

South Carolina Long Term Care Partnership Agent Training Guidelines

Disclaimer

This document is intended to help readers understand:

- General eligibility policy relating to Medicaid payment of long-term care services in South Carolina, and
- The interaction between South Carolina Medicaid policy and the Long Term Care Partnership Program in South Carolina

Insurance Producers: To sell Long Term Care Partnership policies in South Carolina, insurance producers must successfully complete training that had been approved by the South Carolina Department of Insurance. The training must include basic information about South Carolina Healthy Connections Medicaid eligibility as it relates to the Long Term Care Partnership Program.

An individual may not sell, solicit, or negotiate long term insurance unless the individual is licensed as an insurance producer for accident and health or sickness or life. Previously licensed may continue to sell long term care products, but must complete a one-time training course by or before June 30, 2009 and ongoing training every 24 months thereafter. Those who were not yet licensed producers as of July, 2008 must obtain the initial course before beginning to sell long term insurance products. The one-time training shall be no less than eight hours and the ongoing training shall be no less than four hours. Producers who are exempt from general continuing education requirements (as identified by the South Carolina Department of Insurance) are also exempt from the four-hour long ongoing courses. Training can occur in the classroom or online.

South Carolina Medicaid eligibility policy is very complex. It incorporates special regulations and exceptions for various situations, and changes frequently due to legislative regulations. As a result, this document provides basic eligibility information, but not enough for readers to determine if someone may be eligible for Medicaid benefits.

To see how South Carolina Medicaid eligibility policy would be applied to someone's particular circumstances, the person must submit an application to their South Carolina Department of Health and Human Services (SCDHHS) Local Medicaid Eligibility office and provide all information and verifications necessary to determine eligibility. Inquiries about the eligibility status of current beneficiaries must be requested by the beneficiaries or their authorized representatives, or third parties with written consent of the beneficiary.

Training curriculum developers: Information provided in this document may be used as a guide when developing the Long Term Care insurance producer training. It is not

necessary to use this information verbatim, but the training should address the basic elements contained in this document.

This document provides information on one of the subjects that must be included in the training required of individuals seeking approval to sell long-term care insurance policies in South Carolina. Training courses must include all of the topics listed in SC Code SECTION 38-72-69.

Information in this document is up-to-date as of January 1, 2018.

Introduction to the Long Term Care Partnership Program

The Long Term Care Partnership (LTCP) Program is a joint effort between the federal Medicaid Program and Long Term Care (LTC) insurers. The Long Term Care Partnership was developed to encourage people to plan for their future Long-Term Care (CLTC) needs, such as residing in a nursing facility or receiving CLTC waived services in a home or community-based setting.

The LTCP involves private LTC insurers, LTC insurance producers (agents and brokers), the South Carolina Department of Health and Human Services (SCDHHS) and the Department of Insurance (DOI). Although the Partnership is overseen by the federal Centers for Medicare and Medicaid Services (CMS), each state has a great deal of autonomy in its administration. In South Carolina, qualified LTCP policies must provide a specific amount of inflation protection based on the person's age when the policy is purchased and must meet other requirements determined by the Department of Insurance.

A person who requests Medicaid assistance of LTC services after exhausting some or all benefits of a qualified LTCP policy may have certain assets "disregarded" equal to the benefits paid by the qualified LTCP policy at the time the person is determined eligible for Medicaid. These assets are not counted when the person's Medicaid eligibility is determined and will not be recovered during estate recovery when the person dies.

General Criteria for Medicaid Eligibility

To be eligible for Medicaid, a person must fit into an eligibility group and meet specific requirements relating to residency, citizenship, immigration status, third party liability, income, and asset guidelines. General information about each item is included below, with special emphasis on people who reside in a long-term care facility (LTCF) or receive home and community-based services through a waiver program.

Medicaid eligibility groups in South Carolina include the following:

- Children under the age of 21
- Parents or relative caretakers of dependent children
- Pregnant women

- People age 65 or older
- People who are blind
- People with a certified disability
- Women in need of treatment for certain cancers.

People living in a Long Term Care Facility or receiving Home and Community-Based Services (HCBS) are generally either disabled or are age 65 or over.

Medicaid Residency rules require that a person be a resident of South Carolina and intend to remain in South Carolina. With some exceptions the state of residency for someone in a Long Term Care Facility is the state in which the person is physically present on the date of application. South Carolina is not considered the state of residence for:

- A child under 18 whose parent or legal guardian lives in another state
- A person of any age placed in the facility by another state

Medicaid Citizenship and Immigration Status rules require a person to be either a U.S. citizen or a noncitizen with a qualified immigration status. The following must be verified:

- U.S. citizenship and identity when a person declares that he or she is a U.S. citizen
- Immigration status when the person states that he or she has a non-citizen status. Sponsored non-citizens must also provide information about their sponsors.

Medicaid Third Party Liability rules state that Medicaid is the payer of last resort. People must provide information about possible payment sources, such as other health insurance, Medicare or a liable third party. The other payment source pays their portion of medical expenses before Medicaid payments are made.

General Criteria for Medicaid Payment of LTC Services

To be eligible for Medicaid payment of LTC services, a person must:

1. Meet the necessary Level of Care (LOC.) A Level of Care (LOC) is a determination of medical necessity for care. A qualified individual must meet either an Intermediate or Skilled level of care designation. Community Long Term Care (CLTC) or its designee must certify the individual's level of care before Medicaid can pay for long-term care services.
2. Reside in a Long Term Care Facility or receive services through one of the Home and Community Based Waivers.
3. Meet income and resource guidelines.
4. Have home equity of \$572,000 less unless a spouse, child under the age of 21, or blind or disabled child is lawfully residing in the home. This figure is updated annually.
5. Disclose an interest in an annuity for self and spouse, if married. The state must be named as remainder beneficiary of annuities by the individual or spouse.

6. Not be in a penalty period for an uncompensated transfer of income or assets. A look-back is completed by SCDHHS for the five (5) year period prior to the date of application for services. If it is determined an uncompensated transfer occurred, a penalty period is calculated. During a penalty period, Medicaid will not pay for any Long Term Care services.

Income Eligibility Criteria for People Requesting MA Payment of Long Term Care Services

A person's Medicaid eligibility group determines income and budgeting considerations for that person, including:

- Income limits (which are adjusted annually)
- Income which is counted for Medicaid eligibility and that which is excluded
- Deductions allowed from total gross countable income
- Potential Medicaid eligibility if the person's income is over the allowable limit.

Basic budgeting information provided relates specifically to someone in a Nursing Home. People who receive HCBS through other waiver programs may be eligible for the Partnership, but will have different eligibility rules not addressed in this document. It is recommended that they contact their local eligibility office for information relating to their specific situations.

When looking at Medicaid eligibility, income of just the individual in the Nursing Home is counted. Income of a spouse or parent is not counted.

Deductions allowed for institutionalized individuals depend on his or her specific situation. Every deduction is not allowed for each person. General deductions include:

- Health insurance premiums
- An income allocation to a community spouse
- An income allocation to certain other family members (subject to specific limitations)
- Personal needs
- Home maintenance if the person is expected to return to the home within six (6) months
- Health care expenses not paid by Medicaid or a third party.

After allowing applicable deductions, the result is the amount a person must contribute toward the cost of his or her monthly LTC services and is typically paid to the Nursing Home. Medicaid will pay for all other covered services received by the person.

Asset Eligibility Criteria for People Requesting Medicaid Payment of Long Term Care Services

A person's eligibility group and household size determine his or her asset limit for Medicaid. A resident of a Nursing Facility or someone receiving HCBS is considered a household size of one. He or she has an asset limit of \$2,000 in countable assets.

Countable assets are those which are available to the person and are not specifically excluded by the Medicaid program. Examples of countable assets include cash, bank accounts, stocks, bonds, and non-homestead real property.

Excluded assets are not counted toward a person's asset limit. Examples of excluded assets include homestead property in which the person or spouse or certain other family members live, some trusts, certain funds set aside for burial expenses, and one vehicle.

The local eligibility office will review all verified assets and determine which ones are:

- Counted toward Medicaid eligibility
- Excluded and not counted toward Medicaid eligibility
- Determined to be protected for the community spouse, if married
- Protected because benefits of an LTCP policy have been exhausted. (explained later)

The county will also determine if a person needs to reduce assets to the \$2,000 asset limit allowed for someone residing in a Nursing Home or receiving HCBS.

Assets of Married Couples

A person residing in a Long Term Care Facility or receiving HCBS is considered a household of one and has an asset limit of \$2,000, whether the person is married or unmarried. However, evaluating assets of the married person is more complicated and several questions need to be addressed.

- Is the spouse also receiving or requesting Medicaid payment of Nursing Home services? If yes, then each one is treated as a single individual for purposes of the Medicaid eligibility and each has an asset limit of \$2,000 in countable assets.
- Is the spouse living independently in the community? If yes, then that spouse is considered a **community spouse** and the local eligibility office must consider special rules of spousal impoverishment.

Spousal impoverishment regulations require that the couple (the institutionalized spouse and the community spouse) complete an **asset assessment** of their total marital assets.

In an asset assessment, the married couple reports all assets owned by either spouse individually and by both spouses jointly. The eligibility worker then evaluates the reported assets to determine:

- The amount of countable assets that can be kept by the community spouse and not counted towards the institutionalized spouse's Medicaid eligibility and
- When the institutionalized spouse may possibly be eligible to receive Medicaid payment for LTC services.

A community spouse is allowed to keep up to \$66,480. At the initial determination the assets are considered together and the couple cannot exceed \$68,480 in total countable assets. Within 90 days of approval, the assets must be separated so that the

institutionalized spouse has no more than \$2,000 and the community spouse has no more than \$66,480 in countable assets.

South Carolina Medicaid Estate Recovery

In August of 1993, Congress passed a law that requires states to recover amounts that Medicaid has paid for certain recipients. In South Carolina the Estate Recovery Program went into effect on July 1, 1994. The state will recover amounts paid by Medicaid for services received July 1, 1994 or later.

Estate recovery applies to the following beneficiaries:

- A person who was 55 years of age or older when he or she received medical assistance consisting of nursing facility services, home and community based service care to include prescriptions and hospital stays associated with either of these services paid by Medicaid; or
- A person of any age who was an inpatient in a nursing facility, intermediate care facility for the mentally retarded, or long term care facility at the time of death; and, who was required to pay most of his/her monthly income to the facility toward the cost of care.

Recovery may be made only after the death of the decedent's surviving spouse, if one exists, and only at a time when the decedent has no surviving child under age twenty-one or no child who is blind or permanently and totally disabled as defined in Title XVI of the Social Security Act.

Recovery must be waived by the department upon proof of undue hardship, asserted by an heir or devisee of the property claimed pursuant to 42 U.S.C. 1396p(b)(3) and in accordance with the guidance issued by the Secretary of the United States Department of Health and Human Services in the State Medicaid Manual as incorporated into the state plan. The department shall publish and maintain such guidance on the department's web site.

Estate Recovery Process

When a beneficiary dies, the state files a claim with the probate court against the beneficiary's estate to recover amounts paid by Medicaid for the deceased beneficiary's medical care. An estate is all real and personal property and other assets of the deceased person (recipient) as defined in South Carolina State Law. This claim will be similar to claims for funeral expenses, attorney's fees to administer the estate, and tax. This claim will need to be satisfied in order to close the estate; however, it may not require the selling of the decedent's home and land if there are other assets available to pay the Medicaid claim. In the event other assets are insufficient to repay the Medicaid claim and/or other expenses of the estate, the Personal Representative (Administrator, Executor, and Executrix) may choose other options to repay the Medicaid debt. The state is not interested in taking title to anyone's home.

For example, John Doe was in a nursing home for the month of July. He died August 3. Medicaid paid \$2,000 for his care in July and August. His estate is worth \$50,000.

Medicaid will recover only \$2,000 from his estate, after claims with higher priority (i.e., mortgage, funeral expenses, and probate fees) are paid.

In another example, Joe Smith has been on Medicaid for years. Medicaid has spent \$25,000 on the medical services he received since he was age 55. His estate is worth \$20,000. The Medicaid program will recover from the remainder of the estate, after claims with higher priority are paid.

Exceptions and special cases:

- Estate recovery must be deferred if the beneficiary is survived by a spouse or a child under the age of 21, blind, or permanently disabled.
- Estate recovery may be waived if it would create an undue hardship.
- Estate recovery may exempt some or all assets of a Medicaid beneficiary who is covered under a Qualified Long Term Care Partnership (QLTCP) Insurance Policy. Estate recovery will not seek adjustment or recovery from the beneficiary's estate to the extent benefits were paid under the QLTCP policy.

Estate Recovery Hardship

(1) With respect to the decedent's home property, if the decedent could have transferred the home property on or after the date of his or her Medicaid application without incurring a penalty under 42 U.S.C. Section 1396p(c) if the property could have been transferred without penalty to a:

- (a) Surviving sibling of the decedent who possessed an equity interest in the property and who lived in the home for a period of at least one year immediately prior to the date the decedent was institutionalized; or
- (b) Surviving child of the deceased who lived in the home for a period of at least two years immediately before the decedent became institutionalized and who provided care which allowed the decedent to delay institutionalization. Does not apply to a child under the age of 21, or a child who is blind or disabled.

However, hardship under this item only applies if the individual to whom the property could have been transferred without penalty is actually residing in the home, at the time the hardship is claimed and this hardship status only protects a homestead of modest value. A homestead of modest value is defined as fifty percent (50%) or less of the average price of homes in the county where the homestead is located as of the date of the beneficiary's death. To the extent the value of the home property exceeds this modest value, that portion is subject to recovery by the department.

(2) With respect to the decedent's home and one acre of land surrounding the house, if an immediate family member:

- (a) Has resided in the home for at least two years immediately prior to the recipient's death;
- (b) Is actually residing in the home at the time the hardship is claimed;

- (c) Owns no other real property or agrees to sell all other interest in real property and give the proceeds to the department; and
 - (d) Has annual gross family income that does not exceed one hundred eighty-five percent (185%) of the federal poverty guidelines.
- (3) With respect to a sole income producing asset:
- (a) An immediate family member's annual gross family income would fall below the federal poverty guidelines or immediate family member agrees to pay all income in excess of one hundred eighty-five percent (185%) of the federal poverty guidelines to the department.

Interaction between the Long Term Care Partnership Program and Medicaid Eligibility

1. A LTCP participant in South Carolina is someone who either:
 - Requests Medicaid payment of Long Term Care services after exhausting all benefits of a qualified LTCP policy, or
 - Exhausts all benefits of a LTCP policy while receiving Medicaid payment of LTC services, or
 - Receives Medicaid payment of LTC services and dies before the LTCP policy benefits are exhausted.
2. In determining Medicaid eligibility, SCDHHS will disregard an individual's assets in an amount equal to the amount of payments made by the individual's qualifying LTCP policy for services covered under the policy. Documentation of the amount in benefits paid will have to be provided.
3. A LTCP participant receives the following benefits during his or her lifetime:
 - Assets may be designated for protection in an amount equal to the total amount of LTC services paid by the qualified LTCP policy
 - Designated assets are not counted toward the Medicaid asset limit
 - The designated assets may be transferred to any other person without penalty.
4. After the LTCP participant is deceased:
 - Assets which were designated as protected during the person's lifetime are also protected from estate recovery
 - When the amount of assets protected during the person's lifetime was less than total benefits paid by the LTCP policy, additional assets may be protected in the estate recovery process - up to the total amount paid by the LTCP policy
 - If no assets were protected during the person's lifetime, the personal representative may designate assets to protect from estate recovery equal to the total amount paid by the LTCP policy - even if LTCP policy benefits were not completely exhausted.

5. Owning a LTCP policy does not guarantee eligibility for Medicaid, even if the policy holder exhausts all benefits. Individuals must still meet all other Medicaid eligibility requirements. The LTCP allows policy holders to have a portion of their assets disregarded (not counted) during the eligibility process and subsequently protected from estate recovery. REMINDER: Only SCDHHS can determine whether a person will qualify for Medicaid. Agents should be careful not to advise regarding eligibility requirements or whether a person will be eligible for Medicaid.

Two types of assets cannot be protected under the LTCP Program. Federal Medicaid rules require that when a person dies, the following assets must be available to reimburse SCDHHS for the amount of Medicaid benefits paid during his or her lifetime:

- Resources in a Special Needs Trust or a Pooled Trust and
- Annuity interests in which South Carolina must be named as a preferred remainder beneficiary.

How to Apply for South Carolina Medicaid Programs

A person may apply for any of the South Carolina health care programs by completing an application. Applications can be obtained by contacting any local eligibility office or by visiting the agency website: www.scdhhs.gov.

- People may request an application form by:
 - Calling the Member Services Call Center at (888) 549-0820.
 - Visiting or calling their local eligibility office
 - Visiting the agency website at www.scdhhs.gov
- A complete signed and dated application can be faxed or mailed to the local eligibility office
- People may ask the local eligibility office to help them complete the application and contact third parties for required information and/or verifications.
- Health Care coverage generally begins in the month that the county receives a completed, signed and dated application.
- People may ask that Medical Assistance coverage begin up to three months before the date they apply.

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