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daily contribution rate. The result is the client's total cost contribution for the partial month. After all computations have been completed, any cents calculated as part of the result are dropped.

**NOTE:** When the contribution is prorated for the last month of nursing facility residence, only days during which the client resides in the facility are calculated. Days during which the client does not reside in the facility, even if they are bed-hold days, are not considered for the purpose of prorating the last month's contribution.

**NOTE:** This policy applies only to the first and last months of nursing facility residence when Medicaid participates in the payment. It is not used when the client leaves the facility for other medical treatment, for family visits, etc. During all other months, the client must contribute his full resource and be reimbursed by the facility if an overpayment occurs.

When the client's contribution for the initial month of eligibility is prorated, the full month's income and post-eligibility deductions are entered in the data system. No prorated amounts are entered. The Worker notifies the LTC Unit of the prorated amount and the following full month's contribution using the ES-NH-3.

When a client is eligible for payment for nursing facility services under a full-Medicaid coverage group, and is also QMB eligible, he must pay his full contribution, even when Medicare participates in his cost of care, unless Medicare participates for the entire month. When the contribution is prorated for the first or last month of care, it is prorated using the procedure above. The contribution is not prorated based on the date that Medicare begins or ceases participation. When the Worker learns that Medicare participated for an entire month for a QMB eligible client, an ES-NH-3 must be completed to change the contribution to $0 for that month. See Section 17.9,C for individuals who are eligible for QMB coverage only.

During the first month of Medicaid participation in the cost of care, when the client is not in the facility for a full month, the Worker may be asked how much the client is to retain for his personal needs and how much may be contributed to the community spouse and other family members. The process used to determine the Worker's response follows:

- Determine the client's total monthly Personal Needs Allowance (PNA), CSMA or FMA as if the client were to remain in the facility a full month.

- Divide the client's monthly PNA, CSMA or FMA by the actual number of days in the calendar month. This becomes the client's daily deduction rate which is used for this purpose only.

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- Determine the number of days in the calendar month the client expects to reside in the facility and multiply the number of days by the daily deduction rate of the specific deduction. The result is the amount of income the client may retain for the PNA, CSMA or FMA. After all computations have been completed, any cents calculated as part of the result are rounded up.

C. FINANCIAL ELIGIBILITY PROCESS

Eligibility for payment for nursing facility services is determined in any of the following four ways, in the following priority order:

1. QMB Eligible

When a client needs nursing facility services and Medicare is participating in the payment or will participate when the client enters the nursing facility, it may be to the client's advantage to receive payment for nursing facility services as a QMB eligible, until Medicare no longer participates. The QMB medical card pays all Medicare co-insurance and deductibles, and QMB recipients are exempt by law from the post-eligibility process. They, therefore, have no contribution toward their cost of nursing facility services as long as Medicare participates in the payment. See Chapter 16.

However, when the client would be disadvantaged in any way by QMB eligibility as opposed to eligibility under another coverage group, the Worker must use one of the following ways to determine eligibility, if one is more beneficial to him. In addition, when Medicare stops participating in the cost of care, QMB eligibility no longer covers nursing care costs and eligibility must be redetermined according to item 2, 3 or 4 below.

2. Client Is Medicaid Recipient

When the client is a recipient, under a coverage group which provides full Medicaid coverage, at the time he is determined to need nursing facility services, his Medicaid eligibility has already been determined, and no further eligibility test is necessary. The Worker must complete only the post-eligibility calculations to determine the client's contribution toward his cost of care, if any.

**NOTE: SSI, Deemed SSI and other full coverage Medicaid recipients must complete the DFA-LTC-5 at application for LTC services to evaluate any annuities, trusts and/or other potential resources or transfers. See Section 17.12,D.**

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All Medicaid coverage groups listed in Chapter 16 are full Medicaid coverage groups, unless there is a statement specifically to the contrary.

Medically Needy individuals must be receiving a Medicaid card to be determined eligible under this provision.

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The client's spenddown amount, if any, as determined in item C,4 above, is added to this amount to determine the client's total contribution toward his nursing care, except when there is a community spouse. In cases with a community spouse, the spenddown is not added to the computed resource amount. The spenddown is used only to compare to the cost of care to determine eligibility. See item 2 below.

1. Income Disregards And Deductions

   Only the following may be deducted from the client's gross income in the post-eligibility process:

   a. Personal Needs Allowance

      This amount is subtracted from income to cover the cost of clothing and other personal needs of the nursing facility resident. The monthly amount deducted is $50. However, for an individual who is entitled to the reduced VA pension of $90, the monthly Personal Needs Allowance is $90.

   b. Community Spouse Maintenance Allowance (CSMA)

      When the institutionalized individual has a spouse living in the community, a portion of his income may be deducted for the support of the spouse at home.

      To determine the CSMA, the income of the community spouse is subtracted from a Spousal Maintenance Standard (SMS) which is either:

      - The minimum SMS. This is 150% of the monthly FPL for 2 persons; or

      - The minimum SMS, increased by excess shelter/utility expenses, but not exceeding the maximum SMS.

      See Chapter 10, Appendix A for the minimum and maximum Spousal Maintenance Standard amounts.

      The remainder is the amount of the institutionalized spouse's income which can be used to meet his community spouse's needs.

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The determined amount must actually be paid to the community spouse for the deduction to be applied. If the client contributes less than the determined amount, only the amount actually contributed to the community spouse is deducted. If he has been ordered by a court or a Hearings Officer to contribute more to his spouse, the higher amount is deducted.

The following steps are used to determine the amount of the CSMA.

Step 1: Add together the actual shelter cost and the amount of the current SNAP Heating/Cooling Standard (HCS). See Chapter 10, Appendix B. The shelter cost must be from the home the institutionalized spouse and the community spouse shared prior to institutionalization, and in which the community spouse continues to live. It must have been the client's principal place of residence. Shelter costs include rent or mortgage payments, interest, principal, taxes, insurance and required maintenance charges for a condominium or cooperative.

Step 2: Compare the total of the costs in Step 1 to 30% of the minimum SMS. See Chapter 10, Appendix A. When the shelter/utility costs exceed 30% of the minimum SMS, subtract the 30% amount from the shelter/utility costs.

Step 3: Add the remainder from Step 2 to the minimum SMS. This amount, not to exceed the maximum SMS, is used in Step 5. See Chapter 10, Appendix A.

Step 4: Add together the community spouse's gross, non-excluded earned and unearned income.

Step 5: Subtract the Step 4 amount from the amount determined in Step 3 and if there are any cents, round the resulting amount up. This is the amount subtracted from the income of the institutionalized spouse for the needs of his community spouse.

If the Step 4 amount is equal to or greater than the Step 3 amount, no deduction is allowed.

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**NOTE:** The amount used from Step 3 cannot exceed the maximum SMS.

**If the amount in Step 5 is less than the minimum SMS or the Community Spouse will experience extreme financial duress, a hearing can be requested by the client, community spouse or authorized representative to obtain more of the institutionalized spouse's income and/or assets. See Common Chapters Manual, Chapter 700, Section 710.21.**

c. Family Maintenance Allowance (FMA)

When the institutionalized individual has family members who are living with the community spouse and who are financially dependent upon him, an FMA is deducted from his income. This amount is deducted whether or not the individual actually provides the money to the family members.

For purposes of this deduction, family members are the following people only: minor or dependent children, dependent parents of either spouse and dependent siblings of either spouse. This deduction is applied only when the institutionalized individual has a community spouse, and such family members live with the community spouse.

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The amount of the deduction is determined as follows for each family member:

Step 1: Subtract the family member's total gross non-excluded income from the minimum SMS. See Chapter 10, Appendix A. If the income is greater than the minimum SMS, no deduction is allowed for that member.

Step 2: Divide the remaining amount by 3, and round the resulting amount up.

**EXAMPLE:** $201.07 = $202

Step 3: Add together the individual deductions for all family members to determine the total FMA which is deducted from the income of the institutionalized individual.

**NOTE:** The FMA for each family member must not exceed one-third of the minimum SMS. See Chapter 10, Appendix A.

d. Outside Living Expenses (OLE)

Single individuals and couples, when both spouses are institutionalized, receive a $175 deduction from income for maintenance of a home when a physician has certified in writing that the individual, or in the case of a couple, either individual, is likely to return to the home within 6 months. The amount may be deducted for up to 6 months.

When both spouses are institutionalized, only one spouse may receive the OLE. They may choose which spouse receives the deduction.

**The OLE may be deducted during subsequent nursing facility admissions if the individual or couple meets the criteria listed above.**

**EXAMPLE: An individual is admitted to a nursing home for 6 months and then discharged to his home. His condition worsens after 4 months and he is readmitted to the nursing home again. He can receive the OLE again, if his physician certifies he is likely to return home again within 6 months.**

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e. Non-Reimbursable Medical Expenses

When the client is Medicaid eligible, only as determined in items C,2, 3 or 4 above, certain medical expenses which are not reimbursable may be deducted in the post-eligibility process. **These allowable expenses are listed in Section 10.22,D,11,c. Only the expenses of the eligible individual are used.** Incurred medical expenses, including nursing facility costs (except for nursing facility costs for clients with a community spouse), for which the client will not be reimbursed, are subtracted from his remaining income. When the client becomes eligible for nursing facility services after expiration of a penalty period for transferring resources, nursing facility expenses incurred during the penalty period which are non-reimbursable from another source may be used as a deduction. Non-reimbursable means the expense will not be or has not been paid to the provider or reimbursed to the client by any third-party payer, such as, but not limited to, Medicare, Medicaid, private insurance or another individual. The incurred expense must be the responsibility of the client.

**NOTE: The total deduction for medical insurance premiums is given to the person who pays the premium, regardless of which individual carries the insurance coverage. The deduction is not split between the spouses, even if both are receiving nursing facility services. See Chapter 4 for sources of insurance premium verification.**

**EXAMPLE 1: An institutionalized individual carries the insurance and pays the premium for himself and his community spouse. The institutionalized spouse receives a deduction for the full premium amount.**

**EXAMPLE 2: An institutionalized spouse, Mrs. Green, pays the premium for the insurance coverage that her community spouse, Mr. Green, carries for them both. The community spouse, Mr. Green, is admitted to the nursing facility. The insurance premium continues to be a deduction for Mrs. Green since she pays the premium.**

The total of all non-reimbursable medical expenses is entered in RAPIDS. The total amount is not rounded.

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**NOTE:** For all AG's except those with a community spouse, the amount of the client's spenddown, if any, which was calculated during the eligibility determination process, is treated as a non-reimbursable medical expense and subtracted from the client's income along with any other medical expenses the client may have

(1) Time Limits and Verification Requirements for Expenses

A non-reimbursable medical expense may be permitted only for services provided in the month of application and the 3 months prior to the month of application. This includes nursing facility expenses incurred during a penalty period for transferring resources.

**EXCEPTION:** A deduction may be given if there is evidence of a payment in the 3 months prior to application, even when the expense was incurred prior to that time.

**EXAMPLE:** Mrs. C applies for Medicaid for payment of nursing home expenses in October. She obtained a wheelchair in June and made payments in July, August and September. She still owes 10 more payments. The payment may be used as a deduction, even though she purchased it prior to the 3-month period, since there is evidence of a payment in the 3 months prior to application.

**EXAMPLE:** Same situation as above, except that Mrs. C did not make any payments during July, August or September. Since she did not incur the expense in the 3 months prior to the month of application or the month of application and made no payments during the 3-month period, no deduction is given.

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Post-Eligibility

| | | |
|---|---|---|
| Community Spouse Deduction: | $ 600.00 | Shelter |
| | + 366.00 | SUA |
| | $ 966.00 | Total Shelter/Utilities |
| | - 525.00 | 30% Min. SMS |
| | $ 441.00 | Excess Shelter/Utilities |
| | + 1,750.00 | Min. SMS |
| | $ 2,191.00 | |
| | - 950.00 | Total gross monthly non-excluded income of Community Spouse |
| | $1,241.00 | CSMA |
| Family Maintenance Deduction: | $1,750.00 | Min. SMS |
| | - 585.00 | Income |
| | $1,165.00 | Remainder ÷ 3 = $388.33 FMA |

| | |
|---|---|
| $2,050.00 | Income |
| - 50.00 | Personal Needs |
| $2,000.00 | Remainder |
| - 1,241.00 | CSMA |
| $ 759.00 | Remainder |
| - 388.33 | FMA |
| $ 370.67 | Remainder |
| - 158.50 | Medicare premium and doctor bill |
| $ 212.17 | Resource and total contribution toward his care |

The client has a $212.17 resource to contribute to his care. Because there is a community spouse, the spenddown amount determined in the eligibility process is not subtracted as a non-reimbursable medical expense and is not added to the resource to determine his total contribution.