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Title of Document: Fees for Residential Services in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) Facilities

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Applicability: DDSN Regional Centers; DSN Boards and Contracted Service Providers Operating ICFs/IID

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## **I. PURPOSE**

The South Carolina Department of Disabilities and Special Needs (DDSN) is required to establish a cost of care contribution for those served in long-term care facilities such as Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID). DDSN's authority for charging for its services was established by:

1. S.C. Code Ann. § 44-20-350, and
2. The South Carolina Department of Health and Human Services (DHHS) Medicaid Policy and Procedures Manual (DHHS Manual).

This Directive addresses only fees charged for residential services provided in ICFs/IID. Fees for residential services other than those provided in an ICF/IID are addressed in DDSN Directive 250-09-DD: Calculation of Room and Board for Non-ICF/IID Programs.

## **II. POLICY**

### **A. FEES – ICF/IID PER DIEM**

Residential services include room and board and all support services and programs provided as part of an ICF/IID program, except for certain medical services required for the health of an individual or for the medical determination of eligibility for an ICF/IID program.

The fee for residential services is a daily fee. The amount of the daily fee is the current ICF/IID per diem rate as approved in DDSN's Medicaid contract with DHHS. Application of the daily fee will vary depending on the payer, as explained below.

### **B. PAYERS**

Residential services shall be billed in the following priority order:

1. To trusts and third-party insurance;
2. To the individual, as resources allow, and
3. To Medicaid, if the person is Medicaid eligible.

Determination of an individual's ability to pay shall be made according to the regulations governing Medicaid eligibility as outlined in the DHHS Manual. The determination shall be made based on the calculation of recurring income made by DHHS in accordance with an individual's application for Medicaid. This calculation shall be accepted without re-calculation by DDSN personnel. This amount of recurring income shall be used as the basis for DDSN billing a person unless a specific exception is approved, as described below in this Directive.

### **C. SIMILAR SERVICE RATES**

The rate charged to DHHS for service to an individual shall never be greater than that charged for a similar service to someone who pays privately. Any and all amounts received by DDSN from DHHS for services in excess of those rates charged to anyone paying privately for similar services are subject to recoupment by DHHS through withholding and offset or any other appropriate means.

### **D. THIRD-PARTY LIABILITY**

DDSN and community providers must make all reasonable efforts to pursue payment under any health insurance policy which covers the individual. Any insurance proceeds or payment must be shown on the Medicaid claim when submitted to DHHS. If DHHS has paid DDSN prior to receipt of the insurance payment, DDSN shall refund the DHHS payment up to the amount of payment made by DHHS. DDSN and community providers shall advise DHHS of any third-party payer information or resources within ten (10) calendar days of acquiring such information. DDSN and community providers shall make available all financial records necessary for DHHS or its designee to determine if third-party payments have been refunded to Medicaid. DDSN and community provider failure to collect available third-party payments may result in DHHS recoupment of such available payments from funds due to DDSN. DDSN reserves the right to recoup funds from community providers to the extent funds are recouped by DHHS for individuals they serve.

#### E. BILLINGS TO TRUSTS AND PRIVATE INSURANCE

Billings to trusts and insurance companies should be for the maximum allowable payment up to the full cost of care. If DDSN serves as trustee for an individual's funds, a bill should be submitted to DDSN to be paid through the Regional Banking System. If DDSN does not serve as trustee for an individual's trust, a bill should be sent to the trustee of record. Should an individual have insurance that pays for residential care, a bill shall be submitted to the insurance company. All billings will be handled by the DDSN staff person assigned the claims and collections duties at each Regional Center.

#### F. BILLINGS AGAINST PERSONAL ASSETS FOR MEDICAID ELIGIBLE INDIVIDUALS WITH RECURRING INCOME – CARE AND MAINTENANCE

If an individual is eligible for Medicaid and has resources sufficient to contribute to the cost of residential services, the individual shall be billed for each month of service. (See Section G for an explanation of factors that may affect this monthly billing.) The amount of this billing generally will not be adjusted on the basis of allowable days.

#### G. BILLINGS TO INDIVIDUALS NOT ELIGIBLE FOR MEDICAID

Individuals not eligible for Medicaid shall be billed at a fixed monthly rate based on the current Medicaid per diem rate. This fixed monthly rate shall be adjusted whenever the current Medicaid per diem rate is adjusted.

If an individual's financial assets are held by a parent, guardian, or other responsible party, the billing shall be submitted to that party.

#### H. BILLINGS TO MEDICAID FOR ELIGIBLE PEOPLE

Medicaid shall be billed for each allowable day an individual resides in an DDSN Regional Center or community based ICF/IID. The definition of an "allowable" day is determined by the Medicaid regulations found in the Nursing Home, Home and Community-Based Services, and General Hospital Chapter of the DHHS Manual. Bed hold days will be billed in accordance with the DHHS Manual. Unallowable days shall not be billed.

#### I. OTHER MATTERS

##### 1. Partial Month Billings

When an individual is admitted to or discharged from an ICF/IID, the billings shall be adjusted to reflect a partial month. This partial month adjustment does not apply to situations that involve therapeutic leave, as allowed by the DHHS Manual.

##### 2. Maximum Accumulation Level for Medicaid Eligibility

To prevent disruption of Medicaid eligibility, staff responsible for assisting individuals with their financial management shall monitor each individual's available resources to ensure that their

accumulated resources do not exceed the amount allowed under Medicaid eligibility guidelines. Current income limits may be found on the DHHS website.

Staff responsible for assisting individuals with their financial management should contact the individual's Interdisciplinary Team when his or her resources approach the maximum level. All countable resources must be carefully identified in accordance with the "Guide for Organizational Representative Payees." The Interdisciplinary Team should first determine if the individual has unmet personal needs. If such a need exists, the purchase(s) should be made, thus ensuring that the individual's funds are initially expended on personal needs. Staff should consider other uses of countable resources such as prepaid burial contracts, burial savings accounts, funding of a Palmetto ABLE Savings Program account, funding of a trust, etc. If, after all personal needs and other permitted uses of resources have been exhausted, an individual still has excess resources, the individual may become ineligible for Medicaid for a period of time. During that period, full cost of care shall be charged. The amount paid on this billing must be sufficient to bring the individual's resources below the maximum asset level. Actual amounts to be paid shall be determined by the regional staff assigned claims and collections duties.

### 3. Personal Needs Allowances

Each individual, whether they are Medicaid eligible or not, shall retain a portion of income from Social Security, Supplemental Security Income, wages, and other sources for personal needs. This is referred to as their "personal needs allowance." An individual's monthly resources, up to the personal needs maximum, must not be applied to residential or other DDSN billings.

The amount of the personal needs allowance is determined as follows:

Personal Needs Allowance	<ul style="list-style-type: none"><li>• \$100 – Work Therapy Allowance – if the institutionalized individual participates in a work therapy program as a part of the plan of care; or</li><li>• \$30 – Standard Allowance – if the institutionalized individual does not participate in a work therapy program.</li></ul>
Note: Individuals receive the \$30 personal needs allowance from countable income in addition to any excluded income such as VA Aid and Attendance or the \$90 reduced VA pension.	

### 4. Individuals with Earned Income – Work Therapy Allowance

If an individual has earned income from work activities or other sources during a month, that individual may retain his or her total income (from both earned and unearned sources) up to the Work Therapy Allowance level of \$100. An individual's monthly income, up to this level, may not be applied to residential or other DDSN billings.

In calculating the funds to be retained by an individual, earned income after taxes and other withholdings shall be used. (NOTE: This is different from DHHS calculations.) This will result in a smaller amount of billings, but it is consistent with the intention of this directive which is to encourage each individual to realize monetary benefit from their work efforts. As a result of using net wages to determine the amount of funds to be retained, income tax returns shall be filed for all individuals who have had income taxes withheld. The DDSN Regional Finance Director,

or community personnel responsible for assisting individuals with their finances, shall assign responsibility for the completion of personal income tax returns for these individuals. The amount of refunded taxes, up to the difference in billings created by using net wages, shall be billed to the individual after his or her tax refund has been received. Any tax refunds received must be forwarded to the Regional Bank.

5. Receipt of Social Security Back Payments

When an individual receives a Social Security “back payment,” the funds shall be used first to maximize the individual’s personal needs allowance for the past 12 months. (See table below for an example of maximizing a personal needs allowance.) Based on the example below, due to back payment received, \$196 would be given to the individual to “maximize” their personal needs allowance for the last 12 months. Then, if there is any outstanding care and maintenance receivable balance, the back payment shall be applied to that balance. If after correcting personal needs allowances and paying any care and maintenance owed, the entire back payment is not used, the individual shall retain the remaining balance. If this balance gives the individual sufficient resources so that he or she may be determined Medicaid ineligible, the resources shall be used in accordance with permitted uses outlined in this Directive.

<b>EXAMPLE OF MAXIMIZATION OF AN INDIVIDUAL’S PERSONAL NEEDS ALLOWANCE</b>				
<b>MONTH</b>	<b>TYPES OF INCOME THIS MONTH</b>	<b>MAXIMUM PERSONAL NEEDS ALLOWANCE</b>	<b>PERSONAL NEEDS ALLOWANCE RETAINED</b>	<b>DIFFERENCE</b>
1	Unearned	\$ 30.00	\$ 30.00	\$ 0.00
2	Unearned	\$ 30.00	\$ 25.00	\$ 5.00
3	Earned & Unearned	\$ 100.00	\$ 43.00	\$ 57.00
4	Earned & Unearned	\$ 100.00	\$ 58.00	\$ 42.00
5	Earned & Unearned	\$ 100.00	\$ 100.00	\$ 0.00
6	Earned & Unearned	\$ 100.00	\$ 100.00	\$ 0.00
7	Earned & Unearned	\$ 100.00	\$ 98.00	\$ 2.00
8	Earned & Unearned	\$ 100.00	\$ 100.00	\$ 0.00
9	Unearned	\$ 30.00	\$ 0.00	\$ 30.00
10	Unearned	\$ 30.00	\$ 0.00	\$ 30.00
11	Unearned	\$ 30.00	\$ 0.00	\$ 30.00
12	Unearned	\$ 30.00	\$ 30.00	\$ 0.00
			<b>TOTAL</b>	\$ 196.00


6. DDSN as Representative Payee

In cases where a parent or other responsible party has been designated by the Social Security Administration (SSA) as Representative Payee for an individual entering a DDSN Residential Program, it is DDSN’s policy and the intent of the SSA that the entire benefit amount received be spent for the benefit of the individual. If a Representative Payee cannot demonstrate to the

Interdisciplinary Team the proper use of these funds for the individual's benefit, DDSN or the community ICF/IID provider shall request to become Representative Payee for the individual.

7. Waiver of Fees

DDSN is authorized to vary the amount of residential service fees if there is programmatic need for additional funds associated with a planned move of an individual to another residential setting. If an adjustment to waive all or a portion of residential fees is required, a request for a waiver with justification should be forwarded by the Interdisciplinary Team through the Regional staff assigned the claims and collections duties to the DDSN Finance Director located at Central Office. The request will be reviewed and considered for approval. If the waiver is approved, it shall be limited to a maximum of six (6) months. Upon approval or denial, the waiver request will be returned to the Regional staff assigned claims and collections duties, who shall in turn forward a copy to the appropriate unit to be placed in the individual's permanent file. The program plan supporting the waiver should be reviewed by the Interdisciplinary Team and the Regional staff assigned claims and collections duties every six (6) months while the waiver is in effect to determine if there is a continued need.

  
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Barry D. Malphrus  
Vice Chairman

  
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Gary C. Lemel  
Chairman

**RELATED DIRECTIVE:**

250-09-DD: Calculation of Room and Board for Non-ICFs/IID Programs