Medicaid: A New Way Forward

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Common Medicaid Scenarios That Lead to Payment Issues

- Admission of Medicaid pending or long-term care resident who does not qualify for Medicaid
- Incompetent residents with no family or representative able or willing to assist with payment or Medicaid
- Medicaid denial for not timely providing responses to verification requests
- Resident's failure to apply or timely apply for Medicaid
- Guardian's failure to timely reduce resident below resource limit for Medicaid eligibility

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Common Medicaid Scenarios That Lead to Payment Issues

- Uncooperative spouse unwilling to pay or assist in the Medicaid process
- Transfer of real or personal property within the past five years
- CDJFS' delay in processing the Medicaid application
- Medicaid terminated at redetermination for failure to provide requested documentation
- Improper adverse decision by the CDJFS resulting in a denial of Medicaid, termination of Medicaid, incorrect patient liability determination, or a restricted-penalty period
- *AND COMING SOON*– Excess income

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Medicaid Basics

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Basic Eligibility Requirements

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Medicaid Eligibility

- 65 years or older, blind or disabled
- Level-of-care is intermediate or skilled
- Income and resources at or below certain limits

Medicaid Eligibility

- Medicaid coverage can begin no sooner than the 1st day of the 3rd month preceding the date of the application—if:
  - The resident was eligible during the retro-active months, and
  - The services received were services covered by Medicaid
- **TAKEAWAY:** Introduction and education of Residents regarding Medicaid must begin as soon as possible

Financial Eligibility: Income

- *UNTIL JULY OF 2016:*
  - Resident's gross income must be at or below the "special-income level" (SIL)—$2,199
  - If gross income is greater than the SIL, apply spend down—if after spend down the income is equal to or less than the "needs standard", resident is income eligible
    - Needs standard for Individual in own household - $643.00
    - Needs standard in the household of another - $429.00

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Financial Eligibility: Income and Miller Trust

- *AFTER JULY OF 2016:*
  - Resident's gross income must be at or below the "special-income level" (SIL)—$2,199
  - Spend down is eliminated—if gross income is greater than (SIL), resident must establish a Qualifying Income Trust ("QIT" or "Miller Trust") where excess monthly income over the SIL is transferred to the Miller Trust account
- This applies equally to those Residents participating in the Assisted-Living Waiver program
- **TAKEAWAY:** Need to begin to identify the residents with gross income over $2,199

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Financial Eligibility: Income and Miller Trust

- As currently proposed, to establish a proper Miller Trust (QIT), it must meet the following 8 requirements*:*
  1. The Trust must be irrevocable
  2. Only the individual's income can be placed into the Trust
  3. The source(s) of income placed into the Trust must be identified
  4. The individual cannot transfer or assign to the Trust his or her right to receive income

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Financial Eligibility: Income and Miller Trust

- As currently proposed, to establish a proper Miller Trust (QIT), it must meet the following 8 requirements*:*

5. No other property or resources, except for any interest earned on the trust corpus, can be placed into the trust
6. The Trust document must provide that the Trust shall terminate upon the death of the primary beneficiary
7. Upon termination, the Trust document must require the remaining Trust property to be distributed to ODM, which is capped at the amount paid by the state in medical assistance
8. The Trust document must prohibit payment to other persons or creditors prior to distribution to ODM

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Financial Eligibility: Income and Miller Trust

- As currently proposed:
  - The Trust can only contain the income of the individual (i.e. Medicaid applicant or beneficiary)
  - Distributions from the Trust must be in amounts and for the purposes necessary to maintain the individual's income eligibility for Medicaid
  - Distributions from the Trust must be made in the following order:
    - The monthly personal needs allowance
    - The maintenance allowance for the spouse and/or family dependents
    - Incurred medical expenses
    - Payments in an amount up to $15.00 per month for bank fees, attorney fees and other expenses required to establish and administer the Trust

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Financial Eligibility: Income and Miller Trust

- As currently proposed:
  - When income placed into the Trust exceeds the amount paid out or the Trust in accordance with the proposed rule, the excess income may be subject to penalties under the transfer of assets provisions
  - Payments made from the Trust to a third party for something other than in-kind support and maintenance that are not authorized are subject to penalties under the transfer of assets provisions

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Financial Eligibility: Resources

- Until July of 2016, resident can have up to $1,500, which is then increased to $2,000
- For a married resident, the community spouse can retain the greater of $23,844 or half of the countable assets up to $119,220
- Resources are anything the resident has control over that can be converted to cash to be used to pay for care

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Financial Eligibility: Resources

- Some Examples of Countable Resources:
  - Real estate owned by the Applicant that is not or was not the Applicant's principal residence
  - Personal Residence held in a Trust
  - Life estates
  - CCRC / Life Care Community Entry Fee if the money can be used towards the resident's care
  - NOTE – as currently proposed, the funds held in the Miller Trust will NOT count towards Medicaid eligibility

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Financial Eligibility: Resources

- Improper Transfer requires the finding of the following three elements:
  - An asset transferred in the past 5 years,
  - The transfer was for less than fair-market value, and
  - The transfer was done with the intent to qualify for Medicaid
- CDJFS is permitted to presume the intent element if:
  - The first two elements are satisfied, AND
  - The transfer brings the value of the resources below $1,500 ($2,000 after July of 2016)

Financial Eligibility: Resources

- If the CDJFS identifies an improper transfer, a rebuttal statement must be provided before the CDJFS makes its final determination
  - A rebuttal statement is evidence showing that the transfer was for fair-market value or that the transfer was NOT for the purpose of qualifying for Medicaid
  - Examples actually provided in Ohio law: Traumatic onset of disability or blindness (e.g., due to traffic accident); or Diagnosis of a previously undetected disabling condition

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Medicaid Application

- Paper or online application – paper recommended
- Permitted to designate the facility as the Authorized Representative ("AR") on the application—by law the facility or a person at the facility can be the resident's AR
- Assuming the CDJFS does not recognize facility as AR after submitting application, know that CDJFS is required to appoint an AR if the individual is unable to identify an AR because of incapacity or incompetence
- If there is a community spouse, always request a resources assessment in conjunction with the Medicaid application

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Medicaid Application

- As currently proposed, if an Applicant requires a Miller Trust, along with the application and other requested documentation, the following must be provided:
  - Proof of the establishment of the Trust
  - Proof of the required monthly deposit amounts
  - Verification that the required monthly income is directly deposited into the Trust—if this is not possible, you must then:
    - Demonstrate efforts made to have income directly deposited into the Trust
- **TAKEAWAY:** Make the caseworker's job easy

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Basic Verification Requirements and the County's Legal Obligations

Verification and CDJFS' Obligations

- Resident or AR must respond to a verification request by deadline provided thereon
- Resident or AR can request additional time before deadline
- If the deadline is missed, the county must provide written notice that the resident has 10 additional days to respond
- If the resident or AR cannot obtain the requested information, the resident or AR can request for assistance from CDJFS and CDJFS is required to take certain action—also eliminates the possibility of a denial for failure to cooperate (request should be in writing)

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Verification and CDJFS' Obligations

- Why request a Resource Assessment with the submission of the Medicaid application if there is a community spouse?
  - The law provides for mandatory CDJFS' assistance if the spouse is not cooperating, but only if a resource assessment has been requested
- If the spouse refuses to cooperate, whether or not a resource assessment was requested, inform the CDJFS in writing about the spouse's refusal

Verification and CDJFS' Obligations

- The CDJFS must determine eligibility with 30 days from the date of the application—which can be challenged through a state hearing
- Level-of-care determination for residents in NF, where an application for Medicaid has been submitted, must be completed no later than 5 calendar days after all information required for providing the level-of-care determination has been submitted

Patient Liability and the Past-Medical Allowance

Patient Liability and Past-Medical Allowance

- Patient liability is the amount determined by the CDJFS that is required by law to be turned over to the facility each month
- As currently proposed, the patient liability calculation will not change with the transition to 1634
- If Medicaid is approved, the resident's patient liability can be reduced to $0 and the monthly income can be applied to back expenses incurred for medical care—past-medical allowance (ACT 52)
- As currently proposed, the past-medical allowance will remain after the transition to 1634
- The request for a past-medical allowance can only be requested by the resident or the AR

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Redetermination or Renewal Process

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Redetermination

- Once a year, or upon a notification of a change, the CDJFS will re-determine Medicaid eligibility by possibly requiring verification of resources and/or income from the resident
- As currently proposed, redetermination of an individual utilizing a Miller Trust will require providing the CDJFS with documentation of monthly deposits into the Trust
- Resident has 10 days to supply the requested information—failure to provide the requested information will result in termination of Medicaid

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Redetermination

- Failure to produce the necessary information timely does not have to result in a new application
- The CDJFS must reconsider the eligibility of an individual who is terminated for failure to submit the necessary information without requiring a new Medicaid application if:
  - The resident or AR subsequently submits the information within 90 days after the date of termination
  - If the information demonstrates eligibility, coverage must begin on the first day of the month following the month of termination

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State Hearing, Appeal and Judicial Review Process

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State Hearing and Appeal

- The Resident and/or the AR can request a state hearing with the Bureau of State Hearings for adverse decisions and inaction—examples of adverse actions and inaction are:
  - Medicaid denials, delayed processing of application, improper transfer determinations, improper PL calculations, etc.
- State-hearing timeline
  - State hearing must be requested within 90 days of the date of the notice
  - An appeal of the state-hearing decision must be requested within 15 days from the date the state-hearing decision
  - A judicial review must be filed with the county court of common pleas within 30 calendar days from the date the appeal decision was issued

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Avoiding Payment Delinquencies

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Avoid Delinquent Payment

- At admission and anytime the opportunity presents itself, establish proper payment expectation
- At admission explain discharge process and interest if payment is missed
- Request a personal guarantor
- Explain the RP obligations under the Admission Agreement
- Do not promise coverage
- Verify secondary coverage

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Avoid Delinquent Payment

- Get credit card or automatic debit for the residents who will experience a co-insurance obligation
- Make a call or send a letter with the first invoice explaining the reason for the invoice and need for payment
- Personally meet with short-term resident or family of short-term resident transitioning to long-term care to discuss upcoming financial obligations and available options
- Timely follow up on denied or rejected claims

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