

2016 MEDICAID ESSENTIALS¹

INSTITUTIONAL CARE PROGRAM (ICP)

- ❖ The Institutional Care Program (ICP) helps people in nursing facilities pay for the cost of their care and other medical services.
- ❖ Additional technical criteria include:
 - Determined to be in need of nursing facility services and appropriate placement as determined by the Department of Elder Affairs (DOEA), Comprehensive Assessment and Review (CARES) process.
- ❖ Other important criteria for ICP eligibility include:
 - Transfer of Assets – assets transferred on or after January 1, 2010, may potentially affect eligibility. The look-back period for asset transfers is 60 months prior to the application month for long term care (LTC).
 - Spousal Allowance – assets and income are evaluated for married individuals when one spouse is institutionalized and one spouse continues to live in the community (referred to as the “community spouse”). The community spouse may be eligible to receive a portion of the institutionalized spouse’s income.

SSI-RELATED MEDICAID PROGRAMS WITH LIMITED BENEFITS²

- ❖ The Qualified Medicare Beneficiaries (QMB) Program allows qualified individuals to have Medicaid pay for their Medicare premiums (Part A and B), Medicare deductibles and Medicare coinsurance (within prescribed limits)
- ❖ QMB recipients automatically qualify for assistance with Medicare Prescription Drug Plan costs through the Extra Help Program
- ❖ Additional technical criteria include:
 - Entitlement to Medicare Part A.

¹ The information contained in this document is quoted directly from the Florida Department of Children and Families SSI-Related Medicaid Programs Fact Sheet found at <http://www.dcf.state.fl.us/programs/access/docs/ssifactsheet.pdf> (October 2016).

² Not all programs are listed in this document.

- The ICP, Hospice, HCBS and PACE Programs all have additional income and resource (asset) criteria, which are evaluated during the eligibility determination process. These additional criteria are discussed on the next few pages.

❖ SSI-Related Medicaid Technical Requirements:

- Aged, Blind or Disabled – an individual must be aged (65 or older) or, if under age 65, blind or disabled. Note: The disability must prevent the individual from working and be expected to last for a period no less than 12 months, or be expected to result in death. Individuals who receive a disability check from the Social Security Administration (SSA) based on their own disability automatically meet this requirement. A disability determination is completed by Social Security or the state Division of Disability Determinations (DDD). DCF submits requests to DDD after the Medicaid application is received.
- Citizenship Status – an individual must be a U.S. citizen or a qualified noncitizen. Note: There may be a waiting period for non-citizens admitted to the U.S. with a qualified status on or after August 22, 1996.
- Identity – an individual must provide proof of identity. Exception: individuals receiving SSI, Medicare or Social Security Disability based on their own work history.
- Residency – an individual must be a Florida resident
- Social Security Number – an individual must have a social security number or apply for one.
- File for Other Benefits – an individual must apply for other benefits for which they may be eligible (i.e.- pensions, retirement, disability benefits, etc.)
- Report Third Party Liability – examples include health insurance or payments by another party.

SSI-RELATED MEDICAID PROGRAMS WITH FULL BENEFITS³

❖ Medicaid for Aged and Disabled (MEDS-AD)

- This program does not cover blind individuals, unless they are considered disabled.
- Individuals cannot receive Medicare, unless the individual receives ICP, Hospice, or HCBS Waiver. Note: If nursing facility care is required, the individual must meet the additional eligibility requirements for ICP.

❖ Institutional Care Program (ICP)

³ Not all programs are listed in this document.

- The Institutional Care Program (ICP) helps people in nursing facilities pay for the cost of their care and other medical services.
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- Other important criteria for ICP eligibility include:
 - ◆ Transfer of Assets – assets transferred on or after January 1, 2010, may potentially affect eligibility.
 - ◆ The look-back period for asset transfers is 60 months prior to the application month for long term care (LTC).
 - ◆ Spousal Allowance – assets and income are evaluated for married individuals when one spouse is institutionalized and one spouse continues to live in the community (referred to as the “community spouse”). The community spouse may be eligible to receive a portion of the institutionalized spouse’s income.

❖ Hospice

- The Hospice Program helps maintain care for terminally ill individuals. To receive Hospice services, the individual must enroll in a Hospice program.
- Additional technical criteria include:
 - ◆ A medical prognosis that life expectancy is six months or less (as long as the illness runs its normal course)
 - ◆ Election of hospice services
 - ◆ A certification of the individual’s terminal illness by the physician or medical director.

HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVERS

- ❖ The HCBS Program Waivers allow individuals to live in the community in an effort to avoid institutionalization.
 - HCBS Waivers are:
 - ◆ iBudget Waiver
 - ◆ Cystic Fibrosis (CF) Waiver
 - ◆ Familial Dysautonomia (FD) Waiver

- ◆ Model Waiver
- ◆ Program for All-Inclusive Care for the Elderly (PACE)
- ◆ Project AIDS Care (PAC) Waiver
- ◆ Statewide Medicaid Managed Care Long – Term Care (SMMCLTC) Waiver
- ◆ Traumatic Brain and Spinal Cord Injury Waiver

QUALIFIED INCOME TRUST

- ❖ If an individual’s gross monthly income is over the limit to qualify for Medicaid long term care services (including nursing home care) – which currently is \$2,199 per month - a Qualified Income Trust (QIT) allows an individual to become eligible by placing income into an account each month. The QIT involves a written agreement, establishing a special account, and making deposits into the account.
- ❖ Who needs a Qualified Income Trust?
 - A qualified income trust is established when an individual’s income, before any deductions (such as taxes, Medicare or health insurance premiums), is over the income limit for the ICP, Institutional Hospice, HCBS Waiver or PACE Programs.
- ❖ How do I set up a Qualified Income Trust agreement?
 - Professional help may be obtained to set up the QIT agreement. A QIT agreement must meet specific requirements and be approved by Department of Children and Families Regional Legal Counsel. A copy of the QIT agreement must be submitted to an eligibility specialist who will forward these documents for review.
- ❖ What items must be included in the Qualified Income Trust agreement?
 - The QIT agreement must
 - ◆ Be irrevocable (cannot be canceled)
 - ◆ Require that the State receive all funds remaining in the trust at the time of the individual’s death (up to the amount of Medicaid benefits paid)
 - ◆ Consist of the applicant’s income only (Do not include or add assets)
 - ◆ Be signed and dated by the applicant, the applicant’s spouse, or a person who has legal authority to act on the applicant’s behalf
- ❖ How does the Qualified Income Trust account work?
 - After setting up the account, the individual must make deposits into the QIT account every month for as long as Medicaid is needed. This means deposits may be needed before a Medicaid application is approved. Deposits cannot be made for a past or future month. Any income received back from the trust will be counted as income. If a deposit is not made in any given month, or enough income is not deposited, the individual will be ineligible for Medicaid payment. As long as income is deposited into the QIT

account in the month it is received, it will not be counted. Note: The income placed into a Qualified Income Trust is excluded as income in the eligibility determination but counted in the calculation of the patient responsibility.

- ❖ How much income must I deposit into the Qualified Income Trust account?
 - Enough income must be deposited into the QIT account each month so that remaining income is within program standards. Call (866) 762-2237 or visit: http://www.dcf.state.fl.us/programs/access/docs/ssi_fin_elig_chart.pdf for information about current income standards.
- ❖ What happens to the income deposited in the Qualified Income Trust account?
 - The income deposited and withdrawn is used to calculate patient responsibility. If an individual has a patient responsibility, they are responsible for paying that amount. If funds are left in the QIT upon death, it is paid to the State, up to an amount equal to the total medical assistance the State paid on behalf of the individual.
- ❖ How to pay funds remaining in the QIT to the State?
 - The QIT trustee or other individual acting on behalf of the individual should contact the Long-Term care facility to see if any refund for the month of death is due back to the trust. The balance of the QIT as of the date of death, plus any refund from the Long-Term care facility, must be paid to the State. Mail a check payable to the “Agency for Health Care Administration” to: Xerox State Healthcare, LLC, PO Box 12188 Tallahassee, FL 32317-2188. A brief cover letter or note should state that the payment is for a QIT and include the Medicaid recipient’s name, social security number and/or Medicaid ID number. Enclose a copy of the QIT bank statement covering the date of death to confirm the check is for the balance. Also, include documentation of any refunds received from the Long-Term care facility. Contact Xerox State Healthcare, LLC at (877) 357-3268 if you have questions about payment of QIT funds to the State.

SPECIAL POLICIES THAT APPLY TO SPOUSES

- ❖ Resources and income are evaluated for married individuals when one spouse is institutionalized and one spouse continues to live in the community (referred to as the “community spouse”) when applying for the ICP, Institutional Hospice, HCBS Waiver (Cystic Fibrosis, iBudget, SMMC LTC only) or PACE Programs.
- ❖ Resources at Application: All resources of the husband and wife must be counted together to determine the eligibility of the institutionalized individual. After deducting \$119,220 from their combined resources for the community spouse resource allowance, the institutional spouse’s remaining resources must not exceed \$2000 to qualify (\$5000 if the institutional spouse’s monthly income is \$872 or less).

- ❖ Resources after Approval: Resources over the individual limit (\$2000 or \$5000) acquired after Medicaid is authorized must be transferred to the community spouse within twelve months after approval to maintain eligibility.
- ❖ Income at Application: Only the total gross monthly income received by the institutionalized spouse is considered in determining eligibility.
- ❖ Allocation to the Community Spouse
 - To calculate the amount of the institutional spouse's income a special budget is used to determine the monthly patient responsibility amount once the personal needs allowance has been deducted. An additional amount of the institutional spouse's income may be allocated to the community spouse. This is called the community spouse needs allowance.
- ❖ Determining the Community Spouse Needs Allowance
 - The community spouse needs allowance is computed as follows:
 - ◆ \$2,003 (minimum monthly maintenance needs allowance) + excess shelter costs* - community spouse's monthly gross income = community spouse income allowance** *Excess Shelter Cost is the amount by which the community spouse's shelter costs exceed \$601 per month. Shelter costs may include rent or mortgage payment, homeowner's insurance, condominium maintenance fees, and a monthly utility allowance of \$338 (effective 10/2016) based on the Food Assistance Program standard utility allowance. **Total community spouse income allowance cannot exceed \$2,981.
 - ◆ Exception to Spouse Allowance:
 - Court-ordered support. If there is a court order for support that is greater than the above allowance, the court ordered amount will be used as the community spouse allowance.
 - Other Dependents: Under certain conditions, a dependent allowance may also be deducted from the institutionalized individual's income.
- ❖ Budgeting: Calculating Patient Responsibility
 - Medicaid coverage for ICP, Hospice, HCBS (SMMC LTC, iBudget, and Cystic Fibrosis) and PACE programs may have a patient responsibility based on the individual's gross monthly income and their placement. The amount of the patient responsibility is determined by subtracting the personal needs allowance and other allowable deductions from the individual's gross monthly income. The other allowances and deductions that may apply are spousal and/or family allowance, court ordered child support (ICP), and uncovered medical expense deductions (UMEDS).

The amount of the personal needs allowance (PNA) is determined by the placement type where the individual resides; at home, in a nursing facility, or an Assisted Living Facility (ALF).

- The PNA is as follows:
 - ◆ Placement in a nursing facility: \$105
 - ◆ An ALF receiving HCBS is the provider rate plus 20% of the Federal Poverty Level
 - ◆ Residing in the community (at home) receiving HCBS is 300% of the Federal Benefit Rate

- Example 1: The applicant applies and is approved for ICP and reports a nursing home expense totaling \$8,000 (Uncovered Medical Expenses) prior to the month of approval.
 - ◆ Budget: $\$1,300$ monthly income - $\$105$ Personal Needs Allowance (PNA) = $\$1,195$
 - ◆ $\$1,195 \times 6$ months = $\$7,170$
 - ◆ $\$8,000$ nursing home bill - $\$7,170$ = $\$830$ remaining balance of bill
 - ◆ $\$8,000/6 = \$1,333.33 = \$0$ patient responsibility for each month

- Since the nursing home bill exceeds the monthly income, use the remaining balance from the bill when determining the patient responsibility for the next six months. At the six-month review, the remaining balance of the nursing home bill of \$830 is used as an Uncovered Medical Expense Deduction (UMED).
 - ◆ Budget: Remaining balance of bill $\$830/6 = 138.33$
 - ◆ $\$1,195 - \105 PNA = $\$1,090$
 - ◆ $\$1,090 - \$138.33 = \$951.67$ patient responsibility for each month

- Example 2: An individual resides in an Assisted Living Facility and has Social Security Income of \$1,750 each month. The ALF's basic monthly rate is \$1,500.
 - ◆ Budget: $\$1,750$ monthly income - $\$1,500$ *ALF basic monthly rate - $\$198 = \52 patient responsibility for each month *Note: This amount varies as it depends upon the facility's actual room and board charges.

- Example 3: The applicant applies for HCBS waiver and has Social Security income of \$1,900 each month and \$1,500 pension. The \$1,500 pension is placed in an income trust.
 - ◆ Budget: $\$1,900 + \$1,500 = \$3,400$ total monthly income - $\$2,199 = \$1,201$ patient responsibility each month.

SSI-RELATED MEDICAID PROGRAMS: INCOME AND RESOURCE LIMITS

- ❖ An individual's or couple's income and resources (assets) must fall within certain levels, which vary by program, to be eligible.

Eligibility Standards for SSI-Related Programs

Coverage Group (Program)	Income Limit	Asset Limit
Supplemental Security Income (SSI) Individual*	\$733.00	\$2,000.00
Supplemental Security Income (SSI) Couple*	\$1,100.00	\$3,000.00
ICP/HCBS/Hospice/HCDA Individual	\$2,199.00	\$2,000.00
ICP/HCBS/Hospice/HCDA Couple	\$4,398.00	\$3,000.00
MEDS-AD/ICP-MEDS/Individual (88% FPL)	\$872.00	\$5,000.00
MEDS-AD/ICP-MEDS/Couple	\$1,175.00	\$6,000.00
QMB Individual (100% FPL)	\$990.00	\$7,280.00
QMB Couple	\$1,335.00	\$10,930.00
SLMB Individual (100-120% FPL)	\$1,188.00	\$7,280.00
SLMB Couple	\$1,602.00	\$10,930.00
QI1 Individual (120-135% FPL)	\$1,337.00	\$7,280.00
QI1 Couple	\$1,803.00	\$10,930.00
Working Disabled Individual (200% FPL)	\$1,980.00	\$4,000.00
Working Disabled Couple	\$2,670.00	\$6,000.00

*SSI eligibility is determined by the Social Security Administration

Note: figures are as of April 2016