Long Term Care Medicaid

Part 5

Long Term Care (LTC) Medicaid

Long Term Care Medicaid includes:

- Home and Community Based Waivers Medicaid
- Family Care
- IRIS
- Partnership
- PACE
- Institutional Medicaid

Home and Community Based Waivers (HCBW) Medicaid

- Community Waivers enable elderly, blind, and disabled (EBD) persons to live in community settings rather than in state institutions or nursing homes.
- They allow Medicaid to pay for community services, which normally are not covered by Medicaid.

HCBW Medicaid

Community waivers include the following programs:

- Community Integration Program I (CIP 1A and CIP 1B).
- Community Integration Program II (CIP II).
- Community Options Program Waiver (COP-W) .
- Brain Injury Waiver.

HCBW Medicaid

Community waivers include the following programs (*con't.*):

- Program of All-Inclusive Care for the Elderly Anyone age 65 or older. (PACE).
- Wisconsin Partnership Program (WP).
- Children's Long Term Support waiver programs (CLTS). These programs serve children with physical disabilities, developmental disabilities and mental health needs.
- IRIS (Include, Respect, I Self-Direct) Self-Directed Supports Waiver

HCBW Medicaid

To be eligible for HCBW, a person must:

- Meet Medicaid level of care requirements for admission to nursing homes, and
- Meet non-financial requirements for Medicaid, and
- Meet financial requirements for Medicaid, and
- Reside in a setting allowed by community waivers policies, and
- Have a need for long term care services.
- Have a disability determination if under 65 years of age.

HCBW Medicaid

Applicants for Home and Community Based Waivers fall into one of three groups based on income and eligibility for other categories of full benefit Medicaid.

- Group A
- Group B
- Group C

The cost share calculation will depend on which group the applicant is in.

Group A

Group A Waiver members:

- Are functionally eligible for HCBW
- Eligible for full benefit Medicaid through SSI, SSI related Medicaid, MAPP or BadgerCare Plus Standard Plan
- Eligible for full benefit Medicaid through meeting a deductible.
- Have no HCBW cost share

Group B

Group B Waiver members:

- Are functionally eligible for HCBW
- Have gross income at or below the Community Waivers Special Income Limit (currently $2022)
- Have assets below $2000
- May have a cost share based on the members income and allowable deductions

Group B Cost Share Calculation

From the individual's gross income subtract:

- Personal Maintenance Allowance
- Special Exempt Income
- Health Insurance premiums
- Medical/Remedial expenses

Personal Maintenance Allowance

The personal maintenance allowance is for room, board and personal expenses. It is the total, (up to the EBD Maximum Personal Maintenance Allowance), of the:

1. Community Waivers Basic Needs Allowance. This amount can change yearly. The current amount is $854.00.
2. $65 ½ earned income deduction. To calculate this deduction subtract $65 from the member's gross monthly income, divide the result by 2 and add the $65 to that amount.

Personal Maintenance Allowance

Continued from Previous Slide….

3. Special Housing Amount. This is an amount of the person's income set aside to help pay housing costs. If the Group B Waiver member's housing costs are over $350, add together the following costs:
   - Rent
   - Home or Renter's Insurance
   - Mortgage
   - Property tax (including special assessments)
   - Utilities (heat, water, sewer, electricity)
   - 'Room' amounts for members in a CBRF, RCAC, or AFH.

The total minus $350.00 equals the Special Housing amount. The Special Housing amount is not given to members under 18.

Personal Maintenance Allowance

Special Housing Amount

When both spouses are applying for HCBW and both have income:

- And they reside together in the same residence, divide the special housing amount equally between them.
- And they reside in separate rooms in a substitute care facility, but there is only one room and board contract for both, divide the special housing amount equally between them.

Personal Maintenance Allowance

Special Housing Amount

When both spouses are applying for HCBW and both have income:

- And they reside in separate living arrangements (e.g. they reside in two different substitute care facilities OR they reside in the same substitute care facility but each has a private room and his/her own individual room and board contract) then calculate a separate special housing amount for each, based on their individual "rent" costs that are obtained from the care manager.

Personal Maintenance Allowance

Special Housing Amount

When <u>one</u> spouse has income and <u>both</u> are applying:

- And they reside together in the same residence, allocate the full special housing amount to the spouse with income.
- And they reside in separate rooms in a substitute care facility, but there is only one room and board contract for both, allocate the full housing amount to the spouse with income.

Personal Maintenance Allowance

Special Housing Amount

When <u>one</u> spouse has income and <u>both</u> are applying:

- And they reside in separate rooms in a substitute care facility, but each has an individual room and board contract, only the spouse with income gets a deduction for the special housing amount, and it is based on their individual “rent” costs that are obtained from the care manager.

Special Exempt Income

Special Exempt income includes:

- Income used for supporting others: these are payments, either court-ordered or non-court ordered made to a person outside the Fiscal Test Group for purpose of supporting and maintaining that person.
- Court-ordered attorney's fees
- Court-ordered guardian and guardian ad litem fees
- Expenses associated with establishing and maintaining a guardianship

Special Exempt Income

Special Exempt income includes:

- Expenses associated with a Self-Support Plan. Allows the disabled member to receive income and accumulate resources for training or purchasing equipment necessary for self support. Must be approved by the IM agency.
- Minimal costs for heat, electricity and property insurance for homes listed for sale

Health Insurance

All health and dental insurance premiums covering the Waiver member (including Medicare Part D) and for which the member is responsible and pays a premium can be used as expense.

Health Insurance

If the waiver participant is part of a covered group, but not responsible for the premium, find his/her proportionate share by dividing the premium by the number of people covered.

If both members of a couple apply, but only one pays the premium, divide the premium equally. Prorate premiums over the months payment covers.

Medical Expenses

Medical expenses are anticipated incurred expenses for:

- Services or goods that have been prescribed or provided by a professional medical practitioner (licensed in Wisconsin or another state).
- Diagnosis, cure, treatment, or prevention of disease or for treatment affecting any part of the body.
- Are the responsibility of the member, and cannot be reimbursable by any other source, such as Medicaid, private insurance, or employer.

Remedial Expenses

Remedial expenses:

- Costs incurred for goods and services that are provided for the purpose of relieving, remedying, or reducing a medical or health condition.
- The responsibility of the member
- Not reimbursable by any other source such as Medicaid, private insurance or employer
- Do not include housing or room and board services.

The Care Manager is responsible for calculating the remedial expenses and submitting them to the IM worker.

Examples of Medical Expenses

Examples of Medical Expenses are:

- Deductibles and co-payments for Medicaid, Medicare, and private health insurances.
- Health insurance premiums.
- Bills for medical services which are not covered by the Wisconsin Medicaid program.
- For purposes of meeting a Medicaid deductible, medical services received before the person became eligible for Medicaid. (Past medical bills cannot be used for MAPP premium calculations.)

Examples of Remedial Expenses

Examples of Remedial Expenses are:

- Case management.
- Day care.
- Housing modifications for accessibility.
- Respite care.
- Supportive home care.
- Transportation.
- Services recognized under s.46.27, Wis. Stats.
- Community Options Program, that are included in the person's service plan.

Calculating the Group B Cost Share (example)

Gross income (Unearned)	**1400.00**
Basic need allowance	**854.00**
65 ½ earned income	**0.00**
Special housing allowance (Rent 600-350=250)	**250.00**
Health Insurance	**100.00**
Guardian fee	**50.00**
Med/remedials	**120.00**
Monthly cost share amount	**26.00**

Group C

Group C members:

- Are functionally eligible for HCBW
- Have gross income above the Community Waivers Special Income Limit (currently $2022)
- Have assets below $2000.
- Have medical expenses that allow them to meet the medical needy income test.
- Must meet a spenddown to remain eligible

Group C Eligibility Determination

The eligibility determination for a Group C member is a three part process.

Group C Eligibility Determination

The **first** step is to calculate the Countable Net Income.

The Countable Net income is the income that is left after subtracting:

- 65 ½ earned income disregard
- $20 unearned income disregard
- Health Insurance costs
- Special Exempt Income

Group C Eligibility Determination

The **second** step is to calculate the Net Income.

Subtract from the Net Countable Income:

- Medical/Remedial Expenses
- MA by the person that Medicaid will pay once the person Card Coverable Expenses - these are medical expenses incurred is found eligible.

If the Net Income is at or below $591.67 the person is eligible for HCBW as a Group C member.

Group C Eligibility Determination (con't)

The **last** step in the eligibility determination is to calculate the spenddown amount.

The spenddown is the monthly amount the Group C member must incur and be held financially responsible for to remain eligible.

Calculate the Group C Spenddown

Take the countable Net Income (the Net Income with the medical, remedial and MA card coverable expenses added back in) and subtract $591.67.

Group C Eligibility Determination and Spenddown Calculation

Community Waivers Eligibility Determination - Group B		
Gross Earned Income:		$ —
Gross Unearned Income:	+	2,044.71
Excess Self Employment Expenses:	–	—
Student Disregard:	–	—
Gross Income:		$ 2,044.71
Categorically Needy income Limit:		$ 2,022.00

Community Waivers Eligibility Determination - Group C		
Gross Earned Income:		$ —
$65 & 1/2 Disregard:	–	—
Gross Unearned Income:	+	2,044.71
$20 Disregard:	–	20.00
Health Insurance Cost:	–	—
Excess Self Employment Expenses:	–	—
Special Exempt Income:	–	551.80
Countable Net Income:		$ 1,472.91
Medical/Remedial Expenses:	–	2,887.00
MA Card Coverable Expenses:	–	—
Net Income:		$ —
Countable Net Income:		$ 1,472.91
Medically Needy Income Limit:	–	591.67
Spend down Amount:		$ 881.24

Family Care

The Family Care Long Term Care (FCLTC) program is a Managed Long Term Care Program that delivers long-term care services through a Managed Care Organization (MCO) instead of the 'Fee for Service' delivery method.

Family Care

When enrolled in the MCO the individual receives most medical services through a health plan or network of providers which coordinates the services provided. Medicaid pays a fixed rate in advance for each enrollee.

Family Care target groups are elderly people, people with physical disabilities and those with developmental disabilities.

Family Care Administration

Three groups work together to administer the Family Care program:

- An Aging and Disability Resource Center (ADRC) serves as a "one-stop" shopping point to provide information and assistance in accessing available support services, housing, costs, and community services. ADRC staff also assess potential clients' functional level of care, which is an eligibility criteria.
- Income Maintenance Agencies determine and certify Medicaid and Family Care non-financial and financial eligibility, and process Family Care enrollment.

Family Care Administration

Three groups work together to administer the Family Care program (con't.):

- Managed Care Organizations (MCOs) complete a comprehensive assessment and develop a plan of care, as well as provide and/or coordinate long term care services for Family Care enrollees. Participants in the Family Care program choose to be enrolled in a MCO

Family Care Functional Eligibility

Resource Center staff use the Long Term Care Functional Screen to assess a Family Care applicant's long term care needs and to determine level of care. The functional level of care information is provided to the IM Worker so that s/he can determine eligibility for Family Care.

Family Care Functional Eligibility (con't)

The levels of care are:

- Nursing Home (formerly Comprehensive NH)
- Non-Nursing Home (formerly Intermediate & Comprehensive non-NH)
- Individuals who are found functionally eligible for Nursing Home LOC Level of Care, used in the Family Care, PACE, Partnership. and Home and Community Based Waiver Programs are subject to Waiver logic in determining their financial eligibility for Family Care (if they are 65 or older, or have been determined disabled).

Family Care Functional Eligibility (con't)

The levels of care are:

- Individuals who are found functionally eligible for Non-Nursing Home LOC are not subject to Waiver logic in determining their financial eligibility for Family Care. These individuals must meet the criteria for another program of Medicaid to enroll in FC.

Note: There are specific Managed Care capitation rates associated with these new levels of care, so it is important that level of care and level of care effective date information are entered accurately in CARES.

Family Care and Disability Determinations

Individuals who are under 65 years of age can be enrolled in Family Care without a disability determination if they are:

a) Functionally eligible for Family Care and

b) Eligible for one of the following Medicaid/BadgerCare categories:

- BadgerCare Plus Standard Plan
- Well Woman Medicaid
- Medicaid through Adoption Assistance or
- Foster Care Medicaid

Family Care and Disability Determinations

If the individual is under 65 and not eligible for one of the above Medicaid/BadgerCare categories, s/he must be determined disabled by DDB to be tested using for Home and Community-Based Waivers Medicaid logic.

Family Care and Disability Determinations

Even though we allow functionally eligible individuals under 65 to enroll in FC if they are covered under:

- BadgerCare Plus Standard Plan
- Well Woman Medicaid
- Medicaid through Adoption Assistance or
- Foster Care Medicaid

Family Care and Disability Determinations

The process to apply for the disability through Social Security should be started. If the individual loses eligibility under one of the programs displayed on the previous slide, s/he would also have to be disenrolled from FC if s/he is still under 65 with no disability determination.

Family Care Disenrollments

Disenrollment from the MCO may occur for a variety of reasons. Some of the more common reasons for disenrollment include:

- The loss of Medicaid eligibility (disenroll with timely notice)
- A change in functional eligibility (disenroll with timely notice)
- A move out of the MCO's service area
- The member expresses a desire to disenroll

Family Care Disenrollments

Certain disenrollments, listed below, can only be approved by the Aging and Disability Resource Center or by the Department of Health Services (DHS) Office of Family Care Expansion (OFCE):

Member Requested:
must be submitted first to the ADRC and then to the IM agency.

MCO Requested:
must be submitted first to the OFCE for approval.

Family Care and Inter-County Moves

When a FC enrollee moves permanently to a non-MCO county, s/he can remain enrolled in the MCO only if the Resource Center worker informs IM that the following four conditions are met:

- S/he is eligible for COP or waiver services.
- After moving to the new county, the enrollee resides in a long-term care facility (Nursing Home, CBRF Community Based Residential Facility, or AFH).

Family Care and Inter-County Moves

When a FC enrollee moves permanently to a non-MCO county, s/he can remain enrolled in the MCO only if the Resource Center worker informs IM that the following four conditions are met ***(con't.)***:

- The enrollee's placement in the long-term care facility is done under and pursuant to a plan of care approved by the MCO.
- The enrollee resided in the MCO county for at least six months prior to the date on which s/he moved to the non-MCO county.

IRIS (Include, Respect, I Self-Direct) Self-Directed Supports Waiver

IRIS is a self directed fee for service alternative to Family Care enrollment in FC counties. It is also available to Partnership members if Partnership is also operated in the county.

IRIS (Include, Respect, I Self-Direct) Self-Directed Supports Waiver

Under IRIS, the participant will be able to access services comparable to those provided under the current Home- and Community-Based Waivers (HCBW) while managing an individual budget to meet their service needs.

IRIS (Include, Respect, I Self-Direct) Self-Directed Supports Waiver

- Aging and Disability Resource Centers (ADRCs) are responsible for informing participants of all available options through an objective enrollment counseling process.
- ADRCs will refer the IRIS applicant to Independent Consulting Agency (ICA) who then will inform IM agencies of persons choosing to enroll in IRIS.

IRIS (Include, Respect, I Self-Direct) Self-Directed Supports Waiver

- The ICA will provide IM with certain information necessary to determine IRIS eligibility, such as functional eligibility information, medical/remedial expenses, and program start date.
- Individuals began enrolling in IRIS effective July 1, 2008 in counties operating Family Care. The IRIS option is available to people when they come to the ADRC and are found in need of publicly-funded long term care services.

IRIS (Include, Respect, I Self-Direct) Self-Directed Supports Waiver

It is also available to Family Care members (and Partnership members, if Partnership is also operated in the county) if the member requests to change to IRIS. (Such individuals must be disenrolled from their managed care long-term support program in order to participate in IRIS).

IRIS Eligibility

Individuals who wish to participate in IRIS must meet the following criteria in order to qualify:

- Reside in a county operating Family Care
- Have a nursing home level of care as determined by the LTC Functional Screen
- Meet Medicaid Home- and Community-Based waiver financial and non-financial eligibility criteria

IRIS Eligibility

IRIS follows the financial and non-financial eligibility policies for the Home- and Community-Based waiver programs. IRIS eligibility and cost-sharing requirements are identical to those associated with the current waivers.

As Family Care is implemented in a county, people already eligible for the waivers will be eligible for IRIS, if they choose to participate in IRIS.

IRIS Eligibility

People coming off the waiver wait list who choose IRIS will have their eligibility determined exactly as it would be done for any of the existing Home- and Community-Based Waivers.

Partnership Long Term Care Medicaid

The Wisconsin Partnership program is a comprehensive waiver program integrating health and long term support services for people who are elderly or disabled.

Services are delivered in the participant's home or a setting of his or her choice. Through team based care management, the participant, his or her physician, nurses and social workers together develop a care plan and coordinate all service delivery.

Partnership Long Term Care Medicaid

To participate in the Partnership program, people must be eligible for MA and meet the MA nursing home level of care requirement. The program also serves people who are eligible for both MA and Medicare. Participation in the program is voluntary.

Partnership Long Term Care Medicaid

A person not yet 18 years of age may be enrolled in Partnership effective the first day of the month in which s/he turns 18, to the extent that the person meets all other Partnership financial and non-financial eligibility requirements.

As with Family Care the ADRC, the IM Agency and the MCO work together to administer this program.

Partnership Functional Eligibility

An individual must be found functionally eligible at the Nursing Home LOC Level of Care, used in the Family Care, PACE, Partnership. and Home and Community Based Waiver Programs. to be eligible for Partnership. Waiver logic should be used in determining their financial eligibility for Partnership (if they are 65 or older, or have been determined disabled).

Individuals who are found functionally eligible at the Non-Nursing Home LOC are not eligible for Partnership.

Partnership Medicaid Eligibility

Based on their living arrangement, an individual enrolling Partnership will be tested using either Institutional Medicaid or Home and Community Based Waivers Medicaid criteria.

Individuals living in non institutional settings, including CBRFs, AFHs and RCACs are tested using the same financial and non-financial criteria as HCBW Medicaid.

Individuals living in a medical institution are tested using the same financial and non-financial criteria as Institutional Medicaid.

Partnership Disenrollments

Disenrollment from the MCO may occur for a variety of reasons. Some of the more common reasons for disenrollment include:

- The loss of Medicaid eligibility (disenroll with timely notice)
- A change in functional eligibility (disenroll with timely notice)
- A move out of the MCO's service area
- The member expresses a desire to disenroll

Partnership Disenrollments

Certain disenrollments, listed below, can only be approved by the Aging and Disability Resource Center or by the Department of Health Services (DHS) Office of Family Care Expansion (OFCE):

Member Requested:
must be submitted first to the ADRC and then to the IM agency.

MCO Requested:
must be submitted first to the OFCE for approval.

PACE (Program of All-Inclusive Care for the Elderly)

PACE is a program that provides comprehensive community based services, including both acute and chronic care for frail elderly individuals.

PACE (Program of All-Inclusive Care for the Elderly)

Most services are provided in a day health center with an emphasis on continuity and coordination of care. Health and supportive services are also provided in the home, and transportation is provided to specialized care sites as needed.

PACE (Program of All-Inclusive Care for the Elderly)

PACE participants must be non-financially and financially eligible for MA and must meet the MA nursing home level of care requirement. Participation in the program is voluntary.

PACE (Program of All-Inclusive Care for the Elderly)

While there are many similarities between PACE and Partnership, there are some differences.

- PACE requires the use of a day health center while Partnership does not.
- PACE enrollees must agree to receive primary care from the PACE physician while Partnership enrollees may choose from a panel of independent physicians who have agreed to serve Partnership members.
- PACE serves the frail elderly exclusively, while Partnership serves the elderly and younger disabled adults.

Institutional Long Term Care

For Medicaid purposes “institution” means a medical institution. A medical institution can be, but is not limited to, skilled nursing facilities (SNF), intermediate care facilities (ICF), institutions for mental disease (IMD), hospitals.

Institutional Long Term Care

Medical institution means a facility that:

- Is organized to provide medical care, including nursing and convalescent care,
- Has the necessary professional personnel, equipment, and facilities to manage the medical, nursing, and other health needs of patients on a continuing basis in accordance with accepted standards,
- Is authorized under State law to provide medical care, and,
- Is staffed by professional personnel who are responsible to the institution for professional medical and nursing services.

Institutional Long Term Care

Institutionalized person" means someone who:

- Has resided in a medical institution for 30 or more consecutive days, or
- Is likely to reside in a medical institution for 30 or more consecutive days, as attested to by the medical institution.

Institutional Long Term Care

Institutionalized person" means someone who:

An exception to the 30-day period is that a resident of an IMD is considered an institutionalized person until s/he is discharged.

The 30-day period includes situations in which the person resides in more than one medical institution during 30 or more consecutive days.

Institutional Long Term Care

A person residing in an institution must either have income below the Institutions Categorically Needy income limit ($2022) or have monthly allowable expenses that exceed the their income.

The total of the monthly allowable expenses is called the Monthly Need. When the Monthly Need exceeds the person's monthly income, he or she meets the Medically Needy Income limit.

Institutional Long Term Care

To determine the monthly need add together the following costs:

- Personal needs allowance ($45.00).
- Cost of institutional care (use private care rate).
- Cost of health insurance (only if the member owns the policy and is billed for the premium)
- Support payments
- Out-of-pocket medical costs.

Institutional Long Term Care

To determine the monthly need add together the following costs (*con't.*):

- Work related expenses (IRWE).
- Self-support plan
- Expenses for establishing and maintaining a court-ordered guardianship or protective placement, including court ordered attorney or guardian fees.
- Other medical expenses.
- Other deductible expenses.

Calculating the cost of care for Institutional Long Term Care

Once the person is determined eligible the cost of care (also called patient liability) must be calculated.

Subtract the following expenses from the person's monthly gross income:

- $65 and ½ earned income disregard
- Monthly cost for health insurance
- Support payments
- Personal needs allowance ($45.00)

Calculating the cost of care for Institutional Long Term Care

Once the person is determined eligible the cost of care (also called patient liability) must be calculated.

Subtract the following expenses from the person's monthly gross income ***(con't.)***:

- Home maintenance costs (allowed only when a physician certifies the member is likely to return home within 6 months & the spouse is not living in the home or apartment)
- Expenses for establishing and maintaining a court-ordered guardianship or protective placement, including court-ordered attorney and/or guardian fees
- Medical Remedial Expenses

Calculating the cost of care for Institutional Long Term Care

Eligibility Determination		
Gross Earned Income:		$ —
Gross Unearned Income:	+	998.64
Gross Income:		$ 998.64
Categorically Needy income Limit:		$ 2,022.00

Institution MA Patient Liability		
Gross Income:		$ 998.64
COLA/DAC/WW Disregard:	+	—
Accumulated Gross Income:		$ 998.64
$65 & 1/2 Disregard:	–	—
Personal Need Allowance:	–	45.00
Health Insurance Cost:	–	—
Actual Support Paid:	–	—
Home Maintenance:	–	—
Patient Liability:		$ 953.64

To Exit

Congratulations, you have completed:

The Long Term Care Medicaid Training

Click the “X” on the navigation bar to exit properly.