

Department of Public Health  
and Human Services

MEDICAL ASSISTANCE

Section:  
RESIDENTIAL MEDICAL  
INSTITUTIONS

Subject:  
Long Term Care Insurance

**Supersedes:** MA 904-6 (07/01/05)

**References:** ARM 37.82.101; 37.82.1313; Public Law 108-422, Section 202

GENERAL RULE--When an applicant for residential care under Medicaid has long term care insurance, medical need must be evaluated prior to a finding of Medicaid eligibility.

**LONG TERM  
CARE INSURANCE**

Long term care insurance, or nursing home insurance, normally pays for institutionalization on a per day basis. This insurance may pay directly to the institution, or may require reimbursement to the beneficiary.

Benefits of long term care insurance are treated as third party liability rather than income. Per the Third Party Liability Unit, long term care insurance policies are not indemnity policies, and must be entered onto the THPL screen on TEAMS. Contact ACS when these policies are entered on TEAMS. They will add special coding so the policies do not interfere with the billing process for other providers, such as doctors.

Medicare Part A and QMB coverage of periods of institutionalization are considered long term care coverage for this purpose.

**LTC INSURANCE  
PREMIUMS  
DETERMINATION  
OF MEDICAL NEED**

Premiums for long term care insurance are usually suspended when the beneficiary is admitted to the nursing facility. Medical need is determined as follows ( "Step I" budgeting, MA 904-1):

1. Determine the facility's **Medicaid** daily rate.
2. Subtract the long term care insurance daily benefit rate.
3. Multiply the result by the number of days in the benefit month.
4. If the result of #3 is less than the individual's monthly income, there is no Medicaid coverage of nursing home costs. Deny institutional (nursing home) Medicaid, and consider eligibility for non-institutional (ancillary only) medically needy.

**NOTE:** If working a case for non-institutional medically needy, the Medicaid daily rate, less third party liability (long

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term care insurance) can be allowed on the INCU screen for the nursing home costs used to meet the incurment. Other expenses, such as health insurance and prescriptions would be used per the MA 703-1 section.

### VA PER DIEM PAYMENTS

Veteran's Administration per diem payments made to **state** homes for veterans will **not** be used to offset (lower) the Medicaid daily rate for the facility when processing "Step I" budgeting for nursing home eligibility. The client's income will be tested to the full Medicaid daily rate to determine eligibility for nursing home Medicaid coverage.

Montana Veterans' homes are Eastern Montana Veterans' Home in Glendive and Montana Veterans' Home in Columbia Falls.

VA per diem payments made to private nursing homes and county nursing homes will be used to offset Medicaid daily rate when processing "Step I" budgeting for nursing home eligibility.

VA per diem payments are not to be confused with VA Aid and Attendance (A&A) payments, which are made directly to the veteran. See MA 501-1, 904-2 and 904-3 regarding A&A.

### EXAMPLES

#### Example #1 – Medically Needy Individual

Sheldon, a single individual, applies for institutional Medicaid coverage in April. He resides in a Medicaid licensed facility with a Medicaid daily rate of \$80. Sheldon has a long term care policy that pays \$60 per day for 12 months. His monthly income is \$780.

First, we determine his medical need (Step I budgeting):

Facility's Medicaid daily rate	\$80.00
LTC Insurance daily pay rate	- <u>60.00</u>
Net daily cost	\$20.00
# days in month	X <u>30</u>
Net monthly cost:	\$600.00

Sheldon's income of \$780 per month fails Step I budgeting, and nursing home coverage is denied. Sheldon is now processed as medically needy.

Sheldon's medically needy eligibility is processed as follows:

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	Income	\$780.00	
	General income disregard	- 20.00	
	Net income	\$760.00	
	MNIL for one	- \$525.00	
▶	Medically Needy Income Deduction	<u>- \$ 50.00</u>	
	Incurment obligation in the community	\$185.00	
▶	Adjustment for Inst. MA/MA	<u>+\$545.00</u>	(see next section)
	Total incurment obligation	\$730.00	
	Subtract health ins. premium	- 100.00	
	Subtract facility charge (Medicaid rate)	<u>- 600.00</u>	
	Remaining incurment to be met	\$ 30.00	

In order to be medically needy eligible, Sheldon must incur and be responsible for \$30 in additional medical expenses. This will vary from month to month, due to the differences in the number of days in each month. At the point where he meets his incurment, the facility is notified that Sheldon is Medicaid-eligible, and that his liability is \$600 for the month of April, \$620 for the month of May, and \$600 for the month of June, etc.). The NUHS screen is updated to show the months of Medicaid eligibility. This allows the facility to receive "credit" for Sheldon as a Medicaid patient in calculating their daily rate, and for tax purposes. The case manager sets an alert for the month that Sheldon's long term care insurance is expected to expire.

### Example #2 – Medically Needy Spouse

One April 1, Joe, who has a community spouse, entered a Medicaid licensed nursing facility. Joe's income is \$1000 per month. Joe has a long term care policy that pays \$95 per day. The facility's Medicaid daily rate is \$100. Joe does not have any other medical expenses.

When Joe applies for Medicaid, we first determine his medical need:

Facility Medicaid daily rate	\$100.00
LTC Insurance pay rate	<u>- 95.00</u>
Net daily cost	\$ 5.00
# days in month	<u>X 30</u>
Net monthly cost	\$ 150.00

Joe's income of \$1000 fails Step I, and nursing home coverage is denied. Joe is now processed as medically needy.

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Joe's eligibility is processed as follows:

	Income	\$1000.00
	General income disregard	- 20.00
	Net income	\$ 980.00
▶	MNIL for one	- \$ 525.00
	Medically Needy Income Deduction	- \$ 50.00
	Incurment obligation in the community	\$ 405.00
▶	Adjustment for Inst. MA/MA	+\$ 545.00 (see next section)
	Total incurment obligation	\$ 950.00
	Subtract health ins. premium	- 100.00
	Subtract facility charge (MA rate)	- 150.00
	Remaining incurment to be met	\$ 700.00

In order to be medically needy eligible, Joe must incur and be responsible for \$700 in additional medical expenses. This will vary from month to month, due to the differences in the number of days in each month. At the point where he meets his incurment, the facility is notified that Joe is Medicaid-eligible, and that his liability is \$150 for the month of April, \$155 for the month of May, \$150 for the month of June, etc.). The NUHS screen is updated to show the months of Medicaid eligibility. This allows the facility to receive "credit" for Joe as a Medicaid patient in calculating their daily rate, and for tax purposes. The worker sets an alert for the month that Joe's long term care insurance is expected to expire.

▶ Example #3 – Medicare and QMB Recipient

Fritzi is an on-going QMB recipient in the community. Her income is \$800 per month SSA. She falls and breaks her hip, and after hospitalization, is temporarily placed in a Medicaid-licensed nursing facility on July 17 for rehabilitation. The first 20 days of Fritzi's nursing home stay (7/17-8/5) will be covered 100% by Medicare. For days 21-100 (8/6-11/25), she will likely receive Medicare co-insurance days, and QMB will pay her co-insurance. There is no reason to determine nursing home Medicaid coverage during this time as long as Fritzi is confirmed to be on her "Medicare days" at the facility. **Upon receipt of the pre-admission screening form, NUHS will up updated in TEAMS with Fritzi's Medicare coinsurance days of 8/6/07-11/25/07, and an alert will be set for follow up on or about 11/15/07.**

If Fritzi's Medicare covered days end prior to 11/25, Fritzi, her authorized representative or the facility should notify the OPA. For

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November, Fritzi's nursing home eligibility determination for 11/26-30 would be as follows:

First, we determine her medical need (Step I budgeting):

Facility's Medicaid daily rate	\$100.00
# days in month	<u>X 5</u>
Net cost for November:	\$500.00

Fritzi's income of \$800 per month fails Step I budgeting, and nursing home coverage is denied. She is now processed as medically needy.

Fritzi's medically needy eligibility is processed as follows:

Income	\$800.00
General income disregard	- 20.00
Net income	<u>\$780.00</u>
MNIL for one	- \$525.00
Medically Needy Income Deduction	<u>-\$ 50.00</u>
Incurment obligation in the community	\$205.00

**If Fritzi does not intend to return home:**

Incurment obligation in the community	\$205.00 (from above)
Adjustment for Inst. MA/MA	<u>+\$545.00</u> (see next section)
Total incurment obligation	\$750.00
Subtract facility charge (Medicaid rate)	- 500.00
Remaining incurment to be met	\$250.00

**If Fritzi does intend to return home, and we have a doctor's statement:**

Incurment obligation in the community	\$205.00 (from above)
Adjustment for Inst. MA/MA	<u>+\$ 20.00</u> (see next section)
Total incurment obligation	\$225.00
Subtract facility charge (Medicaid rate)	- 500.00
Remaining incurment to be met	\$ -0-

If Fritzi remains in the nursing facility for the month of December, institutionalized coverage will be determined as usual, per MA 904-1 and 904-3.

**► TEMPORARY  
TEAMS  
PROCESSING  
METHOD**

When Sheldon's and Joe's MA/MA cases are worked on TEAMS, they will be given a \$20 disregard from their income, and then their incurments will be based on the MNIL for one (\$525 as of 7/1/01, after the \$50 Medically Needy Income Deduction effective 8/1/07). Because they are in nursing facilities, Medicaid regulations require that they only be allowed \$50 per month for personal needs, plus

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adequate funds to pay their insurance premiums. TEAMS, as currently programmed, will not be able to determine their incurments correctly.



In order for incurments to be determined correctly for situations like these, an artificial income of \$545 must be coded on UNIN with the income code of "OM". (If entitled to home maintenance allowance, "OM" would be \$20.)

If QMB or SLMB are also open in the case, it will be necessary to code the artificial income of \$545 as "CA" on the EXPE screen so QMB/SLMB benefits are not affected.

The community spouse income maintenance allowance and family income maintenance allowance do not apply to situations such as Joe's above, because these clients are not eligible for nursing home coverage, and are being budgeted as non-institutionalized individuals.

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