Institutional Level of Care Q & A

1. **Q:** Can an individual receive institutionalized care in a facility or waiver services in their home if covered by MAGI?

   A: Yes, a MAGI eligible individual may receive care in a facility including in home waiver services. However, there are various eligibility factors for waiver depending on the type of waiver program. The ABD or HHA/MAGI Expansion Process Flow provides more information on waiver requests in MAGI budgeting. .

2. **Q:** A married couple is receiving an institutionalized level of care, should they be budgeted in the same program case?

   A: No, eligibility is determined separately for each spouse. Consider the income and resources each spouse has in their own name. If both spouses are eligible for a Medicaid category, open each in their own master case with their own Medicaid program case. Be sure to list the spouse not in the master case as "Out of Household". Each spouse shall be allowed a resource standard for one. **477 NAC 24 001.02B4**

3. **Q:** If a Medicaid eligibility determination hasn't been made, should the worker wait to send a waiver referral?

   A: The Eligibility & Enrollment (E&E) unit will want to see if the individual is eligible for Medicaid before determining waiver eligibility. However, the worker may send a referral for a LOC request due to possible deprivation. The worker may also send a referral to request a LOC if a LOC determination is needed for SIMP budgeting.

4. **Q:** If an application is denied for being over resources, should a VR be sent advising the client to spend down resources and reapply?

   A: No, a VR should not be sent for this purpose. If the client is over the resource limit, the worker may contact the applicant for further conversation on the resource limits of the program.

5. **Q:** Who should the worker speak with at the facility to determine the per diem rates or level of care?

   A: Every facility is different, but typically it will be an employee in the 'business office,' 'patient accounts,' or a 'billing specialist,' etc. An employee in the nursing unit generally does not have the cost of care information available to them. For further information on budgeting per diem rates, see the Additional Excess Income Guide. If attempts to obtain the per diem rates are not successful, staff may need to reach out to the facility administrator.

6. **Q:** Are medications covered by Medicaid when someone is in a nursing facility?

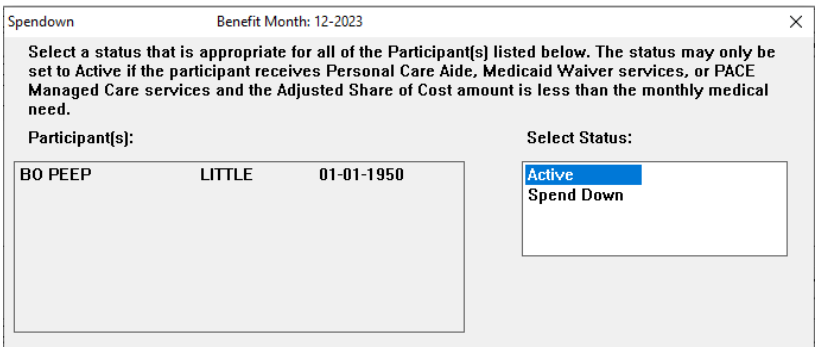
A: There are variables that come into play with prescription coverage in a facility. Medicare (specifically part D) eligibility and coverage within their plan, as well as the patient agreement with the facility can factor into this. If the client has questions about whether a particular medication is paid by Medicaid or the billing statement they receive, encourage them to work with the facility and pharmacy on coverage and effective dates of coverage. The Medicare Part D Co-pay Deductions Q&A contains further information on this topic.

7. **Q:** If the participant moves from one facility into another, which facility should receive notice?

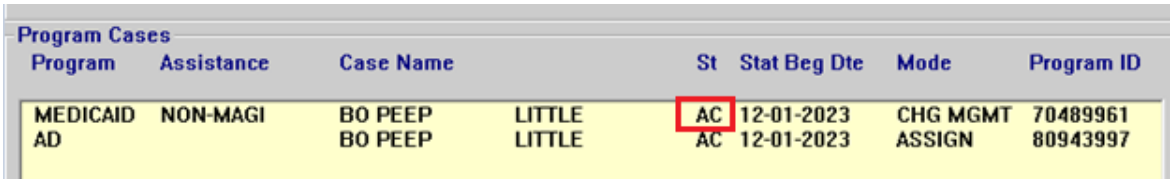
   A: If there is a change in the benefit for the month of transition, both facilities and the participant would need to receive a notice. When there is a change in facilities with no change to the SOC amount, only the new facility would need to be sent a copy of the notice. This is needed because when the facility calls the MMIS number, they are only provided with information that the Medicaid benefit is active, not the SOC amount. The Long-Term Care (LTC) Wink-ed contains further information on this topic.

8. **Q:** How do I set the waiver budget to be ACTIVE and not Spend Down?

   A: When authorizing the MN budget, the SPEND DOWN window pops up. Select Active.



This results in the program case displaying as **ACTIVE** in the Detail MC screen as seen below.



Cases with active waiver **should not** be set to **SPEND DOWN** as seen below.