

Department of Public Health
and Human Services

Section:

RESIDENTIAL MEDICAL
INSTITUTIONS

MEDICAL ASSISTANCE

Subject:

Budgeting Process

Supersedes: MA 904-1 (01/01/08)

► **References:** ARM 37.82.101, .1312, .1313, & .1320

GENERAL RULE--Residential medical institutionalized (e.g., nursing home) applicants must be categorized as either categorically needy or medically needy. After being categorized, a determination of medical need is made to calculate whether the applicant is eligible for Medicaid coverage of institutional cost of care. If eligible, a post-eligibility budget is completed to determine the applicant's required contribution toward cost of care.

NOTE: Income eligibility for a residential medical institution applicant must be determined based on the applicant's income only.

**CATEGORICALLY
NEEDY or
MEDICALLY NEEDY
DETERMINATION**

Use the following calculation to determine whether a residential medical institution applicant is categorically needy or medically needy:

	Unearned income
-	Legally obligated child support payments & arrears (paid)
-	General income disregard (\$20)
=	Countable unearned income
	Earned income
-	Balance of legally obligated child support payments/arrears (paid)
-	Balance of general income disregard
-	Work expense disregard (\$65)
=	Remainder
-	One-half remainder
=	Countable earned income
	Countable unearned income
+	Countable earned income
=	Total countable income ** (use again in following determination)
-	Categorically needy income standard for one (MA 001)
=	Balance

If "balance" is:

1. \$0 or less, client is categorically needy; or

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2. Greater than \$0, client is medically needy.

**DETERMINATION
OF MEDICAL NEED
(STEP 1)**

To qualify for Medicaid coverage of institutional cost of care, an applicant's total countable income (as determined in the categorically needy/medically needy calculation) is compared to the net Medicaid cost of care for the individual at the facility in which they are residing.

This determination is also known as "Step 1" of the eligibility process or as "Determination of Need" in CHIMES, and is calculated as follows:

1. Facility's Medicaid daily rate
2. X # of days person is in the facility in the benefit month
3. = Total cost of care for benefit month
4. - VA A&A payment receipt by applicant/recipient
5. - Medicare/QMB contributions
6. - Long Term Care or other insurance contributions
7. = Net cost of care for benefit month
8. Total countable income** (from category determination above)
9. - Net cost of care for benefit month (line 7 above)
10. = *result*

If *result* is equal to or less than zero, client is financially eligible for Medicaid coverage of the institutional cost of care. Proceed to Post Eligibility Treatment of Income (see following caption).

If *result* is greater than zero, client is financially ineligible for institutional coverage, and no Post Eligibility Treatment of Income determination is made. Deny institutional coverage, and test for medically needy coverage if the applicant is reasonably certain to incur medical expenses greater than the amount of his/her incurment obligation. See "Medically Needy with No Institutional Coverage" caption later in this section.

**POST
ELIGIBILITY
TREATMENT
OF INCOME
(STEP 2)**

If an applicant has been determined eligible for Medicaid coverage of institutional cost of care, determine the amount of the applicant's/recipient's income that must be contributed toward the **cost of care at the** facility in which he/she resides. The determination will be made based on whether the applicant/recipient is a spouse or a single individual, using the appropriate manual section listed below. This determination is also known as "Step 2" of the eligibility process.

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1. "Income Disregards for Institutionalized Spouses," MA 904-2;
or
2. "Income Disregards for Institutionalized Individuals," MA 904-3

**▶ AID &
ATTENDANCE
PAYMENTS**

If an individual is receiving Aid & Attendance (A&A) payments through Veterans Administration, these payments are not considered income. However, the payments ARE considered available to help meet the individual's cost of care in the nursing home, so the income is used in the calculation of medical need and post-eligibility treatment of income. This income should be coded 'VA AA' on the TEAMS UNIN screen; CHIMES will calculate A&A based on information on the total VA pension payment entered into that system.



Effective with the implementation of CHIMES, VA pension income of \$90 or less per month is excluded income. The personal needs allowance of \$50 will be subtracted from countable income.

See MA 501-1 "Veterans Benefits" to determine the amount of a VA payment attributable to VA A&A and to VA pension.

**MEDICALLY
NEEDY with NO
INSTITUTIONAL
COVERAGE**

A nursing home resident who does not pass "Step 1" determination of need, and therefore is not eligible for Medicaid coverage of institutional cost of care may be eligible for Medicaid coverage of other medical expenses.



CHIMES will handle this budget correctly and no work-around or false coding will be necessary. Medical expenses added to the incurment/bill entry web page will include the nursing home Medicaid rate for the benefit month.

TEAMS processing for medically needy with no institutional coverage: In these situations, the incurment must be manually calculated using \$50 personal needs rather than \$525 MNIL. In order for TEAMS to correctly calculate the incurment, enter \$545 "OM" income on UNIN, (if the individual is also eligible for a home maintenance allowance, enter only \$20 as "OM" on UNIN). If QMB or SLMB eligibility is also being determined also enter the \$545 (or \$20) as a "CA" expense on EXPE so QMB/SLMB eligibility is not affected by the artificial "OM" income. If there is a community spouse, the client does not qualify for deductions such as community spouse income maintenance allowance or family income maintenance allowance, as this client is not considered eligible for institutional coverage, and is therefore not entitled to deductions allowed in post eligibility treatment of income.

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Once the incurment has been determined, use the current month nursing home expense at the net Medicaid rate as the recipient's first medical expense toward meeting the incurment (entered on INCU with an "00" day of service).

The recipient will be eligible for medically needy coverage after the incurment requirement has been met. Medically needy coverage will not cover the nursing home cost of care.

The cash option is not available for medically needy with no institutional coverage, because the current month's nursing home expense must be used toward the incurment, and current month medical expenses cannot be used in conjunction with the cash option (and past months' nursing home expenses also cannot be used to help meet an incurment).

When the recipient has met the incurment, the OPA must notify the facility of the individual's liability toward cost of care for each month (which will be shown as a dollar amount...for example, \$2064). It is acceptable to anticipate on-going eligibility (if known circumstances suggest on-going eligibility) by notifying the facility of a series of liabilities at one time (such as, liability for September will be \$3000, liability for October will be \$3100, liability for November will be \$3000, etc. when the facility's Medicaid rate is \$100 per day).

EXAMPLES

Example #1

Tammy entered facility: June 2
 Tammy's monthly income: \$1,500 unearned income
 Net daily Medicaid rate: \$2,610 (\$90 X 29 days)

Categorical determination:

\$1,500 gross monthly income
 - 100 legally obligated child support payment made
 - 20 general income disregard
 1,380 total countable income↓
 - 525 MNIL for one (MNIL for 2007 used for example)
 \$855 *balance*

Balance is greater than zero, so this is a medically needy case.

Step 1 – Determination of medical need:

\$1,380 total countable income
 - 2,610 cost of care at facility

= (1130) LESS THAN ZERO

Tammy is eligible for Medicaid coverage of institutional cost of care because the net daily rate (\$2,610) is more than the Tammy's total countable income.

Step 2 - Post Eligibility Treatment of Income

\$1,500	gross monthly income
- 100	legally obligated child support payment made
- 50	personal needs disregard
\$1,350	income applicable toward care

In this example, the following occurs:

1. Medicaid eligibility will begin on the first day of the application month (assuming client has met all other eligibility criteria). Medicaid coverage of institutional cost of care will begin on the second day of the application month, which is the date of entry into the facility;
2. Tammy will:
 - a. pay \$1,350 toward the cost of care;
 - b. have \$100 to pay on her legal child support obligation;
 - c. retain \$50 for her personal needs; and
 - d. be eligible for all other medically necessary services payable by Medicaid.
3. Medicaid will be responsible for the balance of the facility costs.

Example #2

Tim enters facility:	February 23
Applies for Medicaid:	June 1
Tim's monthly income:	\$3,000 unearned income
Net daily Medicaid rate:	\$2,700 (\$90 X 30 days)

Categorical determination:

\$3,000	gross monthly income
- 20	general income disregard
2,980	total countable income

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- 525 MNIL for one (MNIL for 2007 used for example)
\$2,455 *balance*

Balance is greater than zero, so this is a medically needy case.

Step 1 – Determination of medical need:

\$2,980 total countable income
- 2,700 cost of care at facility
= 280 GREATER THAN ZERO

Tim is not eligible for Medicaid coverage of institutional cost of care because the net Medicaid cost of care (\$2,700) is less than his total countable income.

Step 2 - Post Eligibility Treatment of Income

DOES NOT APPLY. NO ELIGIBILITY ESTABLISHED FOR
COVERAGE OF INSTITUTIONAL COST OF CARE.

Tim is not eligible for Medicaid as an institutionalized individual, and Medicaid will not contribute to the cost of care at the facility for this month. But, Tim will be eligible for Medicaid coverage of non-institutional medical expenses when a total of \$2,950 (\$3,000 - \$50) in medical expenses has been incurred as Tim's responsibility. If Tim is a spouse, he is not eligible for deductions such as a community spouse income maintenance allowance or family income maintenance allowance.

In this example, the following occurs:

1. When Tim incurs an additional \$250 (\$2,950 incurment minus \$2,700 nursing facility cost at Medicaid rate) in medical expenses [Medicare premium will meet a portion of this incurment]:
 - a. determine what date Tim met his incurment.

NOTE: Apply the projected monthly **Medicaid** net payment rate toward the month's medical expenses on INCU using a "00" date (for June, shown as 0600 in the "MTH/DAY MED SVC" field.

- b. Enter a nursing home eligibility span on the system. This is necessary in order for the facility to be credited with a

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Medicaid patient, and allows them a benefit for accepting the Medicaid rate for Tim's care.

- c. Notify the facility that Tim's patient liability is \$2700 for June; the full Medicaid rate multiplied by the number of days in the month (\$90 X 30 days). In this example, the facility is notified that, for June, the patient liability is \$2700. For July, the patient liability is \$2790 (\$90 X 31 days). Do not include the calculation (i.e., \$90 X 31 days) in the notice to the facility, but only the actual dollar amount due to the facility.
2. After medically needy eligibility has been established, Medicaid will:
 - a. **not** pay toward the residential medical costs;
 - b. pay for all other medically necessary services that are benefits of the Medicaid program.

Example #3

John incurred \$3,000 in medical expenses on May 4.

John entered facility: May 25

John's monthly income: \$1,500 unearned income

Net daily Medicaid rate: \$630 (\$90 x 7 days)

Categorical determination:

\$1,500	gross monthly income
- 20	general income disregard
1,480	total countable income
- 525	MNIL for one (MNIL for 2007 used for example)
\$ 955	<i>balance</i>

Balance is greater than zero, so this is a medically needy case.

Step 1 – Determination of medical need:

May	\$1,480	total countable income
	- 630	cost of care at facility
	= 850	GREATER THAN ZERO

By this calculation, John is not eligible for Medicaid coverage of institutional cost of care for the month of May because the net Medicaid cost of care (\$630) for May is less than his total countable income...but there's other eligibility to be considered.

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Because John can meet his incurment with medical expenses incurred in May prior to entering the facility, John will be eligible for Medicaid coverage for the nursing home stay.

He is not, however, eligible for post-eligibility treatment of income. His incurment is calculated based on his community residence at the beginning of the month, and the incurment worked in the system as a regular disabled medically needy program (John is age 61). The nursing home net daily rate would be added to the system as medical expenses for each individual day in which he resided in the facility (MTH/DAY MED SVC of 0525 with the amount of \$90, 0526 with the amount of \$90, etc.)

Because John met the incurment using May 4 medical expenses:

1. Prepare an HCS-454, "Provider Informational Memorandum" (i.e., One Day Authorization) for May 4 and authorize medically needy coverage effective May 5;
2. Notify both John and the facility that he has zero liability to the facility for May.
3. Work eligibility as usual for June's nursing home eligibility, (i.e., two step eligibility determination).



NOTE: *If this scenario arises, please contact your RPS prior to authorizing the benefits or sending an approval notice to either the client or the facility. Your RPS will discuss the case with Central Office as CHIMES will not send a nursing home span to MMIS for payment.*

Example #4

It is sometimes necessary to work a budget by hand for a person who enters a facility after the first of the month, and has already met his/her incurment.

Scott incurred \$500 in medical expenses on March 3.
 Scott entered facility: May 22
 Scott's monthly income: \$1,500 unearned income
 Net daily Medicaid rate: \$ 900 (\$90 X 10 days)
 May cash option payment \$ 19.40

Medically Needy Eligibility Determination (in community)

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\$1,500	unearned income
<u>- 20</u>	general income disregard
\$1,480	TOTAL COUNTABLE INCOME
- 525	MNIL for one (MNIL for 2007 used for example)
<u>- 50</u>	Medically Needy Income Deduction (2007-2008)
\$ 905	incurment

Scott met his incurment for May as follows:

February Medicare premium	\$ 96.40	(2008 premium)
March Medicare premium	96.40	
Paid expenses incurred in March	500.00	
April Medicare premium	96.40	
May Medicare premium	96.40	
Cash option payment	<u>19.40</u>	
Total incurment	\$905.00	

The eligibility case manager must complete a "hand budget" for patient liability to the facility as follows:

Step 2 - Post Eligibility Treatment of Income

\$1,500.00	gross monthly income
- 50.00	personal needs
- 96.40	Medicare Part B premium
- 19.40	cash option payment
<u>- 525.00</u>	home maintenance allowance
\$ 809.20	patient obligation to facility

The expenses for previous months' Medicare Part B premiums, the medically needy income deduction and the paid medical expense from March are not allowable expenses in post eligibility treatment of income (see MA 904-2 and 904-3).

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