Version History Table			
Date:	**Document:**	**Changes Made:**	**Impacted Pages:**
08/2020	Living Arrangement Guide	Updated for HHA/MAGI Expansion	All pages
04/2021	Living Arrangement Guide	Updated additional MAGI and Non-MAGI information for clarification.	All pages
10/2021	Living Arrangement Guide	Updated all sections of document, removed Medically Frail references and added living arrangement definitions.	All pages
09/2023	Living Arrangement Guide	Updated references to countable resources and personal needs allowance	All pages
06/2024	Living Arrangement Guide	Added new information about income adjustments for DAC and EW/W. Updated information about needing to set follow up alerts.	Pgs. 5, 6 and 11

LIVING ARRANGEMENT GUIDE

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Overview:

The living arrangement of a Non-MAGI or MAGI (including Heritage Health Adult (HHA/MAGI Expansion) client can affect Medicaid eligibility at application, renewal, or at the time of a reported change. The client's living arrangement must be reviewed prior to determining eligibility to ensure the client is eligible. (**477 NAC 11-003.01**)

If the client is in a facility, verifying how the facility is licensed and choosing the appropriate living arrangement in NFOCUS will ensure the correct medical income level is used in determining eligibility. Additionally, certain living arrangements have different budgeting procedures, deductions, and allowances which directly affect the Share of Cost (SOC) that is determined when the budget is ran. Therefore, creating or updating a budget requires attention to detail.

MAGI cases will not have a SOC regardless of living arrangement. However, MAGI cases can be budgeted in living arrangements that would typically be budgeted as Non-MAGI. For MAGI categories other than ***HHA/MAGI Expansion*** the case may need to be transitioned to another Non-MAGI category. For ***HHA/MAGI Expansion*** cases see the ABD or HHA Process Flow.

DD Waiver recipients may have a SOC calculated with the 100% FPL and others may have their SOC calculated off the MNIL. If the worker is budgeting a case, it is important to ensure the client is budgeted in the correct living arrangement. For more information on ***DD Waiver recipients*** see the Policy Log: Budgeting DD Waiver Clients.

This guide has been created with the intent to provide an additional tool and information to help with the collection of information and limit errors involving living arrangements.

Resources:

477 Medicaid Manual: The Medicaid 477 NAC manual has been moved to the Secretary of State's website: **477 MEDICAID ELIGIBILITY**. Staff will need to go to the SOS website, click on the applicable chapter and search for the bolded manual references noted throughout this document (Tip: Use Ctrl + F to bring up a search function on the SOS website)

- Appendix 477-000-012 reference: Income Levels/Federal Poverty Levels and Resources;
- Regulation: **477 NAC 23-003.04(A)** Deprivation of Resources;
- Guide: Additional Excess Income Guide;
- Guide: MLTC Change Management Guide;
- Guide: AD Waiver Transition Guide;
- Guide: ABD or HHA Process Flow;
- Regulation: **477 NAC 26-001** through **26-004.05(C)(ii)** Spousal Impoverishment;
- Roster of licensed facilities: Facilities & Services (sorted by facility types); and
- Guide: Medicaid Suspension and Hospital Coverage for Incarcerated Individuals Process Guide.

Reminders Due to a Change in Living Arrangement:

1. An individual who is incarcerated is not eligible for Medicaid based on their living arrangement except for in circumstances outlined in **477 NAC 4-002.01C**.
2. The worker should select the appropriate living arrangement from the NFOCUS drop down list when updating a client's living arrangement.
3. If a client is in a QI1 budget and enters a facility, the worker should contact the client and determine if it is appropriate to update the budget in the current month or for the next applicable month. See Policy Memo 18-02 QI1 and SOC and Non-MAGI Coverage Options Chart for additional information.
4. A change in living arrangement requires the worker to review allowable deductions. The cost of homeownership or rent and utilities can be allowed for up to six (6) months when a Non-MAGI client moves to a long-term care facility or the client has an assisted living waiver living arrangement **477 NAC 25-003.03(B)(iii)**.
    a. Property exclusions are the same for all waiver participants, whether aged, disabled, or developmentally disabled.
        i. Per the regulation linked in #4 above, the agency would not allow this deduction for someone receiving waiver services at home.
        ii. A case alert must be set to process the budget for the month following the end of the initial six-month period, if necessary.
5. A MAGI participant moving to a Non-MAGI budget would require any MAGI allowable deductions to be reviewed and updated in Expert System of NFOCUS, if applicable.
    a. Example: Health insurance premiums are entered into NFOCUS differently based on MAGI or Non-MAGI eligibility.
    b. See MAGI Transitioning to NON-MAGI and the ABD or HHA Process Flow documents for additional information regarding when a client may move from MAGI to Non-MAGI budgeting and vice versa.
6. The expense of a guardian or conservator fee of up to $10 per month is a Non-MAGI allowable deduction off the client's SOC. For additional information see WINK-Guardian Conservator Funds, and NAC references: **477 NAC 25-003.02(B)(ii)** and **477 NAC 25-003.03(B)(ii)**.
7. If the change in living arrangement is from assisted living to assisted living waiver, the worker should update the living arrangement for the date the change occurred and budget for the next possible month taking into account adverse action (do *not* update the current month).
8. For Assisted Living Waiver recipients--the worker should provide an explanation on the notice of action that room and board is owed to the facility in *addition* to the SOC amount that is listed on the notice of action. This will assist in eliminating confusion the client or facility might have regarding what amount is owed to the facility.
9. The living arrangement can determine whether the client has a co-pay for medical services. When a client moves to a LTC facility, their living arrangement must be updated in Expert as of the date of the change to reflect the type of LTC facility they are residing in. The case must be reviewed to determine if a budget should be run. For nursing home and assisted living waiver clients, updating their living arrangement in

Expert will stop their co-pays even if a budget is not processed. Co-pays are tied to the living arrangement and not budgeting.

10. Supplemental Security Income (SSI) recipients have different regulations for budgeting when a move to a medical institution occurs. (477-000-045 Spenddown Procedures for Institutionalized Individuals: Exception.)
    a. When a client is current pay SSI and moves into an LTC facility, the client or authorized representative must be notified by DHHS to contact the Social Security Administration (SSA) and inform their office of the change in living arrangement.
    b. When a client is current pay SSI and moves into an LTC living arrangement, SSA will adjust the client's SSI income to $30 per month. The client may wish to file an application for an AABD grant with Economic Assistance (EA). EA will determine if the client is eligible for a grant for their personal spending needs.
        i. If SSA is not notified of the change in living arrangement an overpayment with SSA may occur.

11. Medicare recipients may have Medicare days which require following a different set of budgeting rules. A case alert must be set for follow up on the continuation of Medicare days and to process the budget when Medicare days end. (See Medicare days chart in this guide *below*.)

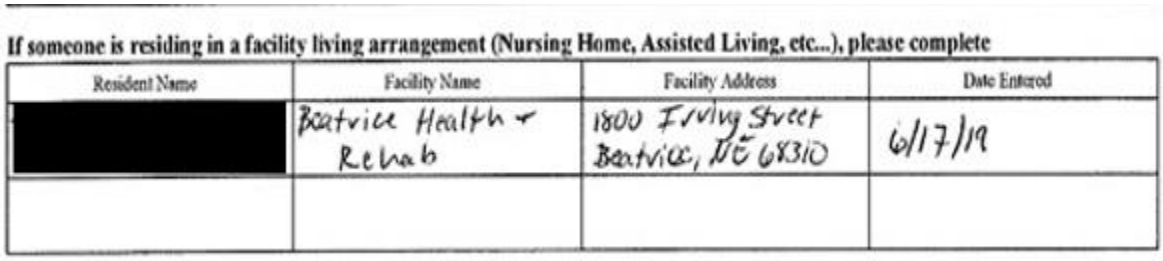
12. A client that has supplemental health insurance and has Medicare days may have the remaining Medicare co-pay paid by their insurance company.

13. When changes in living arrangement occur, the worker will need to review the case to determine if there are resources the client(s) have that will lose their resource exclusion due to their move to LTC. (Their home, for example).

14. When changes in living arrangement occur, the worker will need to review the case to determine if there are Title II income adjustments (Disabled Adult Child or Early Widows or Widowers, for example) that are no longer allowed. Title II income adjustments are not appropriate for individuals living in a medical institution (nursing home, intermediate care facility, etc.). See information about residents of medical institutions in the DAC Guide.

Living Arrangement Review:

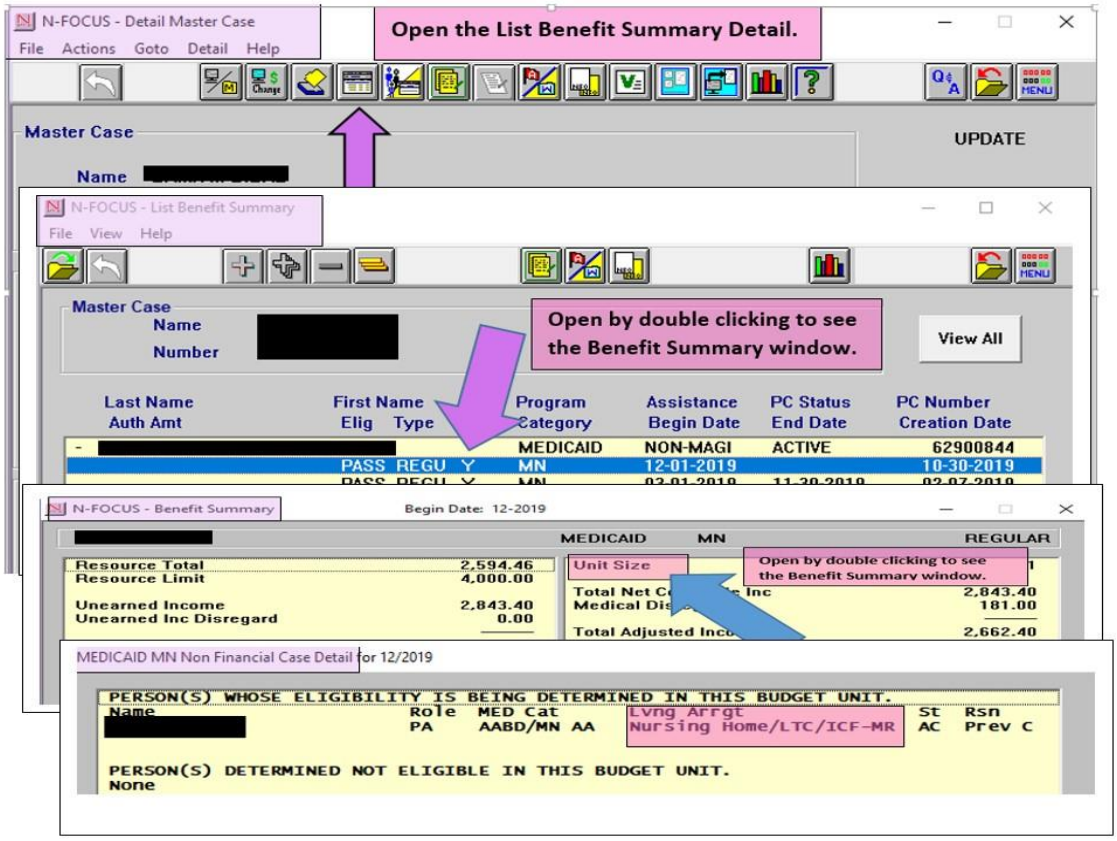
1. When an application or renewal is received, compare the living arrangement listed on the client's application to the living arrangement listed in NFOCUS. The worker must review NFOCUS and determine if the addresses match or if an update is needed.



If someone is residing in a facility living arrangement (Nursing Home, Assisted Living, etc...), please complete

Resident Name	Facility Name	Facility Address	Date Entered
[redacted]	Beatrice Health + Rehab	1800 Irving Street Beatrice, NE 68310	6/17/19

2. The client's living arrangement can be viewed on the Detail Master Case window by:
    a. Opening the List Benefit Summary detail window (pictured below).
    b. Expand the program category applicable to the client.
        a. Double click on the line for the applicable month.
        b. This will open the Benefit Summary detail window. By double clicking on the unit size, you can view the living arrangement the client is currently budgeted in.



3. If the application does *not* indicate the living arrangement, the worker must contact the client or their authorized representative in an attempt to obtain the information. If the call is unsuccessful, the address may provide a lead. A web search on the address could point to an alternate care facility, if so, contact the facility for information including date of admission. If the living arrangement cannot be determined based on the address provided, the worker must contact the client or authorized representative by phone. If unable to contact a verification request (VR) must be sent.
    a. Once the facility is known, the worker should contact the facility.
    b. Document the phone call/attempt including: the name of the person spoken to, the name of the facility that was called, admission date, the phone number, Medicare days, long-term vs. short-term stay, per diem rates, level of care, LTC or other insurance policy coverage and potential payments, and any other pertinent information that is discussed.

4. The Facilities & Services Rosters should be reviewed, as applicable, to ensure the correct living arrangement is used in NFOCUS budgeting. Ensure the correct living arrangement is in Expert.
    a. There are separate rosters for the different types of licensed facilities.
    b. Start your search under the declared licensing.
    c. If the facility is not on the specified licensing roster it may no longer be licensed or it may be licensed under another type of facility, clarification from the facility may be needed.
    d. The living arrangement selected in NFOCUS should match the living arrangement type found with the steps above.
5. After review, if it is determined that the client's living arrangement needs to be updated, this action must be completed in the NFOCUS Expert system.
    a. Check out the master case;
    b. Expand the Non-Financial menu (pictured below);
    c. Locate the living arrangement module;
    d. Select the line to be updated; and
    e. Select the update button. Select the appropriate living arrangement in NFOCUS from the following list:
        i. **Apartment or House** - A building/dwelling in which a client resides in and considers their primary residence.
        ii. **Assisted Living** - An assisted living facility provides housing for clients who need various levels of medical and personal care. Clients may have individual rooms, apartments, or shared quarters. The facilities generally provide a home-like setting that are physically designed to promote the resident's independence.
        iii. **Assisted Living—Waiver** - Clients who reside in Assisted Living Waiver have been assessed and approved by a Waiver Service Coordinator and have met the qualifications for the AD waiver, PACE, or TBI (Traumatic Brain Injury Waiver) program.
        iv. **Battered Women & Child Shelter** - is a shelter where women and/or their children can go to escape living with a batterer.
        v. **Board & Room (use when meals are provided)** - Clients who reside in a board and room living arrangement receive lodging, utilities, and food in exchange for a fee. See the DD living arrangement information below in xiv. For additional information on budgeting a DD client.
        vi. **Campus Housing Meals *NOT* Provided** - Campus housing is any student housing facility that is owned or controlled by the institution or is located on property that is owned or controlled by the institution. (Note: if the client is required to purchase a meal plan as part of the cost of residency the living arrangement is treated as board and room.)

vii. **Campus Housing Meals Provided** - Campus housing is any student housing facility that is owned or controlled by the institution or is located on property that is owned or controlled by the institution. (Note: if the client is required to purchase a meal plan as part of the cost of residency the living arrangement is treated as board and room.)

viii. **Certified Adult Family Home** - Certified Adult Family Homes are state certified homes that provide: room and board, equipment, HH supplies, laundry services, and facilities.

ix. **Child Caring Agency** - A Licensed Group Home for Children/Child Caring Agency provides 24-hour accommodation for minors including care and supervision. The home provides services to two or more individuals who are developmentally disabled.

x. **Halfway House** - A halfway house is a home or center for people recovering from substance use disorders or they are reintegrating back into society after incarceration.

xi. **Homeless Shelter** - a shelter set up to provide for the needs of homeless individuals or families including lodging, food, and other forms of temporary support.

xii. **Hospital - Acute Hospital Care** - is a short-term healthcare facility that provides treatment and care.

xiii. **Institution - Psychiatric Care - Institute of Mental Disease (IMD)** - a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in provided diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and related services.

xiv. **Licensed Center for Developmentally Disabled - CDD** - is any facility, place, or building not licensed as a hospital which provides accommodation, board, training, and other services when appropriate, primarily or exclusively, for four or more persons who are developmentally disabled. Cases with a CDD living arrangement must be budgeted in NFOCUS as CDD (select this option from the drop down in NFOCUS). (Note: A CDD facility/living arrangement is not the same as a CDD waiver case in NFOCUS).

For individuals in any other DD living arrangement other than CDD, their case must be budgeted as Board & Room. See below:

1. DD Living Arrangements:

    a. **Continuous Homes:** Continuous Homes provide continuous care for individuals with intellectual and/or developmental disabilities in a group home like setting. The participants of the continuous homes are taught habitual skills such as personal hygiene, laundry, household chores, meal preparation, social skills, and how to participate in community activities.

Individuals who reside in continuous homes are required to pay a monthly room and board expense.

b. **Host Homes:** Host Homes provide health maintenance and supervision for individuals with intellectual and/or developmental disabilities in a residential setting. The host homes provider is responsible to care for the client in all capacities, teach the clients intensive social and independent living skills, as well as help them form strong community relationships. Individuals who reside in host homes are responsible to pay a monthly room and board expense.

c. **Shared Living Arrangements:** Shared living arrangements provide a safe, structured, living environment for individuals with intellectual and/or developmental disabilities. The families that provide shared living arrangements are responsible to care for the clients in all capacities. Individuals who reside in a shared living arrangement are responsible to pay a monthly room and board expense.

d. There are a couple clues to look for to determine if the client is residing in a DD living arrangement:

   i. The client has an active CDD, DDSC, or DDAC case.

   ii. If the client has an active DD case and the client's current living arrangement is in question an email can be sent to the client's assigned DD worker to verify the client's living arrangement.

   iii. The client indicates they are residing in a room and board or group home.

xv. **Licensed Drug Treatment Center** - A Licensed Drug Treatment Center is a residential rehabilitation program that provides treatment services to assist and support a person in recovering from a substance use disorder.

xvi. **Licensed Mental Health Center** - A Licensed Mental Health Center provides shelter, food, counseling, diagnosis, treatment, care, or related services for a period of more than 24 consecutive hours to persons who have been diagnosed with a mental illness or disability.

xvii. **Nursing Home/Long-Term Care (LTC)/Intermediate Care Facility (ICF-MR)** - A Long Term Care Facility provides rehabilitative, restorative, and ongoing skilled nursing care to patients or residents in need of assistance with activities of daily living.

1. The Long-Term Care Center Roster can be utilized to verify the client's living arrangement. LTC Roster
2. The Intermediate Care Facilities for Persons with Developmental Disabilities Roster can be utilized to verify the client's living arrangement. ICF Roster

xviii. **Public Housing** - When a client enters federally subsidized low-rent public housing from private housing, the budget must reflect the lowered rent amount.

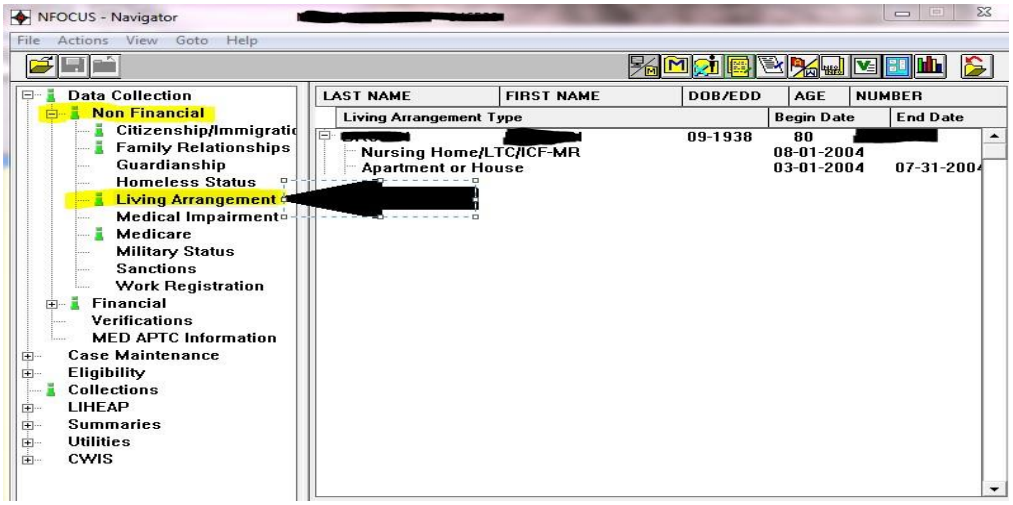
xix. **Room Only** - is a living arrangement for when meals are not provided/included in rent paid by the client.

xx. **Other** - is a living arrangement that should be used by MLTC when no other living arrangement listed above applies to the case that is being processed.

f. Once the worker has determined the applicable living arrangement to select in the NFOCUS Expert system, the worker must update the *begin* and *end* dates for the applicable living arrangements.

g. Click *"OK"*.

h. Run a budget if needed.



Information Regarding Medicare Days:

1. Medicare may cover a different number of days and services for clients residing in a nursing home depending on the situation. A case alert must be set for follow up if Medicare days are currently ongoing. The budget must be updated when the Medicare days end (see chart).
2. A Medicare Part A policy allows for coverage for up to 100 days of care.
3. Medicare may stop payment prior to 100 days because the individual does not meet the requirements for additional days of coverage.

See the following charts on the next page for additional information

	WITH MEDICARE DAYS	WITHOUT MEDICARE DAYS (ALSO APPLIES TO MAGI LTC-EXCEPT THERE WILL BE NO SOC)
NOT PREVIOUSLY ON ASSISTANCE	• Budget in current living arrangement (LA) for the month of application. • Change LA to Nursing Home (NH) but do *not* authorize budget until the first full month there is *no* Medicare involvement. • Temporarily change the *Mass Change Indicator* to ***Process By Worker***. This will prevent the case moving to a Nursing Home budget by MESA. • A case alert must be set for follow up on the continuation of Medicare days and to process the budget when Medicare days end.	• Budget in current LA for the month of application. • Change LA to NH but do *not* authorize a NH budget until the first full month following admission to the facility.
PREVIOUSLY ON ASSISTANCE WITH NO SHARE OF COST (SOC)	• Change LA to NH but do *not* authorize the budget until the first full month there is no Medicare involvement. • Temporarily change the *Mass Change Indicator* to ***Process By Worker***. This will prevent the case moving to a Nursing Home budget by MESA. • A case alert must be set for follow up on the continuation of Medicare days and to process the budget when Medicare days end.	• Change LA to NH but do *not* authorize the budget until the first month following admission to NH allowing for timely and adequate notice.
PREVIOUSLY ON ASSISTANCE WITH SOC	• Continue current SOC until Medicare days expire. • Change LA to NH but do *not* authorize budget until the first full month there is no Medicare involvement. • Temporarily change the *Mass Change Indicator* to ***Process By Worker***. This will prevent the case moving to a Nursing Home budget by MESA. • A case alert must be set for follow up on the continuation of Medicare days and to process the budget when Medicare days end.	• Continue current SOC until the first month following admission, allowing for timely and adequate notice.

Medicare pays for days (chart references Medicare A only):	**Medicare pays for covered services:**	**Client pays for covered services:**
1-20	Full Cost	Nothing
21-100	All but a daily copayment*	A daily copayment* (Current rate can be found on Medicare.gov)
Beyond 100	Nothing	Full Cost

Unlicensed LTC Facilities:

1. Unlicensed medical facilities (such as Veterans Administration (VA) facilities and Masonic homes) are not Medicaid enrolled providers. Clients in one of these living arrangement can be Medicaid eligible however, Medicaid will not pay for their stay at the facility. For additional information see **471 NAC 2-003.03(2) - Standards for Participation**.
2. Unlicensed facilities are budgeted as Assisted Living.
3. Shelter costs are not allowed.
4. Medicaid does not pay the facility.
5. The applicant will owe the facility the amount they charge minus the personal allowance.
6. Clients who are veterans, a spouse of a veteran or a widow of a veteran receiving a pension may be eligible for a $90 Aide and Attendant Payment, for personal needs when in an alternate living arrangement. 477-000-012 Income Levels/Federal Poverty Levels and Resources and **477 NAC 22-005.02(L) - Veterans' Benefits**
    a. When a client has been approved for a $90 Aid and Attendant payment, the worker should enter the amount in the unearned income module as Veterans Personal Needs Allowance.
    b. When the budget processes, the $90 VA payment is *not* counted as income and will *not* show on the budget.

Drug Treatment Facilities:

1. Review the Facility Roster to see if the facility is licensed as a Drug Treatment Center. MH & SUD Roster
2. If the center is licensed, the cost of the client's treatment may be paid with Medicaid funds.
3. Room and board is not paid by Medicaid.
4. Verify with the facility who is responsible for the cost of room and board. 477-000-044 ABD Standard of Need

Regional Centers:

1. If a client is being admitted to or is in a regional center, the worker must verify the unit the client will be residing in, as Medicaid eligibility can be affected depending on which unit the client is in. This can be done by contacting the facility. **477 NAC 11-003.01(B)**
    a. Psychiatric care is only covered by Medicaid to individuals in an IMD who are age 21 or younger or age 65 or older.
        i. If an individual is receiving treatment in a facility on the individual's twenty-first birthday, eligibility continues until either release or the month of the twenty-second birthday, whichever is sooner.

   b. In NFOCUS select from the available living arrangements found in Expert. (Non-Financial tree > Living Arrangement (see the list of living arrangement options to select from, above).
   c. This will ensure the correct Standard of Need is budgeted.

2. Not all regional centers are Medicaid enrolled providers.
   a. If not an enrolled provider and the client will be released within the next 30 days, an application for Medicaid can be submitted on the client's behalf.

Hospice:

1. A client can be on hospice and be eligible for Medicaid.
2. Hospice is not a living arrangement it is a service that a client can receive.
3. A client can receive hospice and waiver services at the same time.
4. A client on hospice must have their living arrangement updated in NFOCUS to reflect the applicable living arrangement they are in while receiving hospice. (Ex 1: a client residing at their home and receiving hospice must be budgeted with a living arrangement of house. Ex. 2: a client residing at an assisted living facility and receiving hospice must be budgeted with a living arrangement of assisted living or assisted living waiver-whichever is applicable to that client.)

Additional Information:

1. Medical expenses paid by another state, county, or city program may be used toward the client's SOC obligation if no federal funds are used to pay the medical expense. This would include programs such as County General Assistance, the Renal Disease Program, or the Medically Handicapped Children's Program. Questions on other programs may be submitted to the Central Office for review. 477-000-045 Share of Cost
2. If an individual moves into an alternate living facility the worker must follow the instructions found in the MLTC Change Management Guide: *Admitted to Nursing Home* section.
3. Per 477-000-045 Change in Facilities:
   a. If the client moves from one facility into another during the same month, the SOC is applied to the care received in the first facility. If the SOC is greater than the cost of care, the SOC is split and the remainder applied to the second facility.
4. Additional Excess Income Guide