STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene
Developmental Disabilities Administration (DDA)
201 W. Preston Street • Baltimore, Maryland 21201
Larry Hogan, Governor – Boyd Rutherford, Lt. Governor – Vann Mitchell, M.D., Secretary

The New EDD DDA Change Unit and DDA Contribution to Cost of Care Procedural Changes

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AUDIENCE

- Residential Service Providers
- Coordinators of Community Services
- Eligible participants receiving residential services

OVERVIEW

On June 24, 2015, Maryland's Eligibility Determination Division (EDD) at the Office of Eligibility Services (OES) created the DDA Change Unit in order to support the increased workload generated by the implementation of new Contribution to Cost to Care procedures for individuals receiving residential services. The DDA Change Unit will also be responsible for processing interim changes such as demographics, service changes, and discharges.

Effective November 1, 2015, the calculation of contribution to cost of care will **completely** transition to the Eligibility Determination Division (EDD), and the PCIS2 CTC form will be disabled for all DDA individuals. In other words, as of November 1st residential providers will **no longer be allowed** to calculate contribution to cost of care for **any** DDA residential participant, and must **only** collect the cost of care amount calculated by EDD. This amount is provided both on the EDD letters mailed to individuals and in PCIS2 under the existing contribution to care screens. Consequently, providers' payments will be reduced by the EDD calculated cost of care.

POST ELIGIBILITY FINANCIAL REQUIREMENT

The "post eligibility financial requirement" is the formal terminology used in Medicaid regulations and guidance for an individual's contribution to cost of care (CTC, also abbreviated COC). In accordance with 42 CFR §441.303(e), contribution to cost of care must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group, known as the optionally eligible group under 42 CFR §435.217. The post-eligibility calculation of CTC determines the amount (if any) Medicaid reduces its payment for services that are furnished to optionally eligible individuals. As a result, the post-eligibility calculation of CTC is the amount (if any) for which an individual is responsible to pay for their waiver services costs.

In the context of the Home and Community Based Services (HCBS) waiver program, Medicaid eligibility determination results in the following three eligibility categories:

1. **Categorically Eligible:** waiver coverage groups that include individuals who are eligible for Medicaid under community rules, without regard to whether they are institutionalized (e.g., SSI beneficiaries).
    a. Includes all waiver coverage groups except H01 (i.e. S02, S98)
2. **Optionally Eligible:** waiver coverage groups that include individuals who would not be eligible for Medicaid except in an institutional setting (e.g., the special income level group). Also known as the "special home and community-based services waiver eligibility group."
    a. Includes waiver coverage groups H01
3. **Ineligible:** individuals who are not eligible for the HCBS waiver program
    a. No waiver coverage group

Individuals, who are optionally eligible (waiver coverage group H01), must contribute to their cost of care. Individuals, who are categorically eligible for the waiver, do **not** contribute to their cost of care. However, there is an exception to this rule: the waiver coverage group "S01" is categorically eligible for the waiver, but the federal grant specific to S01s, determines that those individuals must contribute to their cost of care. In regards to contribution to cost of care policy, S01s are considered part of the optionally eligibility group.

Since the post eligibility financial requirement is a Medicaid waiver requirement, at this current time, contribution to cost of care will not be collected from ineligible (non-waiver) individuals. The DDA is in the process of developing policy and regulation regarding non waiver individuals that includes the applicability and calculation of contribution to cost of care.

INDIVIDUAL WAIVER ELIGIBILITY

EDD determines an individual's Medicaid coverage group and eligibility category using complex federal and state guidelines and formulas. It is important to note that the type of income a person receives is not the sole

determinate of waiver eligibility. The DHMH website has some information on eligibility determination that may be useful (https://mmcp.dhmh.maryland.gov/SitePages/Medicaid%20Coverage%20Groups.aspx).

If a provider believes that a participant's Medicaid coverage group or eligibility category is incorrect, then the provider or the coordinator of community services (CCS) should contact the participant's eligibility case worker or CCS to investigate and follow up with EDD. Please refer to EDD's eligibility case worker roster, and other contact information on whom to contact. This roster can be found on the DDA website, under the "Provider" tab, under "DDA Forms for Providers", under "Contribution to Cost of Care and Room and Board". Providers can also email inquiries to the following dedicated email address: DHMH.DDAEDDinquiries@maryland.gov.

An individual's waiver eligibility status can be located in PCIS2 under the "Consumer" module, under the "Waiver" tab. A provider can also verify the participant's Medical Assistance eligibility by calling the Eligibility Verification System (EVS) at 1-866-710-1447. EVS is an automated system that you can use 24 hours a day, 7 days a week. To use EVS, you will need your provider number and either the participant's medical assistance number or the participant's social security number and the date(s) of service. To retrieve an EVS Brochure call 410-767-6024 to request one or go to the website https://encrypt.emdhealthchoice.org/emedicaid/. The provider should notify the individual's resource coordinator or eligibility case manager to resolve any eligibility issues.

DDA Calculation of Contribution to Cost of Care

Maryland's 1915 (c) HCBS waiver, Community Pathways, describes Maryland's calculation for determining an individual's post-eligibility treatment of income in Appendix B-5, which states that "The State uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse." According to Title 42 Code of Federal Regulations §435.726, the DDA ***'must reduce its payment for home and community-based services provided to an individual, by the amount that remains after deducting the amounts listed below, in the following order, from the individual's total income, including amounts disregarded in determining eligibility.'***

A) **An amount for the maintenance needs of the individual**
   1) The individual maintenance needs allowance formula has been revised in the DDA's HCBS waiver: "For each waiver year, the monthly maintenance needs allowance is reviewed and adjusted based on Social Security Income (SSI) Federal Benefit Rates:
      i) For waiver participants in residential programs, the monthly maintenance needs allowance for a waiver participant is calculated at 100% of the current SSI FBR plus an $85 Earned Income Deduction plus 50% of the remainder of earned income
      ii) For waiver participants in non-residential programs, the monthly maintenance needs allowance is 300% of the current SSI FBR"

B) **For an individual with a family at home, an additional amount for the maintenance needs of the family** (dependents, not spouses)
   1) The current medically needy income standard established under § 435.811 for a family of the same size

C) **Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including**
   1) Medicare and other health insurance premiums, deductibles, or coinsurance charges; and
   2) Necessary medical or remedial care recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the agency may establish on amounts of these expenses
   3) The State of Maryland will exclude expenses older than three months prior to the month of application for initiation of services

No deductions other than the ones listed above are used or may be used to calculate contribution to cost of care.

Once contribution to cost of care has been determined, this amount must be collected and applied towards the individual's cost of care. At this time, the provider will collect the contribution and DDA will deduct this amount from the payment to the provider.

If an individual receives an eligibility letter from EDD with a questionable cost of care amount, then the EDD case manager should be contacted. Providers can also email CTC inquiries to the following dedicated email address: DHMH.DDAEDDinquiries@maryland.gov

Separation of Room & Board Costs from the Contribution Amount

Cost of care and room and board costs are separate costs with distinct policies. Please refer to DDA's "Room and Board Procedural Changes" guidance, for detailed descriptions and procedures regarding the room and board costs. This procedure can be found on the DDA website, under the "Provider" tab, under "DDA Forms for Providers", under "Contribution to Cost of Care and Room and Board". (http://dda.dhmh.maryland.gov/SitePages/Developments/2014/DDA%20Room%20and%20Board%20Costs%20Guidance%20and%20Procedural%20Changes.pdf).

Room & board costs are **not** an allowable deduction to an individual's cost of care. Room and board (representing rent and food) are not covered by Medicaid as they are personal living expenses and the individual is responsible for these costs. There is no protection of an individual's personal income from room & board costs. Even though room and board payments and payments for CTC are collected together by the residential provider, payment for room and board costs go towards rent and food costs, while the payment for CTC goes towards the individual's DDA waiver services costs.

Historically, the PCIS2 contribution to cost of care calculation included room & board costs. This reduced clarity around contribution to care amounts and resulted in the over claiming of federal revenue. With the current contribution to cost of care process, the cost of care calculation is separate from room and board costs. What is calculated by EDD represents only the cost of care amount. Room and board payments should be collected in addition to the cost of care amount. The billing and collection of room & board costs will remain solely the providers' responsibility.

Cost of Care Reporting Instructions

EDD calculates CTC prospectively; therefore information for the current month will be used to calculate the cost of care for the next month. As a result, information for the current month must be sent in to EDD by the end of the month in order for it to be incorporated into the next month's cost of care calculation. It is important to note that the dates of receipts for expenses and salary information do not need to align with the month CTC is being calculated. As an example:

- CTC for the month of August:
  - Collect all income and deduction data up until July 31st
  - Complete reporting forms and mail information to EDD by July 31st
    - If you receive a medical receipt in July with a date of March, include that amount

When reporting, information should be sent by mail to EDD on a person-by-person basis with the correct forms, and evidentiary documentation. The address to submit information to EDD is:

DHMH Eligibility Determination Division

6 St. Paul Street, Suite 400
Baltimore, Maryland 21202

EDD's response time is approximately 30 days. The change will take affect following the month that the change is reported and received by EDD. The consumer will receive a letter, the DHMH DD11A," Notice in Change to Contribution to Care" informing them of their new contribution to care. This letter will also indicate the consumers' Medicaid coverage group. If there is no change to the contribution based on reported information, then a letter, the DHMH DD 11B letter, "No Change to Contribution to Care" will also be mailed to the appropriate persons.

INCOME CHANGES

For Optionally Eligible Individuals and those who Contribute to their Cost of Care

Changes that affect an individual's eligibility, such as changes in income and assets, must be reported to the participants EDD eligibility case worker within ten (10) days of the change. When submitting this information to EDD, please attach supporting documentation to Form DHR/FIA 491, "Change Report Form." This form can be found at:
http://dda.dhmh.maryland.gov/SitePages/Developments/2014/EDD%20DDA%20Change%20Report%20Form.pdf

When reporting changes, information should be sent by mail to EDD on a person-by-person basis with the attached forms, and evidentiary documentation. Use the same address as above.

For Categorically Eligible Individuals

Please continue to report income changes to Social Security and other relevant agencies in accordance with their respective policies and guidelines. Income changes do **not** need to be sent to EDD in addition to these parties.

MEDICAL AND REMEDIAL CARE EXPENSES

Receipts and other forms of documentation of incurred medical and remedial care expenses for **optionally eligible individuals and those who Contribute to their Cost of Care** should be sent to EDD. Since contribution to cost of care is not applicable to most categorically eligible and ineligible individuals, documentation for medical and remedial care expenses do not need to be submitted for these populations.

When sending this information, please use the DHMH OES-001 DDA Form (Updated 08/06/2014), "Request for Non-Covered Services," which can be found at:
http://dda.dhmh.maryland.gov/SitePages/Developments/2014/EDD%20DDA%20Form.pdf.

Considerations for Allowable Deductions:

- Premiums, deductibles, and co-insurance/co-payment charges for health insurance and Medicare premiums
- Necessary medical care recognized under state law, but not covered under the state's Medicaid plan;
- Necessary medical care covered under the state's Medicaid plan incurred prior to Medicaid eligibility
- As long as the incurred medical expenses:
    - Were not incurred more than three months before the month of the Medicaid application
    - Are not subject to third-party payment or reimbursement
    - Have not been used to satisfy a previous spend down liability

- Have not previously been used to reduce excess resources
- Have not been used to reduce client responsibility toward cost of care
- Are amounts for which the client remains liable

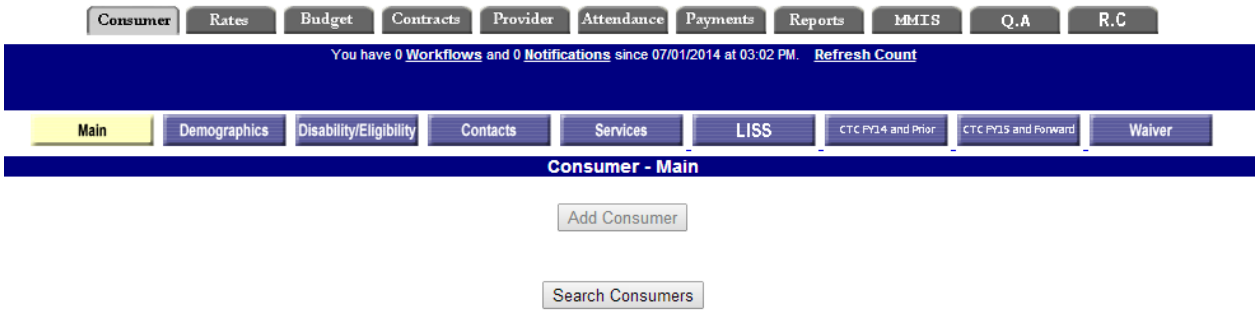
ACCESSING CTC IN PCIS2

Cost of care data is loaded monthly, no later than the 5th of each month, into PCIS2. PCIS2 will notify providers via email, if there is a change in the individual's CTC from the previous month to the current month. Providers should review individual's CTC amounts and collect accordingly.

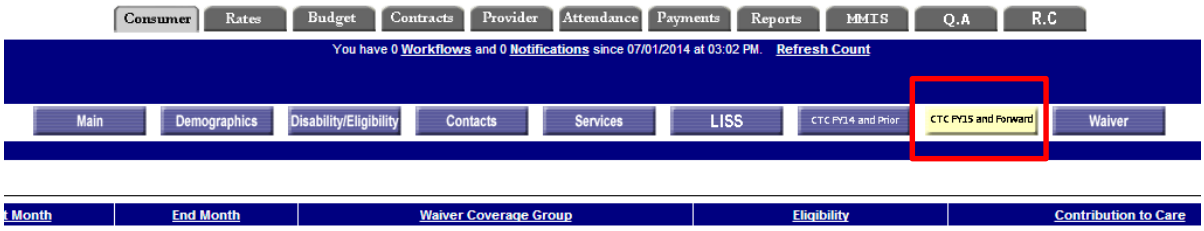
INDIVIDUAL COST OF CARE AMOUNTS

Please do the following in PCIS2 to find the individual's cost of care amount:

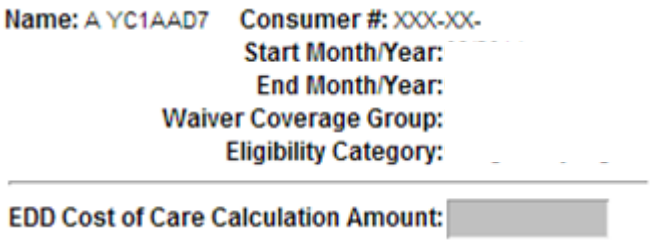
- PCIS2 module: "Consumer"
- Tab: "Main"



- Click "Search Consumer" button
- Enter search parameters
- Click "View"
- Click "CTC FY15 and Forward" button



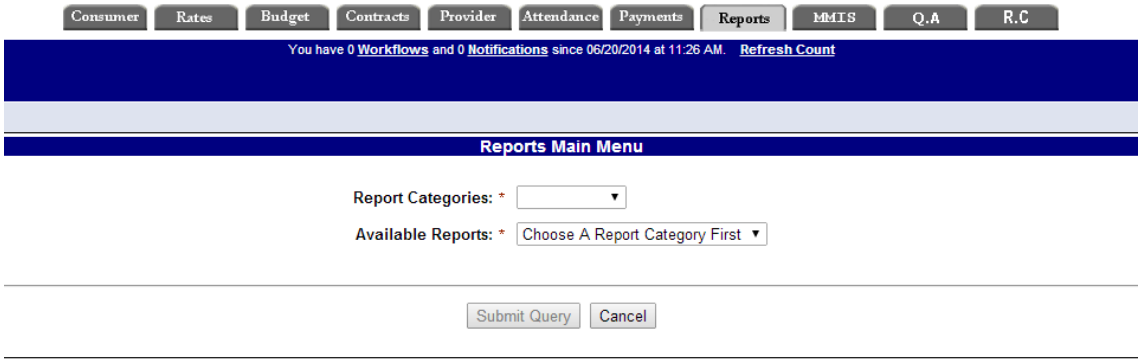
- Click the "View" icon on a contribution to care to see details



REPORTS

Reports showing the monthly CTC for each individual and their eligibility category, since the beginning of the state fiscal year, will be available to providers in PCIS2. To view and download do to the following:

- PCIS2 module: “Reports”



- Reports category: Choose “Consumer”
- Available Reports: Choose “Contribution to Care”
- Enter search parameters
- Click “Submit Query” button

- To download an excel file click “Print to File”

CONTRIBUTION TO CARE AND NON-PAYABLE DAYS

If an individual is in service at least one day of the month, then the individual still owes the full contribution to cost of care amount. However, a provider may not collect a contribution to care amount that exceeds the individual’s cost of services for that month. If contribution to care did exceed the total cost of services for that month, the provider would need to return the difference back to the individual.

Examples: If an individual’s cost of care was $500 for the month, and the residential rate was $100 a day and:

- If the individual moved out of the residential facility on the third day of the month, then the provider should only collect $300. If the provider did collect $500 from the individual, then the provider should return $200.
- If the individual moved out of the residential facility on the 15th day of the month, then the provider collects the full $500 from the individual.

Cost of care is fully reduced from the first paid attendance days of the month. Therefore, individuals who move between providers within the same month should pay cost of care to the provider they resided with at the beginning of the month.