“Weeding Out the Underpayments ”

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Patient Pay Review M1470

Patient Pay: Post Eligibility Treatment of Income

- This is the patients share of LTSS cost
  - Medicaid payment to LTSS provider is reduced by the amount of patient pay
  - Patient pay is calculated in VaCMS
  - Patient pay is available to providers in their systems
  - Providers are responsible for collecting patient pay
  - LDSS is responsible to notify patient or AR of the amount
  - Patient pay does not apply to MAGI Adults in LTSS

Income Available For Patient Pay

3

- Gross monthly income is considered available for patient pay
- The same as used to determine eligibility in the300% SSI group
- This includes types and amounts that are excluded when determining medically needy (MN) eligibility.
- 300% SSI Group - M1470.100.1.C.
- Groups Other than 300% SSI - M1470.100.2.B. and C.

Income Available : 300% SSI Group

4

- Start with gross income used for eligibility (M1460.611)
- Exclude sources from M1460.610 "What is not income"
  - Exception Specific VA Payments (Applies to all LTSS Recipients including residents of a Veterans Care Center)

Count Aid & Attendance and VA Pension Payments in excess of $90.00 per month when the patient is a veteran with no community spouse or dependent child, or the patient is a deceased veterans surviving spouse with no dependent child, or the patient is a veteran's dependent child.

Do not count Aid & Attendance and VA Pension Payments if the veteran has no community spouse or dependent child or the survivor spouse has no dependent child

Available Income Cont.

5

- Exclude:
  - SSI & AG payments
  - Interest or dividends on excluded burial funds
  - Interest less than $10.00 per month
  - Repayments for prior overpayments **IF** S0830.110 exception is met
  - CBC care not purchased by the individual
  - Refundable payments to LTC Facilities made by families/other parties
  - Military Retiree Pension Survivor Benefit Plan Contributions

Income Available : Other Groups

- All countable sources for the 300% SSI group listed in M1460.611 are considered income in determining patient pay including specific VA Aid & Attendance & Pension
- Any other income NOT specified in M1470.100.C
- Non-Refundable Advance Payments to LTSS Providers (See M1470.1100 for calculation when advance payments are made)

Allowable Deductions From Income

7

- M1470.200 Facility Patients (With No Community Spouse*)
  - Order of Patient Pay Deductions M1470.210 - M1470.240
  1. Personal Needs
  2. Dependent Child Allowance
  3. Non-covered Medical Expenses
  4. Home Maintenance

The patient or representative has appeal rights to the determination of patient pay or denial of request for adjustments. If appealed the BPS prepares the summary and attends the hearing.

**See M1480 for Patient Pay when there is a community spouse

Facility Personal Needs

- Basic Personal Allowance $40 per individual
- Guardianship Fee 5% of gross monthly income if there is a legally appointed guardian/conservator AND they charge a fee
- Special Earnings Allowance if the patient participates in a work program as part of treatment of $75.00 of gross earnings plus ½ remainder not to exceed $190.00 total

Dependent Child Allowance

9

- An unmarried individual or married individual with no community spouse who has a minor dependent child(ren) under age 21 in the community can have a dependent child allowance.
- Calculate the difference between the appropriate monthly MN limit for the child's locality for the number of minor dependent children in the home and the child's monthly income. Note if the child lives outside Virginia use the Group III MNIL.

Noncovered Medical Expenses

- Medical and dental services not covered by Medicaid or other insurance
- Some must be approved by DMAS
- If deductions cannot be allowed due to no remaining income or no income available, deny the request
- See M1470.230 for the list of allowable non covered expenses and services NOT allowed
- Documentation includes a copy of the bill, amount owed by the patient and proof of medical necessity

Home Maintenance Deduction

- Can be allowed for a single institutionalized individual for not more than six months if a physician has certified patient is likely to return home within that period
- The individual must have responsibility to pay shelter cost of the former residence in Virginia
- Admission to a nursing facility from an ALF has home maintenance deduction even if not temporary
- Only one spouse of institutionalized married couple is allowed the deduction to maintain a home
- The home maintenance is the MNIL for one person in the locality of residence.

Medicaid CBC Patients

- Deduct CBC Personal Maintenance Allowance
- Dependent Child Allowance
- Medicaid CBC – Incurred Medical Expenses

!!CBC patients are not allowed the home maintenance deduction because shelter cost are included in the personal maintenance allowance.

Appeal rights apply to CBC patient pay.

Medicaid CBC – Personal Maintenance Allowance

- Individuals receiving Medicaid CBC under Virginias waivers or who are enrolled in PACE are allowed the basic monthly PMA
- PMA 01/01/2024 = $1556.00
- 5% gross monthly income for guardianship/conservator if legally appointed and they charge a fee
- Special Earnings Allowance for waiver recipients if working, the work does not have to be part of treatment
  - Employed 20 or more hours – all earned income up to 300% SSI
  - Employed 4 to 20 hours – all earned income up to 200% SSI

  $$$Total amount of PMA cannot exceed 300% SSI

Dependent Child Allowance

- An unmarried individual or married individual with no community spouse who has a minor dependent child(ren) under age 21 in the community can have a dependent child allowance.
- Calculate the difference between the monthly MN income limit for the child's home locality for the number of minor dependent children in the home and the child's monthly income. If the children live in different homes, the allowances are calculated separately. The result is the dependent child allowance. If $0, no deduction.
- Do not deduct an allowance for any other family member.

Medicaid CBC - Non Covered Medical Expenses

- Amounts for incurred medical and dental not covered by Medicaid or another third party
- Health insurance premiums private or commercial deducted or paid from the patient's funds and meet the definition of health benefit plan
- Medicare A and/or B premiums for months not paid by the Medicaid "buy-in". Do not deduct for months paid by buy-in.
- Medicare Advantage (Part C) and Medicare Part D if the individual is responsible for a premium payment
- LTC Insurance premium the month of admission only

Medicaid CBC – Noncovered Medical Expenses

- Noncovered Medical or Dental Services
- If deductions cannot be allowed due to no remaining income or no income available, deny the request
- See M1470.430 for the list of allowable non covered expenses and services NOT allowed
- Documentation includes a copy of the bill, amount owed by the patient and proof of medical necessity
- DMAS approval is not required for deductions of noncovered services when the individual receives CBC regardless of the amount

M1470.520 PACE

- The Program of All-inclusive Care for the Elderly (PACE) individuals have a patient pay
- Use procedures for CBC patient pay if the individual is not medically needy
- PACE recipients are not responsible for Medicare D premiums
- PACE includes most medically necessary services the individual needs, not all CBC medical deductions are allowed
- PACE recipients may enter a nursing facility as part of the benefit package of PACE. Do not change the personal needs allowance unless notification is received from PACE

Medically Needy Patient Pay

- M1470.600 MN Patients – Spenddown Liability section is for unmarried individuals and married individuals with no community spouse. **Do Not Use** this section for a married individual with a community spouse. **Refer to M1480.**
- Individuals with income in excess of 300% SSI must have a monthly spenddown liability that is met before they can be eligible for Medicaid
- Patient pay for each month the spenddown is met must be determined

Facility Patients – Spenddown Liability Less Than or Equal to Medicaid Rate M1470.610

- Can be eligible effective the first day of the month based on projected Medicaid (RUG) rate.
- Determine gross monthly income
- Subtract the SDL and allowable deductions to determine contributable income
- Medicaid must not pay any of the SDL to the provider, the SDL is added to income available for patient pay
- Compare contributable income to the Medicaid rate. The patient pay is the lesser of the two amounts

Facility Patients – Spenddwn Liability Greater Than The Medicaid Rate M1470.620

- Is not eligible until actually incurs medical expenses that meet the SDL for the month.
- Determinations are made retrospectively, after the month has passed and expenses been incurred
- Resources and income must be verified each month before determining if the spenddown has been met
- Eligible for the entire month if the spenddown is met
- Medicaid must not pay any of the recipients SDL to the provider, but SDL is not added to patient pay
- Determine gross monthly income, subtract allowable deductions, compare remaining income to the Medicaid rate, patient pay is the lesser of the two

CBC Patients With Spenddown Liability M1470.630

- Screened and approved waiver service patients with income over 300% SSI are placed on monthly spenddown as institutionalized individuals
- CBC expenses cannot be projected for the spenddown budget period, determinations are made monthly after the month has passed and expenses actually incurred
- CBC expenses along with other allowable medical and dental expenses are deducted daily and chronologically as the expenses are incurred
- Resources and income must be verified each month before determining if the spenddown is met
- Eligible for the full month if the spenddown is met
- SDL is not added to the available income for patient pay

PACE Recipients With Spenddown Liability M1470-640

- Monthly spenddown applies to PACE recipients who have income over the 300% SSI limit, they have been screened and approved for LTSS
- PACE has a capitated monthly rate that is due and payable on the first day of the month. The PACE rate is available from the provider
- The PACE rate and SDL establish if the spenddown can be projected or must be determined retrospectively
- Calculate patient pay based on either projected or retrospective eligibility determinations
- Medicare D premiums cannot be used to meet the spenddown or deducted from patient pay

M1470.800 Communication Between LDSS and LTSS Provider

- The Medicaid LTC Communication Form (DMAS 225) is used to exchange information between the local agency and the providers
- Used by both LDSS and LTSS Providers
- BPS should generate the 225 through VaCMS
- Used to notify of patients Medicaid eligibility status, patient pay available in the system, changes in deductions, document death if an individual, document admission or discharge, provide information on insurances, provide other information that may cause a change in eligibility status or patient pay.

LTSS - No More Underpayments

According to a clarification from the Centers for Medicare & Medicaid Services (CMS), we are not allowed to collect Patient Pay underpayments that have occurred in the past.

A Broadcast was issued on 7/19/2023, "Guidance Regarding LTSS Underpayments," advising that Patient Pay Underpayments should no longer be calculated and should no longer be referred to DMAS Recipient Audit Unit for recovery.

M1470.900: Adjustment and Changes

- Policy was updated to remove references to patient pay underpayments and the requirement to refer individuals to the Recipient Audit Unit (RAU) when an underpayment has occurred.

- What does this mean?
  - We are no longer allowed to calculate or enter underpayments per policy requirements.
  - All increases in patient pay are to be made prospectively and in accordance with advanced or adequate notice guidelines as appropriate.

CR846:VaCMS updates as of 03/31/24

VaCMS will now not apply or calculate any adjusted underpayments as part of CR846 deployment.

Verbiage stating “No adjusted underpayment applied per CMS” was added to the EDG review screen under the Eligibility Summary. The Underpayment amount section was also removed from the Patient Pay Central Print & Manual Notices.

M1470.900: Adjustments and Changes

The Medicaid recipient or his authorized representative is responsible to report any changes in his or her situation within 10 days of the day the change is known.

In situations where the patient pay amount is less than the Medicaid rate, the patient pay must be adjusted within 30 days of notification or discovery of the change.

M1470.900: Adjustments and Changes

CHANGES CAN BE REPORTED BY THE CUSTOMER, THEIR REPRESENTATIVE, OR THEIR PROVIDER. CHANGES CAN ALSO BE DISCOVERED AT REDETERMINATION.

REVIEW THE TYPE OF CHANGE TO DETERMINE THE IMPACT IT MAY HAVE ON THE CASE.

WILL THE CHANGE IMPACT THEIR PATIENT PAY OR THEIR ELIGIBILITY?

M1470.900: Adjustments and Changes

Types of changes that could impact patient pay

- Income: Increase vs. decrease
- Deductions:
  - Provider: Personal needs allowance vs. personal maintenance allowance
  - Household size: loss or gain of a spouse or other household dependents
  - Expenses: loss or gain of a medical deduction

Each of these scenarios could result in what would have previously resulted in an underpayment in VaCMS.

Change in Income

The most common income change that we are already aware of is the annual Cost of Living Adjustment. (COLA) The PHE impacted the mass change process because we were not allowed to take negative actions during that timeframe.

- Prior to this timeframe, an automated process updated the majority of patient pays effective the first of the year with the new Social Security amount.
  - There were scenarios where cases exceptioned out of the process and it was up to the worker to do a manual adjustment. Cases where there was a spousal allowance were part of this group.
- Patient pays were not increased by the COLA for 2021-2023 because no negative actions were allowed during the PHE.
- After the PHE, we could not take action to increase a patient pay until that person had an opportunity to complete a renewal.

Change in Income

Example: Nursing home client renewal overdue. The member submits the renewal on 03/16/2024. The current patient pay amount did not include the COLA increases for 2021-2023 per PHE procedures.

The patient pay should be adjusted using the 2024 income amount moving forward, effective the first month after the member has been given 10 days advance notice.

No underpayment is calculated.

Change in Income

Other income is evaluated at the time it becomes known to the agency. The increase (*or receipt)* of other income is evaluated with consideration to the advanced notice requirements and no underpayment is calculated.

- Pensions/Retirement
- Veteran's benefits
- Earned income

Calculate the new patient pay based on the current income and make the change effective the month following the month in which the 10-day advance notice period ends.

Change in Deductions

Changes to the allowable deductions from the patient pay can result in an increase as well.

- Spousal allowance
  - Death of community spouse
  - Change in community spouse's income or expenses
- Medical expenses
  - Decrease or loss of premiums for supplemental insurance
- Change in provider
  - From personal care to nursing facility

Change in Deductions

Example: At renewal, it is discovered that the customer's spouse passed away six months ago. They are in a nursing home and have been receiving a spousal income allowance from their patient pay.

The loss of the spousal allowance is effective the month following the month that advanced notice is given.

No underpayment is calculated.

Change in household size/allowances

When someone moves from personal care to a nursing facility, their allowable deductions will change.

- Personal maintenance allowance of $1,566 (2024)
- Personal needs allowance of $40.

During the PHE, these individuals did not experience a change in their patient pay as it was considered a negative impact. Nursing facilities continued to contact local agencies wanting an updated patient pay, but it was not allowed to be addressed until the redetermination was completed after the PHE.

No underpayments were calculated.

Case Scenario Changes

Moving from limited to full coverage

The agency receives a DMAS-225 from a nursing home indicating that an ongoing married QMB enrollee has entered their facility as of 08/01/23. After following policy in M14 to ensure case accuracy, they complete the following steps to evaluate the individual for full coverage under the 300% covered group:

- Case put in case change mode.
- Living arrangements updated with effective date of 08/01/23.
- MA Institutionalized screen updated with effective date of 08/01/23 and the questions are answered to ensure that the spousal allowance is calculated.
- Retro-cancel-reinstate (RCR) run as of 08/01/23 to update AC from QMB to LTSS.

The Patient Pay is determined as of 08/01/23. AC updated from 023 to 022. There is no underpayment .

Patient Pay Calculation		
Spenddown Liability	=	N/A
Personal Needs / Maintenance Allowance	-	$ 40.00
Spouse Allowance	-	$ 1825.00
Family Allowance	-	$ 0.00
Dependent Child Allowance	-	$ 0.00
Medicare	=	$ 0.00
Other Health Insurance	=	$ 0.00
Non-covered Medical Expenses	-	$ 0.00
Home Maintenance	-	$ 0.00
Spenddown Liability	=	N/A
Contributable Income	=	N/A
NF Monthly Medical Rate	=	$ 6422.00
Actual Monthly CBC Cost	=	$ 0.00
Actual Patient Pay Amount	=	$ 0.00

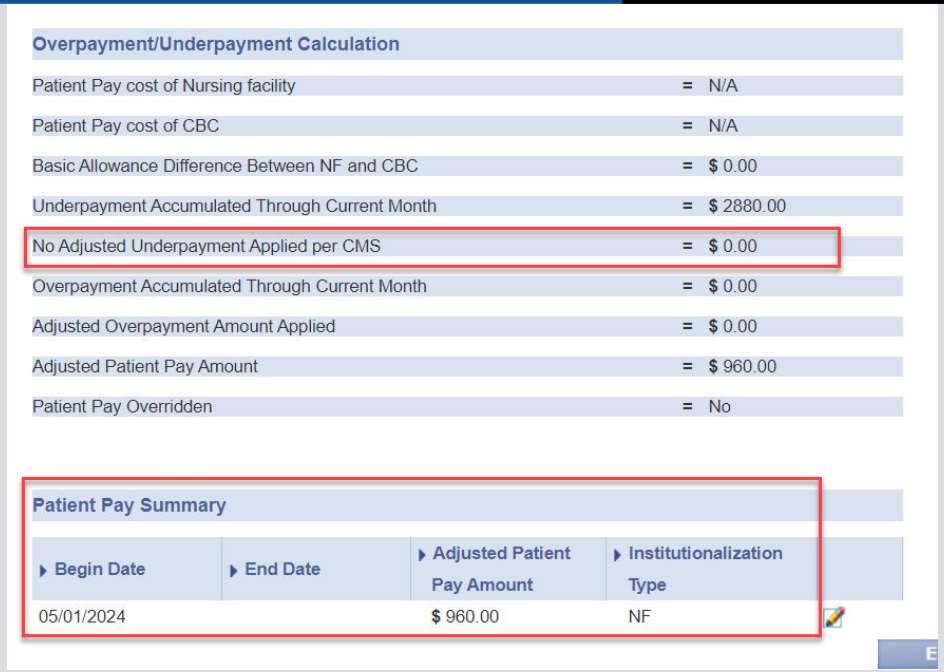
Case Scenario Changes

Changes in Deductions

It is discovered that the community spouse passed away 01/31/24.

- Date of death updated on client screen, and it is indicated that she is out of the home- effective 02/01/24.
- MA Institutionalized screen effective date 02/01/24 updated to reflect that the spousal allowance is no longer being paid. (* VACMS is not intuitive enough to know that there is no community spouse, even when they are attached to the case and marked as deceased. It will continue to allow the deduction.)
- When eligibility is run, there is no change to the prior patient pays. It remains zero for months prior to the month eligibility is run. The new patient pay is effective the month following action taken where ten days advanced notice timeframe is allowed.

The patient pay calculation displays the new verbiage and no underpayment is applied to ongoing patient pays.



Overpayment/Underpayment Calculation

Patient Pay cost of Nursing facility	=	N/A
Patient Pay cost of CBC	=	N/A
Basic Allowance Difference Between NF and CBC	=	$ 0.00
Underpayment Accumulated Through Current Month	=	$ 2880.00
No Adjusted Underpayment Applied per CMS	=	$ 0.00
Overpayment Accumulated Through Current Month	=	$ 0.00
Adjusted Overpayment Amount Applied	=	$ 0.00
Adjusted Patient Pay Amount	=	$ 960.00
Patient Pay Overridden	=	No

Patient Pay Summary

Begin Date	End Date	Adjusted Patient Pay Amount	Institutionalization Type
05/01/2024		$ 960.00	NF


Questions?