ADMINISTRATIVE DIRECTIVE

TRANSMITTAL: 95 ADM-16

DIVISION: Health and Long Term Care

TO: Commissioners of Social Services

DATE: September 20, 1995

SUBJECT: Scheduled Short Term Care in Nursing Facilities

SUGGESTED DISTRIBUTION: Medical Assistance Staff
Staff Development Coordinators

CONTACT PERSON: Loretta Grose, 1-800-343-8859, extension 4-9151 or 518-474-9151, User ID AW0680.

ATTACHMENTS: Attachment I: Facility Authorization for Reimbursement of Retroactive Scheduled Short Term Care Stays. (Available On-Line)

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
			42 CFR 447 10 NYCRR 86-2.36 and Part 410		Title XIX State Plan Amendment 91-44

I. PURPOSE

This Administrative Directive (ADM) informs social services districts of a state plan amendment which allows Medicaid to pay for scheduled short term care in nursing facilities. Scheduled short term care is inpatient care provided by a nursing facility, in accordance with 10 NYCRR Section 86-2.36 and Part 410, to individuals who are determined to need nursing facility care but are being cared for in the community.

II. BACKGROUND

In accordance with federal regulations, 42 CFR 447.250 and 447.272, a state plan amendment, 91-44, allowing Medicaid reimbursement for scheduled short term care in nursing facilities was approved by the Health Care Financing Administration June 21, 1993 with an effective date retroactive to October 1, 1991. Under the state plan amendment, scheduled short term care stays will be available to clients who do not participate in a Home and Community Based Waiver Program (e.g., a Long Term Home Health Care Program). Clients participating in a Home and Community Based Waiver Program are excluded since scheduled short term care is available to them through the institutional respite component of those programs. Eligible clients participating in the Care at Home Program are a part of the Home and Community Based Waiver (HCBS). Unlike other HCBS clients, Care at Home clients can receive scheduled short term care services.

III. PROGRAM IMPLICATIONS

GENERAL

Short term care admissions are intended to provide temporary relief to the client's caregiver(s). As the name implies, these admissions to nursing facilities must be scheduled ahead of time and must be of a specific duration in order to be considered scheduled short term care. Individuals may receive no more than 30 days of scheduled short term care for any given admission, and no more than a total of 42 days of scheduled short term care during a given year. For the purposes of this directive, a given year shall mean the 365 consecutive days following the date of the client's initial admission to a nursing facility for a short term care stay. The scheduled short term care stay should be part of the physician's plan of care.

Scheduled short term care stays in nursing facilities are not intended to provide temporary post-hospital convalescence care in

lieu of alternate level of care, nor are they intended to provide post-hospital rehabilitative services. Although some nursing facility admissions are temporary, in general, admissions from an acute care hospital to a nursing facility are permanent institutional admissions. Scheduled short term care admissions will not be considered appropriate for these types of situations.

IV. REQUIRED ACTION

A. DISTRICT PROCEDURES

Social services districts are to follow normal procedures for clients admitted to nursing facilities, with the exception of the Medicare Maximization process, and the presumption of permanent absence when an individual enters a nursing facility.

Medicare Maximization: As these clients will be admitted from a community setting and, generally, will not have a recent Medicare qualifying hospital stay, there is little potential for Medicare coverage of the nursing facility stay. Scheduled short term care admissions are, therefore, exempt from our Medicare Maximization procedures and no documentation of Medicare application/reconsideration is required before districts authorize Medicaid payment.

While nursing facilities are not required to "Maximize Medicare" for these admissions, they are expected to pursue Medicare coverage when the potential for Medicare coverage exists.

Principal Provider: As with all nursing facility admissions, the social services district must make an entry on the Principal Provider System for each client as having entered a specific nursing facility on a specific date. Medicare Maximization procedures do not apply, and the social services district should enter exception code "2", allowing nursing facility payment, on the Principal Provider System as of the date the client enters the facility.

Since social services districts should be aware of both the proposed admission and discharge dates prior to the client's admission, both dates should be entered on the Principal Provider System when the admission is initially entered. This will assure that the client receives appropriate Medicaid coverage immediately upon returning to the community. Directions for Principal Provider entry are discussed in Section V, System Implications.

Temporary Absence and Excess Income: Individuals who are admitted to a nursing facility for scheduled short term care are expected to return home. Therefore, unless spousal impoverishment budgeting is required, these individuals are considered to be in temporary absence status. In some instances scheduled short term care admission clients will have excess income. If a client has not met his/her spenddown prior to the nursing facility admission, the amount of the spenddown not yet incurred by the client must be entered on the Principal Provider System for the month of

admission. Should the stay carry over into the next month, the full amount of the spenddown would be entered for that month.

Spousal Impoverishment Budgeting: Since spousal impoverishment budgeting is required when an institutionalized spouse is expected to be in a nursing facility for 30 days, there may be instances of scheduled short term care where spousal impoverishment budgeting must be used, in accordance with 18 NYCRR, 360-4.10.

Transfer of Assets: The transfer of assets provisions contained in Department regulation 18 NYCRR 360-4.4 (c) also apply to scheduled short term care.

B. FACILITY PROCEDURES

Scheduled short term care in a nursing facility must be part of the client's plan of care and must be prior-authorized by the social services district. The following are areas of concern for facilities:

Social Services District Authorization: The Health Care Financing Administration has approved an amendment to the New York State Title XIX State Plan (Medical Assistance) which confirms that scheduled short term stays in nursing facilities are within the scope of Medicaid reimbursable services. Social services districts may authorize scheduled short term stays in nursing facilities retroactive to October 1, 1991 and be assured of state and federal financial participation.

The social services district must authorize these stays to assure that the recipient's eligibility is in order and the budget is correct. As the transfer of assets provisions apply to scheduled short term care, recipients who have transferred assets within the retroactive period as specified in Department regulations are not eligible for these long term care services.

Designated Scheduled Short Term Care Beds: While any Medicare/Medicaid certified nursing facility may admit patients for scheduled short term care stays, some nursing facilities have a limited number of beds designated by the New York State Department of Health as scheduled short term care beds. These beds are not counted when the nursing facility computes the daily vacancy rate for bed reservation purposes. Designated scheduled short term care beds are indicated as part of the nursing facility's operating certificate.

Patient Review Instrument (PRI): As noted above, scheduled short term care is available only to individuals who are determined to need nursing facility care. The New York State Department of Health, however, has exempted facilities from the requirement of completing and submitting the PRI form for scheduled short term care. There are only two instances when the PRI must be completed for patients in scheduled short term care: the PRI must be completed if the short term care patient is a resident of the nursing facility at the time of the facility's quarterly or semi-

annual submissions review. In any other situation, individuals must be assessed as needing nursing facility care but the PRI need not be completed.

Medicare Maximization: Although facilities are exempt from Medicare Maximization documentation requirements for scheduled short term care, they are expected to pursue Medicare coverage where the potential exists. Facilities must apply for Medicare coverage when the client has had a 3 day hospital stay within 30 days of the date of admission to the nursing facility; will be receiving care in the nursing facility for the condition that was treated in the hospital; and, requires daily skilled nursing or rehabilitation services.

Federal Requirements: All federal nursing facility statutory and regulatory requirements including those relating to admission, discharge and transfer continue to apply to scheduled short term care.

Payment: A nursing facility providing scheduled short term care is paid at a per diem rate of reimbursement for such services which is the average per diem rate of reimbursement for the facility.

V. SYSTEM IMPLICATIONS

A. PRINCIPAL PROVIDER

In order for the nursing facility to be reimbursed, the social services district must make the appropriate entry on the Principal Provider subsystem for each individual period of scheduled short term care. The initial entry line should include the nursing facility provider number and the specific date of admission. As Medicare Maximization procedures are not required, an exception code of "2" should be entered to allow payment to the nursing facility from the date of admission. The Net Available Monthly Income (NAMI) will generally be zero filled from the first day of the month of admission. A NAMI may be entered if the recipient has not met a spenddown requirement for the month of the scheduled short term care stay.

The next line should close the scheduled short term stay. A "00" should be input under "Principal Provider Type (PP)". The "From Date" should indicate the day after the last approved day of the scheduled short term care stay, (i.e., if the approved stay extends from 8/3/94 through 8/12/94, then the "From Date" for this line should be input as 8/13/94. This allows the nursing facility to be paid for the entire stay including the day of discharge.) Each line should then be stored separately.

An example of a Principal Provider entry for a scheduled short term care stay extending from 8/3/94 through 8/12/94 follows:

PP	PROVIDER	FROM	THRU	T	FROM	AMT	FROM
00		081394					
01	00123456	080394		2	080394	00000.00	080194

Principal Provider entries for scheduled short term care services can be input with dates of service retroactive to October 1, 1991.

B. CLAIMING

Current Claims: (Within 90 days of the date of service). Facilities are to submit claims for reimbursement according to regular claiming guidelines found in the MMIS Provider Manual. A scheduled short term care stay is billed as a regular nursing facility claim and is reimbursed at the facility's average per diem rate. All existing claiming rules apply.

Retroactive Claims: (Over 90 days/2 years). Facilities may bill for scheduled short term care services provided retroactive to October 1, 1991. These claims for services should be submitted according to procedures outlined in the MMIS Provider Manual.

(1) Paper

The New York State Department of Social Services will issue a letter to facilities which will authorize payment of these claims. (Attachment I) Facilities should retain the original letter and include a copy of the authorizing letter with each paper claim submission. These claims will be entered into the normal claims processing cycle.

(2) Tape

If claiming by tape, all retroactive claims for scheduled short term care should be submitted on one tape. No other types of claims should be submitted on this tape. The tape of retroactive claims should be sent to the following address for initial processing:

New York State Department of Social Services
MMIS/Research Unit
P. O. Box 1995
Albany, New York 12201

Reimbursement for tape claims will be made based on processing of all provider tapes on a periodic basis based on scheduling of a separate processing run.

Providers must notify the social services district of all claims prior to submission to the New York State Department of Social Services or Computer Sciences Corporation. The social services district must approve each stay and input the appropriate Principal Provider information prior to reimbursement.

No retroactive claims for scheduled short term care services will be accepted by social services districts or the New York State Department of Social Services after December 31, 1995.

VI. EFFECTIVE DATE

This ADM is effective October 1, 1995, retroactive to October 1, 1991.

Richard T. Cody
Deputy Commissioner
Division of Health and Long Term Care

ATTACHMENT I

FACILITY AUTHORIZATION
REIMBURSEMENT OF RETROACTIVE
SCHEDULED SHORT TERM CARE STAYS

This letter authorizes reimbursement of the attached claim for Scheduled Short Term Care.

Reimbursement for this retroactive claim is justified due to a delay in Medicaid Client Eligibility Determination for this particular service.

Authorization is contingent on local social services district review and approval of the client's eligibility for Scheduled Short Term Care.