Michigan Department of Community Health

MDCH

# Beneficiary Eligibility Bulletin

**Bulletin:** HCEP 05-02

**Distribution:** Health Care Eligibility Policy (HCEP) Manual Holders

**Issued:** April 1, 2005

**Subject:** Adult Benefits Waiver (ABW);
Program of All-Inclusive Care for the Elderly (PACE)

**Effective:** Upon Receipt

**Programs Affected:** Adult Benefits Waiver, PACE

**Adult Benefits Waiver (ABW)**

Due to Centers for Medicare and Medicaid Services (CMS) approval of an Adult Benefits Waiver (ABW) amendment, the medical inpatient hospitalization benefit, including professional services, currently covered under the ABW terminated effective March 1, 2005. Language referencing the previous benefit has been removed from the attached Health Care Eligibility Program Manual pages.

**Program of All-Inclusive Care for the Elderly (PACE)**

Language in the attached PACE policy has been updated to reflect current terminology. No change has been made to the intent of the policy.

**Manual Maintenance**

Discard Chapter III, Section 1 (Bulletin HCEP 04-06), and replace with the attached pages.

Discard Chapter III, Section 5 (Bulletin HCEP 03-02), and replace with the attached pages.

Discard Chapter IV, Section 6 (Bulletin HCEP 05-01), and replace with the attached pages.

**Questions**

Any questions regarding this bulletin should be directed to Eligibility Policy, Department of Community Health, P.O. Box 30479, Lansing, Michigan 48909-7979 or e-mail EligibilityPolicy@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll free 1-800-292-2550.

**Approved**

Paul Reinhart, Director
Medical Services Administration

## LEGAL BASIS

Title XIX of the Social Security Act

**Program(s) Affected:**
Medicaid

## TARGET POPULATION

The Program of All-Inclusive Care for the Elderly (PACE) is a managed care program designed for the frail elderly population. The program provides a comprehensive array of Medicare and Medicaid institutional and community-based benefits under capitation financing, assuming financial risk for the full range of primary, acute and long-term care services. PACE does not have its own eligibility category. However, there are special eligibility rules for the beneficiaries enrolled in the program:

- Medically qualified; and
- 55 years of age or older; and
- Live within an approved geographic area of the PACE provider; and
- Not residing in a nursing facility at the time of enrollment; and
- Not also enrolled in the Medicaid MIChoice Waiver; and
- Not also enrolled in an HMO.

## ADMINISTRATION OF THE PACE PROGRAM

The Michigan Department of Community Health (MDCH) is designated as the state agency administering the program. The program is regulated through a three-party agreement between Centers for Medicare and Medicaid Services (CMS), Michigan Department of Community Health/Medical Services Administration (MDCH/MSA), and the PACE organization. There is also a separate contractual agreement between MDCH/MSA and the PACE organization.

## REFERRALS FOR PACE PARTICIPATION

The PACE organization receives referrals from providers in the community who believe a person meets Medicaid eligibility and nursing facility level of care criteria. The PACE organization will assist prospective enrollees in applying for Medicaid and with collection of asset and income verifications. The PACE organization is responsible for performing the medical/functional assessment that determines if a beneficiary meets the Medicaid Long Term Care eligibility criteria.

## PROCESS FOR ENROLLMENT IN PACE

- The beneficiary must meet Medicaid eligibility requirements and is receiving Medicaid at the time of application.
- The PACE organization completes the medical/functional assessment.

- The beneficiary must meet the nursing facility level of care eligibility criteria.
- The PACE organization submits an enrollment request to MDCH.
- MDCH processes the enrollment request by inputting the level of care codes, the provider type code, and the PACE organization's Medicaid provider identification number in the Customer Information Management System (CIMS).
- All new enrollments are entered prospectively.

## DISENROLLMENT FROM PACE

Disenrollment requests are submitted by the PACE organization for approval and processing by MDCH. PACE enrollees can be disenrolled for the following:

- Death
- Voluntary disenrollment requests
- Program violations
- No longer meets the nursing facility level of care eligibility criteria
- No longer resides in the approved geographic area of the PACE provider

## ASSET ELIGIBILITY

Special Medicaid policies used in the eligibility determination are:

- A PACE enrollee is a group of one, even when they live with their spouse.
- The Special Medicaid Asset Rules apply to PACE enrollees.
- Medicaid Divestment Policies apply to PACE enrollees.

## INCOME ELIGIBILITY

Income for a PACE enrollee must be at or below 300% of the SSI Federal Benefit Rate (FBR). Current Medicaid policies for income and assets are used to determine the net income. Income eligibility cannot be established with a spenddown or a patient-pay amount.

## PATIENT-PAY AMOUNT

A patient-pay amount will be calculated if a PACE enrollee is admitted to a nursing facility. The (post eligibility) patient-pay is the enrollee's share of their cost for the nursing facility. The amount of the patient-pay is the enrollee's total income minus total need.

The PACE organization is responsible for collecting the patient-pay amount; therefore, notice of the start (and the effective date) of a patient-pay amount, and any changes to the amount, must be sent to the PACE organization.

## IDENTIFYING PACE ENROLLEES

A PACE enrollee can be identified on the Electronic Verification System (EVS) with a Level of Care code of 07, and a unique Provider Identification Number assigned to the PACE organization by MDCH.

## NOTICES

PACE services are provided by organizations who have received federal and state approval for administering the PACE program. Therefore, providers can share the following information with a PACE organization without a signed release from the beneficiary:

- A copy of the FIA 3503, Verification checklist
- A copy of the FIA 4598, Medical Program Eligibility Notice (or the LOA equivalent)
- A copy of the FIA 1175, Medicaid Determination Notice
- A copy of the FIA 4588, Initial Asset Assessment Notice

The original FIA 3503, FIA 4598, FIA 1175 and the FIA 4588 must be sent to the beneficiary or the guardian, court, or agency legally responsible for the beneficiary.

**NOTE:** Only the beneficiary's legal guardian, court, or agency legally responsible for the beneficiary can be entered as a third party type. The above list is not all-inclusive.

## ADMINISTRATIVE HEARINGS

The PACE organization is also required to inform a beneficiary of their right to a hearing when any adverse action is taken with the beneficiary's PACE enrollment, program participation, or program services. The PACE organization is MDCH's representative at any PACE administrative hearing.

All hearing requests must be in writing and signed by the beneficiary or a legal guardian.

For further information, contact the Administrative Tribunal and Appeals Division, Michigan Department of Community Health, P.O. Box 30763, Lansing, MI 48909 or through e-mail at administrativetribunal@michigan.gov.

## LEGAL BASIS

**Medicaid:**
1115(a)(1) of the Social Security Act
Title XXI of the Social Security Act

**Application Used:**
FIA-1171, Assistance Application
County Health Plan Application

## TARGET POPULATION

Childless adults, aged 19 through 64 years old, and with countable income at or below 35% of the federal poverty level who are uninsured may be eligible for this category.

Eligibility begins the first day of the calendar month in which the application was submitted, provided all eligibility criteria are met.

All eligibility factors in this item must be met in the calendar month being tested.

**Excluded Population**

Applicants and beneficiaries who do not meet the above-stated criteria or who are eligible for Medicaid through any other category are excluded from eligibility in this category.

**Retroactive Coverage**

There is no retroactive coverage for months prior to month of application for this category.

## NON-FINANCIAL FACTORS

Consider eligibility for Medicaid under every other category before authorizing this coverage. Applicants and beneficiaries eligible for Medicaid under any other program are not eligible for this category.

The non-financial eligibility factors in the following items must also be met according to Medicaid guidelines:

- Citizenship
- Residence
- Social Security Number
- Potential Resources
- Living Arrangement
- Institutional Status (If a person is in a hospital or long term care setting for more than 30 days, there is NO patient-pay amount determination. The case should be re-evaluated for other Medicaid categories, and a disability determination should be completed. The person remains eligible for this program while the eligibility determination for other Medicaid categories is being done).

Applicants/beneficiaries who have comprehensive health insurance are not eligible. If an applicant/beneficiary has access to comprehensive employer-sponsored health insurance, there are state-sponsored options to allow the applicant/beneficiary to join the employer-sponsored plan. (Refer to "Private/Employer Insurance Options" below.)

## FINANCIAL FACTORS

- Fiscal group's total countable income cannot exceed 35% of the Federal Poverty Level (FPL).
- Income eligibility cannot be established with a spenddown.
- The countable asset limit is $3,000.
- Asset eligibility exists when the eligibility criteria for assets are met as defined in Chapter I, Section 11 (Low Income Families), of the Health Care Eligibility Policy (HCEP) Manual.

## FISCAL GROUP COMPOSITION

The fiscal group consists of:

- The applicant/beneficiary; and
- The applicant's/beneficiary's spouse who lives with the applicant/beneficiary and who is not an SSI recipient.

"Lives with" means sharing a home except for a temporary absence. A temporarily absent person is considered in the home.

A person's absence is temporary when:

- Their location is known; AND
- There is a definite plan for their return; AND
- They lived with the group before the absence; AND
- The absence lasted, or is expected to last, 30 days or less.

Exceptions to temporary absences:

- A person in a medical hospital is considered in the home.
- A person is considered in the home when absent for training or education.

If the applicant/beneficiary and/or spouse refuses to provide required information or verification, then neither is eligible.

## BUDGETING

- Use the FIP-related Medicaid policy to determine countable income.
- Budget period is one month.
- Averaged income is income received in one month but is intended to cover several months. Divide the income by the number of months it is intended to cover to determine the monthly countable income.
- At application, use actual income received during the month of application or amount expected to be received if the application month is also the processing month and additional income is forthcoming for that month.
- Base estimates of daily income on a 30-day month.

**Earned Income Disregard**

Deduct $200 from the person's countable earnings. Then, deduct an additional 20% from the person's remaining earnings.

**Paid-Out Child Support Disregard**

Disregard court-ordered support paid for a child outside the home by a fiscal group member from the group's remaining combined earned and unearned income. The disregard cannot be greater than the amount ordered for the month; arrearage payments are not deducted.

**Special Living Arrangement Disregard**

If the applicant/beneficiary has any of the following living arrangements, apply the stated disregard:

| | |
|---|---|
| Adult Foster Home - Personal Care | $710 – 35% of FPL |
| Adult Foster Home - Domiciliary Care | $639 – 35% of FPL |
| Home for the Aged | $427 – 35% of FPL |

## DEPARTMENT REVIEWS

Requests for Department Review, complaints, and grievances regarding **eligibility** for the Adult Benefits Waiver (ABW) will be resolved through the Department Review Process.

The family must be notified of the eligibility decision. Included with the notification is the applicant's/beneficiary's right to request a Department Review.

The family has the right to appeal the eligibility decision made by the Department.

## PRIVATE/EMPLOYER INSURANCE OPTIONS

If an eligible person has access to employer-sponsored health insurance that provides coverage for physician services, pharmacy and inpatient hospital services, the state may provide the person with a voucher (equal in value to the state's cost of providing service) that can be used to join the employer-sponsored plan. Enrollment in the employer-sponsored plan would be in lieu of receiving benefits through the state health plan.

The application for coverage will include a box for applicants to check who wish to enroll in employer-sponsored health coverage in lieu of enrollment in the state health plan. Staff operating the voucher program will contact individuals who check the box. Information will then be collected on the employer plan, the employee's share of the cost, eligible persons to be covered under the employer plan, and open enrollment opportunities. The applicant will have the opportunity to discuss the benefits of choosing employer-sponsored coverage versus the state health plan coverage so that they may make an informed decision. The applicant will also be provided information regarding their responsibilities to maintain coverage through the employer and to report immediately any change related to the employer coverage. Once enrolled in the voucher program, the beneficiary will receive a monthly check for the amount of the employee share of the coverage obtained or the cost of placing the eligible beneficiary in a state health plan, whichever is less.

To ensure the employer-sponsored coverage is actually purchased by the beneficiary, the State will do tape matches with the State's largest insurer (Blue Cross and Blue Shield of Michigan/BCBSM) and will audit a sample of cases where BCBSM is not the employer's carrier. Those selected in the audit sample will be required to provide copies of pay stubs or other verification that all eligible beneficiaries are enrolled as agreed upon between the state agency and the beneficiary. Persons who are found not to have purchased the employer-sponsored coverage as agreed will be required to pay back the amount received in premium assistance for months where the coverage was not in place. The beneficiary will also be excluded from future participation in the voucher program.

To ensure that the cost of the employer-sponsored coverage does not exceed the cost of providing coverage through a health plan under contract with the State Medicaid Program, staff will monitor the cost of buying-in on a per beneficiary level. The cost of buying-in to the employer-sponsored coverage will be compared with the cost to the State and federal governments of purchasing coverage through the State Medicaid Program. If the employer-sponsored coverage were more expensive than the monthly cost of the State Medicaid Program or the county health plan, the beneficiary will not be allowed to buy-in. If the cost of buying-in is less than or equal to the cost of the State Medicaid Program, the beneficiary will be allowed to buy-in to the employer-sponsored coverage. The State's monitoring of each buy-in decision will ensure the cost effectiveness of the buy-in program and ensure that the costs to the federal government are no greater than they would have been without the buy-in.

## LEGAL BASIS

1902(a)(9)(A) of the Act
42 CFR 435.1008
42 CFR 435.1009
DCH Appropriations

**Program(s) Affected:**
Medicaid, MOMS, ABW, TMA-Plus

## ELIGIBILITY REQUIREMENTS

The living arrangement is a non-financial factor considered for program eligibility and coverage of services. When the beneficiary resides in a psychiatric facility, age and living arrangements are considered. (Refer to "PSYCHIATRIC FACILITY" in this item for more information.)

## PARTIAL MONTH

If a beneficiary enters or leaves a facility that is not a covered facility (e.g., jail) during a month of eligibility, they remain eligible for health coverage for the rest of the calendar month. However, services provided to the beneficiary while they are in the non-covered facility are limited (e.g., reimbursable) to services received during an off-site inpatient hospitalization.

## INDEPENDENT LIVING

Beneficiaries in independent living have a level of care (LOC) code other than 02, 08, 22, 55, or 56. Their eligibility is based on the category of medical assistance.

## MEDICAL INSTITUTION

Eligibility for individuals residing in a medical institution is determined differently than community-based individuals. Medical assistance may be available depending on the applicant's or the beneficiary's income and assets, community spouse, possible dependents, and length of stay.

### Length of Stay

Medicaid

An individual's Medicaid eligibility and coverages will not be affected if the stay in the medical institution is less than an entire calendar month.

If the stay is longer than 30 consecutive days, a Post-eligibility Patient-Pay Amount (PPA) must be determined.

Adult Benefits Waiver (ABW)

If an individual is in a hospital or long-term care setting for more than 30 days, there is **NO** patient-pay amount determination. The case should be re-evaluated for other Medicaid categories, and a disability determination should be completed. The individual remains eligible for this program while the eligibility determination for other Medicaid categories is being done as there is no long-term care coverage for this program.

## INSTITUTION FOR MENTAL DISEASES (IMD)

Individuals between the ages of 21 and 65 who are residents of an Institution for Mental Diseases (IMD) are ineligible for medical assistance. Ineligibility applies when an eligibility determination is made, either at the time of application or during any periodic review of eligibility.

If the individual is an inpatient of an IMD when they turn age 21, they are eligible to continue as an inpatient until age 22. However, if the individual is discharged at some time following their 21st birthday, coverage is terminated on the discharge date.

## PSYCHIATRIC FACILITY

An individual between the ages of 22 and 64 in a psychiatric facility (not Institution for Mental Diseases) may qualify for medical services if they were, or are expected to be, a resident for less than the entire calendar month.

## CHILD CARING INSTITUTION (CCI)

Individuals residing in Child Caring Institutions (CCIs) should have eligibility determined on an individual basis. Because some CCIs have both treatment and detention wings within the same facility, the individual may or may not be eligible for full coverage based on their reason for being in the CCI and their placement (detention vs. treatment) within the facility.

Individuals residing in CCIs for purposes of involuntary confinement in a penal facility (such as prison, jail, or detention) may be eligible for assistance; however, coverage is limited to services received during an off-site inpatient hospitalization.

Individuals residing in CCIs only for purposes of receiving care, maintenance, and supervision (other than penal in nature) may be eligible for the full assistance benefit.

## NON-MEDICAL FACILITY

Eligibility is determined based on the individual's medical category; however, coverage of medical services may be limited. For individuals in a non-medical facility, coverage is dependent on the following factors:

- Voluntary Admission vs. Involuntary Admission
- Private Facility vs. Public Facility
- Detention vs. Treatment vs. Transitional Placement

Infants living with the applicant or beneficiary in the non-medical public institution are eligible for the full medical assistance benefit.

## Voluntary Admission vs. Involuntary Admission

Voluntary Admission

If the admission is voluntary and for the entire calendar month, eligibility should be determined based on the categories of medical assistance. The program may be billed for covered services provided.

Involuntary Admission

If the admission is involuntary and for the entire calendar month, eligibility may exist; however, coverage is limited to off-site inpatient hospitalization. For ABW only, if the period continues beyond 30 days, the beneficiary is no longer eligible and the case will close. The facility is responsible for all other medical services provided to the applicant or the beneficiary.

## Private Facility vs. Public Facility

Private Facility

If the applicant or beneficiary is in a private facility, eligibility may exist and full medical assistance coverage may be available.

**Exception:** A private facility under contract to a governmental unit is considered a public facility. Coverage is limited to off-site inpatient hospitalization.

Public Facility

If the applicant or beneficiary is in a public facility, eligibility may exist; however, coverage is limited to off-site inpatient hospitalization.

## Detention vs. Treatment vs. Transitional Placement

Detention

If the applicant or beneficiary is being detained, eligibility may exist; however, coverage is limited to off-site inpatient hospitalization. This includes an individual awaiting trial, awaiting suitable placement in a correctional facility, or in custody. The facility is responsible for all other medical services provided to the applicant or beneficiary.

Treatment

If the applicant or beneficiary is ONLY receiving active treatment (medical and/or mental), eligibility may exist and full medical assistance coverage may be available. The program may be billed for covered services provided.

**NOTE:** If the applicant or beneficiary is receiving active treatment while being involuntarily detained, eligibility may exist; however, coverage is limited to off-site inpatient hospitalization. The facility is responsible for all other medical services provided to the applicant or beneficiary.

Transitional Placement

If the applicant or beneficiary is involuntarily detained while awaiting permanent placement in a non-medical public institution, eligibility may exist; however, coverage is limited to off-site inpatient hospitalization. The facility is responsible for all other medical services provided to the applicant or beneficiary.

A child that is in temporary placement for shelter purposes (e.g., protective custody) is considered a voluntary admission and may be eligible for, and receive, full coverage for medical services.