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17.9 INCOME

There is a two-step income process for providing Medicaid coverag for nursing facility services to individuals in nursing facilities. The client must be eligible for Medicaid by being a member of a full Medicaid coverage group, by being a QMB recipien or by meeting a special income test. See Chapter 16 to determine which coverage groups provide full Medicaid coverage. If the client has a spenddown, it must be met before he is eligible for nursing facility services or it must be able to be met by the cos of the nursing facility. Once Medicaid eligibility is established, the client's contribution toward his cost of care in the facility is determined in the post-eligibility process. Thes processes are described in item D below.

A. EXCLUDED INCOME SOURCES

Income sources that are excluded for the coverage group unde which eligibility is determined are also excluded in the post-eligibility process for nursing facility services. See Section 10.3 for the appropriate coverage group.

B. BUDGETING METHOD

See Section 10.6,B. A monthly amount of income is determine based on averaging and converting income from each source.

Regardless of the day of the month on which the client enter or leaves the nursing facility, all income the client is determined to have, according to Chapter 10, for each month he resides even one day in the facility must be counted in determining eligibility and in post-eligibility calculations No deductions or exclusions are allowed for income already spent in the month the client enters the nursing facility or for expenses he anticipates in the month he leaves.

During the first month and last month that Medicaid participates in the cost of care, it is necessary to prorate the client’s contribution to his care when he does not spend the full calendar month in the facility. This proration is accomplished as follows:

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- Determine the client's total monthly cost contribution amount as for any other nf resident who expects to remain in the facility a full month.

- Divide the client's total monthly cost contribution by the actual number of days in the calendar month. This becomes the client's daily contribution rate, which is used for this purpose only.

- Determine the number of days the client resided or expects to reside in the facility in the calendar month and multiply the number of days by the 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 o 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

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the Worker learns that Medicare participated for an entire month for a QMB eligible client, an ES-NH-3 must be complete to change the contribution to $0 for that month. See Sectio 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 contribute 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.

- 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.

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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.

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

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

Those Medically Needy individuals who have no spenddown meet the requirement of Medicaid eligibility. Those who meet their spenddowns prior to the need for nursing facility care have met the requirement of being eligible, through the current POE. After the POE during which nursing facility services begin, the client's situation is treated according to item 3 or 4 below. Those who do not meet their spenddown prior to the need for nursing facility care are treated according to item 3 or 4 below.

When an applicant is not a recipient of full Medicaid coverage, the following test is made to determine eligibility.

3. Gross Income Test

If the client is not eligible under items 1 or 2 above, Medicaid eligibility may be established as follows:

- Determine the client's gross non-excluded monthly income.

- Compare the income to 300% of the current maximum SSI payment for one person.

To be Medicaid eligible, his income must be equal to or less than 300% of the SSI payment.

Once Medicaid eligibility is established in this manner, the client's contribution toward his cost of care is determined in the post-eligibility process. There is no spenddown amount for persons determined eligible in this way.

EXAMPLE: When the current maximum SSI payment is $545, the client's gross, non-excluded monthly income is compared to $1,635.

NOTE: SSI-Related Medicaid disability and asset guidelines must be met.

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4. SSI-Related Medicaid Test

If the client is not eligible under items 1, 2 or 3 above, his eligibility as an SSI-Related Medicaid client must be explored as another way to receive financial assistance for the cost of nursing facility services.

All policies and procedures in effect for other SSI-Related cases apply to these cases, including the determination of a spenddown amount, if applicable.

EXCEPTIONS:

- Income is not deemed.
- The MNIL for one person is always used. See Chapter 10, Appendix A.
- The spenddown amount is determined on a monthly basis.

When the client's monthly cost of care exceeds his monthly spenddown amount, the spenddown is assumed to be met and Medicaid eligibility is established. In addition, if his monthly spenddown amount exceeds his monthly cost of care, h may become eligible for Medicaid based on a 6-month POC, but not for payment of nursing facility services.

Case examples of the entire process of determining eligibility and the amount of the client's contribution are found below in item D.

NOTE: Only for cases with a community spouse -- the amount of the spenddown is used only for comparison with the cost o care. It is not used as a part of the client’s contribution toward his cost of care as it is for all other nursing facility cases which must meet a spenddown.

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D. POST-ELIGIBILITY PROCESS

In determining the client's contribution toward his cost of nursing facility care, the Worker must apply only the income deductions listed below. This is the post-eligibility process. The remainder, after all allowable deductions, is the resource amount, which is at least part of the amount the client must contribute toward his cost of care. 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, non-excluded 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.

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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.

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 Food Stamp SUA. See Chapter 10,

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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.

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

c. Family Maintenance Allowance (FMA)

When the institutionalized individual has family members who are living with the community spouse and who are financially

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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.

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.

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

e. Non-Reimbursable Medical Expenses

When the client is Medicaid eligible only as determined in items C,2, 3 or 4 above, 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. The incurred, non-reimbursable medical expenses which may be deducted are the same as those which may be used to meet spenddown. See Chapter 10. When the client becomes eligible for nursing facility services after expiration of a penalty period for transferring resources, any nursing facility expenses incurred during the penalty period are deducted as non-reimbursable medical expenses.

All non-reimbursable medical expenses are totalled and any cents rounded up.

NOTE: For all cases 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.

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2. Determining The Client's Total Contribution

Because the amount of medical expenses used to meet the client's spenddown cannot be paid by Medicaid, the spenddown amount becomes part of the client's contribution toward his cost of care.

EXCEPTION: Due to the Lemasters law suit, HCFA and the Department have temporarily agreed that the spenddown amount is not part of the client’s contribution toward his care whe there is a community spouse.

This amount is added to the resource amount determined in item 1 above to determine the client’s total monthly contribution toward the cost of his nursing care.

If the client is Medicaid eligible without a spenddown according to items C,2 and C,3 above, the resource amount from item 1 is his total cost contribution.

When the client resides in more than one nursing care facility during the same calendar month, the Worker must determine the portion of the client's cost contribution whic must be paid to each facility. The Worker follows the steps below to determine how much of the client's total contribution must be paid to the first facility he entered. If the client's total contribution must be paid to Facility #1, no further calculation is necessary. If not, the amount(s) paid to the other(s) is determined in the same way The ES-NH-3 is used for notification of the amount due each facility.

Step 1: Determine the client's monthly contribution toward his cost of care.

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Step 2: Multiply the number of days the client was in Facility #1 by the per diem rate for the facility. The result is the clients cost of care for this facility for the month.

Step 3: Compare Step 1 to Step 2.

If Step 1 is less than or equal to Step 2, the client's entire contribution toward his cost of care is paid to Facility #1.

If Step 1 is greater than Step 2, the Step 2 amount is paid to Facility #1 and the difference between Step 1 and Step 2 is paid to Facility #2.

E. EXAMPLES

EXAMPLE: Single Individual with OLE, Categorically Needy

A Pass-Through Medicaid recipient enters a nursing home and wants Medicaid to pay toward his cost of care. He has $1,650/month unearned income. He is a single individual with OLE.

Medicaid eligibility is already established. Even though his income exceeds 300% of the SSI payment level, he is eligible without a spenddown as a Categorically Needy Medicaid recipient. Therefore, only post-eligibility calculations must be performed. The Worker records that the client was a Deemed SSI Recipient prior to nursing care eligibility so that eligibility may be restored if he no longer requires nursing care. Post-eligibility calculations are as follows:

$1,650	Client's gross monthly non-excluded income
- 50	Personal Needs Allowance
$1,600	Remainder
- 175	OLE
$1,425	Client's resource amount which is also his total contribution toward his cost of care.

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EXAMPLE: Single Individual With OLE, Medically Needy

Same situation as above except that the client is not a Deemed SSI Recipient. His Medicaid eligibility must be established as a SSI-Related individual.

Eligibility

$1,650	Income
- 20	SSI Income Disregard
$1,630	Remainder
- 200	MNIL for 1
$1,430	Monthly Spenddown

The monthly cost of care in the facility is $2,500. Therefore, his spenddown is met for the month and post-eligibility calculations are performed for any additional contribution he must make.

Post-Eligibility

$1,650	Income
- 50	Personal Needs Allowance
$1,600	Remainder
- 175	OLE
$1,425	Remainder
- 54	Medicare premium (non-reimbursable medical expense)
$1,371	Remainder
-1,430	Spenddown (non-reimbursable medical expense)
0	Resource Amount

The client has no resource amount, so his total contribution is $1,430, his spenddown amount. The Department will not pay any part of the $1,430 because it is the client's spenddown and he is by definition, liable for it.

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EXAMPLE: Single Individual Without OLE, Medically Needy

Same as above except the client has no OLE. The client's spenddown amount is the same as determined above.

Post-Eligibility

$1,650	Income
- 50	Personal Needs Allowance
$1,600	Remainder
- 54	Medicare premium (non-reimbursable medical expense)
$1,546	Remainder
-1,430	Spenddown (non-reimbursable medical expense)
$ 116	Resource Amount

The client's total contribution toward his cost of care is:

$1,430	Spenddown
+ 116	Resource Amount
$1,546	Total Contribution

EXAMPLE: Married Individual Without Community Spouse, Medically Needy

Mr. Smith is married but has been separated from his wife for 10 years. He has 1 dependent child still living in his home. His monthly income is $1,670. He has non-reimbursable medical expenses of $54 (Medicare premium).

Eligibility

$1,670	Income
- 20	SSI Disregard
$1,650	Remainder
- 200	MNIL
$1,450	Monthly Spenddown

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Post-Eligibility

$1,670	Income
- 50	Personal Needs
$1,620	Remainder
- 54	Medicare premium (non-reimbursable medical)
$1,566	Remainder
-1,450	Spenddown (non-reimbursable medical)
$ 116	Resource
+1,450	Spenddown
$1,566	Total Contribution

NOTE: Mr. Smith is not eligible for the FMA, because there is no community spouse.

EXAMPLE: Married Individual With Community Spouse, Medically Need

Mr. Holley has the following income:

$960	RSDI
+745	Retirement
$1,705	Total Income

He has a community spouse who has $275/month RSDI income and $365/month earned income, for a total of $640. His child receive $275/month RSDI.

Eligibility

$1,705	Income
- 20	SSI Disregard
$1,685	Remainder
- 200	MNIL
$1,485	Monthly Spenddown

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Post-Eligibility

Community Spouse Deduction:	$ 421	Shelter
	+ 248	SUA
	$ 669	Total Shelter/Utilities
	- 436	30% Min. SMS
	$ 233	Excess Shelter/Utilities
	+1,452	Min. SMS
	$1,685	
	- 640	Total gross monthly non-excluded income of Community Spouse
	$1,045	CSMA

Family Maintenance Deduction:	$1,452	Min. SMS
	- 275	Income
	$1,177	Remainder ÷ 3 = $393 FMA

$1,705	Income
-50	Personal Needs
$1,655	Remainder
1,045	CSMA
$ 610	Remainder
-393	FMA
$ 217	Remainder
-146	Medicare premium and doctor bill
$ 71	Resource and total contribution toward his care

The client has a $71 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.