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HJR 50: SENIOR AND LONG-TERM CARE
MEDICAID ELIGIBILITY AND LEVELS OF CARE

BACKGROUND

The Medicaid program pays for long-term care for elderly and disabled Montanans who:

- meet the financial and nonfinancial requirements for the Medicaid program; and
- need an institutional level of care, based on an assessment of their medical, social, and psychological needs.

Medicaid pays not only for nursing home care, but also for some services provided in a person's home or community if the services will allow the person to avoid placement in an institution, including a nursing home. The level of care a person needs also is factored into the Medicaid payments that an assisted living facility receives.

> Medicaid covers long-term care services for people who meet both financial and level-of-care criteria.

This briefing paper outlines the Medicaid eligibility requirements for long-term care services and the level-of-care determination process.

MEDICAID ELIGIBILITY

Both the federal government and state government pay for Montana's Medicaid program. Federal law establishes a number of different categories of eligibility for the program, each of which has its own specific requirements. States that offer Medicaid programs must cover certain populations -- such as the aged, blind, and disabled -- but can choose whether to expand eligibility to other groups of people.

A person who meets the criteria for a certain coverage group doesn't automatically qualify for Medicaid. The person also must meet certain financial criteria that include, for most people receiving long-term care services, a review of any assets the person has transferred in the past 5 years.

Most Montanans receiving Medicaid-covered long-term care services qualify either because they are:

- 65 years of age or older;
- physically disabled; or
- disabled but working and earning a higher income than Medicaid typically allows for disabled individuals.

Some physically disabled individuals who have not yet received a disability determination from the federal government are eligible for long-term care services under the Medicaid expansion program, which in 2016 extended coverage to some childless adults ages 19 to 64.

Medicaid also allows coverage for certain disabled children without consideration of the parents' income and allows spouses of some individuals to keep more assets than generally allowed, so the spouse can continue living in the community without becoming impoverished.

The table below shows the eligibility criteria for most people receiving long-term care services. The financial criteria for aged, blind, and disabled individuals is set at the Supplemental Security Income level, while the standard for other groups is based on a percentage of the federal poverty level (FPL).

Category	Income Level	Allowable Assets
Elderly or Physically Disabled	Individual: $771/month Couple: $1,157/month	Individual: $2,000 Couple: $3,000
Medicaid Expansion Group	138% of FPL Individual: $1,436/month	Not Counted
Workers with Disabilities	250% of FPL Individual: $2,603/month Couple: $3,523/month	Individuals: $15,000 Couple: $30,000

LEVELS OF CARE

To qualify for long-term care services in nursing homes or under the Big Sky Waiver and Community First Choice programs, people must be screened to make sure they need a nursing home level of care. This screening takes into account:

- how independently a person can handle what are known as Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs); and
- the person's functioning capabilities in a number of areas.

Federal law also requires that a so-called "Level I" screening be completed before a person is authorized to receive Medicaid-funded care in a nursing home. The screening looks at whether the person has a primary or secondary diagnosis of a mental illness or developmental disability. If so, additional screening is completed to determine if the person will need specialized services in the nursing home.

To qualify for the Big Sky Waiver, a person must demonstrate the need for at least one waiver service on a monthly basis.

ASSESSING FOR SERVICES NEEDED

The Department of Public Health and Human Services contracts with a third party to make the level-of-care determination. Each item that is reviewed during the determination receives a score.

The tables below list the items evaluated during the assessment and the scoring criteria used.

Activity of Daily Living	Instrumental Activity of Daily Living
Bathing	Shopping
Mobility	Cooking
Toileting	Laundry and Housework
Transferring from Place to Place	Money Management
Eating/Feeding	Telephone Use
Grooming	Use/Availability of Transportation
Taking Medication	Socialization/Leisure Activities
Dressing	Home Environment
	Ability to Summon Emergency Help
Scoring: 0 = Independent 1 = With Aids/Difficulty 2 = With Help 3 = Unable	

General Categories of Functional Capabilities
Orientation and Responsiveness
Appropriateness of Behavior
Ambulation
Memory Loss
Vision, Speech, and Hearing
Medication and Alcohol/Drug Misuse
Isolation
Danger to Self or Others
Sleep and Anxiety Problems
Need for 24-Hour Supervision
Scoring: 0 = Good 1 = Mild Impairment 2 = Significant Impairment 3 = Total Loss

ASSESSING FOR REIMBURSEMENT PURPOSES

A person who needs a nursing home level of care and qualifies for the Big Sky Waiver may receive services in an assisted living facility, instead. The rates for assisted living facility services are partially based on an assessment of the person's ability to perform ADLs and IADLs.

The scoring criteria for calculating the reimbursement rates vary slightly from those used for assessing whether a person needs a nursing home level of care. The resulting score is multiplied by $34 and used to determine a portion of the reimbursement for the services the person will need in the assisted living facility. The table below explains the scoring criteria, which are based on how much help the person needs to complete the task.

Score	Evaluation Criteria
0	Independent
1	Minimal Assist -- needs prompting or help with set up
2	Direct Assist -- needs help but participates to complete task
3	Extensive Assist -- needs help and participates only in a limited manner
4	Total Dependence

The monthly reimbursement for an assisted living facility is determined by adding up the room and board costs, which are paid by the resident; the service package that Medicaid will cover; and the level-of-care value that is based on the points scored in the assessment. The table below provides an example of the reimbursement calculation.

$545	Room and Board	
+$1,193.70	Service Package	
+$850	Level of Care Value	(25 Points x $34)
$2,588.70	Total Costs	($2,909 Maximum Set by DPHHS)
-$545	Member Pays	
$2,043.70	Medicaid Pays	
$68.12	Medicaid Daily Rate	($78.80 Maximum by rule)

Sources

- Title 37, Chapter 40, Subchapters 1-3. *Administrative Rules of Montana,* relating to nursing home screening, care, and reimbursement.
- "Level of Care Determination Form Instructions (SLTC 86)." Home and Community Based Waiver Policy Manual. *Community Services Bureau, DPHHS Senior & Long-Term Care Division.*
- "Level of Care Determination." Form SLTC-86. *Department of Public Health and Human Services.*
- "Big Sky Waiver Adult Residential Care Calculation." Form SLTC-132. *Department of Public Health and Human Services.*
- Interview with Barb Smith, Administrator, DPHHS Senior and Long-Term Care Division, Oct. 18, 2019.