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LONG TERM CARE BUDGETING

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07/01/04

**MA-3325 LONG TERM CARE BUDGETING**

**07/01/04**

**I. INTRODUCTION**

Long-term care budgeting applies when the individual will be in a Medicaid certified medical institution for more than 12 months. When budgeting for long term care, a Patient Monthly Liability (PML) amount must be entered in EIS.

**A. Definition of Medicaid Certified Medical Institution**

1. A licensed acute care inpatient medical facility providing medical, surgical, and psychiatric or substance abuse treatment,

OR

2. A facility enrolled with the NC Medicaid Program as a psychiatric residential treatment facility (PRTF), providing services to an individual under age 21.

OR

3. A nursing facility (NF) or care for the mentally retarded (ICF-MR).

NOTE: If there is a question regarding whether a medical institution is Medicaid certified, contact the facility or, as a last resort, the Provider Services Unit at, DMA (919) 855-4050) for verification.

**B. Aid Program/Category**

An individual under 21 in long-term care (LTC) may be eligible under any of the following aid program/categories:

1. **MAF: Individual under age 21. Evaluate under regulations in [MA-3230, Eligibility of Individuals Under 21](#).**
2. **MIC: Individual under age 19. Evaluate under regulations in [MA-3230, Eligibility of Individuals Under 21](#).**
3. **HSF: Individual under age 21 and the county agency or a private adoption/child-caring agency has legal custody and/or placement responsibility. Evaluate under regulations in [MA-3230, Eligibility of Individuals Under 21](#).**

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4. **MAD: Individual under age 21 who has been determined to be disabled. Evaluate under regulations in MA-2000, Non-SSI Eligibility Regulations, in the Aged, Blind, and Disabled Medicaid Manual. Parental financial responsibility ceases at age 18. Also refer to MA-2270, Long Term Care Need and Budgeting.**

## II. REQUIREMENTS FOR PLACEMENT OF 12 MONTHS OR LESS

- A. **Long-term care budgeting never applies when an individual under age 21 is placed in a facility for 12 months or less. Do not enter a PML in EIS when budgeting PLA.**
- B. **Determine parental financial responsibility for an individual under age 21 who is placed in a long-term care living arrangement for 12 months or less (with private living budgeting) by whether he is permanently or temporarily absent from his parent(s)' home. Refer to MA-3305, M-AF, M-IC, H-SF Budgeting, to make a determination of parental financial responsibility.**

## III. REQUIREMENTS FOR PLACEMENT OF MORE THAN 12 MONTHS

- A. **Long-term care budgeting applies when the duration of continuous care and treatment has exceeded or is expected to exceed 12 months in a Medicaid-certified facility. When budgeting long-term care, a PML amount must be entered in EIS.**
- B. **Parental financial responsibility never applies in long-term care budgeting. The month of entry is private living budgeting and parental financial responsibility applies for that month only.**
- C. **Parental financial responsibility never applies when the individual has been or is expected to be out of his parent(s)' home for more than 12 months, regardless of the living arrangement, which may be a combination of LTC, acute hospital care, psychiatric residential treatment facility, private group home, and/or other private arrangement. Refer to MA-3305, M-AF, M-IC, H-SF Budgeting, for private living budgeting procedures when the a/r is temporarily out of the home.**
- D. **Budget Unit (B.U.) Membership for LTC Budgeting (Placement exceeding 12 Months)**
  1. **MAF: The b.u. is one following the month of entry.**
  2. **MIC: The b.u. is one following the month of entry.**
  3. **HSF: The b.u. is one.**
  4. **MAD: The b.u. is one. See MA-2270, Long-Term Care Need and Budgeting, in the Aged, Blind and Disabled Medicaid Manual, for procedures.**

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**E. Financial Responsibility**

1. Parental financial responsibility applies for the month of entry into a LTC budgeting situation for MAF or MIC.
  - a. Eligibility for the month of entry is based on the individual's private living arrangement (PLA) on the first day of that month.
  - b. Refer to [MA-3305](#), MAF, MIC, HSF Budgeting, for procedures.
2. The county department of social services has either custody or placement responsibility for an individual in H-SF. Therefore, parental financial responsibility for the PLA month of entry into LTC for an individual in H-SF with long-term care budgeting is based only on court-ordered support and voluntary contributions from the parent(s). Refer to [MA-3305](#), M-AF, M-IC, H-SF Budgeting, to evaluate for H-SF.

**F. Transfer of Resources - Refer to [MA-2240](#), Transfer of Resources, in the Aged, Blind, and Disabled Medicaid Manual**

1. If an a/r, budget unit member or legal representative gives away or sells an asset for less than the current market value he may not be eligible for cost of care in a nursing facility.
2. Apply Transfer of Resources rules only to individuals who are:
  - a. Evaluated under MAF, and
  - b. Request cost of care in a nursing facility, and
  - c. Transferred a non-allowable asset during a specified lookback period or later.
3. Always ask an MAF a/r requesting cost of care in a nursing facility whether he (or anyone in his budget unit) has transferred or given away any resources. If he has, refer to [MA-2240](#), Transfer of Resources, in the Aged, Blind and Disabled Medicaid Manual.

Note: Transfer of resources policy does not apply to individuals in LTC receiving under MIC. However, if an a/r begins to receive assistance with nursing home cost of care under the MAF program, CAP, or assistance with in-home health services and supplies under the MAABDQ program, evaluate all non-allowable transfers of resources for sanction. This includes transfers that occurred while the individual was receiving MIC.

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#### IV. PROCEDURES

The actions the Income Maintenance Caseworker (IMC) takes depends on the type of institution in which the individual is placed.

Do not accept the applicant's statement for documentation of the need for institutionalization or anticipated duration of care and treatment. Medical verifications are required. Refer to [MA-3210, Verification Requirements For Applications](#).

##### A. Determining the Type of Institution

1. The FL-2/MR-2 prior approval form is used to document the care for an individual who is being placed in a Medicaid-certified nursing facility (NF) or an intermediate care facility for the mentally retarded (ICF-MR). Refer to [MA-2270, Long Term Care Need and Budgeting, in the Aged, Blind, and Disabled Medicaid Manual](#) for instructions on the processing and use of the FL-2/MR-2.

Prior approval is granted by the fiscal contractor. Medical records may be requested by the contractor's Prior Approval Unit.

2. Use the [DMA-5045, Certificate of Need for Institutional Care for Individual Under Age 21](#), to document the duration of care when an individual under age 21 who lives in the home with financially responsible relatives is recommended by the attending physician for placement. The placement may be in a licensed acute care inpatient medical facility for medical, surgical, psychiatric, substance abuse treatment, or psychiatric residential treatment.

NOTE: The prior approval process for payment of cost of care is a separate process. Approval of a DMA-5045, Certificate of Need for Institutional Care for Individual Under Age 21, for duration of care is for budgeting purposes.

- a. The IMC is responsible for evaluating whether [DMA-5045, Certificate of Need for Institutional Care for Individual Under Age 21](#), is completed correctly and whether the recommended placement and duration of continuous care and treatment meet the requirements of this section.
- b. Information regarding the duration of care and treatment is required only in order to determine financial eligibility. Therefore, if counting the parent(s)' income and resources will not cause ineligibility, determine eligibility. File the [DMA-5045](#), in the case record and see [IV.B](#).
- c. The DMA-5045, through section 1.b, is completed for care and treatment in a group home or other non-certified facility for 12 months or more. File a copy in the case record for informational purposes.

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**B. Determining Financial Responsibility**

1. Placement in a Nursing Facility (NF) or Intermediate Care Facility -Mentally Retarded (ICF-MR)
  - a. Obtain a copy of the approved FL-2 (for NF) or MR-2 (for ICF-MR) to verify prior approval for the care. File in the case record.
  - b. Obtain a completed DMA-5045 from the attending physician to document the anticipated duration of care and treatment for the purpose of determining financial eligibility. Medical records are not required. File in the case record. Do not send the DMA-5045 to DMA for review.
    - (1) If based on the DMA-5045, care and treatment have exceeded or are expected to exceed 12 months parental financial responsibility ceases beginning with the month following the month of entry into the NF or ICF-MR. See III.E.
    - (2) If you are unable to obtain a fully completed DMA-5045 to verify the duration of care, determine the impact of the parent(s) income on the child's eligibility.
      - (a) If the individual under 21 is eligible considering the parent's income, process as private living. Do not apply LTC budgeting.
      - (b) If the individual under 21 is not eligible with the parent's income, proceed with the DMA-5045. If the DMA-5045 shows care and treatment have exceeded or are expected to exceed 12 months, budget as LTC.
2. Placement in a Medicaid Certified Institution for Acute Medical, Surgical, or Psychiatric Inpatient Care, Including Inpatient Treatment for Substance Abuse and Psychiatric Residential Treatment Facility (PRTF).

Always submit DMA-5045 to DMA when a child is placed and the stay is expected or has exceeded 12 months.

- a. To document the need for continuous treatment for the purpose of determining financial eligibility, the IMC must request the individual's attending physician to:
  - (1) Complete the DMA-5045, Certificate of Need for Institutional Care for Individual Under Age 21 Sections B and C,

AND

  - (2) Submit all of the following required accompanying documentation:

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(IV.B.2.a.(2))

- (a) History of current illness
  - (b) Office medical records for past 6 months
  - (c) Discharge summaries from all inpatient, residential, or group home placements for past 12 months or dates and places of same
  - (d) List of current medications (IV.B.2.)
  - (e) Plan of care with goals and time frames
  - (f) Name of institution in which care and treatment will be provided
- b. Screen the DMA-5045 carefully upon receipt from the physician to determine if form is completed correctly and whether the individual is in a Medicaid-certified medical facility as defined in IA.
- c. Return incomplete forms to the physician. Do not delay the application process by sending incomplete forms to DMA.
- d. Send the completed DMA-5045 and accompanying documentation to:
- Medicaid Eligibility Unit  
Division of Medical Assistance  
2501 Mail Service Center  
Raleigh, North Carolina 27699-2501
- e. DMA will evaluate the documentation and inform the IMC of the acceptability of the recommended duration of care and treatment for the determination of financial eligibility.
- f. If you are unable to obtain a fully completed DMA-5045 to verify the duration of care, determine the impact of the parent(s) income on the child's eligibility. Follow policy in MA-3305, MAF, MIC, HSF Budgeting.
- (1) If the individual under 21 is eligible considering the parent's income, process as private living and authorize Medicaid.
  - (2) If the individual under 21 has excess income, notify him of the deductible based on his parent's income. Pend the application for proof the deductible is met. Follow policy in MA-3210, Verification requirements for Applications, and MA-3215, Processing the Application.

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(IV.B.2.)

g. Individual Placed and Recommended Duration of Care Accepted by DMA

Upon receipt of [DMA-5045](#) with Section D: DMA Acceptance for Determination of Financial Eligibility completed, cease parental financial responsibility and budget as LTC effective the month after the month of the 30<sup>th</sup> continuous inpatient day. For example, if the recipient enters the facility on January 3, 2004, February 3, 2004 is the 30<sup>th</sup> continuous inpatient day, then March 1, 2004 is the LTC effective month.

h. Recommended Duration of Care Not Accepted by DMA

- (1) DMA will notify the client and county by letter if the anticipated duration of care and treatment is rejected.
- (2) Continue to determine eligibility as PLA and apply parental financial responsibility. Refer to [III.E](#).
- (3) Within 11 calendar days of the receipt of the letter rejecting the anticipated duration of treatment, the a/r has the right to appeal DMA's decision. Notice of appeal should be directed to:

Hearings Unit  
Division of Medical Assistance  
2501 Mail Service Center  
Raleigh, NC 27699-2501

3. Individual Not Yet Placed or Not Yet Approved by DMA (Not Applicable to NF or ICF-MR)

- a. Determine eligibility as PLA and apply parental financial responsibility:
- b. If the individual meets all points of eligibility, approve the application.
- c. If the individual has a deductible, pend for the deductible according to application processing requirements.
- d. Deny the application if the individual is ineligible because of excess reserve with parental financial responsibility applied.

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(IV.)

**C. LTC Budgeting**

1. The month of entry into LTC (care and treatment has exceeded or is anticipated to exceed 12 months) is budgeted PLA.
  - a. Determine whether parental financial responsibility applies. Refer to [MA-3305, M-AF, M-IC, H-SF Budgeting](#).
  - b. Determine whether there is a deductible for the month by comparing countable income to the medically needy income limit for the number in the budget unit.
    - (1) If there is a deductible, do not authorize assistance until the date the deductible is met.
    - (2) If there is no deductible, authorize assistance as of the first day of the month.
2. If care and treatment are expected to exceed 12 months, LTC budgeting begins:
  - a. The month after entry when admitted to a NF or ICF/MR facility.
  - b. The month following the month of the 30<sup>th</sup> continuous inpatient day when admitted to a hospital, psychiatric unit of a state mental hospital, or PRTF.
3. Establish need.
  - a. M-AF and H-SF
    - (1) An individual under 21 is in need if his gross income is less than the minimum Medicaid reimbursement rate or the facility's individual rate for 31 days, or
    - (2) The net countable income, after subtracting PLA deductions and the PLA medically needy income level for 1, does not exceed his medical expenses, including cost of care.
  - b. M-IC

An individual is in need if his gross income is equal to or less than the percent of the Poverty Income Level for his age and a b.u. of 1. If the income exceeds the income limit, evaluate as M-AF.
4. Compute a patient monthly liability (PML).
  - a. From gross monthly income, deduct \$30 per month for personal needs.



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(IV.C.4.)

- b. Deduct an amount for unmet medical needs (UMN) following procedures in [MA-2270, Long-Term Care Need and Budgeting](#), in the Aged, Blind, and Disabled Medicaid Manual.
  - c. **If remaining income is greater than the facility's reimbursement rate, the individual is ineligible for help with cost of care. Refer to [MA-2270, Long-Term Care Need and Budgeting](#), in the Aged, Blind, and Disabled Medicaid Manual for principles of LTC budgeting.**
  - d. If remaining income is less than the facility's reimbursement rate for the recommended level of care, round to the nearest whole dollar to establish the PML. (If 50 cents or greater, round up. If less than 50 cents, round down.)
5. Reporting PML
- a. If the duration of treatment has been or is anticipated to exceed 12 months, enter the PML amount in EIS and report the PML to the NF by means of DMA-5016 .
  - b. If the duration of treatment has been or is anticipated to be 12 months or less, budget the case PLA. Authorize on the date that all eligibility factors, including deductible, are met. Refer to [MA-3305, MAF, MIC, HSF Budgeting](#), for DMA-5016 procedures when the a.u. member is temporarily absent in a Medicaid certified medical institution.
  - c. If the medical facility is not certified by Medicaid, the cost of care will not be covered by Medicaid and a PML cannot be established.
  - d. For Hospice patients in a NF, send the DMA-5016 to the Hospice agency.

## V. LONG-TERM CARE OMBUDSMAN

### A. Definition

The Long-Term Care Ombudsman Program is an advocacy program mandated by the Older Americans Act and 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.

(V.)

**B. Implementation**

Refer 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 to the long-term care ombudsman who works in the county in which his facility is located.

**C. List of LTC Ombudsman**

Refer to MA-5900, LTC Ombudsman, for more information on the program and a list of the ombudsmen and the counties they serve.