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Determining Financial Eligibility for Non-Institutionalized Persons

Attachment A: Financial Eligibility for Non-Institutionalized Persons

Frequently Asked Questions (FAQs) and Answers
Objectives for Section 900

1. How to determine eligibility for an assistance unit of non-institutionalized persons;
2. How to determine spend-down eligibility;
3. Explain a Preserved Application.

900.1 Introduction- Financial Eligibility for Non-Institutionalized Persons

This chapter explains how to determine Medical Assistance eligibility for an assistance unit of non-institutionalized persons. A non-institutionalized person is a person who resides in a community setting. Community settings include one's own home, the home of another, and group homes. Community settings do not include long term care facilities. Persons under 21 who are admitted to a long term care facility on any day other than the first day of the month are considered non-institutionalized in the month of admission.

Persons over 21 who reside in a community setting but who are admitted to a long term care facility on any day of the month, and persons under 21 who are admitted on the first day of the month, are considered institutionalized for the whole month. Eligibility for these persons will be determined under Section 10 ("Determining Financial Eligibility for Institutionalized Persons").

(a) Income and Resource Consideration

A financial eligibility determination must be made for an assistance unit unless the unit has been determined technically ineligible. Resources eligibility should be established first, followed by income eligibility. If a unit is determined ineligible due to excess resources, computation of income eligibility is not required. Income and Resources are evaluated in accordance with the provisions of regulations .07 and .08 and measured against the appropriate standards (Schedules MA-1 and MA-2).

(1) Family and Children Unit (FAC)

For a families and children's Unit (FAC), the income and resources of the following persons, including those who are members of other units or who are not applying, must be considered:

- All members of the assistance unit;
- The parents of members of the assistance unit ; and
- The spouse of any member of the assistance unit.

(2) Aged, Blind, Disabled Unit (ABD)

For an Aged, Blind, or Disabled Unit the income and resources of the following persons, including those who are members of other units or who are not applying, must be considered:

- All members of the assistance unit;
- The spouse of the assistance unit member; and
- The parents of a blind or disabled child under 18 years old.

Note: An exception to the Family and Children (FAC) and Aged, Blind, Disabled (ABD) requirements above is the income and resources of an SSI parent or spouse, which is not considered.

900.2 Current Eligibility

Current eligibility is determined for a period of 6 months beginning with the month of application. To be eligible, members of the assistance unit must meet financial eligibility criteria for the 6 month period under consideration.

- Evaluate Non-financial eligibility requirements to determine if the household is eligible
- Evaluate Income and Assets (if necessary) of the Assistance Unit to determine if they are within the Community Medical Assistance guidelines
- If Non-financial and Financial guidelines are met certify for Medical Assistance
  (a) Resources – Refer to Section 800
  (b) Income – Refer to Section 700
  (c) Spend-Down Eligibility

(a) Spend-Down Eligibility

In determining spend-down eligibility, consider medical expenses incurred before the month of application if the expenses:

- Were not considered in any retroactive certification;
- Were not used to establish spend-down eligibility for a prior certification;
- Are not subject to third party payment or reimbursement;
- Remain the obligation of any person whose income and resources are considered in determining eligibility; and
- Have not been forgiven by the provider of the services, as evidenced by account statements dating up to 3 months before the month of application.

Consider medical expenses incurred at any time during or after the month of application and before the end of the period under consideration by any person whose income and resources are considered in determining eligibility if the expenses are not subject to third-party payment or reimbursement.

- No medical bill used to establish entitlement to Medical Assistance may be used in any subsequent determination. If only a portion of a bill was needed to establish eligibility, only that portion of the bill not used to establish eligibility may be considered for payment.

- This precludes the use of any expense that was incurred during a prior period of eligibility and which was or still is reimbursable by the program. The fact that a recipient may have chosen not to present an expense for reimbursement is not a basis for considering the expense for spend-down in a subsequent period.

- Each medical bill verifying expenses must include a statement of the service and the date the service was rendered. For purchases of medicines and medical supplies or equipment, the statement from the provider must include the item purchased and the date and cost of the purchase. For over- the- counter drugs, a cash register receipt listing the item purchased and the cost of the item (or a cash register receipt listing cost only along with the portion of the package including price and name of the item) are acceptable verifications.
- From excess income deduct allowable medical expenses beginning with the earliest time period and in the following order.
- Medicare and other health insurance premiums, deductibles, or co-insurance charges; Expenses incurred for necessary medical care or remedial services that are recognized under State law but are not covered under the State Plan;

(1) Health Insurance Coverage and its Effect on Determining Spend-Down Eligibility

When net countable income is within the MNIL, health insurance coverage has no bearing on eligibility except for the requirements that the applicant/recipient assign the benefits to the Program (the assignment clause is included on the application forms) and that the LDSS/LHD report the insurance on the DHMH 2583. However, when net countable income exceeds the MNIL and there is also health insurance coverage, eligibility exists under spend-down only if it is determined that the person has incurred expenses not covered by health insurance which equal or exceed the excess income. In this circumstance, a determination of eligibility cannot be made until a complete official statement as to the amount of health insurance coverage is provided.

LDSS/LHD staff will need to examine each category of medical expense (hospitalization, physicians' services, dental, eyeglasses, prescriptions, etc.) and determine whether or not the expense is covered by health insurance. The extent of coverage cannot be decided in advance. No category of expense potentially covered by health insurance may be considered for spend-down purposes until it has been submitted to the insurer and rejected for payment. (In general, insurance companies will notify the insured when a bill has been rejected for payment.) The basic rule is that a case of excess income plus health insurance coverage must remain in preserved status until all bills covered by health insurance have been paid and the applicant has presented a written statement from the insurance company identifying the expenses which the insurance will <u>not</u> cover.

Among the expenses which health insurance will not cover are "deductibles", co-insurance charges and other predetermined amounts, which remain the obligation of the insured person. For example, within a benefit period, Medicare, Part A (Hospital Insurance) will pay for all hospital services except for a predetermined amount – the hospital insurance deductible. The amount of the deductable usually increases concurrent with Social Security Cost of Living Adjustments. For the purposes of spend-down, the deductible is considered on incurred medical expense.

Medicare, Part B, (doctors' and diagnostic services and outpatient services) will pay once a person has met his Part B deductible, - a fixed yearly amount; and then only a portion of the covered services will be paid.

Whenever a medical insurance claim is submitted either by the insured or by a doctor or supplier, Medicare will send an Explanation of Medicare Benefit notice to the insured showing what services were covered, what charges were approved, how much was credited toward the deductible, and the amount Medicare paid.

Some providers accept Medicare payment as payment in full. If the provider expects payment above that which Medicare paid, the provider will bill the person for the remaining amount. For spend-down purposes, both the deductible and the co-insurance are incurred medical expenses if they remain the obligation of the insured person.

(2) Prescription Drug Costs under Spend-Down

Any medical expenses that are incurred by the applicant may only be used for spend-down of the assistance unit's excess income. The expenses must be the applicant's obligation to pay and may not be subject to third-party payment or reimbursement, such as premiums or prescriptions not covered by the individual's Medicare Part D pharmacy plan, Medicaid, or other coverage. Any expenses that Medicaid will cover once spend-down is met may not be used for spend-down. However, costs paid in whole or in part by a State-only or local governmental program with no federal funds may be counted as the beneficiary's incurred medical expenses to establish eligibility under Medicaid spend-down, if Medicaid will not subsequently cover any of those costs.

Since enrollment in Medicare Part D is voluntary, some Medicare beneficiaries will not be enrolled in a Medicare Part D Prescription Drug Plan (PDP) or a Medicare Advantage Prescription Drug Plan (MA-PD). A Medicare Advantage Plan generally provides all health care, including prescription drug coverage. For those Medicare beneficiaries enrolled in a PDP or MA-PD, some drugs might not be covered in the plan's formulary. Also, each plan may have a different combination of deductibles, co-pays, and gaps in coverage. Medicaid eligibility case managers should use the following rules to determine if drug costs incurred by Medicare beneficiaries may be used for Medicaid spend-down:

- If the Medicare beneficiary was not enrolled in a PDP or MA-PD on the date of service, allow the prescription drug cost for Medicaid spend-down.

- If the Medicare beneficiary was enrolled in a PDP or MA-PD on the date of service, the plan must issue a periodic (at least monthly) statement to the beneficiary explaining all benefits paid and denied, and amounts attributed to cost sharing. If the drug charge is identified on this statement as a beneficiary liability (i.e., part of a deductible, co-pay, or coverage gap), allow the expense for Medicaid spend-down.

- When a plan denies coverage of a prescription, the beneficiary has the right to request an exception for coverage of the drug. The beneficiary is notified in writing of the plan's decision on any exception requested. If the drug charge appears on the statement as a denial, and the beneficiary did not request an exception, do not allow the charge for Medicaid spend-down.

- If the drug charge appears on the statement as a denial, and an exception was requested by the beneficiary but was denied, allow the charge for Medicaid spend-down.

Applicants should be advised to maintain their statements and other related documentation needed for consideration of pharmacy expenses for Medicaid spend-down.

These procedures will help ensure that legitimate Medicare Part D cost-sharing expenses are allowed under Medicaid spend-down, as well as expenditures for drugs not covered by the PDP or MA-PD. By relying on the plans' statements and exception notices, eligibility case workers do not need to know the cost-sharing rules for each plan, each plan's formulary, or the non-formulary drugs covered under a transition plan or under the exception process.

(3) Medical Services Not Covered or Covered With Limitations

Certain services that are recognized by State Law as medical or remedial services, is not covered or are covered with limitations under the Maryland Medical Assistance Program's State Plan. Some of these services may be covered under Health Choice as an optional service by a recipient's Manage Care Organization (MCO). Also, the individual may have private health insurance or other third party coverage for the service or item.

In order for the incurred medical expenses to be considered for retroactive or current spend-down eligibility, it must be verified that the service or item is not covered by Medical Assistance, the recipient's MCO, or any other coverage for the individual. When considering

expenses incurred prior to the period under consideration, proof that the expenses remain unpaid and the individual's obligation must be obtained from the provider. For an expense to be considered for spend-down eligibility, the applicant must present the MA eligibility case manager with a current bill or receipt specifying the:

- Item or service
- Date of purchase or service, and
- Provider's, charge and the amount still owed by the individual

The individual must also provide the MA eligibility case manager with verification that the item or service is not covered by Medical Assistance, an MCO, or any other party. To verify that the item or service is not covered by Medical Assistance or by any other insurance for the individual, the provider should submit the bill for payment and receive notice of payment rejection.

Call DHMH through the MA Recipient Hotline (410-767-5800 or 1-800-492-5231) with any questions about Medical Assistance covered services or limitations.

Services Not Covered

The non-covered services include, but not limited to, the following:

- Christian Science nurses or facilities
- Experimental or investigational surgery or treatments
- Eyeglasses (except for children)
- Eyeglasses repair or adjustment
- Hearing aids and audiology services (except for children)
- Hypnosis

Services Covered With Limitations

Some services are covered by the Medical Assistance Program but with certain limitations. These services may only be covered for certain groups of people, under particular circumstances, or with a certain frequency. Following is a list of some of these services:

- Assisted living services
- Chiropractor's services
- Dental services and dentures
- Environmental accessibility adaptations
- Occupational therapy
- Physical therapy
- Podiatrists

- Private duty nurses
- Respite care
- Speech therapy
- Vision care services

Expenses incurred for necessary medical care or remedial services that are covered under the State Plan.

Spend-down eligibility is established for the remainder of the period under consideration when the incurred medical expenses equal or exceed the amount of excess income. Refer to Chapter 11 – "Certification Periods ", to determine dates of eligibility.

(b) Excess Income and Preserved Application

When spend-down eligibility is not established during the application process, notify the applicant of his ineligibility and advise him of the spend-down provision. The application date must be preserved for possible spend-down eligibility at any time during the established period under consideration.

Preservation of the application applies when:

- All technical (non-financial) factors of eligibility have been met;
- Resources are within the applicable standard;
- Excess income exists; and
- There are insufficient incurred medical expenses to meet spend-down eligibility during the application process.

(1) Covered Services

COMAR describes the services covered, provider requirements, eligibility requirements, and provider reimbursement. Many of these services are covered under the Health Choice benefits package for managed care enrollees. Services are covered on a fee-for-service basis if the services are carved out of the Health Choice benefits package or if the recipient is not enrolled in Health Choice (e.g., recipients before enrollment in managed care, spend-down eligibles, Medicare recipients, institutionalized persons, enrollees in Rare and Expensive Case Management, enrollees in the Model Waiver for Disabled Children).

COMAR 10.09.24.09

SERVICES COVERED BY MARYLAND MEDICAL ASSISTANCE (MEDICAID)

The following services are covered by Maryland's Medicaid Program, if the services are not covered by Medicare or other insurance and if the Maryland Medicaid Program's specific requirements for the service are met. If you have questions, call the Maryland Medicaid Hotline at 410-767-5800 or 1-800-492-5231.

- Ambulance and wheelchair van services and emergency medical transportation
- Ambulatory surgical center services
- Clinic services
- Dental services and dentures (for beneficiaries under 21)
- Diabetes care services (covered under Health Choice)
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services (for beneficiaries under 21)
- Eye glasses (for beneficiaries under 21)
- Family planning services and supplies
- Hearing aids (for beneficiaries under 21)
- Home and community-based waiver services for targeted populations of developmentally disabled or mentally retarded individuals, older adults, physically disabled adults, medically fragile children, children with autism spectrum disorder, and adults with traumatic brain injury
- Home health agency services
- Hospice care
- Hospital inpatient and outpatient services (acute, chronic, psychiatric, rehabilitation, specialty)
- Kidney dialysis services
- Laboratory and x-ray services
- Medical day care services
- Medical equipment and supplies
- Medicare premiums, co-payments, and deductibles
- Mental health treatment, case management, and rehabilitation services
- Nurse anesthetist, nurse midwife, and nurse practitioner services
- Nursing facility services (nursing homes)
- Oxygen services and related respiratory equipment services
- Personal care services
- Pharmacy services (for beneficiaries not eligible for Medicare Part D)

- Physical therapy
- Physician services (some dental surgery may be included)
- Podiatry services
- Private duty nursing (for beneficiaries under 21)
- School-based health-related services (for beneficiaries under 21)
- Statewide Evaluation and Planning Services (STEPS) (through local health departments)
- Substance abuse treatment services
- Targeted case management for HIV-infected individuals and other targeted populations
- Transportation services to Medicaid covered services (through local health departments)
- Vision care services (eye examination every two years

(2) Transportation Costs for Spend-Down

While transportation to and from medical appointments is a Medicaid covered service through grants to local health departments, the service is not always available to recipients throughout the State. If an applicant incurred the cost of transportation to obtain medical care, this cost may be applied to the applicant's excess income for spend-down. These costs may not be projected, but only counted when incurred. The actual incurred amount must be documented by odometer readings; receipts for taxi, rail, ambulance, or wheelchair van fares; or the manager's knowledge of current MTA fares for bus, subway, or light rail. The applicant must provide a bill or receipt for medical care (including to purchase prescription or over-the counter drugs), with a service date identical to the date for which the cost of medical transportation is claimed. The applicant must provide a signed statement affirming that the sole purpose of the trip was to obtain medical care.

(3) Payment Contracts for Spend-Down

Expenses considered for establishing spend-down eligibility may include certain projected payments for medical care already received. For these expenses to be considered, the person claiming the expense must prove that the service was received, the applicant owes a balance to the provider, and the applicant signed a payment contract or similar document with the provider to pay the debt. If all of those conditions are met, the amount of each expense and the date incurred are determined as stated below. The amount and the frequency of payments specified in the contract are used to help determine when spend-down is met.

- If the projected payment is for a medical or remedial service that was received prior to the first day of the period under consideration, the amount of incurred expense is the total amount due during the period under consideration. Only amounts due during that period should be considered. The expense is considered as of the first day of the period under consideration.

- If the projected payment is for a medical or remedial service that was received during the period under consideration and is under a payment contract, the amount of incurred expense is the total amount due during the period under consideration. The expense is considered as of the date on which the contract or other document establishing the schedule of payment was signed.
- When all of these conditions have been met, place the application in preserved status until the end of the period under consideration.
- When there is excess income coupled with health insurance or other third party coverage, place the case in preserved status until the hospital or other provider reports the amount of coverage it has received from health insurance. If there remains an unpaid portion, compare that remaining amount to the excess income. If the provider bills the person for the unpaid portion, consider it an incurred medical expense.
- If incurred expenses equal or exceed the excess income, the unit is eligible and certification is in accordance with Chapter II (Certification Periods).
- When the incurred medical expenses do not equal the amount of excess income during the period under consideration, eligibility does not exist. If the applicant reapplies, establish a new application date and a new period under consideration.

(c) Expiration of Preserved Status

Preserved status automatically expires at the end of the period under consideration. Instruct applicants to submit medical expenses during the preserved period before the expiration of the period.

However, when the applicant does not present the bills during the preserved period, he may do so after the expiration of the period. Because of the 12 month limitation imposed on providers for billing the Program for payment, it is essential that the applicant provide the bills within 10 months from the date the service was rendered to allow the LDSS/LHD time to determine eligibility and certify the applicant before the 12 month period expires. Although the possibility of Program payment of a bill is reduced if the applicant submits it to the LDSS/LHD after the 10th month, technically, the bill may be submitted for consideration up to the expiration of the 12 month period. These procedures also apply to spend-down cases under Chapter 10, Eligibility for Institutionalized Persons.

This flexible policy applies only to submittal of bills for payment after the expiration of the preserved period associated with a case in preserved spend-down status. It does not apply to cases that are subject to the "Reactivation" procedures.

If an applicant does not submit the bills before the expiration of the preserved period and reapplies after the expiration of the preserved period, the new period under consideration may not include any months that were included in an expired period. However, if the applicant has not established spend-down eligibility during the preserved period and does not intend to do so , or cannot do so because of insufficient expenses, the incurred bills may, with the written consent of the applicant, be applied to the excess income, if any, for the current period. The written consent must be obtained on form DHMH 4284. Bills applied to the current excess income may not at any time be applied to the excess income of an expired period. These policies are consistent with those included in Policy Alert 04-1 regarding establishing periods under consideration.

900.3 Retroactive and Retroactive Spend-down Eligibility

Retroactive eligibility may be determined for the period of one, two, or three months prior to the month of application. It may be considered only for those months in which there were incurred medical expenses.

(a) Resources

Resources to be considered are those which were available to the assistance unit and any persons whose income and resources must be considered during the retroactive month (or months) for which coverage is requested. Eligibility does not exist for any month in which countable resources are greater than the medically needy resource level. Retroactive eligibility may not be granted based on current reduction of excess resources. If resources are equal to or less than the appropriate MA-2 standard, evaluate income.

(b) Income

When countable net income is equal to or less than the medically needy income level, eligibility exists as medically needy.

When the countable net income is greater than the medically needy income level, retroactive eligibility may exist under the spend-down provision.

The policy and procedures listed under current eligibility apply to retroactive and retroactive spend-down with the following exceptions:

- The period under consideration can be no more than 3 months and may be 1 or 2 months based on the applicant’s request and the months in which there were incurred expenses;

- Only income actually received in the period under consideration (or, for a person who does not receive the same income during each of the 12 months of a year, the prorated amount for the period under consideration) may be considered. This includes self-employed persons, farmers, and school teachers whose annual salary is paid over a 10 month rather than a 12 month period.
- The use of incurred medical expenses is limited to those incurred during the period under consideration and
- Only family members who have incurred coverable expenses may be certified.

900.4 Certification of Eligible Persons

Persons determined eligible are certified in accordance with the policies and procedures in Chapter II (Certification Periods).

(a) Ineligible Persons

Persons determined ineligible may not be certified. A decision of ineligibility may be reached for one or more of the following reasons:

- Failure to provide required information; (This may include deficit spending – unexplained expenditures which exceed the ability to spend based on reported income and resources.)
- Failure to meet a specific requirement such as application signatures, etc;
- Failure to meet a technical requirement such as residency, citizenship, etc;
- Disposal of a resource for less than fair market value;
- Excess resources; or
- Excess income.

(b) Notice of Determination

Each separate assistance unit must be sent a notice of eligibility or ineligibility. Address the notice to the head of the household. In cases of children who do not live with a parent or CTROP, mail the notice to the person who takes overall responsibility for a child. In most instances, this will be the person who applied for MA on behalf of the child.

(c) Changes in Assistance Unit Composition and/or Income Resources

If there is a change in the size or composition of the assistance unit, or if a change occurs in the income or resources of any family member whose income and resources have been considered, the income and resources of the assistance unit must be recalculated. For recipients, this will entail an unscheduled redetermination of eligibility for the remainder of the period under consideration, beginning with the month of the change.

Attachment A: Financial Eligibility for Non-Institutionalized Persons

900.5 Persons Admitted to a Long Term Care Facility

To be considered institutionalized, a person over 21 must have resided in a Long Term Care Facility (LTCF) for a continuous period of 30 consecutive days or be likely to remain 30 consecutive days. This means that an adult who is admitted to a LTCF on any day of the month and is expected to remain in the facility for at least 30 days, is considered institutionalized in the month of admission and eligibility for that person is determined by the procedures in Chapter 10.

A child who resides in an LTCF as of the first of the month, and who is expected to remain in the facility throughout the month, is considered institutionalized and his or her eligibility must be determined using the procedures in chapter 10. A child who is admitted to an LTCF on any day other than the first of the month is considered non-institutionalized in the month of admission and eligibility for that is determined based on the procedures in this chapter.

Length of residency in a LTCF and medical need for long term care is verified by the DHMH 257. A level of care of Chronic/Special Hospital, Intermediate or Skilled Nursing Care /Extended Care Facility (SNC/ECF) constitutes medical need.

- A person who is admitted to an LTCF but who is not expected to remain 30 days is considered non-institutionalized, and eligibility must be determined using the procedures in this chapter.
- A person admitted to a LTCF for any length of time but who is not in medical need of such care is also considered non-institutionalized. (When there is no medical need for LTC, the cost of care cannot be used in spend-down, nor can the cost of care be covered by the Program.)

(a) A Person Who is Part of a Larger Unit

An adult A/R who is part of a larger assistance unit is considered separated from that unit in the month of admission if the A/R is expected to remain in the institution for more than 30 days. This person's eligibility is determined using the procedures in chapter 10 regardless of the date of admission, and is considered an assistance unit of one in the month of admission.

A child who is admitted to a LTCF on any day other than the first of the month is considered non-institutionalized in the month of admission and is part of the family unit. A child who is not expected to remain in the LTCF throughout a month is also considered non-institutionalized and is a part of the family unit.

Exception: A child who is admitted to a drug or alcohol treatment center will be considered separated from the family unit effective the month of placement, regardless of the date of admission. For the month of admission to such a program, a child is considered a unit of one and eligibility is determined in accordance with the procedures in chapter 10.

When a person who was part of a larger unit has eligibility determined as an institutionalized unit of one, eligibility for the members of the community MA unit must be redetermined based on the changes in unit size, composition, income and assets. (refer to Redetermination for Remainder of Community MA Unit).

(b) Spend-Down

When eligibility for a person admitted to a Long Term Care Facility (LTCF) must be determined under this chapter, (i.e. community MA) and there is excess income, eligibility may be established under the spend-down provision.

If there is excess income, incurred medical expenses, including medically necessary LTC expenses (as verified by the DHMH 257), it is considered towards the spend-down. If the spend-down is met prior to the date of admission to the LTCF, the A/R is eligible for full Medical Assistance Coverage of the cost of care (COC). If spend-down is met on a day that the person is a resident of the LTCF, the amount of excess income remaining on that day is considered available income to be paid by the recipient towards the (COC).

When a person is determined eligible under spend-down, complete a DES 501, attach the DHMD 257 and forward these to:

Department of Health and Mental Hygiene
Division of Recipient Eligibility Programs
LTC Unit/Special Projects Unit
201 West Preston Street, SS-7C
Baltimore, Maryland 21201

This procedure will enable payment to be made to the LTCF and insure that the excess income is applied to the COC.

(c) Anticipating Expenses State of Maryland Medical Assistance Manual

When a person files an application for Medical Assistance in anticipation of LTC expenses and meets all eligibility factors except income, but does not enter the LTCF within 30 days of the date of application, the LDSS/LHD has the following options:

- Determine spend-down eligibility, preserve the application, send notice of ineligibility, and reevaluate the case when the person is admitted to the LTCF; or
- Apply the provisions of COMAR 10.09.24.04J (4) on Extension of Time Limits. Extending the time limits of the application means the application may remain pending beyond the 30- day time so long as the person continues to express the intent to enter a LTCF. If the extension of time limits is applied, the person must be sent written notice of this action. The case remains in pending status and eligibility is determined when the person is admitted to the LTCF. If the person does not enter the LTCF by the end of the period under consideration, an eligibility determination must still be made for that period.

One of the options above must be selected and should be used consistently within a given local department. An application for Medical Assistance may not be denied because the applicant is not institutionalized. Failure to enter a LTCF is not a basis for a person being determined ineligible.

(d) Admissions to Long Term Care Facilities (LTCF) for Anticipated Stays of Less Than 30 Days

The policies in this section do not apply to persons institutionalized for more than 30 days or who were admitted with the expectation that they would be institutionalized for more than 30 days. Since these persons are considered institutionalized, a LTC application is required, and a DES 501 form would not be used.

A Long Term Care Facility (LTCF) may admit a person for an anticipated stay of less than 30 days. When such a person is admitted to a LTCF from a community setting (including an acute hospital that admitted the person from the community), has a plan of care for a LTCF stay less than 30 days, and is discharged from the LTCF back to the community within 30 days, eligibility is determined for community Medical Assistance under COMAR10.09.24.09. Because this is not a LTC case, the applicant is not entitled to a residential maintenance allowance, and the spousal impoverishment provisions do not apply. If a financially eligible person meets the medical eligibility criteria, as determined by the Medical Assistance Utilization Control Agent, for the services being rendered by the particular facility, MA will cover the cost of care for that person.

For persons enrolled in Health Choice, the Manage Care Organization (MCO) is responsible for the charges during the first 30 days in a nursing home, chronic care hospital, or rehabilitation facility; therefore, the facility must bill the MCO.

When requesting a short stay (less than 30 days) under full MA, the Long Term Care Facility must complete the DHMH 257 form as follows:

1. Complete sections 1 – 2 on the form.
2. In section A, check block 1 "Full MA coverage" and enter the date to begin payment.
3. In section B, checkbox 1 "Discharge to" then check "Community" and enter the date of discharge.
4. The Level of Care Section of the form should be completed by the UCA including the level of care, effective dates, name, signature and date the UCA completed the form.
5. The form should then be sent to:

   LTC processor
   P.O. Box 9307
   Catonsville, Maryland 21228

6. The processor should complete the DES 501 and forward to the Division of Recipient Eligibility Programs.

This procedure will enable payment to be made to the LTCF for brief admissions for fee-for- service (non-Health Choice) recipients.

(e) Spend-Down in Long Term Care Facility (LTCF)

If the LDSS/LHD determines that an applicant's income exceeds the Medical Assistance standard, use the daily costs incurred in the LTCF towards spend-down. The facility will need to provide a bill to itemize the cost of care, ancillaries, and other medical expenses on a day-by-day basis. These applicants may then establish eligibility under the spend-down provision, but will be responsible for a portion of their expenses. A person certified under spend-down based on expenses incurred while in the facility must pay the facility the excess income remaining on the date spend-down was met (the first day of eligibility) as well as the charges used to meet spend-down prior to eligibility. Enter on the DES 501 the applicant's spend-down amount as of the date of eligibility. When eligibility is established, complete the DES 501 to enable payments to the facility.

(f) Medicare Coverage for Medical Assistance Community or Qualified Medical Benefit Recipients (QMB) in Long Term Care Facility (LTCF) for Skilled Care

Medical Assistance is obligated to pay Medicare co-payment days for any MA or QMB eligible recipient who is dually eligible for Medicare. When a community MA or QMB recipient enters an LTCF on Medicare days, the admission should be reported to the LDSS/LHD within10 days, as with any other change in the case.

Medicare covers a Medicare recipient in full for the first 20 days in the LTCF at a skilled or chronic level of care. For the 21st - 100th days in a LTCF, at a skilled or chronic level of care, the Medicare recipient is assessed a co-payment. If the individual is a Medicaid or QMB recipient, Medicaid pays the Medicare Part A co-payment under the Medicare Buy-In Program. Medicare and Medicaid pay the provider since the recipient contribution to the cost of care is not assessed. If the recipient is on Medicare co-pay or needs MA to assist with the cost of the Medicare deductible, the LTCF must send a DHMH 257 to the LDSS/LHD. The 257 does not require UCA approval since Medicare's UCA has already determined the person's level of care as either skilled or chronic. After receiving the 257 requesting Medicare co-payment, the LDSS/LHD will issue a DES 501 to begin co-pay or begin pay effective the date specified on the 257. No further action is required of the LDSS/LHD. However, it is recommended that a long term care application be filed before the 30th day in the LTCF, because the recipient may not require a skilled level of care paid by Medicare for the full 100 days of potential Medicare coverage.

Eligibility for long- term care Medical Assistance should be evaluated on a case-by case basis, so that it may take effect when Medicare coverage ends.

A MA or QMB recipient residing in a LTCF under full Medicare or Medicare co-pay can reside in the facility up to 100 days without being required to file an application for MA LTC. Therefore, if Medicare co-payment days go beyond the 30th day in the LTCF, MA will continue to cover the Medicare co-pay without the need to file a LTC application.

If the individual requires LTCF services beyond the 100 days of Medicare co-payment and is requesting MA payment towards the cost of care, the procedures in chapter 10 of the MA Eligibility Manual must be followed. A long-term care application for Medical Assistance must be filed in a timely manner. The facility must send the DHMH 257 to the UCA for a level of care determination for days not approved for Medical coverage.

(g) Recipients Admitted to a Long Term Care Facility (LTCF)

For persons who were financially eligible for Medical Assistance when admitted to the facility, eligibility will not need to be reevaluated. A person who is already a recipient of community Medical Assistance or QMB at the time of admission to the LTCF will remain eligible throughout the month of admission and will have no income applied to the cost of care.

The above procedure does not apply to those who were admitted and determined eligible for MA under Chapter 10 based on the expectation that they would be institutionalized for 30 days or more, but who were unexpectedly discharged in less than 30 days. These people remain eligible as institutionalized persons throughout the month.

If it is anticipated that a recipient will remain institutionalized, eligibility must be redetermined. Members of a TCA Assistance unit and other children will be entered in the "T "track, Family Long Term Care. SSI recipients and ABD persons are entered in the "L" track, ABD Long Term Care.

900.6 SSI Recipient Enters Long Term Care (LTC)

For an SSI recipient who is expected to remain in the Long Term Care Facility (LTCF) for more than 30 days, or who has been admitted for more than 30 days, the Case Manager must verify that the change of address and living arrangement have been reported to SSA and must verify the benefit amount to which the person is entitled effective with the change.

For these SSI recipients, a LTC application should be completed to satisfy administrative and post-eligibility requirements and to establish eligibility for cost of care payments. The application ensures that:

- A representative is identified
- Home property is evaluated for continued excludability and applicability of a lien
- Disposals of resources for less than fair market value are identified and properly treated
- Any additional income is evaluated for availability toward cost of care or spousal allowances

For an SSI recipient, failure to file an application does not result in termination of eligibility since the SSI recipient is categorically needy. However, eligibility in L01 should not be finalized until the application form is received.

If resources are found to be over scale, delay LTC certification until the Social Security Administration has verified that SSI eligibility will continue. If a disposal for less than fair market value places the recipient in a current penalty period, the recipient is ineligible for nursing facility services (L01) only. The recipient retains Medical Assistance eligibility as S02.

900.7 Redetermination for Remainder of Community Medical Assistance Unit

If the institutionalized person was a part of a larger assistance unit, eligibility must be redetermined for the remainder of the non-institutionalized unit. This means that, when

a member of an assistance unit is considered institutionalized, two separate cases, two separate applications and two separate eligibility determinations are required. If the person has a spouse living in the community, his/her eligibility must be redetermined in the month of admission in accordance with "Spousal Impoverishment provisions."

For persons under 21 years old, the first full month of admission begins a new period under consideration and eligibility for the new period is determined in accordance with Chapter 10. As this is considered an unscheduled redetermination, the LDSS/LHD has the discretion as to whether or not a new application form is required. Regardless of whether or not a new application form is required, all factors of eligibility must be reviewed.

The LDSS/LHD has the following options:

- Request a new application for redetermination for the non-institutionalized unit
- If that unit does not wish to have MA redetermined and an application is not submitted, terminate eligibility for the members of that unit for failure to complete the redetermination process. Cancel the non-institutionalized individuals, and make the appropriate notations in the case narrative. The existing application and case record may then be used for the institutionalized person;
- Request an application for the institutionalized person and base redetermination of the non-institutionalized unit on the original application;
- Use a photocopy of the existing application to determine eligibility for either or both of the units; or
- Require a new application for both units

The LDSS/LHD may exercise any of the above options on a case-by-case basis. The choice must take into consideration the needs of the client and the requirements for determining eligibility. These include:

- Convenience to the client or representative;
- Convenience to the LDSS/LHD
- Time-span between the date of application and admission to the LTCF;
- Accuracy of information on the existing application;
- Number and extent of changes

900.8 Persons Receiving Hospice Services

A person may receive hospice services in three different settings:

- In a person's own home
- In a hospice facility

- In a nursing home

For persons receiving hospice services in their own homes or in a hospice facility, Medical Assistance eligibility is always determined under COMAR 10.09.24.09, i.e., Community Medical Assistance. When determining eligibility for persons receiving hospice care, the cost of the hospice services may be considered in spend-down. The cost of hospice services may not be projected.

For a preserved case or a case certified under spend-down, the excess income must be recalculated based on a shortened consideration period if the A/R dies before the end of the period.

For those already certified under spend-down, this means that eligibility may begin at a date earlier than originally determined. In this situation, it is appropriate to correct eligibility to begin on the earlier date.

When a person receives hospice services while in a nursing home, eligibility is determined under COMAR 10.09.24.10, Financial Eligibility for Institutionalized Persons.

Attachment A

To: Division of Recipient Eligibility Programs
201 West Preston Street
Room SS- 7C
Baltimore, Maryland 21201

From: _____ Department of Social Services
(Local Department)

Name of Recipient _____
First M.I. Last

M.A. I.D. _____

Name of Facility _____

MMIS Provider I.D. _____

Requested Begin Pay Date _____

Date of Discharge _____

Recipient Certified under Spend-down.
Excess income remaining of first day of eligibility: $_____

Case Manager Signature: _____ Date: _____

Telephone No. _____

DES 501 Revised 12/08
White-DREP Yellow-Long Term Care Facility Pink-Case Record

Section 900 Frequently Asked Questions and Answers
Determining Financial Eligibility for Non-Institutionalized Persons

1. Should Families and Children's Unit (FAC) be considered for income and resources?

   No, resources are only considered if the FAC case becomes a spend-down case. However, income of the parents of members of the assistance unit and the spouse of any member of the assistance unit must be considered even if they are members of other units or are not applying.

2. Whose income and resources of an Aged, Blind, Disabled Unit (ABD) should be considered?
   All members of the assistant unit, the spouse of the assistance unit member and the parents of a blind or disabled child under 18 years old.

3. Are there any exceptions to the FAC and ABD considerations for income and resources?

   Yes. If the unit has an SSI parent or spouse they are not considered.

4. When does Preservation of an application apply?

   The Preservation of the application applies when all technical (non-financial) factors of eligibility have been met, resources are within the applicable standard, excess income exists and there are insufficient incurred medical expenses to meet spend-down eligibility during the application process.

5. When does the Preserved status expire?

   The Preserved status automatically expires at the end of the period under consideration.