



DELAWARE HEALTH AND SOCIAL SERVICES
DIVISION OF MEDICAID & MEDICAL ASSISTANCE

Long Term Care Medicaid

www.dhss.delaware.gov/dhss/dmma/

Form 480 (Rev. 07/2022)
Document #350701-02-02-05

STEPS TO LONG-TERM CARE MEDICAID

As life's circumstances change, an individual may find it necessary to seek assistance in paying for long-term care services. Two government plans that may help pay for long-term care services are Medicaid and Medicare. Private insurance may also cover long-term care services.

This guide provides general information about Long Term Care (LTC) Medicaid policy and program requirements. It includes information regarding Federal law and the laws of the State of Delaware. These laws may change from year to year, so please be sure you have the most recent edition of this guide. Always consult your local Medicaid office to supplement and verify the information contained in the following pages.

Please remember: The information provided in this guide is meant to be used along with information that you will receive during the Medicaid application process.

Some of the differences between Medicare and Medicaid:

Medicare	Medicaid
A health insurance program that individuals receive when they get Social Security.	A health insurance program that individuals may receive based on medical and financial need.
Will cover nursing facility care for someone who requires a skilled level of care and has been placed in a Medicare- certified nursing facility bed after a 3-day hospital admission.	Will cover nursing facility care for someone who requires a skilled or intermediate level of care and is placed in a Medicaid-certified nursing facility bed or home care placement.
Does not cover long-term nursing facility care. Coverage is only for a limited number of days.	Medicaid will pay for nursing facility care or home care as long as the resident remains medically and financially eligible for Medicaid.

What services are available in Delaware through LTC Medicaid?

If an individual is a resident of Delaware and meets the medical and financial eligibility requirements, the Delaware Division of Medicaid & Medical Assistance (DMMA) can pay for long-term care (LTC) services through the following Medicaid programs:

- Nursing Facility Program
- Long Term Care Community Services (LTCCS)*
 - Elderly and Disabled
 - Assisted Living
 - Acquired Brain Injury
 - AIDS/HIV
- DDDS Lifespan Waiver
- Long Term Acute Care Program
- Program of All-Inclusive Care for the Elderly (PACE)

*Also known as Home and Community Based Services (HCBS)

Managed Care Organizations

Most of the individuals receiving LTC Medicaid services will be enrolled in a Managed Care Organization (MCO). Individuals that are eligible for the Nursing Facility Program, LTCCS Program, and DDDS Lifespan Waiver must enroll in an MCO. This managed care delivery system will provide improved access to necessary medical care. It will also increase flexibility to more effectively address individual needs and help control the rising long-term care costs that impact Medicaid.

Please note: Individuals that opt to enroll in the Program of All-Inclusive Care for the Elderly (PACE) are not eligible to enroll in an MCO.

Notes/Questions:

Long Term Care Programs

- If a patient in a Medicaid enrolled nursing facility runs out of private funds and becomes eligible for Medicaid payment, the nursing facility cannot discharge the patient if there is an available Medicaid certified bed.
- Some beds in a nursing facility may not be Medicaid certified. If a resident is not in a Medicaid certified bed, Medicaid cannot pay for that resident's care.
- Federal law prohibits nursing facilities from charging Medicaid recipients or their families for items and/or services that are covered by Medicaid.
- Nursing facilities that accept Medicaid cannot ask Medicaid recipients for contributions as a condition of admission, nor can they charge fees to supplement the Medicaid rate.
- Nursing facilities must provide a list of items and services that are included in the basic Medicaid rate. They must also provide a list of items and services that *are not* included and would be paid out-of-pocket by the individual. Individuals may also obtain from the Division of Medicaid & Medical Assistance a list of what Medicaid pays for and what nursing facilities are required to supply.

Considerations for Selecting a Nursing Facility

The Division of Health Care Quality (DHCQ) licenses and certifies Medicaid enrolled nursing facilities. DHCQ issues survey reports to the facilities after each annual survey and each complaint or incident survey. You may obtain a copy of a facility's survey report by contacting the DHCQ's New Castle County office.

Division of Health Care Quality
3 Mill Road, Suite 308
Wilmington, DE 19806-2164
Phone: (302) 421-7400
Fax: (302) 421-7401 & 7402

You can also call a facility to schedule a tour. Visit a facility more than one time. Schedule your second visit on a weekend or in the evening when there may be fewer staff members than on week days. Spend time talking to the residents and staff. Ask questions such as the following

- What are the procedures for handling emergencies?
- How does a patient access medical services?
- Are the residents out of their beds during the day?
- Are they dressed appropriately for the season and time of day?
- Are there a variety of activities?
- Are there social functions and religious services?
- Is the dining room pleasant?
 - Is the food good, the right temperature, and nutritious?
 - Are snacks available?
- Does the staff address residents by name?
- Does the staff respond quickly to resident calls for assistance?
- Is rehabilitative care available routinely to residents who need it?
- Is the nursing facility designed for the needs of older people?
 - Are call buttons in bedrooms and bathrooms?
 - Are there wide doorways and ramps?
 - Are there hand rails where necessary?
 - Is the furniture easy to maneuver around and use?
- Are personal mail and documents respected?
- Are personal possessions safe?
- Does the facility have an unpleasant odor?

Friends and Family

- Please remember that visits from family and friends are very beneficial to any nursing facility resident. Residents who have families and friends that are actively involved in their lives are not only reassured that someone still cares, but usually have a better outlook on life which contributes to better health.

LONG TERM CARE COMMUNITY SERVICES PROGRAM

This program provides individuals who meet level of care (LOC) requirements with an alternative to going into a nursing facility. An individual applying for this program requires a skilled or intermediate level of care as defined by Delaware Medicaid criteria. An individual that has been diagnosed with AIDS or who is HIV positive with two associated symptoms and requires a hospital level of care may also be eligible.

This program allows an individual to remain in his/her own home or an Assisted Living facility and provides special community-based services to help maintain the individual safely in the community. Those who are eligible for this program can receive, as needed, all regular Medicaid services and some special services that Medicaid normally does not cover. These special services include:

- **Case Management** – A case manager is available to help with identifying and obtaining the services necessary for an individual to remain in his/her home comfortably and safely.
- **Personal Care Services** – An aide will help with personal care such as bathing and dressing and can also help with household chores such as light housekeeping and laundry.
- **Medical and Social Day Care** – For this service, an individual attends a Day Care Center near his or her home during the day. The center would provide meals and snacks, nursing services, supervision and recreational and/or medical therapy.
- **Respite Care** – This service allows an aide to visit an individual's home for short periods of time when the primary caregiver must be away from the home. Short-term respite care at a nursing facility is also available.
- **Emergency Response System** – This is a mechanical device that is worn clipped to clothing or as a necklace around the neck. If there is an emergency, such as a fire or if the individual falls, there is a button on the device that calls the police/fire company for help.
- **Cognitive Services** – This service is for individuals with Acquired Brain Injury and assists in the diagnosis and treatment of certain conditions that can result from a brain injury. Cognitive services include: 1) an assessment to identify an individual's needs, and 2) behavioral therapy.
- **Assisted Living** – This is a residential care option that provides support to residents in a homelike setting. Support usually includes personal services and light medical or nursing care. Assisted living allows residents more independence than nursing home care.

- **Mental Health Services** – This is a service consisting of treatment, rehabilitation, and support that is designed to assist clients in maintaining life in the community, obtain relief from AIDS-related psychiatric and neurological symptoms, receive appropriate psychiatric and substance abuse treatment services, and benefit from self-help support groups. Services are provided by specially qualified clinicians who have received advanced clinical AIDS training. Services include one or more of the following: psychiatric evaluation, psycho-social assessment, individual counseling/psycho-educational services.
- **Supplemental Nutrition** – This service is routinely considered for individuals diagnosed with HIV/AIDS to ensure proper treatment of individuals experiencing weight loss, wasting, malabsorption and malnutrition. Oral nutrition supplements are offered as a service to individuals who meet AIDS Waiver requirements and who are at nutritional risk.

Please note: This program does not arrange for or pay housing or other living expenses.

Notes/Questions:

LIFESPAN WAIVER

This program is administered by the Division of Developmental Disabilities Services (DDDS). An individual applying for this program must have an intermediate level of care for persons with intellectual disabilities.

This program provides individuals who may otherwise qualify for the Medicaid Nursing Facility Program with the alternative of living in the community by providing special community-based services. Those who are eligible for this program can receive Medicaid services that are outlined in the State Plan. In addition, they may receive:

- **Case Management** – The DDDS case manager helps the individual determine and obtain services that are needed to promote a safe environment in the community.
- **Habilitation Services** – These services provide specialized training and supervision in certain residential settings. These are group homes, Adult Family Living Homes and Foster Training homes, Neighborhood homes, Supervised Apartments, and Staffed Apartments.
- **Prevocational Services-** These services focus on preparing individuals for paid or unpaid employment that is not task oriented. They are provided to individuals who are not expected to join the general workforce.
- **Supported Employment Services** – These services enable individuals to engage in paid employment in a variety of settings in which persons without disabilities normally work.

- **Day Habilitation Services** – These services enable an individual to attain his or her maximum functioning level and they reinforce skills and lessons taught in school, therapy, etc.
- **Respite Services** – These services are provided on a short-term basis where there is no care giver or where the care giver is in need of relief.
- **Clinical Support** – These services are provided to individuals receiving services from DDDS as dictated in the care plan. These services might include, but are not limited to, psychological, nursing, occupational, physical and speech therapies.

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

This program provides comprehensive community-based care and services to people who meet nursing home level of care as defined by Delaware Medicaid criteria. This program also requires individuals to 1) live within the specified PACE service area 2) be 55 years of age or older, and 3) live safely in the community with the appropriate supports and services at the time of PACE enrollment.

PACE provides all services covered by Medicare and Medicaid as determined necessary by the PACE healthcare team. It also covers other services needed to keep individuals living in the community if those services are part of the plan of care developed by the PACE healthcare team.

Samples of these services include:

- Primary Care (including doctor and nursing services)
- Hospital Care
- Medical Specialty Services
- Prescription Drugs
- Emergency Services
- Home Care
- Physical Therapy
- Occupational Therapy
- Adult Day Care
- Recreational Therapy
- Meals
- Dentistry
- Nutritional Counseling
- Laboratory/ X-Ray Services
- Social Work Counseling
- Transportation

Steps to Receive Medicaid Payment for LTC Services

What are the steps to receive Medicaid payment for Delaware long-term care services?

- Step 1 Referral
- Step 2 Medical Eligibility
- Step 3 Financial Eligibility

How do I begin the process for Medicaid payment for long-term care services?

STEP 1: REFERRAL

- The applicant or applicant's representative must make a referral for LTC services. Applicants or applicants' representatives interested in applying for the Division of Developmental Disabilities Services (DDDS) Lifespan Waiver program must contact DDDS to make the referral. Call **DDDS Statewide at 302-744-9600 or 1-866-552-5758** to make the referral. Applicants or applicants' representatives interested in applying for any other LTC program should call the Division of Medicaid and Medical Assistance (DMMA) **Central Intake Unit at 1-866-940-8963**.

STEP 2: MEDICAL ELIGIBILITY

- Upon receiving a referral for Nursing Facility (NF) or Long Term Care Community Services (LTCCS), a registered nurse (RN) from the Division of Medicaid and Medical Assistance (DMMA) Pre-Admission Screening (PAS) unit will conduct an evaluation of the applicant to determine if he/she requires a skilled or intermediate level of care as defined by Delaware Medicaid criteria. The PAS RN will make this determination.
- Medical eligibility for the Lifespan Waiver is determined by the Division of Developmental Disabilities Services (DDDS).

STEP 3: FINANCIAL ELIGIBILITY

- The DMMA Central Intake Unit (CIU) will send an application packet to the applicant or applicant's representative. The packet can also be sent electronically. The person receiving the packet will be instructed to complete and sign each section of the Medicaid application, including the release of information, and (if applicable) estate recovery forms. Once completed, the applicant or applicant's representative must return that information to the CIU.
- Those wishing to apply may also apply online using the ASSIST website: <https://assist.dhss.delaware.gov>
- The CIU will assign each completed and signed application to a DMMA Senior Social Worker/Case Manager (SSW/CM) for processing. We do not require an in-person interview for LTC Medicaid.

- The DMMA SSW/CM will review the application to determine what information we will need to request of the applicant/applicant’s representative to complete the case. If we are able to verify information electronically (citizenship, income, etc.), we will not need to request that information from the applicant or applicant’s representative.
- The DMMA SSW/CM may call the applicant or applicant’s representative to go over the information that we need to complete the case. The SSW/CM will send a letter to the applicant/applicant’s representative to explain what information we need from them to complete the case.
- The DMMA SSW/CM will give the applicant/applicant’s representative time to collect and submit the requested information. We will include deadlines with each communication we send out to request information. We will give applicants/applicants’ representatives at least thirty days (30 days) to return information. We are able to extend that timeline in special circumstances, so please talk to the SSW/CM if an extension is needed.
- Once all the information has been received, or the applicant/applicant’s representative has failed to return all required information by the deadline, the DMMA SSW/CM will complete a determination of eligibility for LTC Medicaid services.
- DMMA will issue a written notice to explain the determination of eligibility for each application. The effective date of LTC Medicaid coverage is determined on a case-by-case basis and depends on the LTC program in question, the timing of the approval, and date of enrollment with the Managed Care Organization (MCO), if applicable.

Notes/Questions:

Financial Eligibility Determination

What determines if an applicant is financially eligible for Medicaid payments for long-term care services?

- The applicant’s monthly **gross** income must be less than **250%** of the Supplemental Security Income (SSI) standard after certain deductions are made. \$20.00 of a single applicant’s available unearned income will be deducted from the total amount of income used to determine his/her eligibility. \$20.00 of a couple’s combined unearned income will be deducted from their total combined income.
- For applicants who have earned income, the following deductions are applied to the monthly gross earned income:
 - Deduct \$20.00
 - Deduct \$65.00
 - Then ½ of the remainder
- The applicant’s countable resources must be \$2,000 or less. Countable resources are items such as bank accounts, stocks or bonds, annuities and their streams of income, etc. The applicant is also permitted to put aside a certain amount of funds for burial expenses.
- The applicant must be a Delaware resident.
- The applicant must be a U.S. citizen or lawful alien admitted for permanent residency.
- The applicant must be willing to enter a nursing facility voluntarily or accept services through the Long Term Care Community Services (LTCCS) program voluntarily.
- Contact your local Long Term Care (LTC) unit for current income limits. The LTC unit phone numbers are listed on the last two pages of this booklet

Notes/Questions:

Income Eligibility

How is monthly income determined?

- An applicant’s total gross income received on a regular basis, such as monthly or quarterly, is combined to determine the total. Some examples of income are: Social Security benefits, wages, Veteran’s benefits, pensions, annuities and interest income.

What if my gross monthly income is more than the current Medicaid income limit?

- An amendment to Medicaid law allows the exclusion of income if the funds are placed upon receipt in an income qualifying income trust called a Miller Trust. This trust allows those persons who are over the current Medicaid income limit to set up a trust so that they may become eligible. The trust must be irrevocable and must contain only income. **Please note:** Applicants may want to consult an attorney to ensure that the Miller Trust is established in compliance with all regulations.

Resource Eligibility

What is counted as a resource?

Property

- Property, such as a house or land owned solely or jointly by the applicant would be considered a resource, with some exceptions:
 - If the applicant is requesting Long Term Care Community Services (LTCCS) and plans to stay in his or her own home, that home would be excluded.
 - If the property is still occupied by a spouse, dependent adult or adult child who has cared for the applicant, it may be excluded.
 - If the applicant intends to return to his or her home and is competent to state such in writing, the property may be excluded.
 - If the property is income-producing, such as rental property, in some specific cases it can be excluded.
- If the property does not meet any of the above scenarios, selling the property at Fair Market Value may be required. The proceeds would then be used to pay for the applicant's care. **Please note:** The applicant may be eligible before the property is sold if certain conditions are met.
- Once the applicant receives the proceeds from the sale of the property, depending on the value of the property, the Medicaid case may close. Once the funds from the sale of the property are exhausted, the applicant may reapply.

Vehicles

- The fair market value of any cars owned solely or jointly by the applicant or spouse may be counted as a resource. Other motor vehicles, such as motorcycles, boats, trailers, etc. would be counted at fair market value. One car may be excluded if it meets certain provisions for its use.

Liquid Assets

- Any liquid asset owned by the applicant, either solely or jointly, will be considered a resource to the applicant. Jointly owned liquid assets will be considered *owned entirely by the applicant* unless documented proof of ownership by another person is provided.
- The current value of any stocks or bonds would be considered a resource.

- The current balance of any certificates of deposit, money market accounts, retirement accounts, checking accounts or savings accounts would be considered resources.

Burial Arrangements

- An applicant can set aside \$1500 for burial.
- Money paid to a funeral home to purchase a burial plot, a burial space, items such as the casket or the vault, and services such as the opening and closing of the grave would not be considered as resources.
- An irrevocable burial trust of up to \$15,000 may be established and will not be considered a resource.

Pre-Arranged Funeral Agreements

- If the applicant has a funeral agreement, other burial resources such as life insurance and/or an account set up for burial, they may count towards the total resource limit.
- If the applicant has a pre-need funeral agreement that is irrevocable for Medicaid purposes, its value counts towards the \$1,500 in burial allowance if certain criteria are met.
- If the applicant has life insurance that funds an irrevocable funeral contract, it also counts toward the \$1,500 in burial allowance.
- If the applicant has a pre-need funeral agreement that is revocable, the burial space items (see above) are excluded and the remainder counts towards the \$1,500 in burial allowance.

Life Insurance

- If the face value of combined life insurance is \$1,500 or less, it is excluded.
- If the face value of combined life insurance is more than \$1,500, the cash surrender value is considered a resource. If the life insurance policy is designated for burial purposes, \$1,500 of its value may be excluded under the burial exclusion.

Other Resources

- The prior categories of resources cover most scenarios. There may, however, be other resources that would also be counted. The DMMA SSW/CM will assist you once your application has been reviewed and will discuss Medicaid policy and how Medicaid may consider certain resources.
- In cases with trusts or other legal instruments, the type of resource may need to be reviewed by the policy administrator to determine how Medicaid policy would apply. Each case is considered based on its unique set of circumstances.

Transfers

How does Medicaid look at resources that have been transferred or given away?

- Individuals applying for one of the Long Term Care (LTC) Medicaid programs may be disqualified from eligibility for payment of LTC Medicaid services if they transfer property or resources *for less than Fair Market Value (FMV)* during or after the 60-month period immediately prior to the date of their Medicaid application. The difference between the compensation received and the resource's fair market value is considered in determining the length of time the applicant may be ineligible for payment of LTC Medicaid services.

Exempt Transfers

The transfer of resources rule does not apply, and payment of long-term care services is not affected if the title to the individual's home was transferred to his or her:

- Spouse
- Child who is blind, disabled, or under the age of 21
- Brother or sister who has equity in the home and has been living there for at least one year before the individual was admitted to a nursing facility
- Adult son or daughter who has been living in the home and providing care that delayed the individual's admission to the nursing facility for at least two consecutive years.

Substantial Home Equity

Individuals will not qualify for Long Term Care Medicaid payments if the equity of his or her primary residence is more than the "minimum excess home equity" amount as determined annually by the Consumer Price Index (CPI).

This rule does not apply if the primary residence is occupied by:

- A spouse
- A dependent child under age 21 years
- A blind or disabled child of any age

Spousal Impoverishment

How does Medicaid consider a married couple's resources and income?

- Effective September 30, 1989, legislation (Section 303 of the Medicare Catastrophic Act) was passed to change the way Medicaid calculates a couple's resources so that the community (non-recipient) spouse would not become impoverished. This policy provides for resource and income allowances for the community (non-recipient) spouse.

- To be considered as a spousal impoverishment case, one spouse must be institutionalized, planning to be institutionalized or likely to receive services under one of the Long Term Care Community Services (LTCCS) programs and one spouse must be living in the community as a non-recipient of LTC services.

Community Spouse’s Income

- Income received by the community (non-recipient) spouse is not counted when determining income eligibility for the applicant.
- The community (non-recipient) spouse’s income is counted when determining how much of the *applicant’s* income will be set aside for the community (non-recipient) spouse’s monthly household expenses (monthly maintenance needs allowance).

Spousal Impoverishment Resources

- Under the 1989 legislation, Medicaid counts all of the couple’s resources together (everything owned by one or the other spouse, and all the jointly owned resources) to determine a case total.
- If the case total is less than the current minimum community spouse resource allowance, the applicant may be found eligible for Medicaid. **Please note:** The minimum community spouse resource allowance changes annually. Please contact any LTC Medicaid office for the current amount.
- If the case total is above the current minimum community spouse resource allowance, the total is divided evenly, with half attributable to the community spouse and half to the applicant spouse.
- If the community spouse’s half is less than the current minimum community spouse resource allowance, an amount may be taken from the applicant spouse’s portion to bring it up to that amount.
- If the community spouse’s half is more than the maximum amount, the excess is attributable to the applicant spouse and would have to be spent on his/her care. **Please note:** This amount changes annually. Please contact any LTC Medicaid office for the current amount.
- A calculation summary and a target amount for the case total will be given to the applicant. When the case total falls outside of the limits, the applicant will need to reapply.

Notes/Questions:

Patient Pay Amount

Patient Pay is the amount of money that a recipient of certain Long Term Care (LTC) programs may be required to contribute towards the cost of the recipient’s care. LTC Medicaid recipients of Nursing Facility (NF), Assisted Living Facility (ALF), and Lifespan Waiver in a residential habilitation placement may have a Patient Pay.

Medicaid uses the recipient’s gross (before tax) monthly income to determine the Patient Pay amount. Medicaid allows certain deductions from the gross income. The allowable deductions vary by program.

Medicaid may also protect a portion of a recipient’s income for a few allowable expenses: medical insurance premiums, the cost of necessary medical care not covered under the recipient’s health insurance, court-appointed guardianship fees (for nursing facility residents only, and only up to \$100.00 per month), and medical costs incurred during a prior period of ineligibility.

The Patient Pay calculation is specific to each recipient. If a recipient is responsible for a Patient Pay, Medicaid will send a written notice to explain the Patient Pay calculation. Recipients are responsible for paying the Patient Pay each month to the NF, ALF, or DDDS residential habilitation provider.

Notes/Questions:

For more information or if you have any questions about Medicaid Long Term Care Services, please contact any Long Term Care Medicaid Unit.

Central Intake Unit

1-866-940-8963

Wilmington

Long Term Care Financial Unit

980 Justison Street

Wilmington DE 19801

302-657-5420

Newark

Long Term Care Financial Unit

153 East Chestnut Hill Road

Newark DE 19713

302-451-3640

Dover

Long Term Care Financial Unit

805 River Road

Dover, DE 19901

302-857-5070

Georgetown

Long Term Care Financial Unit

546 S. Bedford Street

Georgetown DE 19947

302-515-3150