

Department of Public Health and Human Services	Section: RESIDENTIAL MEDICAL INSTITUTIONS
MEDICAL ASSISTANCE	Subject: Post-Eligibility Treatment of Income for Institutionalized Individuals

**Supersedes:** MA 904-3 (07/01/09), Bulletin MA-101 (04/27/10)

► **References:** 42 CFR 435.725 and .832; ARM 37.82.101, .1320; Bulletin MA-101 (04/27/10)

GENERAL RULE—An unmarried individual's gross monthly income (minus allowable deductions) must be applied toward the cost of his/her institutional care, if Medicaid is contributing to the cost of the institutional care. This budgeting process is known as “Step 2” of the institutionalized budgeting process. An institutionalized individual's incurment is budgeted according to a different method when Medicaid is not contributing to the cost of care. (See MA 904-6.) Allowable income deductions when Medicaid is contributing to the cost of the institutional care may include:

**NOTE:** Total deductions may not exceed the institutionalized individual's gross income.

1. up to \$65 of gross earned income;

**NOTE:** Blind/disabled work expenses do not apply in post-eligibility treatment of income.

2. A personal needs allowance of \$50 (or the amount of the individual's remaining income, if less than \$50).

**NOTE:** Effective with the implementation of CHIMES, VA pension income of \$90 or less is excluded income and all nursing home residents receive \$50 personal needs allowance.

3. incurred medical or remedial care expenses of the institutionalized individual including health insurance premiums (see MA 703-1).

4. court-ordered child support actually paid (see MA 601-3);

5. court-ordered alimony actually paid (see MA 601-3); and

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6. home maintenance allowance.

**NOTE:** When a community spouse enters an institution and Medicaid eligibility is determined for the (former) community spouse, the CSIMA is countable income in the budget, and the (former) community spouse is entitled to a home maintenance allowance, because s/he is treated as an individual.

Tax Stimulus Rebates are excluded income in Post-Eligibility Treatment of Income calculations.

#### **AID AND ATTENDANCE**

Veterans Administration Aid and Attendance (A&A) payments may be converted to Veterans pension payments of up to \$90 per month after the third month of care for a veteran who:

1. is Medicaid eligible;
2. resides in a residential medical facility; and
3. has neither a spouse nor dependent child(ren).

Effective with the implementation of CHIMES, Veterans pension payments which do not exceed \$90 per month are excluded income for nursing home Medicaid eligibility. Veterans pension payments exceeding \$90 per month are countable income.

**NOTE:** The veteran is entitled to the \$50 personal needs allowance if their \$90 Veterans pension is excluded income.

#### **► INCURRED MEDICAL EXPENSES**

Certain medical expenses can be deducted from an institutionalized individual's income when determining liability toward cost of care.

No incurred medical expense deductions are allowed for medical or remedial expenses incurred during an uncompensated asset transfer penalty period.

Incurred medical expense deductions are limited to those incurred medical expenses which:

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- ▶ a. were incurred during the three months immediately prior to application (or coverage request date) for Medicaid coverage of institutional care; or
- b. are current actual payments on expenses incurred more than three months immediately prior to the application for Medicaid coverage of institutional coverage.

In addition, incurred medical expenses must meet all of the following in order to be allowable deductions:

1. were unpaid at the time of application or institutional coverage request date;
2. are recognized and regulated by State law as medical services, supplies or equipment;
3. are not payable by a third party; and
4. were not previously used to meet an incurment or to offset the individual's obligation toward cost of care in a previous month.

Incurred medical expenses are allowed until the full unpaid balance has been deducted or until expenses are paid in full, whichever comes first. Allowable medical expenses incurred prior to Medicaid application must be reported and verified within the application/coverage request processing period, or within three months of the coverage request date, whichever is later. See MA 703-1 for more detail on limitations on medical expenses.

Deductible medical expenses incurred during Medicaid eligibility periods include:

1. Health insurance premiums (including Medicare);
2. Medical expenses incurred while in the institution that are:
  - a. prescribed by a physician;
  - b. not Medicaid-covered services;
  - c. not payable by a third party; and
  - d. subject to the limitations outlined in MA 703-1.

- ▶ **NOTE:** Items such as eye drops, procedure gloves, wipes, etc., are included in the Medicaid payment to the nursing facility as part of Medicaid-covered services, and cannot be billed separately to the nursing home resident, nor are they deductible if

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purchased by the family from a different provider and brought into the facility. Services that are covered by Medicaid but are received from a provider that is not a Medicaid-participating provider are not allowable; providers have up to a year to enroll as a Medicaid provider and up to a year to bill for services.

Medical expenses incurred after application must be reported in a timely manner (within 10 days of knowing of the expense).

## **HOME MAINTENANCE**

The home maintenance allowance is the Medically Needy Income Level (MNIL) for one, and is allowed in the following situations:

1. for the month of entry, when the individual entered the facility from the community (including entering from a hospital stay, if the individual entered the hospital from the community) after the first day of the month; or
2. for up to six months when the individual is intending to return to the community within six months of entry into the institution (even if there are no verifiable housing expenses during the individual's institutionalization); or

**NOTE:** A physician must certify that the individual will return home within six months of entry. This deduction is initially allowed for a maximum of three months of continuous stay in the facility (including the month of entry), with the possibility of a three-month extension, based on a renewed physician's statement in the third month of institutionalization. Intent and medical feasibility must be established upon entry into the facility. If an individual is discharged to return home (not for a visit, medical treatment, or vacation) and remains out of the facility for one full day or more, a new six-month period during which the home maintenance allowance is available may be established, if requested and accompanied by a new physician's statement.

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- for the month of discharge when the individual leaves the facility before the last day of the month to reestablish residence in the community.

**FAMILY CONTRIBUTION TO FACILITY**

If a Medicaid applicant/recipient's family (or anyone else) pays an additional amount directly to the institution to upgrade the person from a semi-private to a private room, the additional payment is not considered in-kind income for shelter. Expenses paid to a residential medical facility are medical expenses, but are not necessary medical expenses, so are not deductible as incurred medical expenses.

**NOTICE**

The Medicaid recipient or authorized representative must receive notice of the institutionalized individual's applicable deductions and liability toward cost of care. The institution must receive concurrent notice of the patient's liability toward cost of care only, even when the liability toward cost of care is zero.

**PROCEDURE**

**Responsibility**

**ACTION**

Applicant or Representative

- Complete and submit a Montana Medicaid application; appear for an interview (if requested); provide required verification.
- Request a preadmission screening (See MA 902-1).

Preadmission Screening Committee

- Provide the caseworker and the facility with SLTC-61, "Screening Determination", indicating whether the applicant's placement in the facility is authorized.

Eligibility Case Manager

- Enter the effective date of the screening determination on the Preadmission Screening web page in CHIMES.



Always enter the actual date of entry into the nursing home in the Nursing Home/Institution web page, regardless of other factors, such as PAS start date, asset transfer penalty periods, etc.

If placement is not authorized by the Mountain Pacific Quality Health Foundation, deny institutional coverage.

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5. If placement is authorized and the person meets all other eligibility criteria, determine financial eligibility.
6. Document case file (include the SLTC-61, "Screening Determination", plus other non-financial and financial verifications).
7. Notify the applicant of the eligibility determination.
8. If eligible, notify the medical institution of the recipient's liability toward cost of care.
9. Transfer the case to the county where the medical institution is located, if requested by the recipient or authorized representative (see MA 103-1).

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