Washington State Health Care Authority

APPLE HEALTH (MEDICAID) MANUAL REVISION

Revision #	**035**
Chapter / Section	**Long term services and supports (LTSS)** **Third party resources and Long term care insurance**
Issued Date	**1/1/2018**
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Summary of Revision

https://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/third-party-resources-and-ltc-insurance

Updated current procedures on third party resources and the effect on LTSS Medicaid eligibility.

Apple Health (Medicaid) Manual revision via track changes:

https://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/third-party-resources-and-ltc-insurance

Third party resources and Long term care

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insurance

Revised 8/1/2017 Purpose: This section explains how long term care insurance and third party resources apply to long term care programs.

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Long-Term Care Insurance

Policies covering long-term care are considered a third party resource.

See rules regarding additional assets allowed under the Long-term care partnership program.

The agency does not count LTC insurance payments when determining income eligibility or participation in the cost of care. LTC insurance is considered a third party resource.

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When LTC insurance payments exceed the private cost of care in a medical facility the amount refunded to the client is:

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- Not considered income
- Considered a resource if any is left over on the first of the following month.

Consult HCS Management Bulletin H06-076 dated October 30, 2006 for additional information on Third Party Liability (TPL) and Nursing Facility Billing Policy Update. This MB includes Provider Q and A attachments regarding insurance billing. The provider is expected to bill the primary insurance first before medicaid.

Long-Term Care Insurance and Nursing Facilities (NF)

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The agency will continue to assign participation, which the nursing facility may collect until the TPL party begins making payments. If the TPL insurance payment is equal to or more than the Medicaid rate, the total participation must be refunded to the individual for the months paid by the TPL party. If the TPL insurance is less than the Medicaid rate, the NF can only collect up to the Medicaid rate as the total payment. The NF must refund any excess participation collected to the individual. The NF should report the amount of the individual's refund to the local HCS office at the time it is refunded.

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The NF will be allowed to charge the TPL insurance companies the private rate and keep the amount paid by the TPL insurance, even if it is over the Medicaid rate. Individuals

will not be reimbursed the difference between the Medicaid rate and the TPL insurance payment amount.

Effective October 16, 2006 the long-term care (LTC) ACES award letter has text advising individuals to let case managers, financial workers, facilities and providers know when they have LTC insurance.

Financial workers must inform new applicants with TPL insurance that pays for NF care that the NF must bill the insurance company directly and the state will not pay for services until the TPL insurance company has either paid or denied payment.

If the NF reports a refund of participation to the individual, review eligibility to ensure that the individual's resources are not over the standard. The refund is considered a new resource and not income. Follow advance and adequate notice and reporting requirements criteria if making changes in participation or eligibility.

What happens if a resident has insurance but the NF is not a network provider for their insurance?

The NF should contact the insurance carrier to determine if they will pay a non-network provider, or can decide to become a network provider if possible.

If neither of these options is possible, the NF needs to contact the HCS social worker to see if it is possible to relocate the resident to a network provider or if there is good cause not to relocate a resident.

The HCS social worker determines if there is good cause not to relocate a resident and notifies the Coordination of Benefits (COB) unit at Health Care Authority (HCA). :

- Once good cause is determined and HCA COB has been notified, DSHS can approve the NF claim.

Complete instructions for the HCS social worker can be found in the LTC manual - Nursing Facility Case Management & Relocation under Home & Community Services Private Health Insurance and Good Cause Determinations.

Private Payments in the Month of Application

- A private payment in the form of a deposit or as part of a contract has no impact on the individual's eligibility for institutional care.

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For patients with the last name beginning with the letters L-Z scan: 360-725-1164¶

- When a friend or relative makes a private payment for institutional care on the individual's behalf:
    - Determine eligibility as if the payment had not been made.
    - Once you determine the individual is eligible for institutional care for that month, the NF is required to refund the payment to the person who made it, then bill DSHS at the facility's DSHS contracted rate. The NF must accept the DSHS payment as "payment in full".
- When an individual prepays a private payment for institutional care from his/her:
    - Income, determine eligibility as if the payment had not been made.
    - Resources, add the payment back to the individual's other resources. If total resources are:
        - At or below the institutional resource standard, determine eligibility as if the payment had not been made.
        - Above the institutional resource standard, consider reduction of resources by medical expenses (WAC 182-513-1350).
- When an eligible individual prepays a private payment to the NF and the payment exceeds the individual's participation in the cost of care, the NF must refund the balance to the individual.

Private Payment for Extras

Don't consider the value of extras purchased by relatives or others for NF individuals (such as telephone, television set, radio, private room) as income if the following criteria is met:

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- Funds for payment of the extras are:
    - From a source other than the individual,
    - Not under the control of the individual and
    - Paid directly to the NF or other provider, and
- The extras purchased are not covered by the medical care or institutional care program , and

- The extras aren't required (implied or otherwise) by the NF as a condition for the individual to receive services covered by the Medicare or institutional care program.

Example: Jane Doe, a NF resident is eligible for CN and institutional care. Her daughter pays the NF directly for a telephone in Jane's room. Don't consider this payment as income to Jane since neither the medical care nor institutional care cover this service and the daughter pays directly to the NF

Medicaid supplementation in long-term settings from Washington LawHelp

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Long-Term Care Insurance and Residential or In-Home Services

Contact Dustin Quinn-Campbell at HCS headquarters when Long-term care insurance is reported in a home or residential setting.

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Third Party Resources and Medicaid

WAC 182-501-0200 Third-party resources

WAC 182-502-0100 (2) General conditions of payment (Medicaid the payer of last resort).

Payments from the Veteran's administration for aid and attendant care or unusual medical expenses (UME) are considered a third party resource. This applies to long-term care services such as nursing home or personal care services. Payments from the VA for aid and attendance or UME are not considered as income in initial or post eligibility. These payments are excluded from SSI related Medicaid eligibility per WAC 182-512-0840. It is essential to code these payments correctly in ACES so the payments aren't used to determine eligibility but applied as a third party resource toward long term care services.

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Worker Responsibilities

An HCA 14-194 Medical Coverage Information form must be completed by individuals with health, dental or LTC or some other type of third party insurance.

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- The coordination of benefits (COB) will receive an automatic assignment of the Medical Coverage Information form once the document is imaged into DMS.

Monitor resource eligibility on cases where LTC insurance payments exceed the cost of care.

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