MA-2270 LONG TERM CARE NEED AND BUDGETING
REISSUED 11/01/07 – CHANGE NOTICE 25-07

I. INTRODUCTION

This section contains instructions for determining income eligibility of individuals in long term care. Long term care is extended care in a hospital or medical facility listed below. Medicaid helps to pay the cost of care for an eligible individual. The a/b must also meet all other eligibility requirements including resource limits (MA-2230), resource protection (MA-2231), and transfer of assets (MA-2240).

II. WHEN TO USE LTC BUDGETING

Use LTC budgeting when a person meets all of the criteria below.

A. The a/b must have begun a continuous period of institutionalization (CPI). The definition of CPI is 30 consecutive days in a medical facility or combination of two or more medical facilities. If the individual in one of these facilities is discharged home or to an adult care home during the first 30 days, there is no CPI. The CPI continues if the a/b is discharged from a Medicaid facility but returns within 30 days.

Once a CPI has been established, it can end when the a/b has been discharged from the medical facility for 30 consecutive days. If the a/b returns to a medical facility for 30 consecutive days then a new CPI begins from that date.

A continuous period of institutionalization begins the first day:

1. The a/b enters a medical facility from a private living arrangement or an adult care home. A medical facility is an institution that primarily provides inpatient medical care (not residential care). A medical facility could be:

   a. A Medicare-Medicaid certified nursing facility, ICF-MR, Skilled nursing facility (SNF), or SNF Rehab. (Refer to III. if the facility is not yet certified.)

      NOTE: A hospice beneficiary is considered long term care if the person is admitted to a hospice inpatient facility or is a patient in a hospital/nursing facility under contract with hospice. If not an inpatient, budget PLA.

   b. Skilled nursing care in a general hospital (called a swing bed or inappropriate level of care bed).

   c. Psychiatric unit in a state mental hospital (Dix, Broughton, Umstead, and Cherry) when the a/b is:

      (1) Age 65 or older, or
      (2) Under age 21, or
      (3) Under age 22, and had 21st birthday while a patient in the state mental hospital.

(II.A.1.d)

d. Psychiatric Residential Treatment Facility (PRTF) when the a/b is:

(1) Under age 21, or
(2) Under age 22, and had his 21st birthday while a patient in the psychiatric residential treatment facility.

e. General/Acute Care Hospital

OR

2. The a/b is admitted to a general/acute care hospital, psychiatric unit of a state mental hospital, or PRTF and his inpatient stay (**of any length**) ends with a direct move to one of the medical facilities listed in II.A.1.a. or 1.b. above,

OR

3. The a/b is admitted to a general/acute care hospital, psychiatric unit of a state mental hospital, or PRTF and his inpatient stay exceeds 30 continuous days, regardless of whether he goes home or into an adult care home.

B. The a/b must have a completed FL-2/MR-2, if required, with at least telephone prior approval. The FL-2 may also be an electronic version and should be printed and put in the record. (See Table D) The county DSS may accept telephone and fax verification of the prior approval from the facility. The IMC must document who he spoke with, that person's position, the facility he works with and the service review number (SRN).

The hospital social worker, county dss, medical facility representative, physician or Local Management Entity (LME) must initiate and complete an FL-2/MR2. The FL-2 is **forwarded to the Claims Processing Contractor Prior Approval Unit and the MR-2 is forwarded to the Murdoch Center for approval** (refer to XV., below). The FL-2 is the Long-Term Care Services prior approval form and the MR-2 is the Mental Health Services prior approval form. It gives a summary of the patient's medical requirements. Medicaid will help to pay cost of care for an eligible individual with an approved FL-2/MR-2. FL-2 is required for a swing bed.

FL-2/MR-2 is not applicable to psychiatric residential treatment facilities. PRTF services have a separate prior approval process. The county department of social services is not responsible for PRTF prior approval. Do not delay long term care budgeting for PRTF approval.

C. Effective date of LTC Budgeting

Long Term Care Budgeting begins:

1. The month after the CPI begins when placed in a Medicaid certified nursing facility or swing bed or inappropriate level of care bed in a general hospital.

2. The month after the CPI begins when the a/b is admitted to a general/acute care hospital, psychiatric unit of a state mental hospital, or PRTF and his inpatient stay (**of any length**) ends with a direct move to one of the medical facilities listed in II.A.1.a. or 1.b. above.

(II.C.)

3. The month following the month of the 30th continuous inpatient day when placed in a general/acute care hospital, psychiatric unit of a state mental hospital, or PRTF.

   For example, an a/b enters a general/acute care hospital on March 18th. The 30th continuous inpatient day is April 16th. Long-term care budgeting begins May 1st.

III. EXCEPTIONS TO LTC BUDGETING

Do not use LTC budgeting procedure when:

A. The case is under a transfer of resource sanction; or

B. The FL-2/MR-2 has not been received in the agency, if required; or

C. The FL-2/MR-2 recommends adult care home level of care; or

D. Individual resides in a facility which is not certified for Medicaid participation;

E. The individual is under VA contract for payment of cost of care; or

F. The individual is not in a Medicaid bed.

When any of these conditions occur, proceed to XIII. in this section for other instructions.

IV. DETERMINING ELIGIBILITY FOR THE MONTHS PRIOR TO LONG-TERM CARE BUDGETING

A. Individuals Under Age 21

If the institutionalized a/b is under 21, has not been determined disabled or blind (not receiving SSI/SSA or MAD), and is expected to remain institutionalized for over 12 full months, evaluate for long-term care eligibility under Family and Children's coverage groups.(See Family and Children's Medicaid Manual, MA-3325, Long Term Care Budgeting.)

B. Aged, Blind, or Disabled Adult/Child Who is an Applicant/Beneficiary

1. For all months prior to the month the CPI begins, the a/b is budgeted PLA and should be budgeted with all persons who are financially responsible for him. (Refer to MA-2260, Financial Eligibility Regulations – PLA.)

2. Effective the month the CPI begins, the budget unit is one.

   a. Count only the a/b's income and determine eligibility under private living arrangement (PLA). Do not count income of the a/b's spouse/parent.

(IV.B.2.)

b. Allow the reserve limit for one, plus the amount of resources protected for the spouse. Refer to MA-2231, Community Spouse Resource Protection.

c. Do not count the PLA homesite as a resource for the first month of the CPI because it was the homesite as of the "first moment." Beginning with the second month of the CPI it is no longer excluded as the a/b's homesite. It is a countable resource unless it can be excluded on another basis (cusp's homesite, intent to return, etc.).

V. LONG TERM CARE BUDGETING COMPUTATION

A. Determine Whose Income to Count

1. Count only the a/b's income in determining financial eligibility when the a/b does not have a spouse, or the a/b is an institutionalized disabled child.

2. Count only the a/b's income when the a/b is married but the spouse remains in a private living arrangement, or in a separate LTC facility, or they share a LTC room but only one spouse requests Medicaid to pay for cost of care.

3. Count both spouse's income when they share a room in a facility and both request Medicaid to pay for cost of care.

B. Establish Financial Eligibility (STEP I)

The a/b must be financially eligible for Medicaid in order to receive help with cost of care. There are several different ways to establish financial eligibility. These are explained in items 1-4 beginning with the most frequently used method. A person only has to qualify under one of the methods. **Use DMA-5008, SUPPLEMENT B, as a guide**. Financial eligibility (Step I) is already established for SSI Medicaid beneficiaries. Refer to MA-1100, SSI Medicaid-County DSS Responsibility.

1. Nursing Facility's Medicaid Reimbursement Rate (DMA-5008, Supplement B, Step I., A.)

Each facility has an assigned Medicaid reimbursement daily rate based on the medical needs of the facility's population. To find that rate go to the website at:

http://www.http://www.ncdhhs.gov/dma/fee/index.htm.

Or contact the Division of Medical Assistance, Medicaid Eligibility Unit, 919-855-4000.

Note: Rates are adjusted quarterly.

(V.B.1)

a. When the daily rate for the selected facility is found, multiply that rate by 31 days and round up to the next highest whole dollar. The resulting figure will be the Medicaid reimbursement rate for 31 days.

b. Compare total gross income (nothing excluded) to the facility's assigned Medicaid reimbursement rate for 31 days.

c. If gross income is less than the facility's assigned Medicaid reimbursement rate for 31 days, the person is financially eligible. Proceed to STEP II to determine the pml.

d. If gross income is greater than the rate, continue to 2, below.

NOTE: Be sure to evaluate the applicant/beneficiary for Passalong eligibility. This evaluation is done in Step I only. See MA-2110, Passalong.

2. Facility's Private Rate (DMA-5008, Supplement B, Step I., B.)

When the a/b's gross income is greater than the Medicaid reimbursement rate for the facility, determine if net income (after exclusions) is less than the facility's private rate. Contact the facility to establish the facility's private rate for 31 days. Compare net income to the facility's private rate to establish whether financial eligibility exists.

a. Determine Net Countable Income

From gross income subtract:

(1) PLA exclusions, deductions, disregards, exemptions, and the MN PLA maintenance allowance.

(2) The **net countable income** is only used to determine financial eligibility in Step 1. **Do not** use this amount in STEP II to determine patient monthly liability (pml).

b. Compare net countable income to private rate for 31 days.

(1) If net countable income is less than or equal to the facility's private rate, the person is financially eligible. Proceed to Step II to determine the patient monthly liability

(2) If net countable income is greater than facility's private rate, continue to 3, below.

(V.B.)

3. Needs Test Using All Other Predictable Medical Expenses (DMA-5008, Supplement B. Step I., C.)

Use the same net countable income calculated in 2., above and:

a. Subtract the facility's private rate for 31 days.

b. Compare the amount left to the total amount of predictable medical expenses that will not be covered by the nursing facility.

(1) If the predictable medical expenses are equal to or greater than the income, financial eligibility exists. Proceed to STEP II.

(2) If predictable medical expenses are less than the income, the a/b is financially ineligible for cost of care. Deny the application for cost of care, or propose termination if an active case.

C. Determine Patient Monthly Liability (PML)--STEP II

After establishing that financial eligibility exists in STEP I, proceed to determine the patient's share of cost. STEP II determines the amount of income an a/b must pay to the facility for cost of care. This is called patient monthly liability (PML). Medicaid pays the remainder up to the Medicaid reimbursement rate. Step II procedures are different than Step I procedures. **DO NOT USE DEDUCTIONS OR NET COUNTABLE INCOME FROM STEP I IN STEP II.** In this step, do not apply passalong.

1. Establish Gross Income for STEP II

Establish gross amounts of all types of income, earned or unearned, that are countable based on policy in MA-2250, Income.

a. Count actual amount of SSA benefit received if it is reduced to recoup an SSA overpayment.

b. Count total VA benefit received in excess of the $90 improved pension, **including Aid and Attendance (A&A) and unreimbursed medical expenses (UME),** for veterans who reside in a North Carolina State Veterans Nursing Home.

2. Subtract Operational Expenses

Subtract operational expenses produced on income-producing real/personal property, or from income produced through the operation of a business. (Refer to MA-2250, Income.)

(V.C.)

3. **Subtract the following personal needs allowances**:

The total deduction for all four types of personal needs allowances cannot **exceed** the **PLA medically needy <u>full</u> maintenance level** for the budget unit. This means $242 for an individual or $317 for a couple who share the same room and both receive Medicaid to pay for cost of care.

a. Personal Needs Allowance (PNA)

(1) $30 for an institutionalized individual, or

(2) $60 for a married couple who share a room.

b. Personal Needs Allowance for court-ordered guardianship fees:

(1) Guardianship fees are deducted only for an individual with a 'guardian of the estate' named by the court. Verify the **<u>actual amount</u>** paid based on the annual report of receipts and disbursements filed with the clerk of court or with the guardian until the first report is filed.

(2) Deduct the lesser of the following amounts:

(a) Actual amount verified in (1) above,
(b) 10% of a/b's total gross monthly income, **OR**
(c) $25 per month.

c. Personal Needs Allowance for non-discretionary mandatory deductions:

This deduction could be from unearned retirement income of a beneficiary in any level of care. It could also be from earned income of an ICF-MR beneficiary.

(1) Subtract mandatory withholdings when the payer of the income verifies that the a/b has no choice (no discretion) in whether these amounts are withheld.

(2) These deductions are limited to:
(a) Federal, state, and local income taxes;
(b) Mandatory retirement contributions; and
(c) FICA.

d. Personal Needs Allowance for work incentive:

This is limited to ICF-MR beneficiaries who have earned income from work activities. Subtract the monthly incentive allowance **<u>after</u>** any mandatory deductions for withholding from earned income.

Net wages means after mandatory deductions from earned income

(V.C)

Monthly Net Wages	Monthly Incentive Allowance
$ 1.00 to $100.99	All up to $ 50.00
$ 101.00 to $200.99	$ 80.00
$ 201.00 to $300.99	$ 130.00
$ 301.00 and greater	$ 212.00

4. Subtract Community Spouse Allowance

   Deduct income required for the support of a community spouse. Refer to VI., below, to calculate the community spouse income allowance.

5. Subtract allowance for dependents when there is a community spouse

   Deduct income required for the support of other dependents at home. Refer to VII., below, to calculate this allowance.

6. Subtract $242 Maintenance Allowance when the a/b is expected to return home within 6 Months from the date his CPI began and he has no spouse at home. See V.D. for policy on return home within 6 months.

7. Allowance for minor dependents at home when there is no community spouse

   a. When there are minor dependents at home and the a/b is not expected to return home within 6 months, subtract the dependents' gross monthly income from the full medically needy income limit for the number of dependents in the home. Deduct the resulting amount from the a/b's monthly income in Step II (See VII., below).

   b. When there are minor dependents at home and the a/b is expected to return home within 6 months, subtract the dependents' gross monthly income from the full medically needy income limit for the number of dependents in the home plus the a/b; e.g. if there are 2 dependents, use the income level for 3. Deduct the resulting amount from the a/b's income in Step II (See VII., below).

8. Subtract Unmet Medical Needs (UMN) following policy in VIII., below.

9. Calculate the PML

   Income remaining after making above deductions must be less than the facility's Medicaid reimbursement rate for 31 days.

   NOTE: Refer to MA-2240, Transfer of Assets, to calculate the PML for partial months of ineligibility due to transfers of resources.

(V.C.9.)

a. If the remaining income is equal to or greater than the Medicaid reimbursement rate, the a/b is ineligible for help with cost of care. Go to XII., below to determine if the a/b could be eligible for other Medicaid services.

b. The income remaining is the pml. (Round to the nearest whole dollar. Round up for 50 cents or more.)

. Send the DMA-5016

10. Corrections or Changes to PML

It may happen that the a/b or facility reports a change (i.e. UMN, income, level of care) to the county. The a/b or representative should report any changes within ten (10) calendar days. This could result in adjustments to the PML. Follow procedures below when a change is reported.

a. Complete the reported change within 30 days.

b. If a client fails to report a change within ten days and the change results in:

(1) An overstated PML (PML should have been lower): Do not decrease PML for past months.

(2) An understated PML (PML should have been higher):

(a) If adjustment can be made by increasing future PML(s), make the change and notify the a/b or his representative using a timely notice.

(b) If adjustment cannot be made by increasing the PML(s), ask the a/b or his representative to make a voluntary repayment to DMA and refer to county fraud/program integrity staff. Refer to MA-2900, Beneficiary Fraud and Abuse Policy and Procedures, X.D. for instructions.

(V.C.10.)

a. If the county causes an error, delay, or fails to complete change within 30 days and it results in:

(1) An understated PML (PML should have been higher) -- Do not increase PML for past months. Document in the record the reason for the error and take no further action.

(2) An overstated PML (PML should have been lower) -- Do not decrease PML for past months:

(a) If the beneficiary was able to pay the overstated PML, deduct as an unmet medical need the difference owed back to the beneficiary from a future month(s) liability; **OR**

(b) If the beneficiary was unable to pay the overstated PML and the outstanding balance owed to the nursing facility cannot be cleared out by adjusting PML for two months, request prior approval from DMA Claims Analysis Unit to change the overstated PML(s) using DMA-5164. Any adjustment amount may be charged to the county.

STEP I FINANCIAL ELIGIBILITY FOR MEDICAID

A. NURSING FACILITY'S MEDICAID REIMBURSEMENT RATE (MRR) NEED TEST

If gross monthly income of the b.u. is less than the lowest monthly Medicaid rate, the client is eligible for help with cost of care.

B. NEED TEST AT FACILITY'S MRR

1. If gross monthly income of the b.u. is greater than or equal to the Medicaid reimbursement rate (MRR), (refer to V.B.1., above, to determine lowest MRR).

a. Daily MRR (t/c to facility)
b. Multiply by 31 days
c. MAXIMUM MONTHLY MA RATE

2. If the gross monthly income of the b.u. is less than the facility's MRR for 31 days, the client is eligible for help with cost of care. **GROSS INCOME IS LOWER. GO TO STEP II.**

STEP II ELIGIBILITY FOR HELP WITH COST OF CARE

A. LTC DEDUCTIONS

1. Enter **GROSS INCOME** of the b.u.
Subtract operational expenses
Countable Income

2. Deductions from Countable Income

a. (PNA) Personal Needs $30/$60
b. Court-ordered Guardianship fees
c. Mandatory deductions
d. Work Incentive deduction
e. Spouse/Dependent Allowance
f. (UMN) Unmet medical needs
monthly

3. Result (PML)

EXAMPLE OF COMMUNITY SPOUSE ALLOWANCE WORKSHEET

A. Maximum Income Available for Deeming to CUSP

1. A/B's countable income from LTC, step II
2. Subtract $30 personal needs allowance
3. Subtract any mandatory deductions
4. Subtract A&A/UME portion of VA payment
5. Difference is the maximum available for deeming
6. Continue to B., if greater than zero.

B. CUSP's Gross Monthly Income

1. Count all, including SSI Special Assistance, & Work First
2. Prorate Work First Based on # in Work First case

C. Is CUSP's GROSS INCOME (from B., above) greater than or equal to Base Allowance

1. [ ] **YES.** Stop and go to D., below.
2. [XX] NO. GROSS IS LESS, ENTER BASE ALLOWANCE HERE

a. Subtract CUSP's gross from Base Allowance: GROSS (B.) (always round down)
b. Result is CUSP's needs. :

c. Do CUSP's NEEDS exceed or equal maximum available from ISP in A., above?

[ ] **YES. DEEM MAXIMUM AVAILABLE IN A.5. ABOVE.** Do not consider shelter cost. Stop here.

[XX] NO. NEEDS ARE LESS THAN MAXIMUM IN A.5. ABOVE. Continue to C.3.below.

3. Does CUSP state monthly shelter expenses are equal to or less than the Standard Excess Shelter Cost.

[XX] YES. Shelter costs are equal to or less than SES, DEEM CUSP's NEED in C.2.b., above. Stop. Enter amount on DMA-5008, Supplement B worksheet.

(V.)

D. A/B Returns Home Within Six Months (Refer to II.A. for CPI Rules):

When the a/b intends to return to a private home (or to any private living arrangement) within six months, allow a portion of the a/b's income for maintenance of his home. This section explains the procedures for handling these situations.

NOTE: The doctor's statement of intent to return home within 6 months has no bearing on exclusion of the homesite from countable resources..

1. A written statement from the "physician of record" is required, in addition to the FL-2/MR-2. The statement must confirm that the a/b may reasonably be expected to return home **within 6 months from the date his CPI began.**

2. Flag the case for review in the 6th month from the date his CPI began. (e.g. Enters LTC 9/23, 6 months equals 3/23. The review should be conducted in the first week of March allowing the a/b a full six months to return home.)

   a. If the beneficiary has not returned home by the first week of the 6th month, verify with the physician or medical facility whether he will return home before the end of the 6th month. If he is to return home in this month, budget PLA after notice requirements are met.

   b. If the physician/medical facility indicates the individual will remain institutionalized beyond the 6th month, stop deducting the medically needy income level for one **after sending timely notice**. Increase the patient liability eginning with the 7th month.

3. If a single a/b (no spouse/dependents at home) returns home within 6 months and he had not been budgeted to return home within six months:

   a. Recalculate the LTC budget for all prior LTC budgeting months through the month of discharge and deduct the full medically needy income level for one in addition to the personal needs allowance.

   b. Notify the Claims Analysis Unit of the revised PML for the previous months. (Send the revised DMA-5016 to the facility when the PML change is entered. (See IX. below)

   c. Budget the remaining months in the certification period as PLA based on procedures in MA-2260, Financial Eligibility Regulations-PLA.

VI. THE COMMUNITY SPOUSE INCOME ALLOWANCE (SPOUSE IN PLA)

When computing the patient monthly liability, an allowance may be deducted from the a/b's income for the needs of his spouse. The following instructions tell you how to do this. See MA-2231, for Community Spouse Resource Protection.

A. Rules For Community Spouse Income Allowance Eligibility

1. Determine when to allow the community spouse allowance and **verify** that the community spouse actually receives this allowance.

   a. If the community spouse is legally married to the a/b and/or separated less than 12 months prior to the institutionalization, you may make an allowance for the community spouse.

   b. If the a/b and the community spouse have been separated for more than 12 months prior to institutionalization, do not make an allowance for the community spouse.

2. Do not calculate an allowance if both spouses are institutionalized.

3. A spouse who receives services in an adult care home is not institutionalized and is eligible to receive this allowance.

4. Income allocated through these procedures is countable to the community spouse in all other assistance programs.

5. The community spouse allowance is a pml calculation deduction in Step II of LTC budgeting. Therefore, if the a/b must be budgeted by PLA procedures for any reason, the community spouse is not eligible for the spousal allowance.

6. The maximum community spouse allowance amount is determined by the maximum available from the institutionalized spouse's income after deductions in STEP II (refer to V.C., above). If the maximum available is $0, there is no allowance.

7. The a/b or representative can choose to make a lesser amount actually available to the community spouse, or the community spouse can request a lesser allowance to not affect eligibility in other programs. Follow instructions below:

   a. Document the lesser amount, and if possible, obtain a written statement from the a/b, the community spouse, or the representative regarding the reason for the lesser amount, and

   b. Deduct the lesser amount when computing the patient monthly liability.

(VI)

8. The income amount allowed for the community spouse is calculated in two steps:

   a. A basic spousal allowance; and

   b. Excess shelter costs (see VI.C.)

B. The Basic Spousal Allowance

There is a standard formula used to calculate the basic spousal allowance. **Use DMA-5008, SUPPLEMENT C, as a guide**.

1. Verify the community spouse's gross monthly income (including SSI, Special Assistance, or Work First). Do not calculate this allowance until the community spouse's income has been verified.

   a. Follow verification procedures in MA-2250, Income.

   b. Do not deduct taxes, work-related expenses, or any other deduction or exemption from the community spouse's income.

   c. Prorate a Work First grant based on the number of Work First beneficiaries.

2. Basic Allowance for Community Spouse

   Compare gross income of the community spouse to the community spouse income standard. (This amount changes yearly in July)

   Note: This standard is 150% of the federal poverty limit for 2 people.

   a. If the community spouse's gross monthly income equals or exceeds the income standard, STOP. Follow directions in VI.C, below, for consideration of excess shelter costs.

   b. If the community spouse's gross monthly income is less than the income standard, determine the basic allowance amount by:

      (1) Subtracting the gross income of the community spouse from income standard.

      (2) Compare this amount to the amount available from the income of the a/b. See V.C., above, and

(VI. B. 2. b.)

(3) Evaluate the results.

(a) If the basic allowance equals or exceeds the amount available from the a/b:

1) The amount available from the a/b is the community spouse income allowance. Enter this amount on the income worksheet.

2) Do not consider excess shelter costs.

(b) If the basic allowance is less than the amount available from the a/b, consider excess shelter costs.

C. Excess Shelter Costs

When determining the community spouse allowance, we can sometimes consider shelter costs. Follow procedures below to determine if there are excess shelter costs.

1. Verifications of Shelter Costs

a. **Applications** - Accept the verbal statement of the representative, the a/b, or the spouse of amount of shelter costs and document in the record.

b. **Reviews and changes** - Obtain at least a signed statement from representative or a/b. If possible obtain a statement from the list of alternative verifications below.

- Rent or mortgage for principal residence only.

  Alternative verification: Verify actual cost by verbal or written statement from a/b or landlord, rent receipt, mortgage payment book, mortgage payment receipts, or statement of mortgage holder.

- Taxes on the homesite, if taxes are paid separately from the mortgage.

  Alternative verification: Verify taxes by tax receipt or statement from the county tax office. Do not include personal taxes on motor vehicles or other personal property.

- Homeowner's or renter's insurance, if paid separately from the mortgage/rent.

  Alternative verification: Statement from the insurance company or by a payment receipt.

(VI.C.1.b.)

- Required maintenance charges or homeowner fees from condominium, cooperative, or homeowners' association.

  Alternative verification: Statement from the homeowner's association or management company, or by payment receipt.

- Utilities

  - If community spouse lives in government subsidized housing, do not deduct for utilities unless the spouse receives notice that an excess utility charge will be added to the rent and reports it to the dss. Treat as a change and redetermine the spousal income allowance for the remainder of the a/b's c.p.

  - For all others, deduct the standard amount from Table C. If the community spouse has roomers or boarders, count them in the household size.

2. The shelter standard is a monthly amount

   If total shelter costs are less than or equal to the shelter standard:

   a. Make no deduction for shelter costs.

   b. The Basic Allowance from VI.B.2.b., above, is the spousal income allowance. STOP.

3. If total shelter cost exceeds shelter standard:

   a. Subtract the shelter standard from the total shelter costs.

   b. The result is excess shelter expense.

4. Add the excess shelter in 3 above, to the maximum community spouse income allowance.

   a. If the combined total is less than :

      (1) Subtract community spouse's gross monthly income from the combined total.

      (2) This amount is the spousal income allowance.

   b. If total is equal to or exceeds the community spouse income standard:

      (1) Subtract community spouse's gross monthly income from the community spouse income standard.

(VI.C.4.b.)

(2) This amount is the spousal income allowance.

c. The community spouse allowance can be adjusted up to the amount available from the income of the a/b when:

(1) A court order exists which establishes a different income amount, or

(2) Through county or state appeal, a decision is made that the community spouse needs additional income because of exceptional circumstances creating significant financial hardship.

5. Exceptions to shelter costs procedure:

a. If the community spouse receives a subsidy to pay all or a portion of shelter costs, deduct the amount of the subsidy from the total expenses.

b. Disregard one-time assistance based upon need, such as LIEAP.

c. If rent includes food, such as a roomer/boarder fee, do not count the amount paid for food in determining shelter costs. Deduct the actual amount paid for food, if the landlord can verify verbally or in writing, from the rent payment.

6. If the community spouse receives Work First/Food and Nutrition Services, use the DSS-8194 to notify the Work First/Food and Nutrition Services IMC of the amount of the spousal income allowance.

VII. THE DEPENDENT FAMILY MEMBER ALLOWANCE

There must be income remaining after subtracting the community spouse allowance from the a/b's income to proceed with the dependent allowance. The dependent family member allowance in VII.A., below, is allowed only when there is a community spouse at home. If there is **no community spouse**, but there is a dependent family member of the a/b proceed to VII.B., below.

A. Dependent Family Member Lives With a Community Spouse

1. Rules for the Dependent Family Member Allowance

A deduction for dependents can be made from the a/b's income in STEP II. A dependent of the a/b or the community spouse includes children (adult or minor), parents, or siblings. To receive the dependent family member allowance all the following criteria must be met:

(VII.1.)

a. The dependent must live with the community spouse. Accept the verbal statement of the representative, the a/b, or the spouse.

b. The dependent must be legally dependent:

(1) Assume an individual under the age of 18 is a dependent if he lives with the community spouse.

(2) Assume an individual over age 18 is a dependent if he is claimed as a dependent for income tax purposes by either the a/b or the community spouse.

2. Maximum Monthly Dependent Allowance

The maximum monthly depend amount is a standard amount that changes yearly, July 1st. This standard dependent amount is or a dependent with $0 income. This allowance is 1/3 of the spousal basic allowance. Income of the institutionalized a/b is allocated to raise the dependent family member's income to that amount.

3. How To Calculate The Dependent Family Member Allowance

a. Calculate the income allowance separately for each dependent family member as follows:

(1) Verify each dependent's total gross monthly income, including SSI and Work First.

(a) Do not deduct taxes or work-related expenses or allow any other deduction or exemption from the dependent's income.

(b) Prorate the Work First grant based on the number of beneficiaries.

(2) Subtract each dependent's gross monthly income from the community spouse income standard.

(3) Divide the remainder by 3. Compare this amount to the maximum amount in VII.A.2 above. The lesser of the two amounts is the dependent allowance.

b. The dependent family member allowance is deducted when computing the a/b's patient liability in Step II of LTC budgeting. Verify this amount is actually paid. If allowance is not actually paid, count in reserve the following month.

(VII.)

B. Allocation for Dependents When There Is No Community Spouse (Refer to V.C.7.)

If the a/b has a dependent family member, but no community spouse, allocate an amount of the a/b's income for the dependent(s). Deduct only the amount the dependents actually receive.

1. Combine gross income of all dependents. Do not make any deductions, and prorate the WFFA grant. Compare gross income to the medically needy income limit for the number of dependents.

    a. If the total gross income is less than the medically needy income limit amount for that number of dependents, subtract gross income from the medically needy maintenance income limit for the number of dependents. The remainder is the allocation amount for dependents.

    b. If the total gross income is equal to or greater than the medically needy income limit allowance for the number of dependents, do not allocate any amount to the dependents.

2. If the dependent family member receives WFFA/ Food and Nutrition Services, use the DSS-8194 to notify the WFFA Food and Nutrition Services IMC of the allocated income.

VIII. UNMET MEDICAL NEEDS ALLOWANCE

When determining an a/b's patient monthly liability an amount can be deducted to pay for medical expenses for which he is responsible. These expenses are referred to as unmet medical needs (UMN). In this section we will tell you how to determine the amount of income to deduct for UMN.

When a transfer of assets sanction period has been imposed, do not allow as an unmet medical need the cost of care for these months or the fractional amount in the last month of the sanction.

A. General Rules

To be considered an unmet medical need, a medical expense must meet all of the following criteria.

1. Be an allowable medical deduction for federal income taxes (see IRS Publication Number 502). UMN cannot include:

    a. Premiums for life insurance policies,
    b. Premiums for policies providing payment for loss of earnings,
    c. Premiums for policies for loss of life, limb, sight, etc., or
    d. Premiums for policies that guarantee an amount each week for a stated number of weeks hospitalized for sickness or injury.
    e. An insurance premium paid by the Health Insurance Premium Program (HIPP) as an UMN. This is an expense paid by Medicaid.

(VIII.A)

2. The expense must not be payable or covered by Medicaid.

   a. The LTC facility is required to provide many medical supplies and services. These supplies and services are covered by Medicaid as part of the facility's reimbursement rate.

      (1) Refer to the LTC Provider's Manual, Scope of Services Section, and MA-2905, Medicaid Covered Services, VII., Nursing Facility Services, for a detailed list of items included in the facility's reimbursement rate for beneficiaries in LTC facilities.

      (2) If it appears that the facility is charging the patient for services covered by the per diem, this should be documented and reported to DMA, Program Integrity Section, 919-647-8000.

   b. If Medicaid does not cover a Medical expense because of a transfer of assets sanction, the expense cannot be deducted from income as an unmet medical need when determining the patient monthly liability (PML). Refer to MA-2240, Transfer of Assets.

3. The expense must be either:

   a. For a service received in a long term care budgeting month; or

   b. An agreed upon payment that is due in a long term care budgeting month. It can be a medical expense incurred in a month before or during Medicaid eligibility. Get a copy of the contract or agreement and a description of each expense to verify amount and due date. The expense cannot be for the cost of care due to an imposed transfer of assets sanction period. This does not affect active LTC cases with contracts in place prior to November 1, 2007.

4. The expense must be for goods and services the a/b received and for which he must pay. It must not be covered by Medicare, private insurance or other third party, such as a family contribution.

   a. The a/b may be billed directly; or

   b. A third party may be billed if he has been or will be reimbursed by the a/b.

   c. Do not allow the charge until third party payment is verified.

   d. Deduct only the portion of the charge for which the a/b has payment responsibility when the third party benefits are verified.

5. The expense has not been used to meet a deductible while the a/b was budgeted as PLA for Medicaid.

6. The expense has not been deducted previously as a UMN.

7. The expense is not a previous patient monthly liability.

8. The expense was not used to reduce reserve.

9. The expense must be reported by the end of the 6 month period following the certification period in which it was incurred.

B. Prescription Drug Charges

Medicare/Medicaid beneficiaries have no prescription drug coverage through Medicaid. For Medicaid beneficiaries, and/or Medicare/Medicaid beneficiaries the cost of prescription drugs may be deducted as unmet medical needs when they are not covered by Medicaid because they exceed the monthly Medicaid prescription limit, or the Medicare Part D Plan does not cover the drugs or the pharmacist does not take Medicaid. The charges must meet the criteria in VIII.A., above.

1. Verify if a/b has any private health insurance coverage for prescription drugs including a Part D provider.

2. Deduct the amount of reported charges for prescription drugs above the monthly Medicaid prescription limit which are either not covered by third party insurance or deduct the unpaid balance that remains after insurance has paid.

3. Because they exceed the monthly Medicaid prescription limit for the same drugs, for ease of administration you may refer the physician to the Basic Medicaid Billing Guide website at, www.dhhs.state.us/dma/medbillcaguide.htm. This guide outlines the requirements for overriding the monthly Medicaid prescription limit when the life of the patient would be threatened without the additional drug(s) and includes a copy of the override request form. Or refer to the Focused Risk Management Program (FORM). Refer to MA-2905, Medicaid Covered Services for more information on FORM.

   Beneficiaries under the age of 21 or residents of intermediate care facilities/mental retardation centers, skilled level of care facilities and beneficiaries residing in assisted living facilities and group homes are exempt from the monthly Medicaid prescription limit.

4. For Medicare beneficiaries, refer to MA-2312, Medicare Prescription Drug Benefits.

C. Physician Charges

Charges for physicians' services may be deducted as UMNs if the physician refuses to accept Medicaid and the criteria in VIII. A., above is met.

1. Determine if the reported charges are covered by the a/b's Part B Medicare coverage. (Refer to MA-2360, Medicaid Deductible, V.C.)

a. If the a/b is a Medicare beneficiary and provides a bill for physician's services on a date already authorized for Medicaid, advise the representative to provide the Medicaid information to the provider.

b. The balance of the total charge after Medicare payment (if EOB used) or 20% of the charge may be used as unmet medical needs if the individual was not yet authorized for Medicaid on the date of service and the provider refuses Medicaid now.

2. The county may give the provider the MID number and the Medicaid eligible dates for which the provider has charges.

a. Physicians and suppliers are required to file Medicare claims for all patients who are Medicare beneficiaries.

b. Physicians and suppliers are required to accept assignment if he is enrolled with Medicare in the Participating Physician and Supplier Program.

c. Do not deduct physician charges for a Medicaid beneficiary who has Medicare Part B coverage.

3. If the a/b has Medicare and private health insurance which covers physician costs (medical), do not make any deduction unless there is a balance left after insurance has paid. Use EOB as verification.

4. If the a/b has private health insurance but not Medicare, only deduct the portion of the charge not covered by insurance. Verify with EOB or from provider.

D. Cost Of A Private Duty RN/LPN

Charges for private duty RN/LPN services may be deducted as UMN if the physician prescribed this care for a specific duration, the nurse refuses to accept Medicaid, and the criteria in VIII. A., above is met.

E. Cost of The Nursing Facility When Medicaid Is Authorized After the First Day of the Month

It may happen that the a/b is not eligible for Medicaid to pay cost of long term care on first day of month, but later in the month becomes eligible. This could happen when the a/b is ineligible for cost of care for a few days because of reserve or the facility is not yet certified. Specific rules to use nursing facility costs as UMN are listed below.

(VIII. E.)

1. Deduct per diem cost of care as an unmet medical need if a/b resides in a newly licensed/certified facility and cost of care is paid from income for the days in the month of certification, but prior to the certification **date** and all of the following are true:

    a. The rules in VIII.A., above, are met (note that VIII.A.2.b.states if Medicaid does not pay for LTC due to a transfer of assets sanction, those LTC expenses may not be an unmet medical need), and

    b. The a/b has an approved FL-2/MR-2 for the level of care.

2. The a/b may be ineligible for a portion of a month due to excess reserve.

    a. Do not allow cost of care as an unmet medical need when the a/b uses his excess reserve to pay cost of care.

        (1) Payment of cost of care "in advance" does not reduce reserve any earlier than the date the cost(s) is incurred. Actual charges are deducted from the reserve total on a daily basis as incurred.

        (2) On the day that reserve is reduced, assign the full PML for the remainder of that month.

    b. You can allow cost of care as a one-time UMN if excess reserve is reduced by purchasing other goods or services and cost of care is paid from **income** for the month in which reserve is reduced.

F. Charges for Medical Care During an Ineligible Period

Charges for medical services incurred during a period of ineligibility may be deducted from income as unmet medical needs if they meet the criteria below.

1. The charges are for a month when the a/b was ineligible for Medicaid.

2. There is a written agreement between the a/b and the facility specifying the amount to be paid and the schedule for paying.

3. The agreed upon payment to the facility can be allowed as UMN.

    Note that expenses Medicaid does not cover due to a transfer of assets sanction cannot be used as an unmet medical need. See VIII.A.2.B. above.

G. Report Unmet Medical Needs

1. Unmet medical needs must be reported to the IMC by the a/b, the representative, LTC facility, or other medical provider as follows:

(VIII.G. 1.)

a. For applications:

(1) Include only those costs which are reported and verified by the time the application is approved.

(2) Do not pend an application past the 45/90th day for verification of reported costs.

(3) Do not hold the application until the 45/90th day for unmet medical needs if no costs have been reported.

b. For authorized cases:

Costs must be reported by the end of the six month certification period which follows the certification period in which the service was rendered/cost was incurred.

NOTE: If the a/b's representative reports a decrease or terminated unmet medical need (i.e. medical insurance stopped), verify from the source. Revise PML after timely notice is issued.

2. Verify all non-covered medical costs:

a. At application, use DMA-5097, Request for Information.

b. At the regular six-month review use suggested form (DMA-5163).

c. Send the request to:

(1) The a/b if acting on his own behalf;

(2) The representative acting for the a/b; or

(3) The business office of the LTC facility if the a/b cannot be reasonably expected to provide the information and has no representative.

3. Charges reported to the county dss after processing the application, completion of a redetermination, or during an authorized c.p. are treated as a change in situation. The county should respond and complete the change within 30 days.

H. Budgeting Procedures for UMN

Calculate the total allowable cost of UMNs.

1. Convert the following types of UMNs to a monthly amount and deduct from the a/b’s income.

a. Private health insurance premiums; and

b. Scheduled payments for medical bills.

2. Deduct the amount of UMNs that occur incidentally from the a/b's income by reducing a future month(s)' PML.

   a. After UMNs are reported and verified, deduct entire amount owed.

   b. Revise PML effective the next month after notice requirements in MA-2420, Notice and Hearings Process, are met.

3. Never decrease a PML for a month that has already been billed unless it is the month of discharge or death. Refer to IX.C.

4. If a change is reported during a CP:

   a. Revise PML effective the next month after notice requirements are met.

   b. Notify the beneficiary of the following:

      (1) Amount and effective date of the PML(s) which are reduced because of incidental UMN charges; and

      (2) Amount and effective date of the ongoing PML for the month(s) after the deduction for non-monthly UMN charges is satisfied.

   c. When the PML is changed, NC FAST sends the automated DMA-5016 giving the beginning month of the new PML.

5. If the a/b or his representative reports a change in unmet medical needs (including charges that are prorated and deducted monthly) and they result in:

   a. An overstated PML (a/b paid too much in a prior month): Make the necessary adjustment by deducting additional UMN charges from the next month's liability after the notice requirements are met.

   b. An understated PML (a/b paid too little and received UMN allowance to which he was not entitled in a prior month):

      (1) If adjustment can be made by increasing future PML(s), make the change and notify the a/b or his representative using a timely notice.

      (2) If adjustment cannot be made by increasing the PML(s), ask the a/b or his representative to make a voluntary repayment to DMA and refer to county fraud/program integrity staff.

(VIII. H.5.)

6. If the LTC beneficiary is discharged to PLA (including a move to an adult care home):

   a. Inform the a/b, his representative, or the facility that any previously unreported UMN charges must be reported within ten days of the change in living arrangement.

   b. Deduct verified UMN charges from his PML for the month of discharge. The UMN deduction cannot be greater than the PML. Charges which exceed the amount of his PML and were reported within ten days may be used towards the PLA deductible. Refer to MA-2360, Medicaid Deductible.

   c. If the beneficiary moved to an adult care home and he will be authorized for Medicaid under the Special Assistance program, deduct charges up to the amount of his PML in the month of discharge.

7. If the beneficiary dies:

   a. Verify any reported patient responsible medical charges which have not been allowed previously.

   b. Deduct allowable charges up to the amount of the PML for month of death only.

IX. REPORTING PATIENT MONTHLY LIABILITY ON DMA-5016

A. Purpose of DMA-5016

1. The DMA-5016 notifies the nursing facility of the patient's monthly liability for his share of the cost of care. There are two ways to transmit the DMA-5016 to the facility. One is an automated DMA-5016 issued by NC FAST. The other way is a manual DMA-5016 issued by the county caseworker.

2. For Hospice patients in a nursing facility, enter the Hospice code in NC FAST to ensure the automated DMA-5016 is sent to the Hospice agency.

B. Issuing a DMA-5016

1. NC FAST issues an automated DMA-5016 when the caseworker:

   a. The a/b goes from pla (including adult care home or hospital) to a nursing facility, or

   b. Increases or decreases the amount of the PML, or

   c. Changes the case address, or

(IX. B. 1.)

d. Enters a new facility code, or

e. Changes the facility code.

2. The caseworker completes a manual DMA-5016 when:

a. The a/b is in 2 or more facilities in a month and each facility is due a portion of the pml. (See IX.D., below for procedures to split the PML.) Different levels of care within a hospital such as acute care and swing bed are considered two separate facilities for claims processing purposes. The caseworker must send a manual DMA-5016 to each facility to notify it of its share of the PML, **OR**

b. There is a deductible balance and a PML in the same month. This situation occurs when the a/b moves directly from acute care in a hospital to a swing bed within the same facility or to a separate nursing facility. The IMC must send a manual DMA-5016 to the facility to notify it of the PML. This applies even when the PML is "$0."

3. There are specific situations in which a DMA-5016 is never sent. These occur when a case is budgeted according to PLA procedures and is authorized only for other Medicaid covered services. These situations are:

a. There is no approved FL-2 when the FL-2 is required; or

b. The a/b is under a transfer of asset sanction; or

c. The facility is not certified yet.

C. Procedures When PML Changes

1. Beneficiary notice requirements

a. If PML amount increases, timely notice is required.

b. If PML decreases, adequate notice is required.

(IX. C.)

2. Special Situations

a. If one of the following exceptions applies, notify DMA, using DMA-5164

(1) The beneficiary died and has unmet medical needs which have not previously been deducted. Revise the PML for the month of death only. [This is the only reason you can revise for unmet medical needs in month of death.]

(2) The a/b goes home unexpectedly within six months and must be rebudgeted for prior months as well as month of discharge.

(3) The a/b returns home anytime, and must be rebudgeted the month of discharge only to allow a deduction for maintenance of the home.

NC FAST sends an automated DMA-5016 when the Claims Analysis Section at DMA enters the change.

b. If the county dss wants to change a PML amount already posted in EIS for a previous month, the Claims Analysis Unit at DMA **must** give prior approval. (See V.C.10., above.) NC FAST sends an automated DMA-5016 when Claims Analysis keys the revision.

D. Patient Liability When A/B is in More Than One Facility in a Month - Split Liabilities

If the a/b receives care in more than one medical facility in a calendar month, it may be necessary to determine how much of the liability the patient owes to each facility. **Remember that different levels of care within a hospital such as acute care and swing bed are considered separate facilities for claims processing purposes**. The caseworker enters the total PML for the month and then completes a manual DMA-5016 to split the pml between the facilities.

(IX. D.)

1. A/B Does Not Have Medicare

On the **first** day of month, the beneficiary is in the:

a. **Hospital**-- Assign the full PML to the hospital.

b. Nursing Facility

Report the **lesser** of these amounts to the facility:

(1) The full PML owed each month; or

(2) The facility's Medicaid per diem multiplied by the number of days (do not count date of discharge) that the patient was in the facility.

c. The amount of the "split" PML which is reported to the second facility following a **non-Medicare** hospital or facility admission is:

(1) The remaining balance of the full PML after deducting the portion assigned to the first facility, or

(2) If there is no balance, zero PML.

2. A/B Has Medicare

The PML for Medicare beneficiaries is applied only to the month of admission to a hospital because the beneficiary is only responsible for the Medicare deductible amount. When LTC a/b has to enter a different medical facility, follow procedures below on assigning PML.

a. Hospital

(1) Admission date is on the first day of the month

(2) Assign full PML not to exceed the Medicare deductible amount.

b. Second facility

The amount of the "split" PML which is reported to the second facility following a Medicare hospital admission is:

(1) The remaining balance of the full PML for admission month minus the Medicare deductible amount.

(IX. D. 2.b.)

(2) If hospital discharge month is different from admission month, assign the full PML to the second facility for discharge month.

c. If a Medicare a/b remains in the hospital for several months, the hospital will not collect the PML. However, the actual PML must be entered into EIS.

3. If the LTC a/b is within the 21-100 days for Medicare and is moved to a second nursing facility within the same month assign number of days in the first **facility** times the Medicare co-payment rate to the first facility. Do not include the discharge date. This is the actual amount for which the beneficiary is responsible. Report the remaining balance of the PML to the second facility. Reminder: Medicare may not pay the first 100 days in every situation. Contact the facility to verify this information.

4. If a third or more facility is involved, repeat the process in IX.D.1.c. or 2.b., above, according to whether the a/b has Medicare until the PML is exhausted.

5. Do not round or drop cents.

6. Any remaining PML not collected will accumulate in the beneficiaries personal funds as reserve the following month.

NOTE: Flag case to check reserve monthly when the client is in danger of exceeding the reserve allowance.

(IX. D.)

7. **Complete a manual DMA-5016** for the split PML to each facility. Include the ending date of split PML on the DMA-5016.

8. NC FAST sends a separate DMA-5016 reporting the PML amount and effective date for the ongoing (next) month.

X. HOSPITAL LEVEL OF CARE CHANGE AND DECERTIFIED FACILITY PROCEDURES

A. Hospital Inappropriate Level Of Care Bed Or Swing Bed

(Refer to Table A for reimbursement rates.)

There are two types of hospital beds for LTC care. These are: (1) inappropriate level of care bed; and (2) swing bed. Sometimes when patient is ready to be discharged to ltc, there is no available ltc bed. A hospital may continue to provide care for patients who are approved for LTC, pending discharge to a facility. This care is provided in an inappropriate level of care bed or swing bed.

1. All hospitals have inappropriate level of care beds. When level of care changes from acute to skilled nursing:

   a. A hospital has three (3) administrative days (starting with the day after the day the level of care changes), in which to move the patient to a Medicaid nursing facility. During these three days, the hospital may continue to bill at the acute level.

   b. On the 4th day after the level of care changes, the hospital must bill at the inappropriate level of care if it has not been able to move the patient to a nursing facility.

2. Swing beds are hospital beds that have been certified as nursing home level beds. Not all hospitals have swing beds. A swing bed must be certified as such by Medicare.

   a. The hospital must begin billing at the swing bed level of care rate the day after the level of care changes.

   b. If the hospital has no swing beds or if all swing beds are occupied, they must bill at the inappropriate level of care rate after the three day administrative period. (see X.A.2., above)

(X. A.)

3. Impact on Month of Institutionalization

   If the patient moves from a general hospital stay of less than 30 days directly to an inappropriate level of care bed or a swing bed, the patient became institutionalized on the first day of the hospital admission. (See II.A.l.b., above)

4. Prior Approval for Inappropriate Level Bed and Swing Bed

   The hospital is responsible for completing the FL-2 and sending it to the claims processing contractor for prior approval.

B. Decertified LTC Facility

When a LTC facility fails to meet standards of patient care, the Centers for Medicare and Medicaid Services/Division of Health Service Regulation (DHSR) terminates the Medicaid certification. DHSR may also revoke the facility's license.

1. DMA sends a letter to:

   a. The beneficiaries representative; and

   b. The a/b's county dss of residence (county handling the Medicaid case).

2. The letter advises the following:

   a. Medicaid will not pay for cost of care in that facility and the effective date.

   b. The representative can request assistance from the county dss in locating another facility that accepts Medicaid.

   c. That the patient may choose to remain in the facility beyond the Medicaid payment cut-off date; however, he is responsible for his cost of care.

3. If the beneficiary/representative chooses to remain in the facility past the Medicaid payment cut-off date, returns home, or enters an Adult Care Home, begin PLA budgeting the first day of the following month after timely notice is issued. (See XIII. below, for procedures.)

   NOTE: Timely notice requirements apply. Notice should be sent in time to affect the deductible the month following the last month of Medicaid payment.

4. After relocating to a new facility, update the facility code in NC FAST to ensure the DMA-5016's are sent to the new facility's address.

XI. CHANGE IN SITUATION

This section explains how to handle ongoing Medicaid case maintenance when a change in situation is reported. The change could be a beneficiary move from PLA to LTC or LTC to PLA. If more than one change occurs in the same calendar month, evaluate the changes in the order they occur.

A. Ongoing Beneficiary Becomes Institutionalized (Change From PLA To LTC)

When a PLA beneficiary begins a CPI follow the procedures below to determine eligibility for cost of care.

1. Do a special review with the a/b or representative using the last DMA-5007/5008 and document any changes. Review the record for any transfer of assets. (Refer to MA-2240, Transfer of Assets.) Complete the community spouse resource protection assessment if the a/b has a community spouse. (Refer to MA-2231, Community Spouse Resource Protection.)

2. Use PLA budgeting for the month the CPI begins for both a single or married a/b. **However, if the a/b enters a nursing facility, ICF-MR, swing bed/inappropriate level of care bed, or psychiatric hospital during this first month, a pml is assigned to the medical facility for claims purposes as follows**:

   a. A/B is authorized the entire month for Medicaid prior to entering the hospital or medical facility.

      Assign a $0 pml. NC FAST generates the DMA-5016 for this month only.

   b. A/B meets Medicaid deductible before entering a nursing facility in the same month.

      Assign a $0 pml to the facility and send a manual 5016.

   c. A/B is not authorized (has to meet a deductible) for Medicaid prior to entering the medical facility. The medical facility charges help to meet the deductible.

      (1) When the individual enters a hospital and has no Medicare coverage that meets his deductible. Refer to MA-2360, Medicaid Deductible.

         (a) Report his deductible balance to the hospital as instructed in MA-2360, Medicaid Deductible.

         (b) If he goes into long-term care in that month report a $0 PML as instructed in XI.A.2.b.

(XI.A. 2. c.)

(2) When the individual enters a nursing facility or psychiatric residential facility, the facility's daily private rate is applied to the deductible. When the deductible is met, assign the amount of facility charges incurred on the date the deductible is met to the facility. A DMA-5016 will be automatically generated and the county does not have to send a manual DMA-5016.

3. Begin LTC budgeting the month after the month the CPI begins following instructions in V., above.

4. Notify the beneficiary of the patient monthly liability (PML) amount.

a. Timely notice is required to budget LTC and assign PML to an authorized PLA beneficiary who remains in a general hospital and continues to receive acute care for more than thirty continuous days (a continuous period of institutionalization).

b. Only adequate notice is required to budget LTC and assign PML to any beneficiary when the beneficiary begins to receive nursing home level of care:

(1) In a nursing home facility;

OR

(2) In a swing/inappropriate level bed in a hospital. Unlike acute hospital care, a nursing level of care is a new benefit which was not approved previously.

5. Special Changes in Situation Involving Hospitalization

When a pla beneficiary is hospitalized for 30 days or more

a. Do not budget as LTC when:

(1) The a/b has already been discharged back to PLA when you learn he was hospitalized, or

(XI.A. 5.a.)

(2) He will be discharged back to pla before a pml can be effective following timely notice requirements.

b. Do re-budget the beneficiary as LTC when:

(1) He is still hospitalized; or

(2) There are placement plans or his length of hospital stay is indefinite; or

(3) He begins to receive care in a nursing home or a swing/inappropriate level bed in the hospital.(XI.A)

B. Non-SSI Special Assistance Beneficiary Moves To Nursing Home Level Of Care (Refer to MA-1100, SSI Medicaid – County DSS Responsibility, for SSI Beneficiary Moves to LTC).

1. Do a special review using the last SA workbook and document reserve items and income on Supplement D to the DMA-5007/5008.

2. Do not re-verify information unless:

a. Total countable resources exceed the MA reserve limit; or

b. A change has occurred to income or resources; or

c. The new Medicaid c.p. extends beyond the SA payment review period; or

d. A transfer of resources has occurred (refer to MA-2240, Transfer of Assets).

(XI.B.)

3. Budgeting principles:

   a. Patient liability is always $0 for the month of entry into nursing care even if the move takes place on the first day of the month. NC FAST generates a DMA-5016.

   b. Budgeting by LTC rules and assignment of PML begins the month after entry into an approved level of care. (Refer to V., above).

4. Use the DSS-8110A (automated) to notify the beneficiary and the representative of the patient liability amount.

5. Complete the program transfer. .

   a. Failure to change category from SA to MA prior to first LTC month does not prevent payment of cost of care.

   b. The full PML for the next month.

6. NC FAST sends an automated DMA-5016.

C. VA Contract For Payment Of Cost Of Nursing Care Ends

LTC budgeting begins the same month the contract ends. (Refer to XIII.A. 4. below)

D. Moves from LTC Facility To Different LTC Facility or Hospital

1. When LTC beneficiary moves from LTC facility to hospital:

   a. Continue with LTC budgeting procedures. Refer to IX.D., above, for instructions on ”split” liabilities.

   b. The LTC facility is not required to hold a bed for the a/b while he is in the hospital. The LTC facility is required to readmit the a/b if it has an available bed when he's ready to be discharged from the hospital. If a bed is not available the a/b will be either discharged to a new LTC facility or to PLA. Medicaid does not pay to hold a LTC bed while the a/b is in the hospital because that would be duplication of services.

(XI. D. 1. b)

(1) The a/b's family can pay the cost of holding a bed directly to the facility. This would not be considered income to the a/b.

(2) The cost of holding a bed is not considered an unmet medical cost to the a/b.

2. When LTC beneficiary is discharged **From LTC Facility To New LTC Facility:**

Continue LTC budgeting procedures. Refer to IX.D. above for procedures to split liabilities.

E. From LTC To A Private Living Arrangement

When a/b returns to PLA, review financial eligibility based on PLA rules. The transition to PLA budgeting is different depending upon how long an a/b has been in LTC.

1. Do not recompute the PML for the month of discharge if:

   a. The a/b has a spouse or dependents at home; or

   b. He was budgeted to return home in six months and is now returning.

2. For a/b, with no spouse or dependents, who was not budgeted to return to PLA within six months and returns to PLA within six months refer to V.D.3., above.

3. For a/b with no spouse or dependents who return home after six months, recompute the PML for the month of discharge.

   From the patient monthly liability:

   a. Deduct any reported UMN; and

   b. Deduct PLA full medically needy income limit for one.

      (1) If there is no excess income, report $0 PML for month of discharge.

      (2) If there is excess income, round up or down to the nearest whole dollar and report the PML as the lesser of the following:

         (a) Medicaid per diem times the number of days the a/b was in the facility (do not count the day of discharge).

         (b) The amount of excess income.

(XI.E)

4. For the remainder of the c.p. determine eligibility using PLA procedures in MA-2260, Financial Eligibility Regulations – PLA, for all M-AABD Coverage Groups.

   a. If the a/b had a spouse or dependents at home, determine the new b.u., and include their income and needs in the determination of eligibility.

   b. If the predicted medical expenses of the b.u. are expected to meet the deductible, continue the case in deductible status and authorize when the deductible is met.

   c. If the predicted expenses will not meet the PLA deductible, terminate the case.

5. Notify the a/b with the proper notice determined by the type of action taken. Refer to MA-2420, Notice and Hearings Process.

F. Beneficiary In Nursing Home Level Moves To An Adult Care Home

1. The PML for the month of discharge is the nursing facility's Medicaid daily rate times the number of days at that level (exclude the day of discharge) up to the full PML.

2. Evaluate the a/b for Special Assistance. Refer to the Special Assistance Manual for policy requirements.

3. If the a/b is ineligible for Special Assistance, consider eligibility for other Medicaid covered services:

   a. Budget like any other individual in a private living arrangement beginning the month following entry into adult care home.

   b. Cost of room and board in an adult care home is not a medical expense; do not count towards the Medicaid deductible.

   c. Cost of personal care services received in an adult care home is a medical expense. Verify with the provider the amount and count towards the Medicaid deductible.

XII. PROCEDURES FOR OTHER MEDICAID COVERED SERVICES ONLY (STEP III)

When an a/b's PML (see V.C.7.b., above) exceeds the Medicaid reimbursement rate for the nursing facility he is ineligible for Medicaid to pay any of his cost of care. However, he may be eligible for Medicaid to pay other medical services. The section instructs you how to make this determination.

A. Use Step III procedures when:

1. Need (financial eligibility) was established in Step I; **BUT**

2. After all Step II deductions, the a/b's income is equal to or greater than the facility's Medicaid rate for 31 days for the level of services being provided.

B. Subtract the following from the a/b's gross monthly income to determine net countable income in Step III:

1. The monthly $20 general income exclusion;

2. Earned income exclusions (Refer to MA-2250, Income);

3. From net earned income, $65 earned income exclusion plus 1/2 of the remainder;

4. The facility's Medicaid rate for 31 days (FL-2 is required to establish level of care); and

5. The PLA medically needy full maintenance for 1 (or 2 for spouses in the same LTC room). Do not deduct for the spouse or dependents at home.

C. Multiply the remaining income by the number of months in the prospective or retroactive certification period to determine the deductible amount.

1. The result, rounded to the nearest whole dollar (50 cents-up; 49 cents-down), is the amount of the deductible which must be met.

   a. **Do not apply the cost of care toward the deductible** because it has already been deducted from net countable income in XII.B.4., above. Refer to MA-2360, Medicaid Deductible, for allowable charges to count toward the deductible.

   b. Eligibility for all other Medicaid covered services begins no earlier than the day the deductible is met.

2. There is no financial responsibility for spouses not living together. Therefore, do not apply the medical expenses of the spouse at home to the a/b's deductible.

(XII.)

D. When all eligibility criteria are verified, including documentation that the a/b can reasonably be expected to meet the deductible:

1. At application:

   a. Send the DMA-5099, Your Application for Medicaid is Pending for a Deductible, notifying the applicant and/or representative of the deductible amount.

   b. Send a manual DMA-5016 to the facility notifying it of the applicant's patient monthly liability (PML). The PML is the facility's reimbursement rate for a 31 day month.

   c. When the deductible is met, approve the application and authorize the case. The automated DMA-5016 will be issued by NC FAST.

2. At the end of the first (and any subsequent) certification period:

   a. If the deductible was met,

      (1) Notify the applicant and/or representative of the new deductible amount and recertify for an additional 6 months.

      (2) Send a manual DMA-5016 to the facility notifying it of the PML. See XII.D.l.b., above.

   b. If the deductible has not been met, propose termination.

   c. When the deductible is met, authorize the case. NC FAST will issue the DMA-5016.

E. Whenever a Step III deductible is met, whether at approval of the application or when a certified case is authorized and the PML is keyed, NC FAST **notifies the facility of the a/b's PML using the DMA-5016.**

The living arrangement code is based on level of care for anyone authorized or certified by Step III procedures for other covered services only.

XIII. PLA PROCEDURES WHEN THE A/B IS INELIGIBLE FOR COST OF CARE FOR REASONS NOT RELATED TO INCOME

An a/b in a LTC living arrangement may be in financial need but not be eligible for Medicaid to pay cost of care because of reasons not related to income. Medicaid may be able to help with other medical costs under PLA budgeting. This procedure is different from STEP III budgeting, above, because STEP III is related only to the a/b's income. This section instructs you on when to do this and how.

A. The following reasons result in PLA budgeting:

1. The case is under a transfer of resources sanction. Apply the cost of medically necessary care for which the a/b is responsible to the deductible DAILY, as incurred. (FL-2 is required)

2. The completed FL-2/MR-2 has not been received in the agency for the appropriate level of care with at least telephone approval. Do not apply the cost of care to the deductible.

   NOTE: The FL-2/MR-2 must be received by EDS within 10 workdays of telephone prior approval.

3. Individual in a facility which is not yet licensed or certified.

   a. Budget PLA for months prior to the month of certification and for the month in which certification begins.

   b. Apply the facility's Medicaid per diem costs for the appropriate level of care (FL-2 required) to the PLA deductible. Verify the actual amount with the facility's business office.

      (1) Use the amount the a/b is responsible for towards the PLA deductible to the extent that it is not covered by insurance or paid by any third party, including family.

      (2) If the deductible is met prior to facility's certification:

         (a) Authorize for other covered services only.

         (b) Do not enter a PML amount.

         (c) Code the living arrangement PLA.

      (3) If the deductible is not met prior to facility's certification the a/b is ineligible for Medicaid to pay other covered services.

(XIII. A.3.)

c. Begin LTC budgeting, using instructions below, when the facility becomes certified/licensed.

(1) Shorten the deductible period. The last PLA budgeting month is the month in which certification begins on any day.

Eligibility for help with cost of care begins with the day of nursing home certification. Issue a DMA-5016 using the deductible balance, (may be $0), as the PML amount for the month of certification, beginning with the date of certification through the last day of the month. If the deductible was met in a prior month or there is not a deductible, NC FAST sends the DMA-5016.

(2) The first month of LTC budgeting and full patient liability is the month after the facility is certified.

(3) Deduct the facility's Medicaid per diem costs for the appropriate level of care (FL-2 required) as a one-time unmet medical need from the first LTC month's PML if:

(a) Date of service was during the month, and prior to the day, certification of the nursing home begins,

(b) The PLA deductible is met prior to the date of nursing home certification, and

(c) The charges were paid from the a/b's income. Refer to VIII.E.3., above, for procedures and an example.

4. The individual is under a VA contract for VA payment of cost of care. There is no cost of care charged to the veteran.

a. LTC budgeting begins the **same month** that the contract ends.

b. The patient's liability (PML) to the facility for a first or transition month is the lesser of these amounts:

(1) A full month's liability as computed in Step II, or

(2) The number of days after the contract ends, multiplied by the facility's Medicaid daily rate (per diem).

(XIII.)

B. If PLA budgeting results in:

1. No Deductible

a. Authorize the individual for help with other Medicaid covered services.

b. Notify the applicant using the DSS-8108 (approving the application) or beneficiary (continuing eligibility), the representative, and the facility:

(1) That the cost of care in the facility will not be paid by Medicaid;

(2) The reason or specific condition of eligibility which has not been met.

(3) That the applicant/beneficiary is eligible for coverage of other Medicaid covered services only.

2. A Deductible

a. For the applicant:

(1) Send the DMA-5099, Your Application for Medicaid is Pending for a Deductible, when all other eligibility requirements are met.

(2) If the deductible cannot be met, deny the application, following procedures in MA-2304, Processing the Application, for deductible cases.

b. For the beneficiary:

(1) Certify the case in deductible status and notify the beneficiary, the representative, and the facility of the deductible amount and the need for medical bills.

(2) Terminate at the end of the certification period if the deductible is not met.

XIV. MEDICARE COVERAGE

From time to time the IMC may need to know information about Medicare benefits. The material below explains some of the Medicare benefits.

(XIV.)

A. Approved Medicare SNF Care In A Nursing Facility

1. Medicare Part A may cover nursing home costs for a limited period of time if the care meets Medicare SNF requirements. Contact the facility to confirm Part A coverage.

   a. There is no co-payment for the first 20 days of Medicare approved SNF care.

   b. There are daily co-payments for the 21st through the 100th day of Medicare approved Medicare SNF. (See Table B for amounts.)

2. Medicaid will pay the Medicaid per diem rate less any Medicare payment but no more than the Medicare coinsurance amount.

B. Medicare Hospitalization Benefits

1. Hospitalization benefit period

   a. Begins when the individual enters for the first time:

      (1) A general hospital

      (2) A nursing home where he is Medicare approved for SNF care

   b. A new benefit period begins 60 continuous days after discharge from his last hospital or Medicare approved SNF.

   c. An individual who goes from care in a nursing facility which is not Medicare approved SNF to a hospital may establish a new benefit period.

2. Diagnosis Related Groups (DRG) Reimbursement.

   a. A set fee, based on the hospital's classification under Medicare and the patient's diagnosis, is incurred on the date of admission.

      (1) The entire Medicare Part A deductible is due on the date of admission provided a new hospital benefit period has begun.

      (2) When splitting the patient's PML between the hospital and the nursing facility, use only the Part A deductible for the portion assigned to the hospital instead of the actual hospital charges or per diem. Request the amount the a/b owes to the hospital. The PML is not changing, only to whom it is assigned.

(XIV.B.2.a.(2))

b. If the patient is not admitted under DRG, he is responsible for actual daily hospital charges until the Medicare Part A deductible is met.

(1) Use the actual daily charges at the Medicaid per diem, until the Medicare Part A deductible is met when splitting the PML.

(2) If the amount of PML not already owed to the NF for the month is less than the Part A deductible, assign that amount as PML to the hospital.

3. From Medicare approved SNF to the hospital, the a/b may remain in the same benefit period with no responsibility for the Part A deductible, but with the possibility of co-insurance responsibility.

4. Be sure to involve the hospital business office and/or NF since their knowledge of Medicare coverage assists in determining the a/b's responsibility to the hospital.

XV. PRIOR APPROVALS (FL-2 AND MR-2)

Certain types of care require prior approval by DMA. The FL-2/MR-2 are the Long-Term Care Services and Mental Health Services prior approval forms which give a summary of the patient's medical requirements. This section instructs you on the prior approval process.

A. Levels Which Require Prior Approval

1. Nursing facility level of care, including inappropriate level and swing beds in a general hospital. Care at this level also requires the Pre-Admission Screen and Annual Resident Review (PASARR) to be completed prior to EDS/Murdoch Center approval (See Table iii). The PASARR process assures that persons with serious mental illness, mental retardation, and/or conditions related to mental retardation receive appropriate placement and services.

2. ICF-MR level of care is intermediate care in a facility for the mentally retarded (ICF-MR).

3. Prior approval for treatment of head injury (HI level) care requires additional medical information not requested on the FL-2 form. The caseworker may be asked to request additional medical information.

(XV.)

B. Determination Of Level Of Care

The Long Term Care Provider Manual (published by EDS) contains the medical criteria for levels of care.

1. The Long Term Care level (FL-2) is approved/disapproved by the Prior Approval Unit at EDS. The Mental Health Services level (MR-2) is approved or disapproved by the clinical staff at the Murdoch Center.

2. The county DSS must review the patient's Medicaid eligibility if the change is to a private living arrangement, including home or adult care home level of care.

Refer to the appropriate letter (figures) at the end of this section.

C. Prior Approval Process

1. The patient must have at least applied for Medicaid.

2. The FL-2/MR-2 may be initiated for completion by any one of the following people: the social worker at the county dss, the hospital discharge planner, the nursing facility, or the patient's attending physician. The Local Management Entity (LME) may also initiate the MR-2.

3. The FL-2/MR-2 should be completed by the patient's attending physician or licensed psychologist according to instructions on the back of the form. The MR-2 must also be signed by the LME representative. The PASARR must also be completed as required (See Table iii).

4. The patient’s attending physician or his designee should send all three copies of the completed FL-2 to EDS, Prior Approval Unit, P.O. Box 31188, Raleigh, NC 27622. The MR-2 should be sent to the Murdoch Center, Specialized Services, P.O. Box 3000, Butner, NC 27509. Include information below to assist in routing of the form or to resolve questions of the reviewer.

    a. Name and mailing address of patient.
    b. Name and address of patient’s representative if other than patient.
    c. Name and telephone number of person completing the form.
    d. Name and telephone number of contact person in county DSS, if available.
    e. Patient's county of residence.
    f. Patient's Medicaid ID number in block 5. The facility must contact DSS if the Medicaid ID number is not known.
    g. Name and address of the patient's attending physician.

(XV.C.)

5. Incomplete FL-2 forms submitted to EDS will be returned to the county DSS and must be forwarded on to the attending physician with a request to complete and return as quickly as possible. The Murdoch Center faxes requests for incomplete information on the MR-2 form to the LME. The LME will then contact the appropriate person.

6. A new FL-2/MR-2 is required after 90 days, if Medicaid eligibility is lost or application is denied.

7. The approval process is complete when the stamped approved FL-2/MR-2 is returned from the fiscal contractor or the local management entity (LME) to the county.

   a. The approval date in block 13 of the FL-2/MR-2 will always be the date prior approval was given on the telephone or the date it was approved at EDS/Murdoch Center if the information was not telephoned to EDS/Murdoch Center. The effective date will be the same as the approval date unless a retroactive effective date is requested.

   b. If the admission date shows N/A, the effective date will be the same as the approval date.

   c. If the effective date is different from the approval date, it will be written in block 11 or 14 on the FL-2. It is usually written in by the person asking for prior approval and "highlighted".

8. If the facility or county realizes after receipt of the stamped approved FL-2/MR-2 from EDS/Murdoch Center that the approval date needs to be backed up to the date of admission, the facility must call EDS/Murdoch Center and give them the needed date. The IMC should be alert to this possibility.

9. If the recommended level of care cannot be approved:

   a. The prior approval analyst will request additional information.

   b. If no response is received within 48 hours, a letter will be sent to the facility and the county DSS indicating approval at the lower level of care.

D. Types of Prior Approval

1. Telephone/Fax

   a. Temporary FL-2/MR-2 prior approval may be obtained for patients who have been placed or are ready for placement. FL-2 prior approval may be obtained by calling EDS PA Unit Monday through Friday at 800-688-6696 or 1-919-851-8888. MR-2 prior approval may be obtained by faxing the request to the Murdoch Center at 1-919-575-1083 or by calling the Murdoch Center at 1-919-575-1070.

(XV. D. 1.)

b. Only individuals knowledgeable of medical terminology may call for telephone approval. These individuals may include:

(1) Physicians,
(2) Registered nurses,
(3) Licensed practical nurses,
(4) Nursing home administrators who are RNs,
(5) Social Workers, or
(6) Case Managers.

c. The attending physician or his designee will send the completed FL-2 to the EDS PA Unit. The MR-2 is sent to the Murdoch Center. The form must be received by EDS/Murdoch Center within 10 workdays after telephone or fax approval. Telephone/fax prior approval becomes invalid after 10 workdays.

2. Retroactive Prior Approval

a. Retroactive prior approval may be granted by telephone without additional medical information for up to 30 days immediately preceding the date the FL-2/MR-2 was telephone approved or reviewed.

b. The retroactive prior approval received by phone must be documented on the FL-2/MR-2, and a copy of the FL-2/MR-2 showing the retroactive prior approval should be provided to the IMC. The IMC should revise the budgeting of the case, if needed.

c. Medical records must be submitted for review if the days needing approval exceed the 30 day limitation.

d. Retroactive prior approval will not be approved for time periods exceeding 90 days from the date Medicaid eligibility was established.

3. After the initial FL-2/MR-2 is approved, any further prior approval requests are the responsibility of the facility.

E. Prior Approval Responsibilities

1. Responsibilities of The County DSS

a. The day after receiving FL-2/MR-2, distribute to the appropriate IMC the stamped FL-2 (including additional information) received from EDS and forward a copy to the facility. Distribute to the appropriate IMC the stamped MR-2 received from the LME. A copy does not need to be forwarded to the facility. Retain a copy in the case record.

b. Request/submit a new FL-2 if eligibility is lost for more than 90 days.

(XV. E.)

2. Responsibilities of the Prior Approval Unit

a. Give telephone prior approval.

b. Decide if the patient meets criteria for recommended level of care.

c. Upon approval, a 13-digit service review number (SRN) is systematically generated and is entered in block 12. The number remains valid if the patient:

(1) Enters or remains in a nursing facility and receives that level of care; or

(2) Is admitted to a hospital and then returns to the NF and receives the same level of care.

3. Responsibilities Of The Nursing Facility (NF)

a. Do not accept or transfer a patient if prior approval is in doubt.

b. Retain a copy of the FL-2/MR-2 and the DMA-5016(s) in the patient's file and make these available for state and federal review.

c. File claims for reimbursement from Medicaid.

d. Notify the county DSS within 48 hours of plans to:

(1) Move the patient to a different facility or hospital.
(2) Discharge the patient to home.
(3) Readmit the patient from the hospital.

e. When the patient is transferred to a different facility, provide a copy of the current approved FL-2/MR-2 with the current service review number.

F. Validity of Approval And Expiration Dates

The stamped approved FL-2/MR-2 is valid for the period of time listed below.

1. For an individual still in PLA

If the patient is at home when the FL-2 is completed, he must be placed within 30 days or a new FL-2 is required.

2. For an individual in a hospital

An approved FL-2/MR-2 is valid until the patient in the hospital is placed or until his condition changes.

(XV. F.2.)

a. If a patient must remain in the hospital inappropriate/swing bed because no appropriate bed can be located, a new FL-2 is required only if his condition changes.

b. A discharged patient must be placed within 30 days of discharge from the hospital or a new FL-2 is required.

3. For an individual in a LTC facility

After placement, a physician, physician assistant, or nurse practitioner must certify that the patient continues to need approved services in a nursing facility.

a. Skilled - At 30, 60, and 90 days after admission/readmission, and every 60 days thereafter.

b. ICF/MR - On admission and recertified annually.

G. Patient Approved For Adult Care Home Level of Care

If the a/b is receiving nursing home care in the hospital or nursing facility but the FL-2 shows approved for adult care home level of care only, no facility charges for room and board can be applied to the deductible. Adult care home room and board is not a medical expense. Personal care services in the adult care home can be applied to the Medicaid deductible because personal care services are a medical expense. Use PLA budgeting procedures if the a/b applies for Medicaid only.

H. Reconsideration Review

1. If the level of Nursing Facility care which the attending physician recommends is denied initially or if the recommended level is changed at Utilization Review, the IMC should advise the patient or representative that a reconsideration review may be requested by:

a. The physician, who provides additional information on the patient's condition; or

b. The patient or their representative who makes a written request by contacting the Department of Health and Human Services (DHHS) Hearing Officer at DHHS.

DHHS Hearings and Appeals
2501 Mail Service Center
Raleigh, NC, 27699-2501
(919) 855-3260

2. The patient whose level of nursing care changes is not required to move to another bed or to change nursing facilities during the reconsideration review process. He will continue at the same level of care during the appeal process.

(XV. H.)

3. The notice of the change in level of care sent by Clinical Policy at DMA to an active beneficiary outlines the correct procedure to request a reconsideration review and the time limits to make the request. Refer to the notices at the end of this section.

XVI. LONG TERM CARE OMBUDSMEN

The Long Term Care Ombudsman Program is an advocacy program mandated by the Older Americans Act and the North Carolina General Statutes. Long term care ombudsmen are stationed throughout the State to assist long term care patients and their families with problems and questions related to long term care. Please refer to http://www.dhhs.state.nc.us/aging/ombud.htm, for more information on the program.

If you have a client who has a complaint about how he is being treated in a long term care facility or who needs to talk with someone about a particular long term care issue, please refer him to the long term care ombudsman who works in the county in which his facility is located.

XVII. TABLES

TABLE A -- LTC RATES To be budgeted using LTC procedures:

* The A/R must be institutionalized,
* Have an approved FL-2 as outlined in MA-2270, and
* Must be in need, as determined in Step I.

MINIMUM MEDICAID REIMBURSEMENT RATES

To determine the minimum Medicaid reimbursement rate (MRR) for 31 days for a skilled nursing facility, refer to V.B.1. The following is the MRR for 31 days for the facilities as listed:

ICF/IDD	$8,959
Hospice Care in a NF (SNF)	$5,895
Hospice Inpatient Care (Acute hospital)	$13,196

ACTUAL RATES

The particular facility's unique Medicaid reimbursement rate for 31 days.

1. NURSING FACILITY

   Verify the unique Medicaid per diem rate with the facility's business office for the approved level of nursing services.

2. HOSPITAL INAPPROPRIATE LEVEL OF CARE BED

All hospitals have these beds available. These rates apply to all general hospitals.

	Per Diem	For 31 Days
Skilled	$129.15	$ 4,003.65
Ventilator	$403.44	$12,506.64

3. HOSPITAL SWING BEDS

A swing bed is certified as a swing bed by Medicare. Not all hospitals have swing beds. Swing bed rates are the same as Hospital Inappropriate Level of Care beds.

4. HOSPICE CARE IN A NURSING FACILITY

The business office of the Hospice agency can verify the actual rate for room and board and other services provided to the specific individual.

Or contact the Budget Management Section of the Division of Medical Assistance at 919/855-4200. Be prepared to state the patient's level of care and the name and address of the nursing facility.

TABLE B – MEDICARE CO-PAYMENT AMOUNTS **Effective 01-01-20**

MEDICARE PART A

A. Approved Medicare SNF in a Nursing Facility

1. 1-20 days SNF --- no co-pay.

2. 21-100 days --- $176.00 per day.

B. PART A Hospitalization Benefits

1. First 60 days --- Medicare Part A deductible, $1,408.00 total.

2. 61st through 90th day --- $352.00 per day.

3. 91st – 150th Lifetime reserve days --- $704.00 per day.

REVISED 12/10/19 – CHANGE NOTICE 13-19

TABLE C -- STANDARD UTILITY ALLOWANCE **Effective 01/01/20**

Household Size	Standard Allowance
1	$434
2	$482
3	$530
4	$578
5 or more	$626

TABLE D -- When To Submit A FL-2, LOC or DHB-2193, Memorandum CAP Waiver Enrollment Status For Prior Approval

New Prior Approval Required [FL-2 with or without PASARR]

	TO					
FROM	Hospital	Nursing Facility	ICF/IDD	CAP/DA & CAP/C	Innovations	PRTF
Home	NO	FL-2 w/PASARR	LOC	DHB-2193	LOC	NO
Hospital	NO	FL-2 w/PASARR	LOC	DHB-2193	LOC	NO
Nursing Facility	NO	FL-2 w/PASARR	LOC	DHB-2193	LOC	NO
ICF/IDD	NO	FL-2 w/PASARR	LOC	DHB-2193	LOC	NO
CAP/DA & CAP/C	NO	FL-2 w/PASARR	LOC	DHB-2193 is required if change in level of care	LOC	NO
Innovations	NO	FL-2 w/PASARR	LOC	DHB-2193	NO	NO
PRTF	NO	FL-2 w/PASARR	LOC	DHB-2193	LOC	NO

NOTE: Rehabilitation centers usually provide either SNF care, or the more specialized level of care, HI (head injury). Individuals who request Medicaid payment of cost of care in a nursing facility rehabilitation center are requested to have prior approval on the FL-2. If the care is HI, additional medical documentation will be submitted with the FL-2.