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SECTION I - INSTITUTIONALIZATION

SECTION I - CONT'D

INSTITUTIONALIZATION
PUBLIC INSTITUTIONS

A. GENERAL (42 CFR 435.1008 and 1009)

Federal Financial Participation (FFP) is not available for services provided to individuals who are inmates of public institutions. An inmate of a public institution is a person who is living in or under the direct control of a public institution. A public institution means an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control.

B. INSTITUTIONS NOT CONSIDERED PUBLIC INSTITUTIONS

The following are not public institutions and FFP is possible for individuals who reside in such a facility if all other factors of eligibility are met.

1. Medical Institution

A medical institution is one organized to provide medical care, including nursing and convalescent care, that is Title XIX approved, such as hospitals, nursing facilities and extended care facilities.

2. Publicly Operated Community Residence That Serves No More Than 16

In general, this means it is designed to serve no more than 16 residents and provides some services beyond food and shelter such as social services, help with personal living activities, or training in socialization and life skills. Occasional medical or remedial care may also be provided.

Residential facilities located on the grounds of or adjacent to any large institution and correctional or holding facilities for prisoners or individuals being held under court order as witnesses or juveniles are considered public institutions and are not eligible for FFP.

INSTITUTIONALIZATION
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3. Child Care Institutions

Child care institution means a non-profit private child-care institution, or a public child-care institution that accommodates no more than twenty-five children, which is licensed by the State in which it is situated, or has been approved by the agency of the State responsible for licensing or approval of institutions of this type, as meeting the standards established for licensing. The term does not include detention facilities, forestry camps, training schools or any other facility operated primarily for the detention of children who are determined to be delinquent.

4. Foster Family Homes

Children receiving foster care payments under Title IV-E of the Social Security Act or who receive AFDC-foster care under Title IV-A of the Social Security Act and who reside in a child care institution described above are not residing in a public institution.

5. Institution for the Mentally Retarded or Related Conditions

Institution for the mentally retarded or persons with related conditions means an institution (or distinct part of an institution) that -

- Is primarily for the diagnosis, treatment, or rehabilitation of the mentally retarded or persons with related conditions; and

- Provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination, and integration of health or rehabilitative services to help each individual function at his greatest ability.

INSTITUTIONALIZATION
PUBLIC INSTITUTIONS

C. INDIVIDUALS WHO ARE NOT CONSIDERED RESIDENTS OF PUBLIC INSTITUTIONS

Individuals who reside in the following types of facilities are not considered residents of public institutions and can therefore be determined eligible for Medicaid if eligible on all other factors.

1. Persons Receiving Educational or Vocational Training

Persons who reside in public facilities in order to receive educational or vocational training provided by the facility in preparation for gainful employment (e.g., a State school for the blind) are not considered to be "residents" of public institutions and are therefore entitled to Medicaid coverage if determined eligible.

2. Residents of Public Emergency Shelter for the Homeless

A homeless individual is one who is not under the control of any public institution and has no currently usable place to live. **t**emporary residents of an emergency shelter for individuals whose homelessness poses a threat to their lives or health or residents of public institution or that part of a public institution used as an emergency shelter by a governmental unit, are not considered residents of a public institution.

3. Safe Havens Programs

Participants residing in a safe haven program, which is usually low cost housing provided to homeless individuals, are not considered residents of a public institution.

4. "Temporary" Placement in a Public Facility

An individual who is placed in a public institution on a temporary emergency basis pending other arrangements appropriate to his/her needs is not considered a resident of the public institution.

INSTITUTIONALIZATION
PUBLIC INSTITUTIONS

5. Inpatients of Medicaid Institutions

Inpatient means a patient who has been admitted to a medical institution as an inpatient on recommendation of a physician or a dentist and who -

- Receives room, board and professional services in the institution for a 24 hour period or longer, or

- Is expected by the institution to receive room board and professional services in the institution for a 24 hour period or longer even though it later develops that the patient dies, is discharged or is transferred to another facility and does not actually stay in the institution for 24 hours.

6. SSI Payment Policy for Inpatients of Medical Institutions

Under the SSI Program, for any full month where Title XIX pays more than fifty percent of the cost of an eligible person's care in a public Title XIX medical facility, the individual will be considered to be a patient in a medical institution for purposes of SSI benefits; such persons are entitled to SSI benefits based on a $30 payment standard. Persons in public medical facilities whose SSI benefits are suspended solely because Title XIX does not pay more than fifty percent of the cost of their care and who thus become ineligible as "SSI recipients" can retain Medicaid coverage under a MAO Long Term Care Coverage Group.

INSTITUTIONALIZATION
PUBLIC INSTITUTIONS

D. PUBLIC INSTITUTIONS

Persons who live in a public institution which is not certified a Title XIX facility, whether admitted or placed on a voluntary basis or committed under some legal process, are considered to be "inmates" and are not entitled to Medicaid as long as they reside in the facility. **Ineligibility for persons classified as inmates begins on the day institutional status commences and ends on the day institutional status ends by discharge, parole or permanent release.** Public institutions include, but are not limited to, the following:

1. Penal Institutions

Penal institutions include jails, prisons, reformatory or correctional (training) schools. Inmate status extends to a person detained by legal process under the penal system during a pre-trial period.

2. Group Homes

Group homes which are owned or leased by a governmental agency and administered through staff employed on a salaried basis by the agency, e.g., as counselors or house parents rather than as foster parents.

3. Institutions for Mental Diseases

These include State mental institutions or the portions thereof not certified as Title XIX distinct parts of the institution, such as,

- Mississippi State Hospital at Whitfield,
- Ellisville State School at Ellisville, and
- East Mississippi State Hospital at Meridian

4. Institution for Tuberculosis

Institution for tuberculosis means an institution that is primarily engaged in providing diagnosis, treatment, or care of persons with tuberculosis, including medical attention, nursing care, and related services. Whether an institution is an institution for tuberculosis is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of tuberculosis, whether or not it is licensed as such.

INSTITUTIONALIZATION
PHYSICIAN'S CERTIFICATION

A. GENERAL

Federal regulations require that Medicaid recipients who enter long term care be in need of the medical care for which payment will be made. In accordance with this requirement, a physician's certification of need and level of care is required for the following types of coverage:

- Nursing Home placement,
- ICF-MR placement,
- HCBS for the Physically Handicapped Waiver participation, and,
- Disabled Child Living At-Home coverage.

A peer review agency under contract with the Division of Medicaid is charged with the responsibility for certifying the medical necessity of long term admissions to:

- Psychiatric Residential placements,
- Swing Bed placements, and,
- Long Term Hospitalizations.

INSTITUTIONALIZATION
PHYSICIAN'S CERTIFICATION

B. POLICY/ PROCEDURES

Prior to the approval of a MAO Long Term Care case (including SSI-only and/or DHS LTC cases), the following documentation of medical necessity must be present in the case record. Note: The physician's certification requirement is in addition to a DDS decision for establishing disability for categorical relatedness.

1. LTC in a Nursing Facility (DOM-260NF)

Individuals who enter LTC in a nursing facility must have a DOM-260NF completed and signed by a physician. The nursing facility must provide the Regional Office with a copy of the completed/signed and dated DOM-260NF before the LTC application can be approved. The physician's signature certifies the medical necessity of the placement for eligibility purposes. The physician must also mark one of the 3 lower "Choice" boxes. If no "Choice" is checked, the 260 is invalid, and eligibility cannot be approved.

If the 2nd block is checked, a Level II screening is required and a memo from the Health Department indicating an approval of a Level II screening which is called PASARR is required. This is the review the Department of Mental Health must complete for a patient who has a diagnosis or related condition of mental illness or mental retardation. The PASARR is Pre-admission Screening Annual Resident Review. The cover memo signed by the Department of Mental Health indicates two types of approvals; however, either type of approval is permissible for eligibility purposes. If the memo is not received or if the memo indicates denial, the 260NF is invalid and eligibility cannot be approved.

The initial DOM-260NF valid at the time of admission remains valid until it is replaced with a new form or rescinded by DOM medical staff.

A new DOM-260NF is required only when a reapplication is filed on an applicant who has been ineligible for Medicaid for a period longer than 2 months and there has been a break in institutional status. No new DOM-260NF is required if the applicant is still in LTC and continuity of patient status has not been interrupted. Periods of ineligibility that exceed 12 months require a new DOM-260NF.

If no DOM-260NF is received by the Regional Office by the end of the application processing period, the application must be denied.

Effective November 1, 1999, in conjunction with the new Long Term Care Alternatives Program, a legible copy of the 260NF must be faxed to the DOM State Office in Jackson within twenty-four hours of completion of the form. This time frame is for any 260NF that does not require a Level II evaluation. A 260NF that requires a Level II evaluation will not be submitted to the DOM until the Appropriateness Review Committee (ARC) with the Department of Mental Health has approved the individual for nursing facility placement.

2. LTC in an ICF-MR (DOM-260MR)

Placement in an ICF-MR requires that a physician sign and a DOM-260MR and medical staff with the Department of Mental Health approve the DOM-260MR. The ICF-MR facility must provide the Regional Office with a copy of an approved DOM-260 MR before the LTC application can be approved for eligibility purposes.

The initial DOM-260MR approved at the time of admission remains valid until replaced with a new form or rescinded by DOM or Department of Mental Health medical staff.

The same procedures for requiring a new DOM-260NF (described above) apply for requiring a new DOM-260MR. Also, if no DOM- 260MR is received or if the DOM-260MR is disapproved for ICF-MR placement, the application must be denied.

INSTITUTIONALIZATION
PHYSICIAN'S CERTIFICATION

3. Disabled

Child Living At-Home (DOM-260DC)

Disabled children age 18 or under in this coverage group must have a completed/signed DOM-260DC by a physician that is sent for review and approval of this type of care with medical staff within the Division of Medicaid's Maternal Child Health (MCH) Unit. The Regional Office must forward the completed DOM-260DC to the MCH Unit for review along with all relevant medical information. A DOM approved DOM-260DC is required prior to approval of a DCLH case. A disapproved DOM-260DC will result in a medical denial.

Completion of a new DOM-260DC is required at either one-year or three year intervals as required by MHC. Refer to Section G, page 7313 for the criteria of each interval.

4. HCBS Waiver Programs (DOM-260HCBS)

Disabled individuals in the Waiver Programs must have a completed/signed DOM-260HCBS by an approved physician. The Regional Office must receive an approved DOM-260HCBS prior to approval of a HCBS Waiver application. A disapproved DOM-260HCBS will result in a medical denial.

Completion of a new DOM-260HCBS is required every 12 months. Each year the medical necessity of this coverage must be reapproved by DRS/DOM or AAA/DOM.

5. LTC in a PRTF

Children who enter a Psychiatric Residential Treatment Facility (PRTF) must be certified by the PRO agency under contract with the Division of Medicaid who determines the medical necessity of the placement. This review is performed separate and apart from the eligibility process and it is not necessary for the Regional Office to verify PRO approval before, during or after the application process. The PRTF must issue a DOM-317 to the appropriate Regional Office in order for payment to the facility to be authorized.

6. LTC in a Swingbed

If a facility plans to bill Medicaid for a swingbed admission, the facility must issue a DOM-317 to the Regional Office. However, the PRO agency is responsible for authorizing the medical necessity of the swingbed stay and this is performed separate and apart from the eligibility process. It is not necessary for the Regional Office to verify PRO approval for a swingbed stay.

INSTITUTIONALIZATION
SPOUSAL IMPOVERISHMENT

A. GENERAL

Section 303(a) of the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360) issued a new Section 1924 of the Social Security Act to mandate specific protection of income and resources for the maintenance needs of a community spouse when the other spouse is in a medical institution in long-term care (LTC) . This special treatment of income and resources for certain couples is referred to as Spousal Impoverishment (SI). These rules are designed to assure that a Community Spouse (CS) maintains a certain level of financial security so he/she does not become "impoverished" in order to obtain Medicaid eligibility for the Institutionalized Spouse (IS).

1. SI Income/ Resource Rules - Applicability

The SI income and resource rules described in this subsection apply to an IS with a CS when:

- The IS/CS are legally married under State law. SI rules apply in an IS/CS situation regardless of whether
  - the couple was "separated"prior to the IS entering LTC, or,
  - the couple is considered "separated" after the IS enters LTC, or,
  - a prenuptial agreement exists.
- The IS remains institutionalized for 30-consecutive days or longer.
- The IS enters LTC on or after 09/30/89.

INSTITUTIONALIZATION
SPOUSAL IMPOVERISHMENT

2. When SI Rules Do Not Apply

SI income/resource rules do not apply when:

- A change in circumstances occurs resulting in a couple who are no longer an IS with a CS. SI rules no longer apply the first full month following:
  - the death of either the IS or CS
  - divorce of the IS/CS
  - the IS discharged from LTC, or
  - the CS enters LTC.
- The IS is already in LTC as of 09/30/89 unless the IS leaves LTC for 30-consecutive days or longer then reenters LTC.
- The IC/CS are not legally married at the time of institutionalization. SI rules can apply only if the one in LTC leaves LTC for 30-consecutive days or longer and reenters LTC as an IS with a CS.

INSTITUTIONALIZATION
SPOUSAL IMPOVERISHMENT

B. IS/CS RESOURCE COMPUTATION

In order to determine spousal shares of resources owned by an IS/CS, determine the couple's countable resources in the month of institutionalization. The first month the IS enters LTC, compute resources as follows:

1. Combine Countable Resources

To determine resource eligibility for an IS with a CS, combine the value of all countable resources belonging to the IS and/or CS whether owned separately by each spouse or jointly by both spouses. Countable resources include all resources that are counted under ongoing liberalized resource policy.

If a CS or IS own resources jointly with another person or persons, count the proportionate share of the IS or CS ownership interest per ongoing policy for the type of resource involved.

2. Verify Resources

The couple must provide complete resource verification of all countable resources owned as of the month the IS entered LTC. Verify resources per ongoing policy for the type of resource owned. Failure by the CS to verify resources owned by the CS will result in a Medicaid denial for the IS.

3. CS Share of Resources Based on the Federal Maximum

The CS share of total countable resources is the maximum allowed under federal law. In order for a CS to receive a share larger than the federal maximum, a court order would be required granting the CS a greater share of total resources after Medicaid has made a decision regarding spousal shares.

The resource maximum applicable is the resource maximum in effect in the month of institutionalization of the IS, Spousal Impoverishment Resource Maximums in effect since 10-01-89 are located in the Appendix, Page 1.

The CS is assigned his/her share of total countable resources as of the month of IS institutionalization. If total resources are less than the federal maximum, the CS is entitled to all of the total resources owned by the IS/CS.

If total resources are greater than the federal maximum, the IS entitled to the amount in excess of the maximum. The IS resource limit is equal to $3000; therefore, if the IS share of total resources exceeds $3000, the IS is ineligible for Medicaid until the IS share is equal to $3000 or under.

Note: The CS resource maximum is enforceable only at the time of application. Once an IS is determined eligible for Medicaid under SI rules, the CS resource maximum no longer applies. This means a CS can acquire resources in excess of the maximum after eligibility for the IS is established without affecting eligibility for the IS.

4. Protected Period for Transfer of Resources

The IS can transfer resources to the CS to bring resources up to the federal maximum with no penalty. Allow up to 90 days after application or longer if court action is required to complete a transfer. Resources that are not transferred out to the IS name within 90 days (or longer-if good cause exists) will be used to determine eligibility for the IS. The 90-day period begins after the IS/CS or representative is informed in writing of the need to transfer resources to the CS.

The exception for requiring resources to be transferred to the CS is when the IS dies prior to transferring resources to the CS.

During the 90-day period, the case may be approved and a tickler set for 90 days after approval. Also, during the 90-day grace period, do not count as income to the IS any income generated by a resource that is being transferred to the CS. If the resource is not transferred to the CS by the end of the 90-day period (and no good cause exists), then resources and income are counted toward the IS.

Exception for Long Term Hospitalization Applicants. Require resources of the IS to be transferred to the CS prior to approval of the LTC application.

5. Undue Hardship

If the CS holds resources at the time of application that exceed the CS maximum and does not make the excess resources available to the IS, the excess will continue to be counted as the IS share of resources unless undue hardship exists. That is, if a denial of Medicaid eligibility for the IS would result in life sustaining services being denied, counting the excess toward the IS share may be waived.

Undue hardship situations must be reviewed individually. A statement for the CS is required in this situation citing the reason for the refusal to make resources available as required under federal law.

The statement must be submitted to the State Office along with other pertinent income and resource information for a review of the circumstances.

6. SI Rules for CS Living Out of State

There is no requirement for a CS to live in Mississippi; however, SI resource/income rules are more restrictive in that:

- home property located out of state must be transferred to the CS' name during the 90-day protected period for transferring resources.

- any income allocated to the CS must be closely monitored to ensure the allocation is actually sent to the CS.

C. ASSESSMENT OF RESOURCES VS. APPLICATION FOR MEDICAID

When requested by either member of a couple (the IS or the CS) or by a representative acting on behalf of either the IS or CS, the Regional Office must complete an assessment of the couple's resources:

- An assessment is a "snap-shot" of the couple's total countable resources in the month of institutionalization, i.e., what was true in the month the IS entered an institution for 30-consecutive days or longer on or after 09/30/89. If one spouse has not yet entered an institution on the date the assessment is requested, an assessment cannot be provided.

- An assessment is separate from an application for Medicaid. If the IS wishes to apply for Medicaid, an "assessment" is not required. Resources will be evaluated under Spousal Impoverishment rules and the appropriate Medicaid notice used to approve or deny eligibility. However, if the couple only wants to know how Medicaid would evaluate their total resources if application were filed, an assessment is required.

- An assessment provides a written evaluation of resources to the couple giving the following information:

  - the total value of countable resources;

  - the basis for the determination;

  - the CS share based on the maximum standard allowed as of the month of the assessment;

  - whether the IS would be currently resource eligible if application were to be filed

  A "Resource Assessment Notice" will be used to document the information specified above.

INSTITUTIONALIZATION
SPOUSAL IMPOVERISHMENT

1. Verification of Resources for Assessments

In order to provide an accurate assessment of a couple's resources, verification must be provided to determine current market value and the couple's ownership interest in the resources. The couple must provide accurate verification of the resources owned in the month of institutionalization in order for an assessment to be completed. Failure to provide necessary verification means the assessment cannot be completed. Allow 45 days for an assessment to be completed. If verification is not received within the 45 day time frame, no further action is necessary.

If verification is provided for an assessment, complete the "Resource Assessment Notice" and provide copies to each member of the couple while retaining a copy in the Regional Office Correspondence File (if an application is later filed, the copy becomes part of the case record). The notice documents the value of resources at the time of institutionalization and specified the CS and IS share of total resources.

2. Changes in Assessments

The assessment completed to document resources as of the month of institutionalization remains intact unless:

- The agency obtains proof that accurate information was not provided at the time of the initial assessment which means another assessment must be completed.

- The couple alleges that the initial assessment was inaccurate and provides proof to show otherwise, in which case a new assessment must be completed.

- The IS leaves the institution for 31 days or longer and then reenters an institution in which case a new assessment must be completed evaluating resources as of the month of reinstitutionalization.

INSTITUTIONALIZATION
SPOUSAL IMPOVERISHMENT

3. Application After Assessment or Instead of Assessment

When an IS applies for Medicaid, all countable resources held by either spouse at the time of institutionalization are considered in order to determine the amount to count as the CS and IS share:

1. If an assessment has been completed, the value of countable resources attributed to the CS and the IS have been determined and all that remains to do is evaluate remaining resources available to the IS to determine if the IS is resource eligible.

2. If an assessment was not requested or completed, the IS and CS shares are determined in the same manner described under the IS/CS Resource Computation.

INSTITUTIONALIZATION
SPOUSAL IMPOVERISHMENT

D. INCOME COMPUTATIONS FOR IS/CS CASES

Use the following rules governing couples' ownership of income to determine the IS share of income to be counted in determining eligibility based on income. These income rules also apply in the Post Eligibility computation (Medicaid Income) for the IS.

1. Income From Non-Trust

Unless evidence to the contrary is presented:

- Consider income paid to one spouse to be the income of that spouse.
- Consider available to each member of the couple one-half of any income paid to both spouses.
- Consider available to each member of a couple amounts equal to each spouse's proportionate share of income paid in the name of either spouse, or both and at least one other party. When income is paid to both spouses and the couple's individual interests are not specified, consider available to each spouse one-half of their joint interest in the income.
- Consider available to each member of the couple one-half of any income which has no instrument establishing ownership.

2. Income From Trust Property

Use ongoing policy regarding trust income except as provided below:

- Consider available to each member of a couple income from trust property in accordance with the specific terms of the trust.
- When a trust instrument is not specific as to the couple's ownership interest, follow the rules specified in Income from Non-Trust Property.

INSTITUTIONALIZATION
SPOUSAL IMPOVERISHMENT

3. Deeming of IS/CS Income Prohibited

Do not deem any CS income to be available to the IS for the purpose of determining the IS eligibility for any month of institutionalization, including the month of entry. Note: If the CS applies for Medicaid under an at-home coverage group, do not deem or combine income of the IS to the CS in the month of entry or any month thereafter. SI income rules apply in this instance.

INSTITUTIONALIZATION
RESOURCE/INCOME COMPUTATIONS-NON SI RULES

A. CURRENT POLICY-NON SI LTC CASES

Spousal Impoverishment (SI) rules apply only in LTC cases where one member of a married couple is in an institution and the other spouse remains non-institutionalized in the community. For all other LTC cases that do not fall under SI rules, the following policy is applicable.

1. Children Who Enter LTC

There is no deeming of resources or income from parents to a child under age 18 who enters an institution, not even for the month of entry. Resource and income eligibility is based on resources owned and income received by the child or his/her proportionate share of jointly owned resources or income. Income eligibility is based on the Institutional Income limit and resources are tested against the individual resource limit.

2. Individuals Over Age 18 who Enter LTC

Each individual who enters LTC is tested against the Institutional income limit and the individual resource limit using the individual's own income/resources or his/her proportionate share of jointly owned income/resources.

3. Couples Who Enter LTC

Couples who enter institutions are each treated as individuals effective with the month of entry. Each member of the couple is tested against the individual income and resource limit based on each individual's own income or his/her proportionate share of jointly owned income or resources. This is true regardless of whether the couple enters the same or separate institutions in the same month or different months.

INSTITUTIONALIZATION
RESOURCE/INCOME COMPUTATIONS-NON SI RULES

B. INCOME & RESOURCE POLICY FOR COUPLES PRIOR TO SI POLICY

The income and resource rules specified below apply to individuals who applied for Medicaid prior to 10-01-89. The resource policy specified below continues to apply to individuals institutionalized (for 30-consecutive days or longer) prior to 09-30-89 who remain institutionalized.

1. Eligible Couples

a. One at home, one in an institution

(1) Deeming of income ceases the month after the month of separation. The institutionalized spouse is treated as an individual for income purposes effective with the first full month of institutionalization.

(2) Resources are combined for the first 6 months following the month the couple no longer live together in the same household. An institution is not considered a household. The couple resource limit is used during the 6 month period.

b. Both are in an institution, same facility or different facilities

(1) Income and resources are combined for 6 full months following the month of entry into an institution. The couple resource and income limit applies.

(2) Effective with the 7th month, each member of the couple is treated as an individual for income and resource purposes. The individual income and resource limit applies.

(3) If a couple is ineligible as a couple for income or resource purposes, it is possible to test one member of the couple as an individual with no deeming of income or resources from the ineligible spouse effective with the first full month of institutionalization.

INSTITUTIONALIZATION
RESOURCE/INCOME COMPUTATIONS-NON SI RULES

2. Eligible With An Ineligible Spouse

These rules apply regardless of living arrangements.

a. The eligible is treated as an individual for income and resource purposes effective the month after the month the couple no longer share the same household.

b. Consider only the resources owned by the eligible or his/her proportionate share of a jointly owned resource.

INSTITUTIONALIZATION
LTC BUDGETING PROCESS

A. INSTITUTIONAL BUDGET FORM, DOM-336

For each client in LTC, an Institutional Budget (DOM-336) is completed, either in MEDS or on paper, at the time of application and at each Redetermination. The budget form determines:

- eligibility based on income
- coverage group and fulfillment of the 30-consecutive day requirement
- the monthly maintenance needs allowance for a community spouse and/or other dependent family members
- the amount of Medicaid Income

1. Eligibility Based On Income

All individuals applying will have their total income received in the month counted as income for each month eligibility is being determined. Income for eligibility purposes does not include:

- any averaged income. Income subject to averaging is counted in its entirety in the month received for eligibility purposes.
- any VA Aid & Attendance
- gross rental income (consider only net rental income)

When testing total income of the eligible individual against the appropriate Federal Institutional Income limit, the income must be less than the Federal income limit in order for the applicant to be eligible in any month. If the total income is equal to or greater than the appropriate Federal maximum, eligibility must be denied for that month (unless an Income Trust is in effect).

INSTITUTIONALIZATION
LTC BUDGETING PROCESS

2. Coverage Group Determination & 30-Consecutive Day Requirement

For institutional purposes, an individual falls into one of 2 categories:

- Individuals who would be eligible for SSI at-home
- Individuals who would not be eligible for SSI at-home

A determination as to which coverage group the individual would fit into is used for statistical purposes only.

Since there is no deeming of income from parent(s) or an ineligible spouse in any month of institutionalization, the SSI coverage group determination is based on the eligible's income only. If the individual or couple applying already receive SSI at-home, the coverage group is predetermined.

The 30-consecutive day requirement must be documented for any individual who is not Medicaid eligible at home. If the 30-consecutive day requirement is met for those who are not Medicaid eligible at home, the beginning date of Medicaid eligibility is potentially the first of the month of admission provided the applicant is eligible on all other factors for the first partial month.

3. Monthly Maintenance Needs Allowance For A CS and/or Dependents

This budgeting is completed only if the institutionalized individual has a community spouse. If the community spouse has other dependents residing in the same home with him/her, an additional allocation to the other dependent(s) may be allowed. Refer to the following subsection, "Medicaid Income Computation," for a complete discussion of this budgeting step.

4. Medicaid Income

If an institutional client is determined eligible based on income, then the client's income is then used to determine the client's cost of care, known as Medicaid Income. Refer to the following subsection on the "Medicaid Income Computation" for a complete discussion of this budgeting step.

INSTITUTIONALIZATION
LTC BUDGETING PROCESS

B. SSI ELIGIBLES ENTERING LTC (SSI-ONLY)

An SSI recipient with no income or gross income less than $50 per month will continue to be eligible for SSI/Medicaid while in a nursing facility. No separate application for Medicaid is required of SSI eligibles who enter LTC whose SSI will continue; however, a review of the client's financial factors of eligibility is required to determine if the SSI recipient is eligible for a vendor payment.

1. SSI-Only Case Record

Each Regional Office is responsible for maintaining an SSI-only case record for each SSI eligible who enters a LTC nursing facility in the region. A Master Card on each SSI-only client must also be prepared.

The case record will consist of:

- Form DOM-260 from the nursing facility to document need for LTC,
- SVES Response and/or TPQ response verifying SSI-status and income from SSA,
- Form DOM-317 from the nursing facility,
- MEDS budget information or DOM-336, Institution Budget,
- Any relevant resource information,
- Notices to the client (DOM-305 or 306).

2. Financial Review of SSI-Only Cases

An independent review of the SSI eligible's income and resources is required to determine if income or resources are available to the client that may or may not affect his/her SSI status but would affect eligibility for a vendor payment or affect payment of Medicaid Income.

SSI payments are not counted as income so it is unlikely that an SSI eligible will have any Medicaid Income payable; however, it is possible that the SSI eligible receives countable income unknown to SSA that must be counted in Institutional budgeting (such as sheltered workshop earnings). If income is received, Medicaid Income for an SSI-only would be payable. Notify SSA of the income via DOM-319.

A vendor payment for an SSI eligible will not be authorized until the ownership of countable resources is developed. Resources must be developed to determine if:

- **excess countable resources exist, or**
- **any transfers of resources exist within 36 months of entering LTC,**
- **a trust or conservatorship exists with excess countable resources.**

If the SSI eligible is determined to be ineligible for a vendor payment based on resources, issue a Notice of Adverse Action, DOM-306, explaining the denial of vendor payments. Notify SSA via DOM-319 of the denial.

Note: Any appeals involving SSI eligibility must be filed with SSA. Any appeals regarding Medicaid Income or a denial of vendor payment must be handled by Medicaid.

3. Approvals

A Notice of Approval, DOM-305, must be issued for SSI-only cases determined eligible for a vendor payment. The Notice will report any Medicaid Income payable. DOM-317 must also be issued to the facility verifying the beginning date of eligibility for the vendor payment.

4. Redeterminations An annual review of SSI-only case records must be performed to update all case record information and verify patient status.

5. Changes Any changes that are discovered after the approval of an SSI-only case are handled as follows:

- An increase in Medicaid Income or the subsequent denial of nursing home vendor payments due to excess resources must be handled with a DOM-306, Notice of Adverse Action. Issue DOM-317 to the nursing facility.

- Closures due to death or termination of an SSI payment are handled by SSA but the Regional Office must take appropriate action to close out LTC and Liability in MEDS and issue a DOM-317. The same action is required if the SSI-only recipient is discharged from the facility.

- Any changes that become known to the Regional Office concerning an SSI-only recipient that would affect SSI eligibility must be reported to SSA via DOM-319 and monitored by the Regional Office.

INSTITUTIONALIZATION
LTC BUDGETING PROCESS

C. SSI ELIGIBLE ENTERS LTC BUT SSI TERMINATES (SSI TO MAO)

SSI eligibles whose SSI terminates upon entry into LTC or anytime after entry require a redetermination of their eligibility for continued Medicaid coverage as LTC. If the SSI recipient is terminated by SSA due to income or resources will be issued an SSI Redetermination Form, DOM-300B, as outlined in Section C, Applications/Redeterminations. If the SSI terminates for any reason other than income or resources, a MAO application is required to establish LTC coverage for the former SSI recipient.

MAO LTC coverage cannot be approved until SSI/Medicaid terminates. However, Medicaid Income must be calculated during the SSI to MAO period if the client is eligible for a vendor payment. Note: An SSI to MAO client who is ineligible based on excess resources (or a trust or conservatorship) will not be eligible for a vendor payment, the same as for an SSI-only client.

If the SSI to MAO client is determined resource eligible during the SSI months, handle as follows:

- Issue DOM-305 to the client reporting Medicaid Income payable and the effective date of vendor payment eligibility. Do not count any SSI payment received by the client as Income or Medicaid income.

- Issue DOM-317 to the nursing facility

- Issue DOM-319 to SSA to inform SSA that the recipient is in a nursing facility.

The MAO portion of the application or redetermination process will be completed per ongoing policy.

INSTITUTIONALIZATION
LTC BUDGETING PROCESS

D. AFDC OR FOSTER CHILDREN ENTERING LTC

When an AFDC, AFDC-related or Foster Child receiving Medicaid with DHS as the source enters LTC, a separate application for LTC coverage is required, or is not required, as follows:

- If the admission is to a PRTF (Psychiatric Residential Treatment Facility), no separate application for Medicaid as MAO is required as long as the DHS source of eligibility remains open. A vendor payment to the PRTF can be authorized by entering the case in MEDS as "SSI/DHS Only."

- If an admission to a LTC Nursing Facility or ICF-MR will be or is less than 30-consecutive days, no separate application for LTC Medicaid is required. A vendor payment to the facility can be authorized by entering the case in MEDS as "SSI/DHS Only."

- If an admission to a LTC Nursing Facility or ICF-MR will be or is more than 30-consecutive days, a separate application for MAO or SSI as a disabled individual must be filed for the child. DDS must determine that the child is disabled and the child must be income/resource eligible before the nursing facility vendor payment will be authorized.

1. MAO or SSI Application Filed

If a LTC Nursing Facility or ICF-MR placement will exceed 30-consecutive days, an application for MAO coverage in LTC must be filed with the Regional Office that handles the county either where the parent(s) live or where the county DHS office with custody is located.

If preferred, the parent or DHS office with custody can file an application for SSI for the child. The Regional Office handling the case for vendor payment purposes must verify with SSA that an application for the child has been filed.

INSTITUTIONALIZATION
LTC BUDGETING PROCESS

2. Authorizing LTC Vendor Payment for Nursing Facility or ICF-MR Placements

During the application period for MAO or SSI the case can be set up in MEDS the same as an "SSI/DHS only" case. An approved 260 Form must be obtained (if appropriate) and the child's income and resources verified prior to authorizing the vendor payment. A notice to the representative and a 317 to the facility is then required.

If the child is determined eligible for LTC on all factors, the Regional Office must advise the county DHS office to terminate the child's Medicaid eligibility through AFDC or foster care if they have not already done so. Once the DHS is closed, the MAO application can be approved in MEDS.

If the child is not eligible for LTC, the vendor payment must be terminated by the Regional Office regardless of whether DHS closes out the child's Medicaid eligibility for AFDC or foster care.

3. DHS-Only Case Records for PRTF Admissions

The PRTF facility, whether in State or out of State, must issue a DOM-317 to the appropriate Regional Office advising of the admission. Upon receipt of the DOM-317, the Regional Office will:

- Set up a "DHS-Only" case record for the purpose of calculating liability and LTC and filing notices/317's. The child's income must be verified only if the child receives income in his/her own name. Do not count any portion of a TANF payment or Foster Care payment as Medicaid Income unless the income is made available to the child. Issue the DOM-317 to the PRTF.

- The case will be set up in MEDS as "SSI/DHS-Only." DO NOT ENTER THE PRTF ADDRESS AS EITHER THE CARD MAILING OR NOTICE MAILING ADDRESS. All notices and the Medicaid card must be issued to the parent or representative of the child or to the DHS county office with custody of the child.

- Check with the PRTF at least every 3 months to make sure the child is still a resident of the facility.

INSTITUTIONALIZATION
LTC BUDGETING PROCESS

E. MAO AT-HOME ELIGIBLES ENTERING LTC

If a MAO eligible at-home enters a nursing home, a redetermination of eligibility is required, i.e., the MAO at-home case will not close if the eligible remains Medicaid eligible in the institution. This means a level of care decision is required via DOM-260 and a 317 Form from the nursing home is required documenting the date of entry.

If the recipient remains MAO eligible, send a DOM-305 advising of the amount of Medicaid Income payable. If the at-home eligible is ineligible for LTC, issue advance notice to close the case.

F. MAO APPLICATION NO PREVIOUS ELIGIBILITY

An application for LTC Medicaid coverage is required for anyone entering LTC who is not already Medicaid eligible as an MAO at-home eligible or SSI eligible.

INSTITUTIONALIZATION
MEDICAID INCOME COMPUTATION

A. GENERAL

Once an individual has been determined eligible for Medicaid in a medical institution, the individual must pay toward the cost of his/her care provided his/her income exceeds allowable deductions outlined in this subsection. The payment the client is liable for is referred to as Medicaid Income (MI). It is paid to the medical facility and consists of the client's total income less allowable deductions. The Medicaid Income computation is part of the institutional budgeting process; however, it is a post-eligibility computation used only to determine the client's liability amount for the cost of care. The Medicaid Income computation process differs from the eligibility budgeting process as outlined in this subsection.

1. Eligible Couples Treated as Individuals

Each eligible individual is treated as an individual in determining the amount of MI payable, even though the individual may be marred to another individual who is also in LTC and Medicaid eligible. Each member of a couple is treated as an individual for MI purposes effective with the month of entry.

2. Medicare Covered Days - No MI Payable

Medicare covers skilled nursing home care for up to 100 days per calendar year provided the facility is Medicare (Title XVIII) certified and the individual is hospitalized at least 3 days before admission to a skilled nursing facility. Medicare covers the first 20 days at 100% of the expense. For the 21st-100th day, there is a co-insurance charge which Medicaid will pay if the individual is Medicaid eligible.

INSTITUTIONALIZATION
MEDICAID INCOME COMPUTATION

Medicaid applications for long term care are handled as per ongoing policy for individuals in skilled care where Medicare is the primary payor. Medicaid Income is computed for these individuals and reported to the facility; however, Medicaid Income is not payable until Medicaid begins reimbursement (not co-insurance) for nursing home care. As a result, income for a Medicaid eligible may accumulate during his/her Medicare covered days and excess resources may result. For this reason, explanations should be made to a client or representative regarding income that may accumulate and cause Medicaid ineligibility during this time. The worker should explain allowable means of spending excess resources.

Note: No MI is payable by a Medicaid client during the first 100 days of care as long as Medicare is the primary payer of the nursing care. No MI is payable during co-insurance days. The only instance where MI is payable is if Medicaid becomes primary payer during the 100-day period. This can occur if client is admitted to a hospital and the nursing facility holds the client's bed. In this situation, the nursing facility must "discharge" the client as a Medicare patient and "admit" the client as a Medicaid patient, thus making MI payable.

INSTITUTIONALIZATION
MEDICAID INCOME COMPUTATION

B. INCOME USED IN THE MI COMPUTATION

In computing MI, only the eligible individual's income is considered. Deemed income is never included in the MI computation. The MI computation begins with the eligible's income only.

The eligible's income to consider is the total income received in the month of the computation with the exception of the following:

- Total income does not include any SSI payments received by the eligible. Do not count any SSI payment received for any month of institutionalization in the Medicaid Income computation.

- Total income does not include the full amount of any irregular or infrequent income subject to averaging. Income of this type is averaged first before adding the averaged amount to the eligible's total income.

1. Nonrecurring Lump Sum Payments

Certain lump sum payments are excluded from income determinations (for eligibility purposes) while others are not excluded. Income eligibility policy specifies the types of payments considered as income in the eligibility computation. However, in determining whether income, such as a lump sum payment, should be counted as income in the Medicaid Income computation, the general rule is to determine whether the payment has previously been counted as income for MI purposes. Two examples will illustrate:

- A former SSI recipient currently in a nursing home receives a retroactive title II payment that meets the qualifications for excluding the payment from income in the Eligibility Test, i.e., the payment has been reduced by the amount of SSI payments previously received, so it is not counted as income according to SSI policy. Although the payment can be excluded as income for eligibility purposes, it cannot be excluded as income in the Medicaid Income computation because the retroactive title II payment has not previously been counted as income for Medicaid Income purposes. In this instance, the lump sum title II payment is counted as income in the month received in the Medicaid Income computation only if there is sufficient time to count the payment.

- A nursing home recipient who receives a VA pension has his VA benefits suspended for failure to verify medical expenses. The recipient remains entitled to his full VA payment, therefore, the full basic pension amount of the VA benefit continues to count as income in both the Eligibility Test and the MI computation. However, when the recipient receives a lump sum payment from VA which represents payments previously suspended, the lump sum payment is not counted as income for eligibility or Medicaid Income purposes. This is because the payment has previously been counted as income in both computations.

2. Recurring Lump Sum Payments

If a payment is recurring, such as annual rental payments, the policy governing irregular and infrequent income applies, which means the payment is subject to averaging.

One-time (nonrecurring) lump sum payments are not subject to averaging and are handled according to the lump sum payment policy described above. If a payment has not been previously counted as income, the payment is subject to being counted as income in the month received in the Medicaid Income computation.

INSTITUTIONALIZATION
MEDICAID INCOME COMPUTATION

C. AVERAGING INCOME IN THE MI COMPUTATION

Recurrent income that varies in amount and/or frequently be averaged in the MI computation provided the client is eligible based on income in the month the payment is received without averaging. For eligibility purposes, all income is counted in the month it is received. If the client is eligible based on income in the Eligibility Test, the provision requiring averaging for Medicaid Income purposes applies. If the client is ineligible based on income when counting irregular or infrequent income in the month of receipt, do not average the payment in the Medicaid Income computation.

Averaging applies in the Medicaid Income computation since it is a post-eligibility budgeting procedure. Income averaging is applicable only when determining the amount of the client's gross income for Medicaid Income purposes and when determining the amount of income for a community spouse or dependent for allocating purposes. The computation used to obtain an average, as explained below, must be documented in the case record.

1. Monthly Income That Varies

Income received monthly in amounts that vary must be averaged over a 12-month period using the 3 most recent monthly payments available to obtain the averaged amount. When projecting the averaged amount over a 12-month period, allow for any known changes that will occur in the income.

If the 3 most recent payments are not available, document the case and use the best available information. In certain instances, it would not be appropriate to use the most recent 3 months payments. For example, the monthly payment may not have started being paid until a month or 2 before the average is being determined. Or, the payment may have been reduced drastically over the 3 most recent payments and there is no reason to suspect that the monthly payment would ever again increase to a higher level. In either case or in similar situations, justify the reason for using a different average from the most recent 3 payments.

2. Infrequent Income

Income received non-monthly is averaged over the period of time the payment is intended to cover provided the payment was counted as income in the month last received and the client was eligible when counting the payment. Infrequent income that is not counted as income in the month received is treated as a countable resource in subsequent months.

The stipulation that infrequent income must be counted as income in the month received before it is subject to averaging avoids averaging "after the fact" when the income may no longer be available to the client for averaging. When infrequent income is treated as income in the month received and subsequently averaged, the client must be notified that the payment will be averaged over the period it is intended to cover and availability will not be an issue.

An example of infrequent income averaging as explained above would be an applicant who receives annual land rent income. The last payment was received six months prior to application and another payment is expected in six months. When determining eligibility, the land rent payment is not subject to averaging since it was not counted in the month received. However, a tickler must be set so that the next rent payment received can be counted and, if eligible, averaged over the next 12 months.

Infrequent payments are averaged over the period of time the payment is intended to cover, i.e., annual payments are averaged over 12 months, quarterly payments over three months, and so on. One-time payments are not recurrent income and are not subject to averaging but are counted as income in the month received, if applicable, for Medicaid Income purposes.

INSTITUTIONALIZATION
MEDICAID INCOME COMPUTATION

D. PROTECTION OF INCOME FOR MONTH OF ENTRY

Individuals determined eligible for long-term care in the month of entry into a medical facility are entitled to protection of income. This means that if the recipient is eligible for the month of entry, the recipient pays no Medicaid Income for any partial month of entry. The purpose of protecting income is to allow for essential expenses incurred by the recipient in connection with admission to a medical facility. Protection of income does not apply for recipients who transfer into a medical facility from another medical facility.

Income is "protected" by reducing MI to $0 for the month of entry into a nursing facility. Medicaid Income is payable, if applicable, effective with the first full month in the facility (if determined eligible for that month). Medicaid Income amounts are shown on the DOM-317 and the notice to the client.

For the month of discharge from or death in a medical facility, a recipient's income is not reduced to zero (protected). Medicaid Income is, however, prorated based on the number of days the recipient resided in the facility during the last month.

The fiscal agent determines the amount of Medicaid Income payable from a recipient in any partial month of institutionalization due to death, discharge or transfer. Form DOM-317 notifies the fiscal agent and the facility of the necessity to prorate the patient's income since the income figure shown represents a full month's income.

INSTITUTIONALIZATION
MEDICAID INCOME COMPUTATION

E. PERSONAL NEEDS ALLOWANCE (PNA) DEDUCTION

The first type of deduction from a client's total income is the allowance of a PNA deduction. The PNA is intended to cover the cost of personal needs on a monthly basis (such as toiletries, etc.) that are not covered by Medicaid. The amount of each individual's PNA is determined as follows:

1. $44 PNA

Each individual in LTC is entitled to at least a $44 monthly PNA provided income equals $44. Individuals in LTC who have income less than $44, such as SSI eligible individuals who receive a $30 monthly SSI payment, are entitled to keep the full amount of their income up to $44 per month to meet their personal needs.

2. $88 PNA

Each individual engaged in work or work therapy programs (such as enrollment in a sheltered workshop) and individuals who engage in activities such as the making of handicrafts for sale on a regular basis are entitled to a higher PNA of $88 per month. The higher PNA is allowed for these individuals to allow for increased personal need expenses related to their work.

Note: Individuals who earn in excess of the increased PNA per month will have the excess counted in determining the remaining deductions and the resulting Medicaid Income. Individuals who earn less than the PNA of $88 per month are entitled to the full $88 allowance nonetheless.

For example, an individual in an institution with $90 per month in average earnings will be entitled to an $88 PNA the same as an individual with only $30 per month in average earnings.

Earned income must be shown in MEDS as wages in order for the $88 PNA to apply.

INSTITUTIONALIZATION
MEDICAID INCOME COMPUTATION

3. Additional Work Deduction

Effective July 1, 2000, individuals with wages greater than $44 will have their wages reduced by an amount that is 2 the SSI FBR, less the $44 PNA. The resulting amount is added to any other income and the $44 PNA is deducted from the remaining income. Each year, as the SSI FBR increases, the deduction for wages will increase.

Example: An institutional individual has $450 in wages and $550 Social Security.

$450 - Wages
-212 - 2 FBR ($512. 2 = $256) - $44 PNA
$238 - Excess (countable) earnings
+550 - RSDI benefits
$788 - Total Income
- 44 - PNA
$744 - Medicaid Income

Individuals with wages less than $44 will continue to receive the $88 PNA.

4. $90 PNA

For single veterans and surviving spouses of veterans in nursing homes who are subject to the reduced pension, the PNA is equal to the reduced pension payment. If the pension payment is $90, the PNA is $90. Note: If the pension payment is less than $44 (or $88 if the client works), the PNA would be $44 or $88, whichever applies and is greater than the reduced pension.

The client gets to keep the entire payment for personal needs but does not receive an additional PNA along with the pension. Note: Receipt of a lump sum retroactive reduced pension payment is not reflected in the client's budget. Do not adjust the PNA retroactively. Instead, the payment is free and clear. The payment may affect resources in subsequent months.

INSTITUTIONALIZATION
MEDICAID INCOME COMPUTATION

A. GENERAL

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MEDICAID INCOME COMPUTATION

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INSTITUTIONALIZATION
MEDICAID INCOME COMPUTATION

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INSTITUTIONALIZATION
MEDICAID INCOME COMPUTATION

C. AVERAGING INCOME IN THE MI COMPUTATION

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INSTITUTIONALIZATION
MEDICAID INCOME COMPUTATION

D. PROTECTION OF INCOME FOR MONTH OF ENTRY

Individuals determined eligible for long-term care in the month of entry into a medical facility are entitled to protection of income. This means that if the recipient is eligible for the month of entry, the recipient pays no Medicaid Income for any partial month of entry. The purpose of protecting income is to allow for essential expenses incurred by the recipient in connection with admission to a medical facility. Protection of income does not apply for recipients who transfer into a medical facility from another medical facility.

Income is "protected" by reducing MI to $0 for the month of entry into a nursing facility. Medicaid Income is payable, if applicable, effective with the first full month in the facility (if determined eligible for that month). Medicaid Income amounts are shown on the DOM-317 and the notice to the client.

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The fiscal agent determines the amount of Medicaid Income payable from a recipient in any partial month of institutionalization due to death, discharge or transfer. Form DOM-317 notifies the fiscal agent and the facility of the necessity to prorate the patient's income since the income figure shown represents a full month's income.

INSTITUTIONALIZATION
MEDICAID INCOME COMPUTATION

E. PERSONAL NEEDS ALLOWANCE (PNA) DEDUCTION

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1. $44 PNA

Each individual in LTC is entitled to at least a $44 monthly PNA provided income equals $44. Individuals in LTC who have income less than $44, such as SSI eligible individuals who receive a $30 monthly SSI payment, are entitled to keep the full amount of their income up to $44 per month to meet their personal needs.

2. $88 PNA

Each individual engaged in work or work therapy programs (such as enrollment in a sheltered workshop) and individuals who engage in activities such as the making of handicrafts for sale on a regular basis are entitled to a higher PNA of $88 per month. The higher PNA is allowed for these individuals to allow for increased personal need expenses related to their work.

Note: Individuals who earn in excess of the increased PNA per month will have the excess counted in determining the remaining deductions and the resulting Medicaid Income. Individuals who earn less than the PNA of $88 per month are entitled to the full $88 allowance nonetheless.

For example, an individual in an institution with $90 per month in average earnings will be entitled to an $88 PNA the same as an individual with only $30 per month in average earnings.

Earned income must be shown in MEDS as wages in order for the $88 PNA to apply.

INSTITUTIONALIZATION
MEDICAID INCOME COMPUTATION

3. Additional Work Deduction

Effective July 1, 2000, individuals with wages greater than $44 will have their wages reduced by an amount that is 2 the SSI FBR, less the $44 PNA. The resulting amount is added to any other income and the $44 PNA is deducted from the remaining income. Each year, as the SSI FBR increases, the deduction for wages will increase.

Example: An institutional individual has $450 in wages and $550 Social Security.

$450 - Wages
-212 - 2 FBR ($512. 2 = $256) - $44 PNA
$238 - Excess (countable) earnings
+550 - RSDI benefits
$788 - Total Income
- 44 - PNA
$744 - Medicaid Income

Individuals with wages less than $44 will continue to receive the $88 PNA.

4. $90 PNA

For single veterans and surviving spouses of veterans in nursing homes who are subject to the reduced pension, the PNA is equal to the reduced pension payment. If the pension payment is $90, the PNA is $90. Note: If the pension payment is less than $44 (or $88 if the client works), the PNA would be $44 or $88, whichever applies and is greater than the reduced pension.

The client gets to keep the entire payment for personal needs but does not receive an additional PNA along with the pension. Note: Receipt of a lump sum retroactive reduced pension payment is not reflected in the client's budget. Do not adjust the PNA retroactively. Instead, the payment is free and clear. The payment may affect resources in subsequent months.

INSTITUTIONALIZATION
MEDICAID INCOME COMPUTATION

F. CS MONTHLY MAINTENANCE NEEDS ALLOWANCE (MMNA)

A Monthly Maintenance Needs Allowance (MMNA) is calculated for a CS provided:

- The Institutionalized Spouse (IS) and the Community Spouse (CS) are legally married under State law; and,
- The MMNA is actually made available to or for the benefit of the CS and this can be documented, and,
- The CS remains in a private living arrangement and remains married to the IS. The MMNA ends the month after a CS enters an institution or is no longer a CS through death or divorce.

If the IS refuses to make the MMNA available to his/her CS, discontinue the MMNA in the current month.

The Maximum MMNA Allowed By Federal Law Is the need standard used to calculate the MMNA for the CS. The MMNA standard applicable is the maximum in effect in the budget month. The "Community Spouse Monthly Maintenance" limits in effect since 10-01-89 are located in the Appendix, Page 1.

The MMNA is reduced by:

- the CS' own income. Use "gross" income of the CS, whether earned or unearned, to determine the MMNA. Infrequent or varying monthly income of the CS is averaged to obtain the CS' monthly income amount.
- the income limit for a long term care recipient, i.e., the federal maximum
- the PNA of the IS which must be deducted from the income of the IS first before a CS allowance can be deducted.

INSTITUTIONALIZATION

MEDICAID INCOME COMPUTATION

1. CS is Medicaid Eligible At-Home

A CS that is Medicaid eligible may have his/her SSI or Medicaid eligibility affected as a result of the MMNA received from an IS. If the CS would rather retain or gain Medicaid eligibility at-home (either as SSI or MAO), he/she can refuse the MMNA or refuse only that amount that would result in Medicaid termination for the CS.

If the CS opts to retain Medicaid eligibility by refusing a portion of the MMNA from the IS, obtain a written statement to this effect from the CS or his/her representative. The IS Medicaid Income would then be reworked to include the amount refused back into the Medicaid Income computation.

2. IS Receives VAIP

Veterans are required to apply for VA Improved Pension (VAIP), which may include payment for unreimbursed medical expenses (UME) and Aid & Attendance (A & A). UME & A & A is not countable income to the IS; however, if the CS receives this income from the IS it is not disregarded as income to the CS.

When VA payments for UME and A & A are made available to the veteran's CS, this money is counted as income in determining the CS' eligibility for Medicaid along with any other income received by the CS including the CS MMNA computed.

Whatever amount of income the CS of a veteran gets as a CS MMNA, it must be reported to the VA via DOM-318, Exchange of Information Form.

3. CS Enrolled in HCBS Waiver for Elderly & Disabled

If a CS is an SSI eligible enrolled in the HCBS Waiver Program, the CS should be cautioned not to accept a CS MMNA that would affect his/her entitlement to SSI. Since the HCBS Waiver Program is limited to enrollment of only SSI recipients and these participants receive additional waivered Medicaid services, it would not be beneficial to a CS to jeopardize his/her SSI entitlement.

Effective 07-01-2000, beneficiaries of the Elderly and Disabled Waiver can have income up to 300% of the SSI Federal Benefit Rate, which is the institutional income limit. As a result, the CS can accept more of the CS MMNA and remain eligible for Medicaid. A change in coverage groups might be necessary.

4. CS Receives SSI or AFDC

Any income received by a CS in the form of an MMNA must be reported to SSA if the CS receives SSI or to DHS if the CS receives AFDC or AFDC-related Medicaid. Use Form DOM-318 to report the CS MMNA.

5. Notice Requirement for IS/CS

The Regional Office must provide written notice to both spouses (or their representatives) advising them of the CS allocation amount and the IS Medicaid Income. This can be accomplished by use of the Notice of Action or Notice of Adverse Action, whichever is appropriate for the situation. The nursing facility must also be notified of the CS MMNA amount via DOM-317.

Either spouse has the right to appeal the calculation of income and/or the determination of ownership and availability of income.

INSTITUTIONALIZATION
MEDICAID INCOME COMPUTATION

G. OTHER FAMILY MEMBERS (MMNA)

Certain other family members are entitled to a Monthly Maintenance Needs Allowance (MMNA). The calculation of the allowance differs depending on whether there is also a CS living with the other family members or no CS.

1. Family Members and CS Live Together

Certain other family members are entitled to an MMNA provided the dependent resides with the CS and provided the IS has income remaining after deducting the PNA and CS allowance from the income of the IS.

Deduct allowance(s) for other family members regardless of whether the allowance is made available to such persons by the IS. This is the opposite of the CS allowance requirement whereby the CS allowance must be made available to the CS by the IS before the deduction is allowed.

Other Family Members Include:

- children under age 21 who live with a CS
- children age 21 and older who live with a CS and who may be claimed as dependents by either the IS or CS for tax purposes
- dependent parent(s) of either the IS or CS. who reside with the CS and who may be claimed as dependent(s) by either the IS or CS for tax purposes
- dependent sibling(s) of either the IS or CS (brother, sister, half siblings or adopted siblings) who reside with the CS and who may be claimed as dependent(s) by either the IS or CS for tax purposes

The family member maximum, which is the need standard used to calculate each family member's MMNA, is listed in the "Chart of Need Standards and Resource Limits" located in the Appendix under Spousal Impoverishment Maximums.

The MMNA for each family member is an amount equal to 1/3 of any deficit remaining after gross income is applied to a family member maximum.

Each family member's MMNA is calculated separately, as follows:

Family Member Maximum
-Family Member's Own Income
Difference divided by 1/3 = that Family Member's MMNA

Note: The dependent family member has the same option as the CS to refuse all or a portion of the MMNA if the extraincome will result in SSI or Medicaid ineligibitliy. If any dependent refuses his/her allowance, obtain the refusal in writing for the case record.

2. Dependent Child(ren) At-Home - No CS

The MMNA for dependents cited above applies only when there is a community spouse living in the household with the dependent(s). If an IS has a dependent child or children under 18 who live in the community but no community spouse due to death or divorce or abandonment, the MMNA for the child(ren) is based on AFDC requirements for the number of dependent children (including step-children) of the IS. The AFDC requirements are listed in the Appendix.

To determine the appropriate allowance for child(ren) when there is no CS, use the AFDC requirement for the total number of children of the IS and subtract the total income of the child(ren) to arrive at the monthly allowance to be deducted from the IS income. Do not reduce this amount by 1/3.

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Liberalized Policy

Effective 07-01-99, to determine the appropriate allowance for child(ren) when there is no CS, use the following calculation:

Family Member Maximum
- Family Member's Own Income
Difference divided by 1/3 = that Family Member's MMNA

When a child reaches age 18, the allowance must be discontinued in these types of cases.

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MEDICAID INCOME COMPUTATION

H. HEALTH INSURANCE PREMIUM DEDUCTION

A health insurance premium incurred by a recipient that is not subject to payment by a third party is an allowable deduction from the recipient's Medicaid Income. This deduction is limited to one health insurance premium per recipient provided the recipient pays the premium out of his own funds. If a recipient owns more than one health insurance policy, the recipient must choose the one premium that is to be claimed as a deduction.

1. Verification Required

Before a health insurance premium is allowed as a deduction, the recipient or representative must verify that the recipient is the one who pays the expense. In addition, verification must be submitted to show that the recipient is the insured, the amount of the premium and the period of time the premium covers. Failure to verify the expense properly will result in the disallowance of the expense.

The recipient or representative must submit any and all official documentation necessary to verify the information specified above. Copies of premium notices, the health insurance policy, and/or other official notices may be required. All verification submitted must be photocopied and filed in the case record to clearly document the allowance of the expense.

Form DOM-339, Statement Regarding Payment of Health Insurance Premiums and Non-Covered Medical Expenses, will be used in conjunction with the client's own records, to verify payment of a health insurance premium. A DOM-339 will be issued on an annual basis, in accordance with the instructions for the form, even if the expense is paid monthly.

INSTITUTIONALIZATION
MEDICAID INCOME COMPUTATION

2. Retrospective Budgeting of Health Insurance Premiums

The premium that the recipient claims will be allowed as a one-time deduction in the third month following the month in which the premium is billed. Recipient cases with premiums claimed are reworked quarterly, if applicable (if a premium was billed in the previous quarter). Quarters are divided as follows:

Oct	Jan	Apr	July
Nov	Feb	May	Aug
Dec	Mar	June	Sept

Premiums billed in October are allowed as a one-time expense in January. Likewise, premiums billed in November are allowed in February. Premium expenses billed monthly are deducted retrospectively, also; however, it is only necessary to verify and recalculate amounts on a quarterly basis. Premiums are deducted in one month only (in Institutional budgeting) in the month which is the third month following the month billed. If the premium amount exceeds the recipient's Medicaid Income, any excess is not carried over into subsequent months.

Health Insurance will be verified once per year regardless of whether the expense is allowed monthly, quarterly, semi-annually or annually.

Policy Liberalization

Effective April 1, 2001, health insurance premiums will be allowed in the current month that the premium is billed. Retrospective budgeting will no longer be used.

3. Effective Date of Premium Deduction

For newly approved Medicaid eligibles, i.e., the client was not Medicaid eligible upon entry into LTC, the first month a health insurance premium is allowed is the third month following the month in which the premium is billed. The premium must be billed in or after the month of initial eligibility. For example, if an annual premium is billed in October and eligibility does not begin until November, the premium cannot be allowed until the quarter after the quarter of the next billing.

For Medicaid eligibles who enter LTC, i.e., the client enters LTC eligible as SSI or MAO (any existing MAO coverage group), a health insurance premium billed in the quarter prior to entry can be allowed in the quarter of entry into LTC. The premium is deducted retrospectively; however, a premium billed in the quarter prior to entry is an allowable deduction in the first quarter provided the client was eligible (as SSI or MAO) in the month billed. For example, a PLAD eligible is billed for a quarterly health insurance premium in August and enters a nursing home in October. The August premium is an allowable expense in November if properly verified.

Note: Allow a health insurance premium deductions to begin in the first quarter following the expiration of a transfer penalty provided the client was eligible for all other services during the transfer penalty and was billed in the previous quarter for the premium.

Effective April 1, 2001, a health insurance premium deduction will be allowed in the current month that premium is billed provided the transfer penalty has expired.

4. Reconciliation in Last Quarter of Eligibility

When an institutionalized recipient becomes ineligible for Medicaid, dies or leaves the institution, the worker must make a final one time adjustment to reconcile the allowable expenses from the previous quarter and the expenses incurred in the last quarter of eligibility. This one time adjustment will allow the previous quarter's expenses and the final quarter's expenses as a one time deduction in the month of ineligibility.

INSTITUTIONALIZATION
MEDICAID INCOME COMPUTATION

For example: Client dies in January. In the month of January, the current budget reflects actual expenses incurred in October. A one-time adjustment must now be made to allow expenses that would have been deducted for November, December and January in order to reconcile all expenses that would have been allowed had the client lived and remained eligible.

This will require verification of the final quarter's allowable expenses up until the client become ineligible or dies. Verification will be obtained via DOM-339 allowing 10 days for verification to be submitted.

Note: If the client was ineligible in the previous quarter, allow only final quarter expenses in the reconciliation. For example, if a client becomes eligible and dies in the same quarter, allow expenses in the month(s) prior to and including the month of death as a one time deduction.

A reconciliation for health insurance will be completed in order to bring the budget in line with allowing the premium in the current month. After this reconciliation has been completed, there will not be a reconciliation during the month of death. Applications approved after April 1, 2001, will not require a reconciliation.

INSTITUTIONALIZATION
MEDICAID INCOME COMPUTATION

I. NON-COVERED MEDICAL EXPENSE DEDUCTION

Certain incurred non-covered medical expenses that a recipient must pay out of funds belonging to the recipient can be allowed as a Medicaid Income deduction provided the expenses are not subject to payment by any insurance policy or any other individual. The only allowable "non-covered" medical expenses are those that are covered under the State Plan but, due to service limits placed on these services, the expenses were not covered by Medicaid. In other words, allowable expenses are limited to "covered" non-covered medical expenses.

1. Allowable Expenses

Expenses that can be allowed are limited to the following:

- Physician visits in excess of the 12-per-year limit. This is limited to those few recipients who are not eligible for Medicare since there are no physician visit limits on Medicare/Medicaid recipients. If a Medicare claim is non-assigned (which means the doctor did not accept assignment thereby preventing a claim from crossing-over to Medicaid for payment of the deductible and/or coinsurance) do not accept the expense as non-covered. The Medicaid Program will pay the Medicare deductibles and coinsurance on any assigned claim; therefore, it is necessary for the recipient to find a participating physician so as to benefit from the unlimited coverage of Part B physician services under the Medicare Program.

- Inpatient hospital days in excess of 30 per year.

Non-covered Medicaid expenses, such as eyeglasses, dentures, hearing aids, durable medical equipment or any expense paid by a third party, are not allowed as deductions from Medicaid Income. (Mississippi's non-covered medical expense policy is based on recognized State Plan Services; therefore, the above-listed expenses are not allowed as a deduction, as they are not covered items under Mississippi's State Plan.)

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MEDICAID INCOME COMPUTATION

2. Verification Required

An allowable expense must be verified via Form DOM-339, Statement Regarding Payment of Health Insurance Premiums and Non-Covered Medical Expenses, before it is allowed as a deduction. In accordance with the instructions for the form, the expenses billed to the recipient must be verified by the Doctor or Hospital rendering the service. In addition, the recipient or representative must verify that the recipient is the one who will pay or has paid for the expenses submitted via DOM-339.

The completed DOM-339 Form must be submitted to the Regional Office by the 5th day of the month following the end of the previous quarter. For example, expenses for October - December must be submitted to the Regional Office via Form DOM-339 by January 5th. If the form is mailed in, it must be postmarked by the 5th day of the month in order to be considered timely received. Note: If the 5th day of a new quarter falls on a weekend, allow until the following Monday as the deadline for submitting expenses.

Form DOM-339 must be filed in the case record for each quarter that expenses are allowed. When a completed DOM-339 is received for a given quarter, another DOM-339 must be mailed to the recipient or representative and the file documented as to the date mailed.

INSTITUTIONALIZATION
MEDICAID INCOME COMPUTATION

3. Retrospective Budgeting of Non-Covered Medical Expenses

Expenses are calculated on a quarterly basis. Actual expenses incurred in one quarter are not budgeted as a deduction until the next quarter. Quarters are divided as follows:

Oct	Jan	Apr	July
Nov	Feb	May	Aug
Dec	Mar	June	Sept

Regardless of when an allowable medical service is rendered, an expense is considered incurred in the month billed. Specifically, the month that the recipient is billed for his/her portion of an allowable medical expense, i.e., after all other third parties have paid, is the month the recipient incurs the expense. For the purpose of the non-covered medical expense provision, the month an expense is billed to the recipient determines the month the expense is allowed.

An allowable expense billed in October is allowed in January. Likewise, expenses billed in November are allowed in February. All verified expenses billed in a given month are allowed as a one-time deduction in the third month. Expenses are allowed (deducted) in one month only. If the recipient's Medicaid Income is reduced to zero after all allowable expenses are deducted, any excess is not carried over into subsequent months.

When the completed DOM-339 for a previous quarter's expenses is received by the 5th day of the month following the end of a specified quarter, the worker has until the 20th of the month to rework Medicaid Income for the current quarter. For example, expenses for October - December must be submitted by January 5. The worker then has until January 20 to budget the expenses submitted for January - March and possibly increase Medicaid Income for January. This would allow time for advance notice to be issued 10 days prior to the first of the month, in accordance with policy governing increasing Medicaid Income. If there will be no increase in Medicaid Income for the current month after allowing expenses submitted, the worker has until the last day of the first month of each quarter to rework Medicaid Income computations.

4. Effective Date of Medical Expense Deduction

For newly approved Medicaid eligibles, i.e., the client was not Medicaid eligible upon entry into LTC, the first month a non-covered medical expense deduction is allowed is the third month following the month in which the expense is billed. The expense must be billed in or after the month of initial eligibility. For example, if a non-covered expense is billed in October and eligibility does not begin until November, the expense cannot be allowed.

For Medicaid eligibles who enter LTC, i.e., the client enters LTC eligible as SSI or MAO (any existing MAO coverage group), a non-covered medical expense billed in the quarter prior to entry can be allowed in the quarter of entry into LTC. The expense is deducted retrospectively; however, an expense billed in the quarter prior to entry is an allowable deduction in the first quarter provided the client was eligible (as SSI or MAO) in the month billed. For example, a PLAD eligible is billed for a non-covered medical expense in August and enters a nursing home in October. The August expense is an allowable expense in November if properly verified.

Note: Allow a non-covered medical expense deduction to begin in the first quarter following the expiration of a transfer penalty provided the client was eligible for all other services during the transfer penalty and was billed in the previous quarter for the expense.

5. Reconciliation in the Last Quarter of Eligibility

When an institutionalized recipient becomes ineligible for Medicaid, dies or leaves the institution, the worker must make a final one time adjustment to reconcile the allowable expenses from the previous quarter and the expenses incurred in the last quarter of eligibility. This one time adjustment will allow the previous quarter's expenses and the final quarter's expenses as a one time deduction in the month of ineligibility.

For example: Client dies in January. In the month of January, the current budget reflects actual expenses incurred in October. A one-time adjustment must now be made to allow expenses that would have been deducted for November, December and January in order to reconcile all expenses that would have been allowed had the client lived and remained eligible.

This will require verification of the final quarter's allowable expenses up until the client become ineligible or dies. Verification will be obtained via DOM-339 allowing 10 days for verification to be submitted.

Note: If the client was ineligible in the previous quarter, allow only final quarter expenses in the reconciliation. For example, if a client becomes eligible and dies in the same quarter, allow expenses in the month(s) prior to and including the month of death as a one time deduction.