **recover** that money as result of an audit.

The **best practices handout** in your packet can help guide you in asking the right questions to determine the Admit to Medicaid date. Eligibility sites should work to get this Admit to Medicaid date from the LTC facility.



These sections will be short. Section 5 – County Transfer – you would use that in the event of a client transferring between counties.

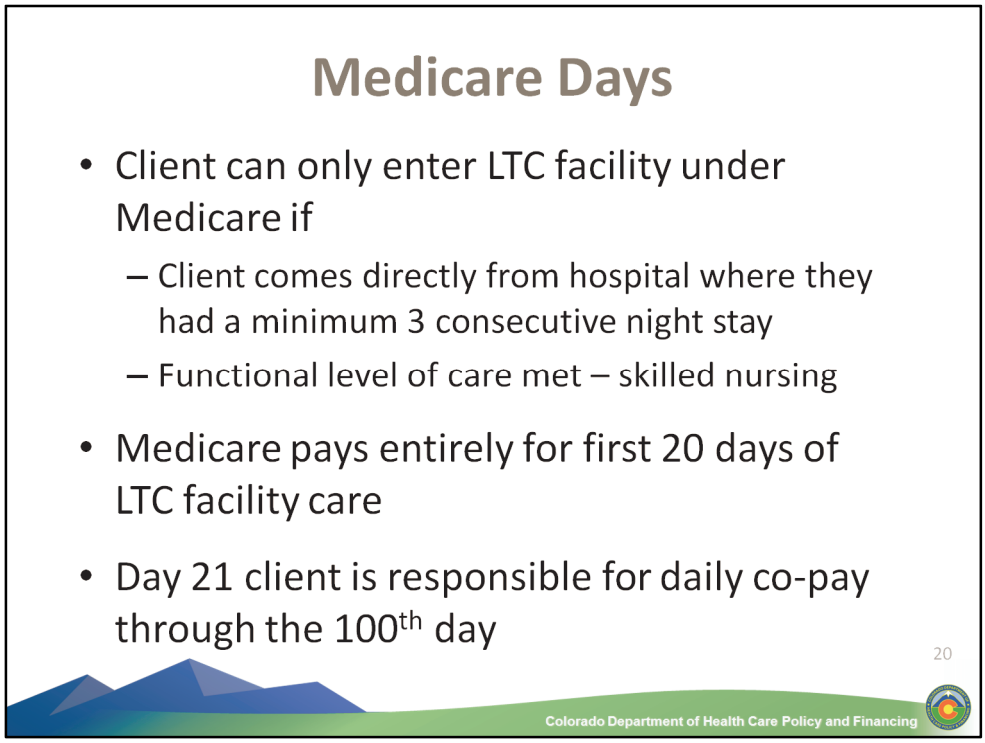
Section 6 is also titled County Transfer - However, I that leads to a lot of confusion and the **Department is working on getting this changed** to something more appropriate. I think Eligibility Status might be more appropriate. Not sure yet what it will be called.

But section 6 is very important to complete. Without completing this section, a PAR cannot/should not be generated. You should be entering the Effective Date which is the first day you are approving the nursing facility to start billing. It should be the latter of the following dates: when the client meets income/resource, or disability and level of care (unless there is a period of ineligibility due to transfer without fair consideration). The other choices (Approved, Discontinued and Denied) could be represented by an "X" or check mark.

And again **utilizing the comments** section for any additional notes or notifications is always helpful to help everyone track the paper trail and know what you or others have done or expect to happen.

And sign and date by the county technician.

Questions at point?

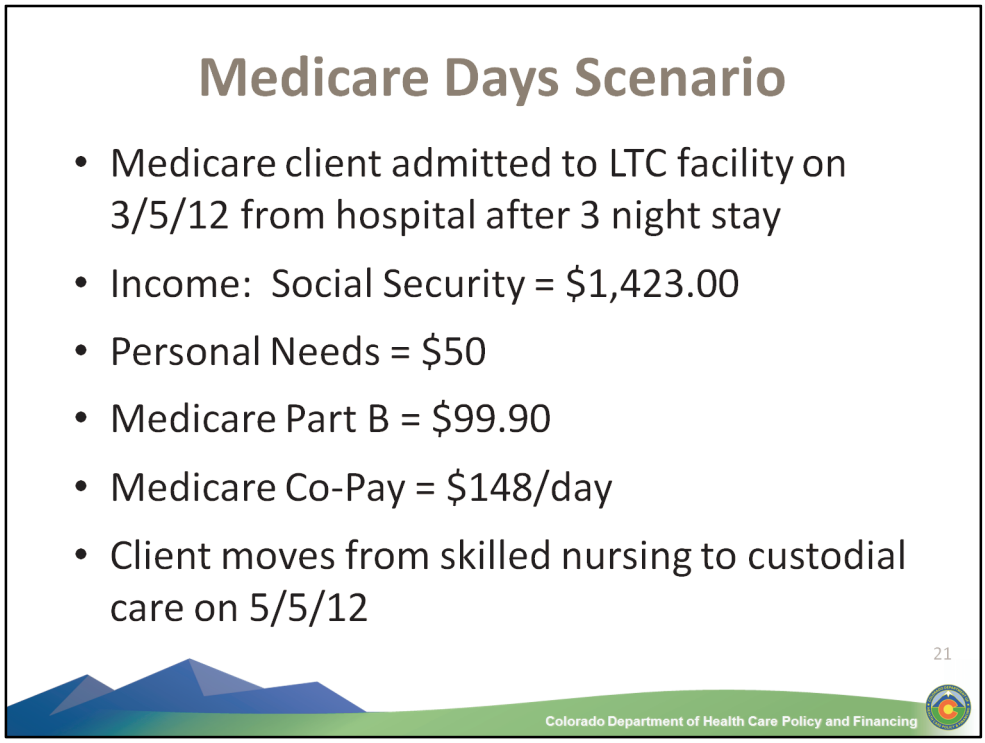


Medicare only pays for a client entering a LTC facility if they have come directly from the hospital after a 3 consecutive night stay
The functional level of care must be met. In this instance, Medicare covers skilled nursing, but not lower levels of care.

Medicare will pay 100% for the **first 20 days** the client is in the facility

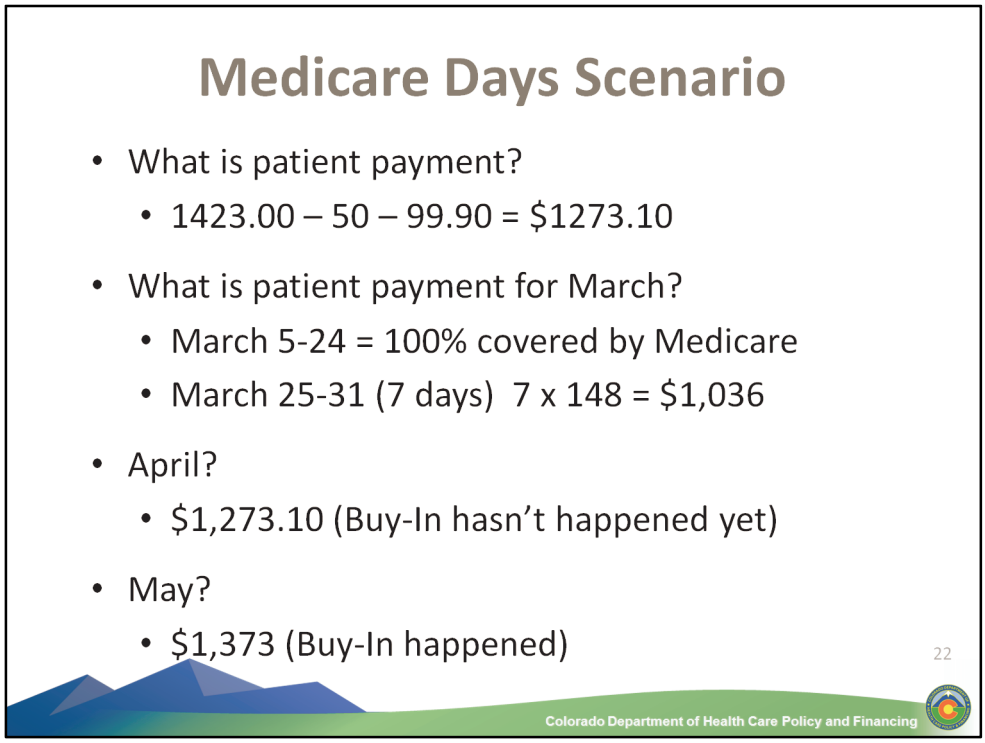
Day 21 thru 100 is when Medicare asks the client to start paying a co-pay

Let's look an a scenario for this….



Here are the facts – these figures correspond to examples of 5615's that we have printed up as handouts

Depending on time – work through in small groups or walk through it together.



Need to figure out **regular patient payment** based on income/adjustments first, and then factor in Medicare co-pays for Admit, 1st, 2nd month -- *Regular patient payment is $1273.10

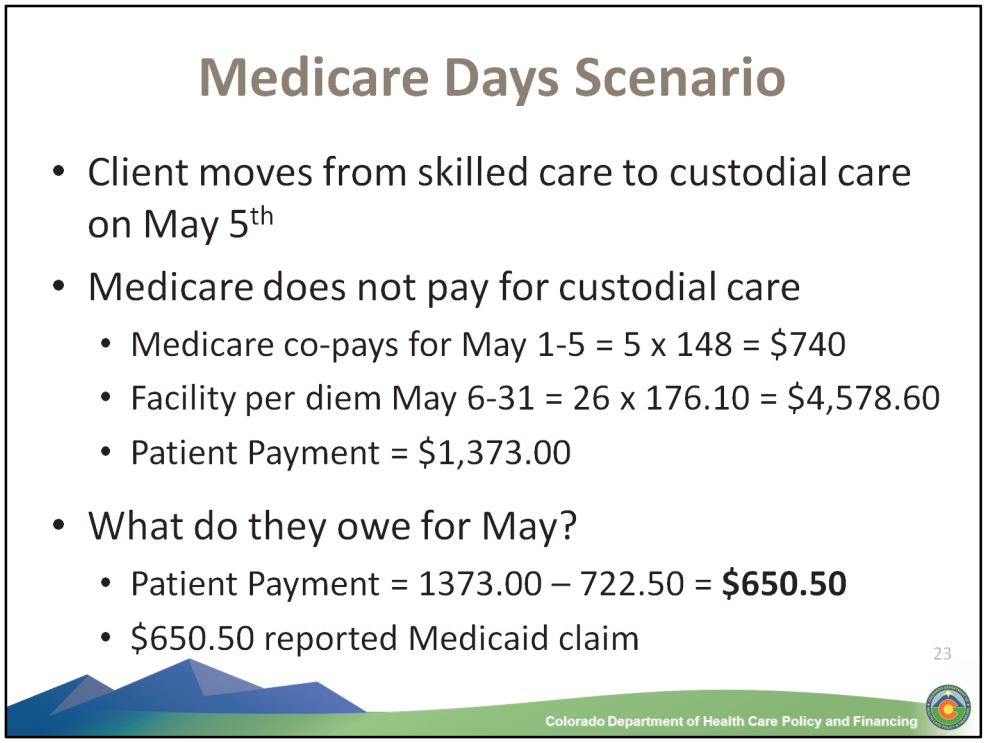
Medicare pays 100% for days 1-20 = March 5 – March 24

If stay is continuous, what date should Medicare co-pays begin? – *Co-pays begin March 25th (day 21)

March – Because Medicare per diem is less than what would have been the client's patient payment for March, Client is only responsible for that co-payment amount.

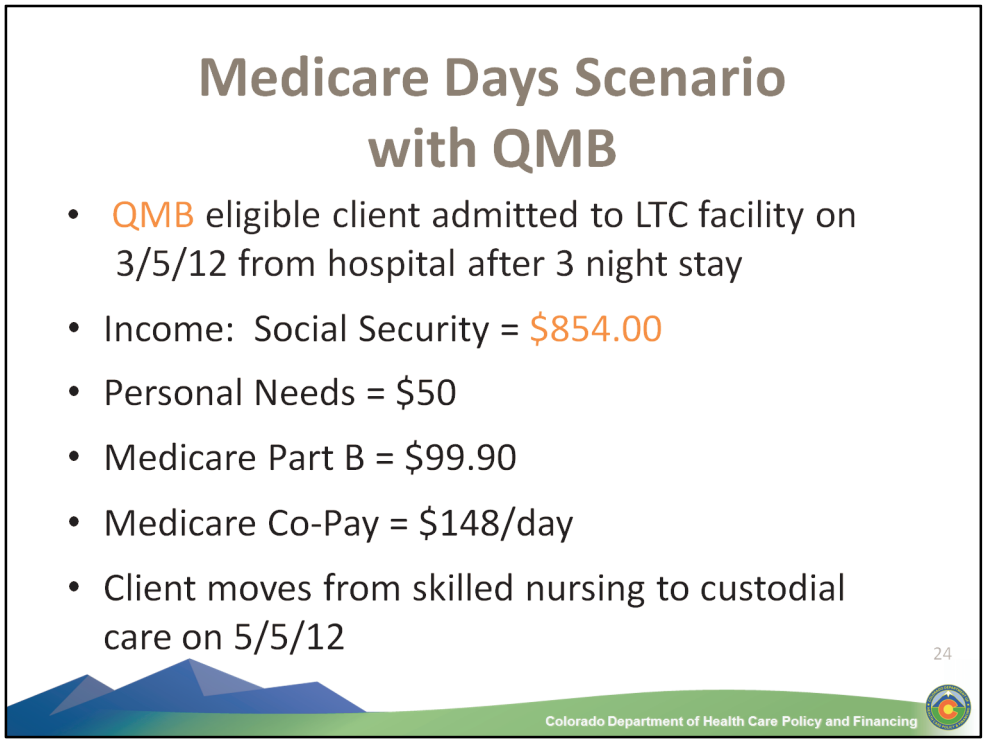
*April – Because 30 days of the Medicare co-payment would be over 4000 dollars, that is more than the client has, so they are only responsible for *1273.10 in April

*May – We are assuming that the Buy-In happens and so we don't adjust for the 99.90 any more and the patient payment is now *1373 going forward



But in our story something else happens in May – the **client moves** from skilled care to custodial care on May 5th. Again, Medicare covers skilled nursing but not custodial care, Eligibility sites may also know this as moving to Regular Medicaid.
- ***Medicare** co-pays for 5 days
- ***Facility** per diem for rest of month
- ***What do they owe for May -** Because the patient payment is ***less** than the facility per diem rate, they only pay the patient payment, part of that goes to Medicare co-pay days, the rest goes to the facility.

Why do eligibility sites need to know or tell a LTC facility how to divide up a client's payment
- most of the time you don't – the facility's accounting staff would usually take care of this
- however, it's good for you to know in case:
    - if client switches facilities mid-month, you will need to know how much has already been spent and how to divide the rest among the two facilities

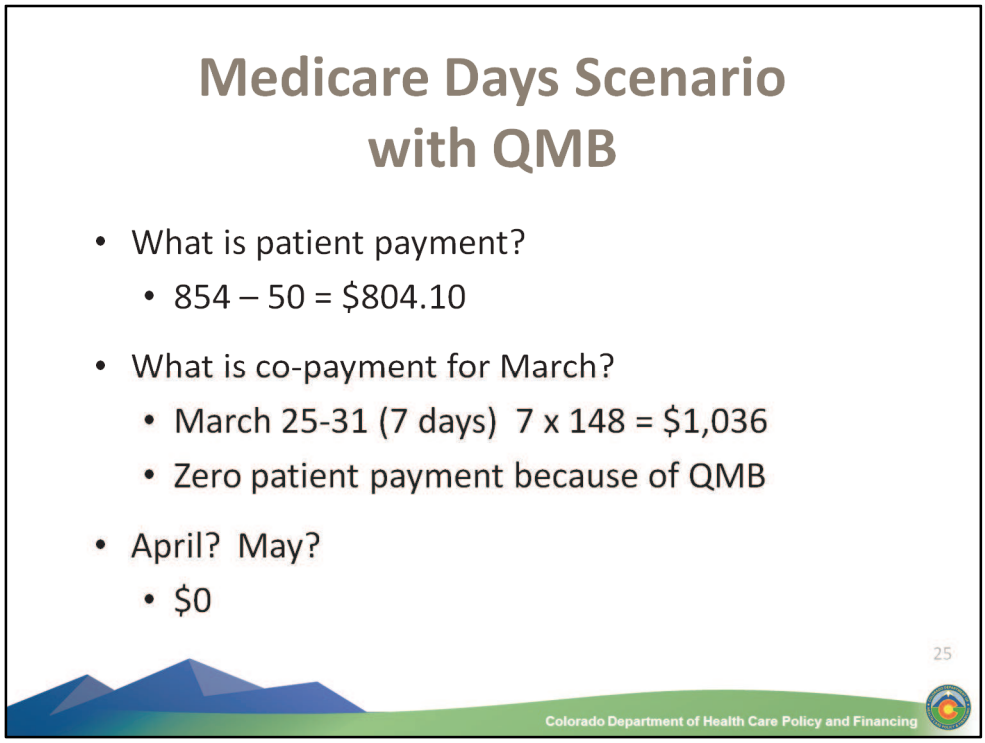


Here are the facts

The only things that we've changed for this scenario is the client is now **QMB** eligible and we've used a **new income** total of $854.00

Refer to example 5615s

QMB = Qualified Medicare Beneficiary – Medicaid pays for Medicare co-pay for days 21-100 for clients who can't pay the co-pay



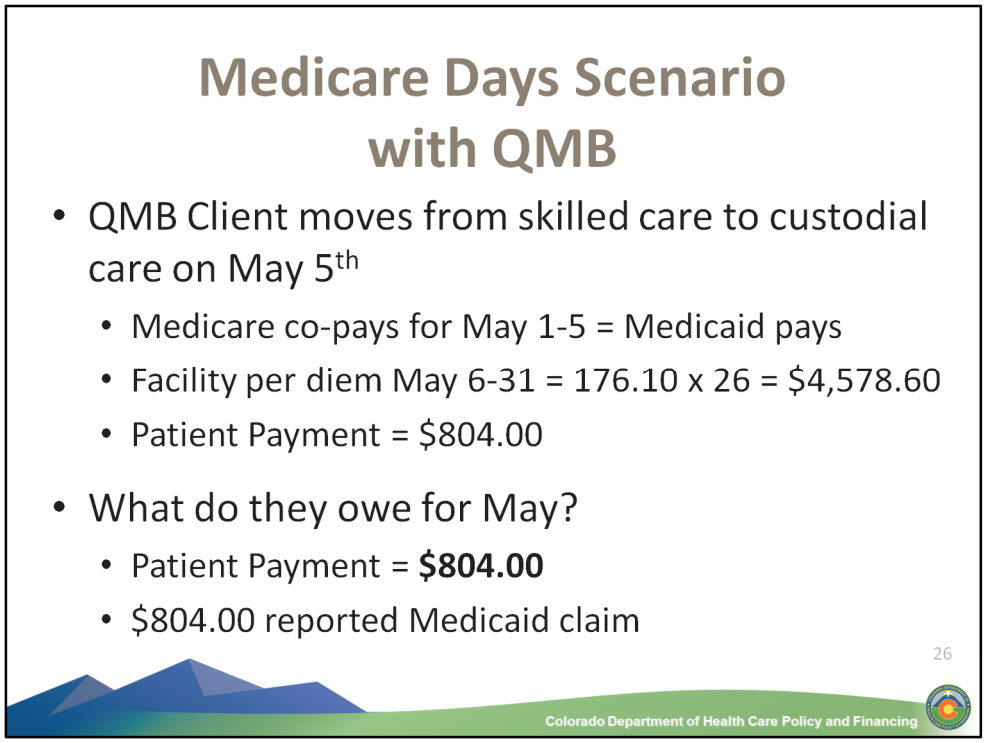
*Need to figure out regular patient payment based on income/adjustments first, and then factor in Medicare co-pays for Admit, 1st, 2nd month -- Regular patient payment is $804.10

*Co-pays begin March 25th (day 21) = $1036

*March – Because this is a QMB eligible client, Medicaid pays the co-payments and the Part B premium for the client for days 21-100, so the client's payment is zero.

*In this case April and May are zero also

After day 100, client will go back to regular patient payment based on their income, etc.



*But again in May – the **client moves** from skilled care to custodial care on May 5th

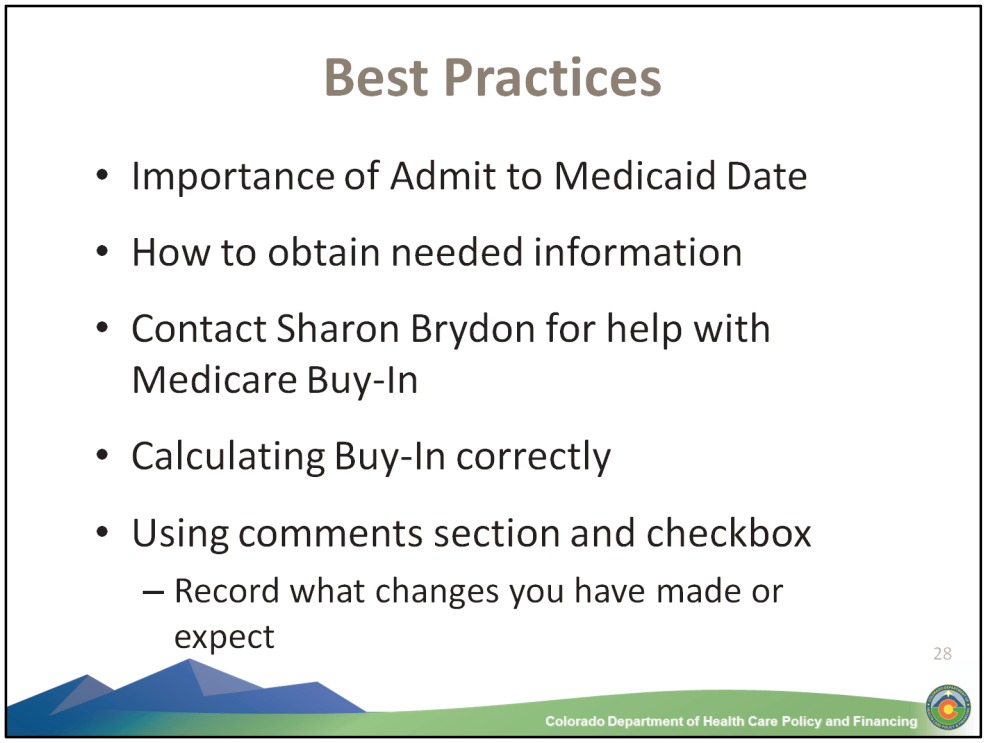
- ***Medicare** co-pays occur for 5 days – but QMB covers that – client is not responsible

- ***Facility** per diem for rest of month

- ***What do they owe for May -** Because the patient payment is ***less** than the facility per diem rate, they only pay the patient payment.

Best Practices

Write down an action idea, something you can put into practice



We went through a lot today, so to wrap up I hope you walk away with these 5 things

The Importance of the **Admit to Medicaid Date**

Some **resources** on how to obtain needed information and specific rules

To contact **Sharon Brydon** for help with Medicare Buy-In rather than spending time altering the forms

Calculating **Buy-In** correctly to avoid double-dipping and audit recoveries

Using **comments** section and checkbox
Record what changes you have made or expect

Resources

Colorado.gov/hcpf

Providers > Long-Term Services and Supports > LTSS Training

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You can find all of the documents from today's presentation here


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June 2013
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Colorado Department of Health Care Policy and Financing

Questions?