

Department of Public Health
and Human Services

Section:

RESIDENTIAL MEDICAL
INSTITUTIONS

MEDICAL ASSISTANCE

Subject:

Montana State Hospital Residents

Supersedes: MA 907-1 (07/01/06)

References: 42 CFR 435.725, .832, and .1008-1009, & 441.151; ARM 37.82.101, .1301, .1305, .1306, .1312, .1313, .1321, .1330, .1331, .1336-.1338

GENERAL RULE--Residents of Montana State Hospital at Warm Springs (MSH) who are over age 21 and under age 65 are not eligible for Medicaid payment of ANY medical services, regardless of whether the services are provided at MSH or away from MSH, or by an MSH staff member or any other Medicaid provider. However, their Medicaid may remain open to more easily accommodate their return to the community by providing immediate access to Medicaid upon release.

However, a Medicaid recipient who was admitted to MSH for a continuous period that began prior to his or her 21st birthday remains eligible for Medicaid coverage through the date he or she reaches age 22, unless found ineligible for Medicaid for another reasons (e.g., resources, disability, etc.)

An individual who is not eligible to receive Medicaid coverage under these provisions may remain open for Medicaid on the system for up to six months. Medicaid will close when six months of institutionalization have occurred. The eligibility case manager must manually set a TEAMS alert for six months.

When any Medicaid recipient enters MSH, the period of institutionalization must be recorded in TEAMS by entering an MSH span on the right side of the 'WACI' screen. In CHIMES, this will mean entering a span on the "Benefit Suspension Maintenance" web page if the person is not eligible for Medicaid coverage of services according to the policy above.

**RESIDENTS
UNDER 21 OR
65 AND OVER**

When a Medicaid recipient is temporarily admitted to MSH, MSH will contact the eligibility case manager where the recipient's Medicaid is open, and provide the patient's admission date.

If the Medicaid recipient is expected to return to the community by the end of the following month, the OPA that has the open case at the time will maintain the OPEN Medicaid case, and set an alert to follow up on the recipient's return to the community.

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If the Medicaid recipient is expected to remain at MSH past the end of the following month, the OPA will transfer the OPEN Medicaid case to the Deer Lodge County OPA. Deer Lodge County OPA will maintain the Medicaid case through the recipient's stay at MSH.

DISCHARGE

As a part of a discharge plan, MSH will notify the OPA that has the open Medicaid case regarding the planned discharge date. If the recipient will reside in a different county, transfer of the authorized Medicaid case will be made to the new county of residence.

If the Medicaid case has been closed, MSH will notify the county to which the former Medicaid recipient will be released, and will assist the individual with completing the Medicaid application process. If the individual is reapplying for Medicaid ONLY (rather than Medicaid and Food Stamps, for example), a redetermination form may be used as a reapplication at county discretion, if the Medicaid closure occurred within 30 days. The processing of the Medicaid application should be expedited in order to allow the individual immediate access to necessary medical services upon discharge. If the case was previously open in another county, the new county will notify the previous county of the change and pertinent documents from the physical case file must be faxed to the new county of residence within one working day. The physical case file should then be mailed to the new county of residence within three working days.

If a Medicaid recipient is in MSH for an extended period of time, the OPA must monitor disability re-examination dates. Re-examination dates are set by SSA or MEDS, depending on which entity determined disability. If the individual is not receiving SSI or SSDIB continuously, re-examination of disability criteria will be made through MEDS, when re-examination is due.

For MSH residents who are not open for Medicaid, and who do not have a current finding of disability, and have not had SSA disability denied within the past 12 months, the MEDS process will be used to make disability determinations for anticipated release dates which are more than 30 days into the future. MSH staff will assist in completing the MEDS process.

CONVALESCENT LEAVE AND CONDITIONAL RELEASE

An individual over age 21 who is away from MSH on convalescent leave or conditional release is no longer considered a resident of MSH and will be eligible for Medicaid payment for services during the convalescent leave or conditional release. Conditional release does not include a temporary release for the purpose of obtaining medical treatment.

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For purposes of Medicaid coverage of services for an individual who has attained age 21 while an inpatient at MSH, but has not yet turned 22, convalescent leave and conditional release do not constitute unconditional release from the facility, and therefore do not disrupt their status as continuously institutionalized.

**TEAMS
PROCESSING
RESIDENTS AGES
21 (or 22)-64**

Medically Needy: The OPA will assure Medicaid rollover each month. The incurment will not be worked on the system unless the MSH patient is on convalescent leave.

The OPA will close Medicaid at the end of six months, based on the system alert that is generated when the incurment is not met for six months. Timely notice must be given.

Categorically Needy: Medicaid cases with no incurment will auto-authorize. The eligibility case manager will set an alert to close Medicaid at the end of six months. Timely notice must be given.

**RESIDENTS
UNDER AGE 21 &
AGE 65 OR OLDER**

Individuals under age 21 (or 22, see General Rule) and age 65 or older may be eligible for Medicaid coverage and payments for services will be made. All financial and non-financial criteria for nursing home residents apply to individuals residing in MSH. These may include:

- Budget processes to determine amount of income applicable toward cost of care (MA 904-2 and 904-3)
- Home maintenance allowance
- Resource assessments when there is a community spouse (MA 903-1)
- Spousal income maintenance (MA 904-2)
- Family income maintenance (MA 904-2 and 904-3)
- Temporary absence from home (MA 402-1 "Home and Surrounding Property")
- Conditional Assistance (MA 402-4)

TEAMS is not programmed to calculate and track the resource assessment or to appropriately budget the income applicable to cost of care. Therefore, the eligibility case manager must manually process the resource assessment and spousal income maintenance, as well as the income applicable toward cost of care. See examples in MA 904-1.

NOTE: This manual processing procedure is the same as is used to process eligibility for nursing home residents who have income that causes them to fail STEP 1 on IMBD.

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Montana State Hospital is not a nursing home. No nursing home eligibility span will be entered on the NUHS screen for MSH residents, under any circumstances. Medicaid subtypes used to register the MSH patient's Medicaid on TEAMS will be non-institutionalized subtypes (in other words, NOT MA/IA or MA/ID).

NOTICES

Medicaid recipients residing in Montana State Hospital, or any state-run facilities, must receive timely notice of changes to their eligibility, as well as the initial eligibility determination. This includes notification of contribution toward cost of care (patient liability) for patients under age 21 (or 22) or age 65 or older---even if patient liability is determined to be zero.

In addition, Montana State Hospital billing staff must be notified of the patient liability for those residents under age 21 (or 22) or age 65 or older, even if the liability is zero. DPHHS Fiscal is notified via TEAMS notice to the following:

▶ Margaret Bennetts
DPHHS Reimbursements
2500 Continental Drive
Butte, MT 59701

If a community spouse income maintenance allowance is included in the calculation of patient liability for the MSH patient under age 21 (or 22) or age 65 or older, the community spouse must also receive notification only of the community spouse income maintenance allowance.

In most cases, TEAMS notice X013 will be used. The eligibility case manager should construct the notices to resemble notices I108 and I704.

▶ OFF-SYSTEM INCOME BUDGETING

Individuals residing in MSH are not allowed the \$20 general income disregard. Instead, they are allowed \$50 personal needs allowance (\$90 if VA income is involved) in addition to other appropriate disregards of income (i.e., health insurance, Medicare premium, home maintenance or community spouse income maintenance allowance, family income maintenance allowance, incurred medical expenses, etc.).

Step 1 processing from MA 904-1 applies to MSH residents. Residents who pass Step 1 using the cost of care furnished by MSH staff are eligible for post eligibility treatment of income, including spousal income maintenance and family income

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maintenance deductions. Those who do not pass Step 1 are only eligible to use medical expense deductions to meet an incurment.

TEAMS PROCESSING

TEAMS is not programmed to calculate the patient liability (post eligibility treatment of income) for Medicaid cases entered as subtypes other than MA/ID, MA/IA or waiver subtypes. Therefore, the eligibility case manager will first follow the procedure shown above to determine patient liability, and then will make necessary entries into TEAMS to enable approval of Medicaid.

Medicaid eligibility should not be authorized on TEAMS for those MSH patients who are between the ages of 21 and 65, unless the individual is an SSI cash assistance recipient. Others (such as those who are medically needy and between the ages of 21 and 65) should be rolled into future months without authorizing Medicaid coverage.

For MSH patients who are under age 21 (or 22) or age 65 or older and who are eligible for Medicaid, the case should be set up in TEAMS in the same manner as the patient would be set up if residing in the community. If the patient is under age 21 or age 65 or older, the incurment should be offset using the following expenses in the following order:

1. Medicare premium.
2. Other health insurance premiums.
3. Other incurred medical expenses.
4. Community spouse income maintenance allowance (if Step 1 budgeting was passed).
5. Family maintenance allowance (if Step 1 budgeting was passed).
6. Personal needs allowance, if necessary to allow authorization of the INCU screen.

For those 'expenses' listed above which are not truly medical expenses (and therefore have no expense codes on INCU), use the appropriate "generic" expense code that is normally used for bills of non-participating providers.

With the exception of true medical expenses (items 1, 2 and 3 above), these amounts used to offset the incurment cannot be carried forward into future months' INCU screens.

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