STATE OF TENNESSEE
BUREAU OF TENNCARE
DEPARTMENT OF FINANCE & ADMINISTRATION
310 Great Circle Road
NASHVILLE, TENNESSEE 37243

IMPORTANT MEMO

DATE: September 9, 2011

TO: Administrators and Office Managers of Medicaid Nursing Facilities and ICFs/MR
CEOs and COOs of TennCare Managed Care Organizations

FROM: Patti Killingsworth, Chief of Long Term Care

SUBJECT: **IMPORTANT Information regarding Patient Liability and Item D Deductions**

This memo clarifies federal requirements pertaining to post-eligibility provisions (i.e., collection of patient liability), and advises you of recent changes made to the *Medicaid State Plan* regarding allowable medical deductions from patient liability (commonly referred to as "Item D").

I. Clarification regarding Patient Liability

As you know, **"patient liability"** is the ***monthly*** amount that persons receiving Medicaid-reimbursed LTC services are required to contribute to the cost of their care if their incomes are at certain levels. In the CHOICES program (as it was in the fee-for-service system prior to CHOICES), nursing facilities are obligated to collect each Medicaid resident's patient liability. Medicaid payments made by the MCO to the facility for each month must be reduced by the *entire* amount of patient liability due for that month.

Patient liability is applied *only* to the cost of long-term care services or hospice room and board charges, and cannot exceed total Medicaid payments for such services provided during the month.

In the CHOICES program, while an MCO may, for purposes of claims processing, convert a person's monthly patient liability to a daily (or per diem) amount, the MCO remains obligated to deduct the ***entire*** **monthly** patient liability amount from its payment for claims, so long as that amount does not exceed Medicaid payments for long-term care services or hospice room and board provided during that month. This means that if a person is absent from the facility and there is a non-covered day, (because the person has exhausted his bed hold days or the facility does not meet minimum occupancy requirements to bill bed hold days), the facility must still collect the patient liability amount for that day and the total Medicaid payments made by the MCO for the month must still be reduced by the total monthly patient liability amount, so long as the total patient liability collections do not exceed total Medicaid payments for nursing facility services or hospice room and board for the month.

This does not preclude the facility from requiring a payment from the resident to hold the bed. However, the patient liability collected from the resident cannot be retained by the facility for that purpose, as the full monthly amount of patient liability must, pursuant to federal law, be deducted from payments made by the MCO.

Any payments made by an MCO for nursing facility services or hospice room and board for which all required monthly patient liability amounts were not deducted and/or any patient liability amounts collected and retained by a facility that were not used to reduce the Medicaid payments for nursing facility or hospice services constitute an overpayment of Medicaid funds.

Pursuant to §6402 of the Affordable Care Act, **providers (including MCOs) have 60 days from discovery to return any overpayments and provide explanation of the reason for the overpayment in order to avoid additional liability under the State and Federal False Claims Acts**. Nursing facilities should make these payments to the MCOs for services delivered under the CHOICES program. Explanation of the reason for the overpayment should accompany the payment to the MCO and be copied to TennCare. A copy of the Bureau's policy is attached hereto. Because federal post-eligibility provisions (i.e., collection of patient liability) is a federal requirement which has always been in effect, recovery is not limited to any particular time period.

II. Changes in Allowable Item D Expenses

As you also know, Item D deductions are allowable deductions from a person's patient liability amount for certain medical or remedial care that is **recognized under State law but not covered by the *Medicaid State Plan***. By definition, these should be expenses that are not covered by TennCare.

In that regard, two clarifications have been made in the *State Plan* with respect to benefits covered under the TennCare program that should not be allowed as Item D expenses. These changes were effective **March 1, 2011.**

a. Language has been added to clarify that **Item D deductions for "Eyeglasses and necessary related services" are limited to those medically necessary items "not covered under the *State Plan* or the TennCare Demonstration."** Items covered under TennCare include "Medical eye care, meaning evaluation and management of abnormal conditions, diseases, and disorders of the eye (not including evaluation and treatment of the refractive state)... One pair of cataract glasses or lenses is covered for adults following cataract surgery." As such, these services and are not allowable Item D expenses. Items and services not covered under TennCare for adults age 21 and older, including "[r]outine, periodic assessment, evaluation or screening of normal eyes, and examinations for the purpose of prescribing, fitting, or changing eyeglasses and/or contact lenses" continue to be allowed as Item D deductions.

b. **Item D deductions are no longer allowed for specialized wheelchairs.** This is because wheelchairs (including customized and/or power wheelchairs) are covered as medically necessary by TennCare. For persons who are dual eligible, Medicare is the primary payer source. Regardless, the resident should not be responsible for payment of medically necessary wheelchairs, such that an Item D deduction is not appropriate. The *State Plan* has never provided for wheelchair repairs to be reimbursed as an Item D deduction.

In addition, the recent *State Plan Amendment* clarifies the period of time for which medical expenses incurred prior to the month of application for Medicaid can be deducted from patient liability. Based on the new SPA, **only those allowable medical expenses incurred within three months prior to the month of application for Medicaid are allowed as an Item D expense when the person would have been income and resource eligible at the time the expense was incurred.** Medical expenses incurred more than three months prior to the month of application are disallowed and may **not** be submitted as an Item D expense. No deductions will be allowed for medical expenses that were incurred as the result of imposition of a transfer of assets penalty period.

Please note also that Item D deductions are **not** allowed for non-covered bed hold days.

If facilities have any questions about this memo, please contact your TennCare MCO or the Long-Term Care Division.