TO: Local District Commissioners, Medicaid Directors

FROM: Judith Arnold, Director
Division of Health Reform and Health Insurance Exchange Integration

SUBJECT: Spousal Impoverishment and Transfer of Assets Rules for Certain Individuals Enrolled in Managed Long Term Care

ATTACHMENT: LDSS-3183, "Provider or Managed Long Term Care Plan/Recipient Letter"

EFFECTIVE DATE: Immediately

CONTACT PERSON: Local District Support Unit
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The purpose of this General Information System (GIS) message is to advise local departments of social services (LDSS) of the expansion of spousal impoverishment budgeting for persons enrolled in managed long term care (MLTC) plans. There are three types of MLTC plans: Partially Capitated Plans, Program of All-Inclusive Care for the Elderly (PACE), and Medicaid Advantage Plus. This GIS also informs LDSS staff of the requirement to apply institutional eligibility rules, including transfer of assets provisions, when an enrollee is in receipt of long term nursing facility services or is an institutionalized spouse.

Pursuant to federal approval under the State's 1115 waiver, all individuals enrolled in MLTC with a spouse residing in the community who is not participating in a home and community-based services (HCBS) waiver or enrolled in MLTC ("community spouse"), must have Medicaid eligibility determined under the spousal impoverishment rules that apply to HCBS waiver participants. Spousal impoverishment treatment of income includes a post-eligibility deduction from the MLTC enrollee's income for a community spouse monthly income allowance (up to a maximum of $2898 for 2013), a family member allowance (up to $647 for 2013), if applicable, and a personal needs allowance (PNA), ($375 in 2013). If it is more advantageous to budget only the MLTC enrollee's total net income, after applying all appropriate community SSI-related income disregards, and compare it to the Medicaid income level for one, this option is available. This budgeting methodology also applies to couples with a spouse participating in PACE. See GIS 12 MA/013, "Spousal Impoverishment Budgeting with Post-Eligibility Rules for Individuals Participating in a Home and Community-Based Waiver Program," for a further explanation of the rules to be used when spousal impoverishment post-eligibility rules are not favorable for a couple. Under both options, spousal impoverishment rules are to be applied to the couple's resources.

Effective April 1, 2013, certain Long Term Home Health Care Program (LTHHCP) waiver participants began transitioning into MLTC. For couples with a "community spouse," spousal impoverishment rules will continue to apply as they transition to MLTC. Therefore, the transition to MLTC should not result in a change in eligibility.

NOTE: When the MLTC enrollee is subject to eligibility under spousal impoverishment rules, the special income standard described in Administrative Directive, 12 OHIP/ADM-5, "Special Income Standard for Housing Expenses for Individuals Discharged from a Nursing Facility who Enroll into the Managed Long Term Care (MLTC) Program" does not apply.

If an individual with a "community spouse" was enrolled in MLTC prior to April 1, 2013, eligibility must be re-determined using spousal impoverishment budgeting at next client contact, case maintenance or at renewal, whichever occurs first.

Monthly Spenddown

Medicaid recipients with a monthly spenddown are eligible for participation in MLTC. Once the LDSS receives verification that an individual is eligible for participation in a MLTC plan, 06 (provisional coverage) or 19 (community coverage with community based long term care) coverage, as applicable, should be authorized. Currently, Coverage Code 06 will not convert to the Prepaid Capitation Plan (PCP) Coverage Code 30 (PCP full coverage) in order to allow payment to the MLTC plan. However, a system change is pending that will convert the 06 to 30, when there is a prospective MLTC enrollment line in the PCP subsystem. Until districts are notified of the effective date of this change, 01 (full coverage) must be authorized.

The MLTC plan is responsible to collect the amount of the spenddown from the enrollee. The LDSS must inform both the Medicaid eligible applicant/recipient and the plan of the amount of the spenddown. A copy of the eligibility notice with just the enrollee's information displayed may be used for this purpose. Additionally, WMS will pass the spenddown amount to the MLTC plan on a monthly roster. A list of providers that participate in MLTC can be found on the website of the Division of Long Term Care.

Since certain out-of-pocket medical expenses (e.g. co-insurance charges) and expenses for necessary medical and remedial services that are recognized under State law but are not covered by Medicaid, which are the responsibility of the enrollee, must be used first to meet a spenddown liability, the amount owed to a MLTC plan must be reduced by these costs. Receipts, bills or other evidence of incurred expenses must be submitted to the LDSS by the enrollee. The district will need to advise both the MLTC enrollee and the plan when such expenses have been applied toward the monthly spenddown. The LDSS-3183, "Provider/Recipient Letter (Financial Obligation of Recipient Toward Medical Expenses)" has been revised for use in providing this notification. The revised letter is attached to this GIS.

Nursing Facility Admissions, Institutional Eligibility Rules, NAMI

The local district will be notified by the MTLC plan when an enrollee is in receipt of long term nursing facility services (more than 29 days of short-term rehabilitation) or the person is an institutionalized spouse. When an enrollee is to receive more than 29 days of short-term rehabilitation or the person is an institutionalized spouse, the LDSS must conduct a 60 month resource "look back" to determine whether a prohibited transfer of assets was made that may affect eligibility. If the individual is also determined to be permanently institutionalized or the person is an institutionalized spouse, chronic care budgeting rules are applied to determine the institutionalized individual's net available monthly income (NAMI). Since the responsibility for collection of the NAMI from the enrollee is pursuant to a contract between the nursing home and the MLTC plan, the local district must send a

copy of the eligibility notices to the nursing facility and the MLTC plan. The LDSS does not make a principal provider subsystem entry on WMS.

> **NOTE:** For a permanently institutionalized spouse whose eligibility was determined under spousal impoverishment rules while in the community, the nursing home budget needs to be changed to include a $50 PNA instead of a PNA of $375.

If the LDSS determines that the enrollee has transferred assets within the 60 month look-back period and as a result, is not eligible for Medicaid coverage of nursing facility services, the district must notify the plan that the enrollee is ineligible for payment of nursing facility services. The enrollee must be involuntarily disenrolled by the district. Upon disenrollment, the coverage must be changed to the appropriate coverage code based on the specific case circumstances (see 06 OMM/ADM-5, "Deficit Reduction Act of 2005 – Long Term Care Medicaid Eligibility Changes").