

MISSISSIPPI DIVISION OF MEDICAID

Eligibility Policy and Procedures Manual

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500.01 INTRODUCTION

This chapter provides instructions for institutional or long-term care eligibility and budgeting criteria for each institutional category of eligibility, which includes:

- All Home & Community Based Services (HCBS) Waiver programs – these are long term care alternative programs that use institutional rules, treating the HCBS waiver participant as if the individual is residing in a medical institution even though the individual is residing in a private living arrangement.
- The Katie Beckett program –a disabled child under age 19 must be in need of a level of care ordinarily provided in a hospital, nursing facility or ICF/IID in order to qualify for this program resulting in the child’s eligibility being evaluated using institutional rules even though the child lives in a non-institutional living arrangement.
- Long Term Hospitalization admissions – an individual who is admitted to an acute care hospital for 30-consecutive days or longer has eligibility evaluated using institutional rules.
- Individuals residing in a Title XIX (Medicaid) Nursing Facility (NF), or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) have eligibility determined using institutional rules.
- Individuals in an acute care (hospital) setting that are placed in a swing-bed, i.e., a bed that serves as an acute care and skilled nursing care placement, have eligibility determined using institutional rules.

To qualify for Medicaid coverage discussed in this chapter, an individual must meet all financial and non-financial aged, blind or disabled criteria applicable. Individuals eligible in non-institutional coverage groups who are eligible for Medicaid upon entry to a medical institution may qualify for institutional services under certain conditions that are outlined in this chapter.

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500.02 CATEGORICAL ELIGIBILITY CRITERIA

To qualify for Medicaid in an institutional or long-term care program, an individual must meet ALL of the following categorical requirements:

1. Reside in a medical facility or alternative placement for 30-consecutive days or longer. These include:
 - Licensed and certified Title XIX (Medicaid) Nursing Facilities (NF), which must be one of the following:
 - Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF),
 - Swing Bed in a hospital bed that has been designated as such,
 - Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).
 - HCBS Waiver programs operated by the MS Division of Medicaid,
 - Inpatient hospital (acute care) admissions that meet long term hospitalization criteria. NOTE: A Psychiatric Residential Treatment Facility (PRTF) provides inpatient psychiatric services to children under age 21. This type of medical facility is treated as an acute care hospital admission for eligibility purposes,
 - Suitable private living arrangements where cost-effective medical care is provided for a Katie Beckett Program child in order to meet the Katie Beckett criteria.

The 30-consecutive day requirement is waived under certain conditions that include:

- Applicant dies before 30-day period is met,
 - Individual is Medicaid-eligible in another full-service COE.
 - Refer to the 30-consecutive day policy provision for further details.
2. Be in need of a level of care appropriate for the placement. An individual must be medically approved for long term care placement, which is documented in a variety of ways, as stated in policy for the specific placement.
 - Long Term Hospitalization does not require a level of care determination for eligibility purposes.
 - Admission to a PRTF for a child under age 21 does not require a level of care determination for eligibility purposes.
 3. Must not have transferred resources within the 5-year look back period as defined in Transfer of Assets policy in Chapter 300, Resources. NOTE: There is no transfer penalty for Long Term Hospitalization but if the individual transfers

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from a hospital to a nursing facility or HCBS waiver program, the transfer of assets provision applies.

4. Must meet all non-financial eligibility criteria as outlined in Chapter 102.

Specifically, all of the following non-financial policy provisions are applicable:

- Identity
 - Citizenship/Alienage
 - State Residency
 - Enumeration/Furnishing a Social Security Number
 - Disability for those under age 65
 - Assignment of Rights to Third Party Medical Payments
5. Meet all income eligibility criteria, including:
 - Verification of income requirements
 - Income that is below the institutional limit that is 300% of the Individual SSI FBR
 - Income Trust requirements for individuals with income above the 300% limit.
 - NOTE: The provision for qualifying for Medicaid under an Income Trust is applicable only to individuals in a nursing facility, swing-bed and ICF/IID or in a HCBS waiver program. Refer to Chapter 300 for a full discussion of the Income Trust provision.
 6. Meet all resource eligibility criteria, including:
 - Verification of resource requirements, which includes certifying on the ABD application the "Disclosure of Financial Information" provision requirement
 - Equity in home property that meets the substantial home equity limit provision, as outlined in Chapter 300, Resources
 - The total of all countable resources cannot exceed the resource limit applicable to the individual, i.e., resource computations are evaluated according to whether the individual is:
 - Married with a spouse living in the community,
 - Single
 - Married but spouse is also in an institution.Spousal impoverishment rules apply to institutionalized spouses with a spouse living in the community.
 7. May be subject to the Estate Recovery provision whereby DOM is required to seek recovery of payments for NF services and/or HCBS services and certain other services from the estate of a deceased Medicaid recipient who was age 55 or older when these services were received. Refer to Chapter 102, Non-Financial Requirements. The full Estate Recovery provision is outlined in 102.09.06.

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8. In addition to all of the above provisions, an individual applying for or transitioning to an ABD institutional category of eligibility may require an in-person interview, if they come into the office or telephone interview, as appropriate, for the purpose of explaining the ABD provisions unique to institutional eligibility as well as other Medicaid requirements. Refer to Chapter 101, Interviews with DOM at 101.06 for further details.

500.03 INSTITUTIONAL COVERAGE GROUPS LIVING "AT-HOME"

The following categories of eligibility or COE's are considered institutional or long-term care COE's that live in a private living arrangement as opposed to residing in a medical facility. The factors that all of the following COE's have in common are:

- The individual's own income is tested against the institutional need standard that is 300% of the SSI Individual FBR. Total income of the individual is tested against the 300% limit; there are no income exclusions or disregards that apply to the individual's income unless the income is the type that is not considered income, such as VA Aid & Attendance or another income type that is not counted as income for ABD purposes.
- There is no deeming of spousal or parental income for any of these types of institutional COE's.
- Spousal impoverishment policy applies to individual's qualifying in any of these COE's provided the married couple lives together and one spouse is not applying or is not eligible in a COE that uses institutional policy, i.e., there must be one institutional spouse, and one spouse considered a community spouse.
- There is no Medicaid Income or patient liability payable toward the cost of care for these COE's.

500.03.01 KATIE BECKETT PROGRAM ELIGIBILITY CRITERIA - COE-019

Section 134 of the Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248) allowed States, at their option, to cover disabled children under age 19 who require a level of care provided in a hospital, nursing facility or ICF/IID but are provided such care in a non-institutional setting. It must be cost-effective and appropriate to provide such care outside of a hospital or nursing facility setting. State enabling legislation established the authority to cover this optional category of eligibility effective July 1, 1989. This program was initially called Disabled Child Living at Home (DCLH). The name changed to the Katie Beckett Program on July 1, 2025.

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To be eligible under the Katie Beckett category, the child must meet all of the following criteria:

- The child must be determined disabled using SSI criteria, as determined by DDS. Disability and obtaining a disability decision is discussed in Chapter 102, Non-Financial Requirements, beginning at 102.09.01 through 102.09.04.
- In addition to being determined disabled, the child must require a level of care at home that is ordinarily provided in a hospital, nursing facility (skilled or intermediate), including an intermediate care facility for individuals with intellectual disabilities.
- The child must not have income or resources that are in his/her name that exceed the current standards for an individual in an institution. The child's resources, if any, are evaluated using SSI rules, not liberalized policy. There is no deeming of parental income and resources to the child provided the child qualifies on all Katie Beckett eligibility factors.
- The cost of the child's care must not exceed the cost Medicaid would pay if the child was in the appropriate institutional setting.

Parental Choice

The ABD Application Form requests that a parent of a minor child make a selection regarding the child's Medicaid coverage and providing parental income and resource information. Specifically, if a parent (or authorized representative) elects to provide and verify parental income and resources, the child will be considered under any and all categories of eligibility for Medicaid and/or CHIP. However, if the parent or representative elects not to provide needed financial verification of parental income/resources, the child will be considered for coverage only under the Katie Beckett category of eligibility, even though the child may qualify for an alternate ABD or MAGI-related COE. If the disabled minor child does not meet the Katie Beckett eligibility criteria, e.g., the child does not meet the level of care requirement or the child is not disabled according to SSI criteria, the parent or representative can change their election and provide information needed to determine eligibility for an alternate placement for the child.

Disability Decision

The applicant child must be determined disabled according to SSI criteria. A DDS decision must be obtained in the usual manner, using all appropriate forms and processes outlined in Chapter 102, Non-Financial Requirements, in Section 102.09. The DOM-323A, Disabled Child Questionnaire Form, is a DDS required form for their use in determining disability or continued disability for any DDS requested re-examination for the child.

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- If the child's disability is denied by DDS, the Katie Beckett application must be denied. However, if the parent or representative elected to have the child's eligibility determined under any and all COE's and parental income has been verified, begin the process of evaluating possible MAGI-related eligibility. A DDS denial would not allow an alternate ABD placement.
- If the child's disability is approved by DDS, continue with the Katie Beckett application.

Level of Care Decision

The Division of Medicaid uses a contractor to conduct the institutional level of care review for the Katie Beckett application and renewal process. The level of care decision is based on the services and specialized care provided by the parent that would routinely be provided to the child in an inpatient hospital, nursing facility or ICF/IID facility. The contractor's medical staff reviews the child's medical history within the last 12 months and other information related to the child's condition in making the level of care recommendation and relays the level of care recommendation back to DOM. DOM in house medical staff review the recommendation, make a final level of care decision, and transmit the level of care decision to the RO.

Regional Office Responsibility for the Level of Care Decision

For each application made by a parent or representative for Katie Beckett coverage only, or for which Katie Beckett is the primary or first choice for coverage, the following are RO duties at the application interview and throughout the process:

- Provide the parent or other individual applying for the disabled child the Katie Beckett program information and discuss it with them. **NOTE:** Explain if Katie Beckett is approved, at each annual review that requires an updated level of care decision, as determined by the contractor, the information will be provided/discussed, as applicable at review.
 - **Katie Beckett Frequently Asked Questions (FAQs)** must be provided and discussed.
 - **Welcome Letter** must be provided and discussed. It describes the level of care (LOC) requirement for Katie Beckett coverage, required documentation for a LOC decision and the contractor's role.
 - **Katie Beckett Program Medical Necessity/Level of Care Statement** must be provided after entering the child's name, date of birth and Social Security Number. Explain the form must be fully completed and signed by the child's

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- treating physician. A level of care response by the treating physician is required. If the physician recommends a level of care, the form must also be signed by the parent; however, if the physician notes level of care as N/A, the parent is not required to sign the form. NOTE: When the form is returned, the specialist must review to ensure it is complete with required entries and signatures before submission to the contractor for the LOC determination.
- **Katie Beckett Parent Skills Checklist** must be provided and discussed. This form is for the parent to detail what treatment and/or skilled care the parent provides for the child at home. If the parent does not provide treatment and/or skilled care for the child, they will indicate that on the form.
 - **Level of Care Indicators:** Discuss LOC indicators which are the basic criteria the contractor will use to make the LOC determination.
 - **Nursing Facility LOC Indicators:**
 - Skilled nursing ordered/provided 7 days per week **OR**
 - Skilled rehab services ordered/provided at least 5 days per week.
 - **Hospital LOC Indicators:**
 - Services are required 24 hours per day **and** required to be ordinarily furnished in an appropriately licensed institution for the care and treatment of patients with disorders other than mental illness.
 - **Intermediate Care Facility for Individuals with Intellectual Disability (ICF-ID) Indicators:**
 - IQ =/ $<$ 70, **OR**
 - Standard score =/ $<$ 70 in at least 3 of 5 domains of function (cognitive, language, motor, social-emotional and adaptive) on a standardized development tool **or** an overall score of =/ $<$ 70, **OR**
 - Age-equivalency composition $<$ 50% of chronological age **or standard** score =/ $<$ 70 in at least 3 domains of function on a standardized adaptive functioning test **or** composite score =/ $<$ 70; **OR**
 - Childhood Autism Rating Scale (CARS) score $>$ 37 **or** the Gilliam Autism Rating Scale (GARS) score is $\geq$ 121.
 - **Required Medical Documentation for the Level of Care Applicable to the Child**
 - For **Nursing Facility Level of Care**, the following must be provided:
 - Physician Order for Nursing or Rehab Therapy
 - Nursing Notes*, as applicable
 - Rehab Therapy Notes*, as applicable
 - Individual Educational Plan (IEP) or Individual Family Support Plan (IFSP), if in effect. **NOTE:** If IEP or IFSP provided for DDS, provide copy to LOC contractor and do not duplicate information requests.

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- For **Hospital Level of Care**, the following must be provided:
 - Physician Order for Nursing or Rehab Therapy
 - Nursing Notes*, if applicable
 - Rehab Therapy Notes*, if applicable
 - Hospital Records, if applicable.
- For **ICF-ID Level of Care**
 - Developmental Evaluation** **with score** (ages 0-5)
 - Psychological Evaluation** **with score** (ages 6 and up)
 - IEP or IFSP, if in effect

***Nursing and/or Rehab Therapy Notes** must be dated within the most recent 3 months and include comments, notes, progress reports, etc. from a physical, occupational, speech or language therapist, nurse or other medical professional regarding the child's medical status, treatment and/or plan of care. If the child has not seen any type of therapist or medical professional within the last 3 months, use the case worker comment section on the Level of Care Routing Form to inform the contractor the parent reports no nursing or therapy notes (or hospital records) are available.

****Developmental Evaluation or Psychological Assessment:** must be signed and cannot be more than 3 years old.

- Explain to the parent if the child's disability is approved by DDS, all medical information that has been provided for the applicant child's level of decision will be submitted to the contractor to make the LOC decision and, if Katie Beckett is approved, updated medical information will be requested at the intervals specified by the contractor for subsequent LOC reviews.
- Provide **DOM KBP-307**, Request for Information, for initial level of care requests to inform the parent to provide the completed and signed DCLH Medical Necessity/Level of Care Statement and required medical documentation based on the level of care recommended by the child's physician. Attach the Katie Beckett medical/LOC form, parent skills checklist, and accompanying information, i.e., form instructions, level of care information and required medical documentation. Retain a copy of KBP 307, if issued manually.
- **DOM KBP-309**, Request for Information, will be used to follow-up when no LOC information or incomplete information is received in response to the initial request via KBP-307. Retain a copy of KBP-309 if issued manually.
- Send only DDS disability approvals to the contractor for a level of care decision. The timeframes for notifying contractor of the need for LOC decision are as follows:

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- **Applications** – notify the contractor within 2-business days of receipt of the DDS approval. The 2-day count begins the day after receipt of the DDS approval.
- **Reviews** – notify the contractor no earlier than 60-days, but no less than 30-days, prior to the end of the child’s current 12-month eligibility period of the need for a new decision.
 - If a DDS re-exam is requested at the same time as the LOC re-review, obtain the DDS decision prior to requesting the updated level of care decision.

NOTE: The DDS re-exam material may be sent to DDS at the first of the month prior to the requested re-exam month.

- For the LOC determination, provide the fully completed and signed Katie Beckett Program Medical Necessity/Level of Care Statement, Parent Skills Checklist, DDS decision, and all medical information received to date to the Contractor with the Katie Beckett Program Application Checklist. .

NOTE: For reviews, send only the current medical information used by DDS to approve continuing disability.

- After reviewing the contractor’s recommendation, DOM medical staff will notify the RO of one of the following outcomes:
 - **Administrative Denial:** If the contractor is unable to make a LOC decision due to insufficient medical information, the regional office will be notified to deny administratively, and the denial reason will be required information was not provided.

NOTE: When failure to provide requested information causes Katie Beckett eligibility to be terminated, a courtesy call is required before the adverse action is taken.

- **Approval:** If the level of care is approved, the contractor will send their Notice of Approval for the case record with a review interval of 1, 2 or 3 years. The RO will make the final decision regarding the child’s eligibility on all other factors of eligibility and issue notice of the DCLH approval.
- **LOC Denial:** If LOC is denied, DOM medical staff will notify DOM to deny Katie Beckett eligibility on level of care. The DOM action must take place first. Then contractor issues their LOC medical denial decision to the parent.

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While the parent is responsible for obtaining/providing completed medical forms and other applicable documents to the regional office, the RO needs to provide as much assistance possible, when assistance is requested or known to be needed.

Compliance After Administrative Denial

When a parent or guardian provides additional information for level of care after an Administrative Denial on an application within the specified time frame as outlined in Chapter 101, Section 101.08.06 Compliance After Denial, the application should be registered again using original application date and the additional information should be uploaded to the contractor for reconsideration.

When a parent or guardian provides additional information for level of care after an Administrative Denial on a renewal within the specified time frame as outlined in Chapter 101, Section 101.15.12 Requested Information Provided After Closure for Renewals, the worker should register a reinstatement contact and the additional information uploaded to the contractor for reconsideration.

Appeals

When a hearing is requested due to a LOC denial, a State Hearing should be submitted to Central Office. Include any additional information submitted after the LOC denial as part of the appeal record for reconsideration. Additional information submitted after a LOC denial should not be uploaded to the contractor.

500.03.02 HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVER PROGRAMS

The Division of Medicaid has been granted the authority under Section 1915(c) of the Social Security Act to implement Home & Community Based Services (HCBS) waiver programs. HCBS waiver programs provide in-home services that are in addition to regular Medicaid covered services, i.e., individuals eligible in a HCBS waiver program receive all regular Medicaid services plus expanded waiver services. All HCBS waiver programs are limited to individuals who meet an institutional level of care but are able to receive in-home services as an alternate to institutionalization. The 30-consecutive day requirement for long term care placement is presumed for HCBS, i.e., an assumption is made that an applicant will remain in an HCBS placement for 31 days or longer.

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Participating COE's

HCBS waiver programs allow certain other COE's to participate in the waiver without a separate application for HCBS eligibility. For example, all HCBS waivers allow SSI-eligible individuals to participate if the SSI-eligible individual meets the clinical requirements for the waiver. For eligibility purposes, this means there is no requirement for the individual to be converted to a waiver-specific COE. An application for the appropriate waiver COE must be initiated by the regional office if eligibility in a participating COE end. Policy describing each HCBS waiver program below addresses participating COE's.

Non-Participating COE's – Require an ABD Application or ABD Review

Individuals who are eligible for Medicaid but not in a participating COE must have eligibility determined for HCBS using institutional rules. The regional office will be notified by appropriate Long Term Care bureau staff that an individual has been determined clinically eligible for participation in a waiver and that eligibility is needed in a waiver-specific COE. The notification comes in the form of an internal two-way form that is designed to confirm clinical eligibility for waiver services and for two-way communication between HCBS waiver staff and eligibility staff in the regional office. Upon receipt of a two-way form from the Long-Term Care bureau, take the following action as appropriate:

Non-Participating COE's – Require an ABD Application or ABD Review (Continued)

- If the individual identified on the two-way form is eligible in an ABD at-home COE, action is needed by the regional office to determine continued eligibility using institutional rules. A new ABD application is not needed unless a review is due; however, all factors of institutional eligibility must be reviewed and verified as outlined in 500.02, Categorical Eligibility Criteria.
- If the individual is eligible in a MAGI-related COE, action must be taken to determine ABD institutional eligibility, and all factors of eligibility outlined in 500.02 must be verified. Issue an ABD application form but request only information that is not available or has not been verified as part of the MAGI application process.
- If the individual is not eligible for Medicaid, the regional office must initiate an ABD application via a Request for Information (DOM-307) and track the application so that a response can be provided to the Long-Term Care bureau regarding approval or denial of eligibility.
- If the individual is discharging from a nursing facility into a HCBS waiver

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program, the regional office must take action to convert the individual to the appropriate HCBS waiver COE. No further action is needed unless a review of the case is due. Notify the Long-Term Care bureau of the action taken. The end date for the NF COE should be the end of the month of discharge from the NF or ICF/IID to ensure proper payment to the facility.

- If a HCBS waiver participant enters a nursing facility or ICF/IID, notify the Long-Term Care bureau via email of the admission so that the individual can be discharged from the HCBS waiver. Delay the conversion to a LTC COE until the two-way form is received from the Long-Term Care bureau. Approve eligibility in the LTC bureau as of the first of the month of admission to the nursing facility or ICF/IID to ensure proper payment to the facility.

Effective Date of HCBS Eligibility

Eligibility in any of the HCBS waiver programs cannot begin prior to the effective date specified by the Long-Term Care Bureau on the two-way form. The beginning date of HCBS eligibility is either the effective date on the two-way form or the first of the month in which all eligibility factors are met.

500.03.02A ASSISTED LIVING (AL) HCBS WAIVER - COE-062

Qualified participants must reside in a licensed Personal Care Home – Assisted Living facility approved to provide assisted living services and be age 21 or older. The only participating COE is SSI (COE-001). All other participants must be determined eligible using institutional rules by the appropriate regional office for COE-062 eligibility.

Refer to the DOM website for a complete listing of waiver services offered in the Assisted Living waiver program. The Long-Term Care bureau with the Division of Medicaid maintains a current listing of Assisted Living facilities throughout the state that are approved for Assisted Living waiver participation.

500.03.02B ELDERLY AND DISABLED (E&D) HCBS WAIVER - COE-063

Qualified participants must be age 21 or older and be determined disabled by DDS (if under age 65) and also clinically eligible for waiver participation. Those age 65 and over must be determined clinically eligible for participation. The clinical assessment for waiver eligibility is the responsibility of the Area Agency on Aging with the Planning and Development Districts throughout Mississippi. The only participating COE is SSI (COE-001). All other participants must be determined eligible using institutional rules by the appropriate regional office for COE-063 eligibility.

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Refer to the DOM website for a complete listing of waiver services offered in the Elderly and Disabled waiver program.

500.03.02C INTELLECTUAL DISABILITIES/DEVELOPMENTAL DISABILITIES (ID/DD) HCBS WAIVER -COE-064

The ID/DD waiver program provides services to individuals of any age who meet waiver criteria. It is administered jointly by the Department of Mental Health and DOM. There are multiple participating COE's that include:

- SSI (COE-001) individuals,
- Foster Care children (COE's 003 and 026),
- Protected Foster Care individuals (COE-007),
- Parent/Caretaker (COE-075) individuals,
- MAGI-eligible children up to age 19 (COE's 071, 072, 073, 074),
- Katie Beckett (COE-019) children,
- Working Disabled individuals (COE-025), and
- Disabled Adult Child (COE-094) eligible individuals.

All other participants must be determined eligible using institutional rules by the appropriate regional office for COE-064 eligibility.

Refer to the DOM website for a complete listing of waiver services offered in the ID/DD waiver program and for contact information on the Department of Mental Health Regional Centers, which are the initial point of contact for enrolling in the ID/DD waiver program.

500.03.02D INDEPENDENT LIVING (IL) WAIVER HCBS (COE-065)

Qualified participants must be age 16 or older and have severe orthopedic and/or neurological impairments and meet all other clinical requirements. It is administered jointly with the Department of Rehabilitation Services and DOM. There are multiple participating COE's that include:

- SSI (COE-001) individuals,
- Foster Care children (COE's 003 and 026),
- Protected Foster Care individuals (COE-007),
- Parent/Caretaker (COE-075) individuals,
- MAGI-eligible children ages 16 to 19 (COE's 073, 074),
- Katie Beckett (COE-019) children,
- Working Disabled individuals (COE-025), and
- Disabled Adult Child (COE-094) eligible individuals.

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Refer to the DOM website for a complete listing of waiver services offered in the Independent Living waiver program and for contact information on the Department of Rehabilitation Services, which is the initial point of contact for enrolling in the Independent Living waiver program.

500.03.02E TRAUMATIC BRAIN INJURY/SPINAL CORD INJURY HCBS WAIVER (TBI/SCI) COE-066

The TBI/SCI waiver program provides services to individuals of any age who meet waiver criteria. It is administered jointly by the Department of Rehabilitation Services and DOM. There are multiple participating COE's that include:

- SSI (COE-001) individuals,
- Foster Care children (COE's 003 and 026),
- Protected Foster Care individuals (COE-007),
- MAGI-eligible children up to age 19 (COE's 071, 072, 073, 074),
- Katie Beckett (COE-019) children,
- Working Disabled individuals (COE-025), and
- Disabled Adult Child (COE-094) eligible individuals.
- Parent/Caretaker (COE-075) individuals,

Refer to the DOM website for a complete listing of waiver services offered in the TBI/SCI waiver program and for contact information on the Department of Rehabilitation Services, which is the initial point of contact for enrolling in the TBI/SCI waiver.

500.04 INSTITUTIONAL COVERAGE GROUPS

The following categories of eligibility or COE's are considered institutional or long-term care COE's residing in a medical facility. The factors that all of the following COE's have in common are:

- The individual's own income is tested against the institutional need standard that is 300% of the SSI Individual FBR. Total income of the individual is tested against the 300% limit; there are no income exclusions or disregards that apply to the individual's income unless the income is the type that is not considered income, such as VA Aid & Attendance or another income type that is not counted as income for ABD purposes.
- There is no deeming of spousal or parental income for any of these institutional COE's.

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- Spousal impoverishment policy applies to individuals qualifying in any of these COE's provided there is one institutional spouse and one spouse living in the community.
- All of the following provisions apply to institutional COE's with the exception of Long-Term Hospitalization. PRTF admissions are exempt where noted below:
 - Medicaid Income or patient liability is payable toward the cost of care unless allowable deductions reduce Medicaid Income to \$0.
 - The transfer of assets provision applies along with the 5-year look back for transfers that may have occurred within 5-years prior to the first application for institutional Medicaid. (PRTF admissions are exempt.)
 - The substantial home equity provision applies for any home property that has equity value that exceeds the limit. (PRTF admissions are exempt.)
 - An Income Trust is available for individuals whose income exceeds the 300% need standard but does not exceed the private pay rate for a 31-day month in the facility in which the individual resides. (PRTF admissions are exempt.)
- All other categorical eligibility criteria as outlined in 500.02 above apply, as appropriate.

500.04.01 LONG TERM HOSPITALIZATION (LTH)

Long term hospitalization is defined as 30-consecutive days or longer in an acute care hospital. An individual can qualify for Medicaid using institutional rules (with certain exceptions) after meeting the 30-consecutive day requirement. Refer to 500.09.02 for a complete definition of 30-consecutive days. **NOTE:** An individual who would qualify in an at-home full-service COE (MAGI or ABD) or as QMB-only should have eligibility determined for at-home eligibility before attempting LTH because an acute care admission will be paid as a Medicaid covered service. However, if at-home eligibility is not possible, evaluate LTH as appropriate.

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There are 2 separate COE's for long term hospitalization applicants that are determined based on income of the individual. For both LTH COE's, institutional provisions apply as follows:

- No deeming of spousal or parental income applies in evaluating the income of someone applying or eligible for long term hospitalization.
- Spousal impoverishment provisions apply. The spouse in the hospital is the institutional spouse or IS. Resources must be transferred from the institutional spouse to the community spouse prior to approval of the long-term hospitalization application if needed in order for the IS to become Medicaid eligible.
- Institutional provisions that do **not** apply to a long-term hospitalization applicant are:
 - The transfer of assets provision. There is no 5-year look back or transfer penalty imposed for someone qualifying for LTH. If the individual enters a nursing facility, the transfer of assets provision applies upon entry to the facility.
 - The Income Trust provision does not apply to someone applying for LTH. An individual eligible for LTH must have income that is less than the 300% maximum limit.
 - The substantial home equity provision does not apply to someone applying for LTH. If the individual enters a nursing facility, the substantial home equity provision applies upon entry to the facility.
 - Medicaid Income is not payable to the hospital. MEDS will not calculate Medicaid Income for an individual whose living arrangement is "hospital."
 - There is no physician certification needed prior to approval of an LTH application. The medical necessity of the placement is determined by prior authorization and other medical services and claims processing policy.
- All other categorical factors of eligibility, as outlined in 500.02, must be met with the exception of the provisions that do not apply to LTH specified above. Continued hospitalization must be verified, at a minimum, every 3 months.

Appropriate ticklers must be created by the Specialist to verify continued hospitalization status.

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500.04.01A LONG TERM HOSPITALIZATION (LTH) UNDER 300% - COE-011

An individual is placed into this COE by MEDS whenever a time period is entered with a “hospital” living arrangement and the individual’s own income exceeds the current SSI individual income limit (based on FPL). For all such applicants, the length of stay must equal or exceed 30-consecutive days unless the individual dies prior to the 31st day. Failure to meet the 30-consecutive day requirement results in a denial of eligibility unless the individual would be eligible in an at-home COE.

500.04.01B LONG TERM HOSPITALIZATION (LTH)-WOULD BE SSI AT-HOME – COE-014

An individual is placed into this COE by MEDS whenever a time period is entered with a “hospital” living arrangement and the individual’s own income is equal to or less than the current SSI individual income limit (based on FPL). For all such applicants, the length of stay in the hospital must equal or exceed 30-consecutive days unless the individual dies prior to the 31st day. Failure to meet the 30-consecutive day requirement results in a denial of eligibility unless the individual would be eligible in an at-home COE.

500.04.02 LONG TERM CARE IN A NURSING FACILITY OR ICF/IID

Long term care in a nursing facility (SNF or ICF) and/or an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) is defined as 30-consecutive days or longer. An individual can qualify for Medicaid using institutional rules after meeting the 30-consecutive day requirement. Refer to 500.09.02 for a complete definition of 30-consecutive days and how it is possible to meet the requirement.

NOTE: For an individual eligible in an at-home ABD COE upon entry to a nursing facility, refer to 500.10.04, ABD Eligible Child or Adult Enters Long Term Care, for instructions on the requirement to convert at-home ABD eligibility to LTC eligibility for all admissions, even those that do not equal or exceed 30-consecutive days.

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There are 2 separate COE's for long term care applicants/recipients that are determined based on income of the individual. For both long term care COE's, institutional provisions apply as follows:

- No deeming of spousal or parental income applies in evaluating the income of someone applying or eligible for long term care in a nursing facility or ICF/IID. Refer to Section 200.11.04F and G for policy on changes in deeming status for spouses and parents.
- Spousal impoverishment provisions apply. The spouse in the facility is the institutional spouse or IS. Resources must be transferred from the institutional spouse to the community spouse during a 90-day protected period if needed in order for the IS to become Medicaid eligible. Refer to 500.07 for Spousal Impoverishment policy.
- The transfer of assets provision applies along with the 5-year look back period prior to the first application for Medicaid that was not withdrawn. Refer to Chapter 306, Transfer of Assets Policy.
- The Income Trust provision applies. Individuals with income above the 300% maximum limit are permitted to qualify under an Income Trust provided their income does not exceed the private pay rate for the facility in which they reside for a 31-day month. Refer to Section 304.04.04, Income Trusts, in Chapter 304.
- The substantial home equity provision applies. Individuals whose equity interest in home property exceeds the home equity limit in effect at the time of the application or in any subsequent month will not be eligible for Medicaid to pay for room and board in a nursing facility or ICF/IID in any month in which the equity exceeds the limit. Refer to Chapter 302, Section 302.04.01, Home Property, "Equity Interest Disqualification."
- Medicaid Income is payable to the facility unless authorized deductions from an individual's income reduces income to the point where Medicaid Income is \$0. Refer to 500.10, Medicaid Income.
- Physician certification is required prior to approval of an application for long term care in a nursing facility or ICF/IID. Refer to 500.06, Physician's Certification.
- All other categorical factors of eligibility, as outlined in 500.02, must be met.

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Supervisory Responsibility for Monitoring LTC Admissions

The regional office is notified of a LTC admission to a Nursing Facility or ICF/IID by way of the DOM-317 form issued by the facility through LTSS. All 317 forms require a Medicaid eligibility status response from the RO, including a response that no application was filed for individuals with no current eligibility. 317 forms for individuals admitted to a NF or ICF/IID with no current eligibility on file are routed to the Specialist assigned to the facility for application processing. Standard reports track the application once received, but Specialists must abide by the Reasonable Efforts to Assist provision outlined in 101.03.07 for non-compliant applicants or those that fail to follow through with an application.

317 forms that report entry or discharge of an at-home Medicaid or CHIP recipient into a NF or ICF/IID are required to be monitored by appropriate supervisory staff. Supervisors must track 317s received through LTSS and monitor timely and correct action until the required long term care decision has been reached, as directed in 500.10, Recipients Eligible Upon Entry to Long Term Care, for the following:

- SSI-only recipients and SSI recipients that must transition to Medicaid-only,
- Foster children in the custody of DCPS and/or former foster children,
- MAGI eligible children or adults, including CHIP children, and
- ABD eligible children or adults

Monitoring of the 317 forms must begin within 30 days from receipt of the 317 to ensure the conversion is on track to be completed within 45 days. The supervisor must respond to the 317 in LTSS when a decision is reached or an application is not filed.

In addition to using LTSS as a tracking tool, supervisory staff assigned to Specialists handling NF's and ICF/IID's must utilize appropriate systems reports that identify MAGI clients with institutional segments. Use reports to ensure that an ABD application is in process during the 90-day period allowed for MAGI in long term care and ensure that the MAGI individual is transitioned to ABD or appropriately denied ABD. Do not terminate a child's MAGI eligibility or stop the per diem payment unless Central Office clearance is provided per 500.10.03.

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500.04.02A LONG TERM CARE IN A NURSING FACILITY OR ICF/IID UNDER 300% - COE-010

An individual is placed into this COE by MEDS whenever a time period is entered with a “nursing home” living arrangement and the individual’s own income exceeds the current SSI individual income limit (based on FPL). For all such applicants, the length of stay must equal or exceed 30-consecutive days as specified in 500.09.02.

500.04.02B LONG TERM CARE IN A NURSING FACILITY OR ICF/IID-WOULD BE SSI AT-HOME – COE-013

An individual is placed into this COE by MEDS whenever a time period is entered with a “nursing home” living arrangement and the individual’s own income is equal to or less than the current SSI individual income limit (based on FPL). This determination is made using the individual’s own income since deeming of spousal or parental income is not applicable once an individual enters long term care. The systematic placement of an individual into this COE may not accurately reflect his/her literal at-home eligibility potential.

500.04.03 LONG TERM CARE IN A SWING-BED

Swing bed services are extended care services provided in a hospital bed that has been designated as a “swing bed.” Generally, swing beds are utilized when a nursing facility bed is not available, and the required services cannot safely and effectively be provided in the individual’s residence. For eligibility purposes, an individual placed in a swing bed is treated the same as an individual who enters long term care in a nursing facility. All of the provisions addressed in 500.04.02, Long Term Care in a Nursing Facility or ICF/IID, apply to swing bed admissions.

NOTE: Most swing-bed admissions are covered by Medicare. Refer to 500.09.03, Medicare Covered Days in a Nursing Facility, for additional information on Medicare covered admissions for long term care.

Just as for long term care in a nursing facility, there are two separate COE’s for swing bed admissions that are based on the individual’s income.

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500.04.03A LONG TERM CARE IN A SWING BED UNDER 300% - COE-012

An individual is placed into this COE by MEDS whenever a time period is entered with a “swing bed” living arrangement and the individual’s own income exceeds the current SSI individual income limit (based on FPL). For all such applicants, the length of stay must equal or exceed 30-consecutive days as specified in 500.09.02.

500.04.03B LONG TERM CARE IN A SWING BED –WOULD BE SSI AT HOME - COE-015

An individual is placed into this COE by MEDS whenever a time period is entered with a “swing bed” living arrangement and the individual’s own income is equal to or less than the current SSI individual income limit (based on FPL). This determination is made using the individual’s own income since deeming of spousal or parental income is not applicable once an individual enters long term care. The systematic placement of an individual into this COE may not accurately reflect his/her literal at-home eligibility potential.

500.06 PHYSICIAN CERTIFICATION

Federal regulations require that Medicaid recipients who enter long term care be in need of the medical care for which payment will be made. A level of care (LOC) is a determination of medical necessity for care. An individual placed in long term care (not in acute care) must meet either an Intermediate or Skilled level of care designation. Generally, a physician or his/her designee is the one who certifies the level of care designation. Tools used for determining LOC are the completion of the Pre-admission Screening (PAS) or DOM-260ICF/IID form. The resulting score is used in determining if a LOC designation is warranted. Prior to 11/1/22, the PAS or DOM-260 ICF/IID was sent directly to the RO along with the 317. Since 11/1/22, the LOC paperwork is kept in LTSS and is required before the facility can submit the 317 through LTSS to the RO. Any LOC paperwork prior to 11/1/22 should be retained in the case as proof of physician certification.

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For eligibility purposes, the LOC processes utilized by the various types of long-term care programs is not the responsibility of eligibility staff.;A 317 in LTSS that is in “Awaiting Regional Medicaid Office” status has met the LOC requirements. Additional LOC documentation is not needed. Do not accept an admission 317 directly from the facility or one in LTSS that has not reached “Awaiting Regional Medicaid Office” status as proof of the LOC.

Long Term Care Placement	Required Physician Certification
Nursing Facility (SNF/ICF) NOTE: an individual discharged from a hospital into a nursing facility for continued treatment of a condition for less than 30 days does not require a LOC. These are usually admissions covered under Medicare in a SNF. Medicare payment verifies the medical necessity in such a situation.	A 317 in LTSS in “Awaiting Regional Medicaid Office” status is proof that the LOC has been confirmed.
Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)	317 in LTSS in “Awaiting Regional Medicaid Office” status is proof that the LOC has been confirmed.
All HCBS Waiver Programs	Accept the two-way form issued by the Long-Term Care Bureau through LTSS with an effective date as verification of physician certification.
Katie Beckett Program	The LOC decision reviewed by the contractor and confirmed by DOM medical staff is verification of physician certification.
Long Term Hospitalization	No physician certification needed for the case record. Physician certification is presumed.

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Long Term Care Placement	Required Physician Certification
Psychiatric Residential Treatment Facility (PRTF)	Accept the 317* issued by the PRTF as the only documentation for need for placement.
Swing Bed	Accept the 317* issued by the hospital as documentation.

*The DOM-317 Form, entitled "Exchange of Information Between Long Term Care Facility and Regional Medicaid Office," is the agency's communication form between the two entities. It is the single source of verification of an admission, discharge and transfer of a Medicaid applicant or recipient by the facility. It is also used to notify the regional office of the death of an applicant or recipient. The regional office utilizes the form to notify the facility of an applicant's eligibility status and the cost of care payable by a recipient (Medicaid Income).

The DOM-317 and LOC are the responsibility of the facility that is required to complete and issue the forms to the appropriate Regional Medicaid Office. If a case is due for completion and the DOM-317 form is the only missing type of verification that has not been received, the RO should contact the facility to request the missing forms. Document each contact. Do not request this form from the family or representative of the institutionalized individual; however, a documented contact to the person acting on behalf of the institutionalized individual is required to explain that the needed form from the facility has not been received and this is delaying the final eligibility decision. As a result of the contact, the family or representative may be able to assist or expedite the process of issuing the forms.

If the form is not received when the case is otherwise ready for approval and a good faith effort has been made to discuss this matter with the facility and the representative of the institutionalized individual, refer the case to the Benefit Program Manager who must discuss the specifics of the case with Central Office staff for resolution.

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500.07 SPOUSAL IMPOVERISHMENT RULES

Section 303(a) of the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360) created a new Section 1924 of the Social Security Act mandating specific protection of income and resources for the maintenance needs of a community spouse when the other spouse is institutionalized. This special treatment of income and resources for married couples is referred to as Spousal Impoverishment rules designed to ensure that a community spouse maintains a certain level of financial security so that he/she does not become impoverished in order to secure Medicaid eligibility for the spouse in the institution. The following rules apply to institutionalized spouses entering long term care on or after 09/30/1989.

500.07.01 DEFINITIONS

For purposes of spousal impoverishment rules, the following definitions apply:

Institutionalized Spouse (IS) – An IS resides in a nursing facility, hospital (for 30-consecutive days or longer) or participates in a HCBS waiver program.

Community Spouse (CS) – A CS is legally married under state law to the IS and resides in a community setting such as a home, residential care facility or assisted living facility. A CS may also be a participant in a HCBS waiver program, but only for post-eligibility income allocation purposes. If the married couple is considered “separated” but not legally divorced, IS/CS rules apply as discussed in this section.

Family Member – A family member may be a minor or dependent child, a dependent parent and/or a dependent sibling of the parent who resides with the CS. A complete list of “other family members” is defined in 500.07.09 below.

500.07.02 SPOUSAL IMPOVERISHMENT AND RESOURCES

At the initial eligibility determination, the resources belonging to both the IS and the CS, whether owned individually or jointly with each other or with other people, must be considered.

- Verify combined resources of the IS and CS. Not all resources will count, but the value of all resources must be verified as part of separating resources. Use the month of institutionalization to determine spousal shares based on verified

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values as of the month of entry into the nursing home, hospital or HCBS waiver program.

- Apply all resource exclusions to the resources owned by both spouses.
- Subtract the CS' spousal share which is referred to as the "federal resource maximum" under Spousal Impoverishment Maximums in the Appendix Chart of Institutional Limits & Transfer of Assets Divisors. The federal resource maximum is subject to change each January.
- After the spousal share is subtracted from the couple's countable resources, the remainder must not exceed the \$4,000 resource limit that the IS is allowed to retain and qualify for Medicaid.
 - Example 1: The CS applies for Medicaid for the IS who entered a nursing facility in October. Combined countable resources total \$157,300.00 in the month of October. The federal resource maximum in effect at the time is \$154,140.00. The CS may keep up to \$154,140.00, leaving the IS \$3,160.00. The IS resource limit is met.
 - Example 2: The CS applies for Medicaid for the IS who enters a nursing facility in July. Combined countable resources total \$65,000 in July. The CS is entitled to keep the full amount of spousal resources since it is less than the federal maximum in effect at the time. The CS may choose to leave an amount less than \$4,000 in the IS's name.
 - Example 3: The CS applies for Medicaid for the IS who enters a nursing facility in December. The federal maximum is \$154,140.00. The combined countable resources of the IS/CS is verified to be \$163,000.00 in the month of entry into the facility. The CS may keep up to \$154,140.00, but the remaining \$8,860.00 results in excess resources countable to the IS. The IS cannot be eligible until the excess \$4,860.00 (\$8,860.00 less \$4,000 the IS is allowed to keep) is spent.

If the remaining IS spousal share of resources does not exceed the \$4,000 IS limit, the CS spousal share must be separated from the IS's resources within 90-days of informing the CS of the need to transfer resources, as outlined below.

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500.07.03 SEPARATION OF THE SPOUSAL SHARE - RESOURCES

The CS share of total countable resources is the maximum allowed under federal law. 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 the Division of Medicaid has made a decision regarding the CS spousal share. The resource maximum is the limit in effect in the month the IS is institutionalized.

NOTE: The CS resource maximum is enforceable only at the time of application for the IS. Once an IS is determined eligible for Medicaid under spousal impoverishment provisions, the CS resource maximum no longer applies. A CS can acquire resources in excess of the maximum after eligibility for the IS is authorized without the excess resources affecting eligibility for the IS.

Protected Period for Transferring Resources from the IS to the CS

The IS can transfer resources to the CS to bring the CS spousal share up to the federal maximum provided the necessary transfers are accomplished within 90-days after the CS is informed in writing of the need to transfer resources from the IS to the CS. When it is determined a spousal transfer is needed, the CS must be informed promptly to begin the 90-day count. Resource ownership must be changed according to spousal rules. The IS can be approved for Medicaid eligibility prior to the expiration of the 90-day period if the IS is otherwise eligible.

The **exception** to this rule is for approval of an IS for Long Term Hospitalization or short-term nursing home admissions that end prior to issuing the 90-day notice. Transfers to the CS must occur prior to approval in these two instances.

MEDS will track the 90-day period once it is entered and issue an alert to the Medicaid Specialist if resource ownership and the spousal shares have not been rearranged in MEDS by the end of the protected period. If resources have not been transferred prior to approval of the IS, the approval notice will specify the end of the 90-day period. The 90-day period is a literal 90 days. Use a calendar if manually calculating the 90-day period.

If the spousal share is not transferred to the CS and verification provided to the regional office within the assigned 90-day period and no court order exists, the IS becomes ineligible for Medicaid beginning the month following the month in which the 90-day period ends. Adverse action applies.

Verification of the separation of the spousal share must be documented in the case record.

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Example of Spousal Share Separation:

An IS enters a nursing home on April 23rd and is approved on June 15th. He has a CS. The value of their countable resources in April is verified to be as follows:

Countable Resource	Owner(s)	Value
Money Market Account	IS/CS	\$20,000
CD	CS	\$5,000
CD	IS	\$5,000
Checking Account	IS	\$2,000
Checking Account	CS	\$5,000
Life Insurance-FV \$12,000	IS	\$6,000
Checking Account	IS/CS	\$20,000
TOTAL RESOURCES		\$63,000

Resources must be transferred to the CS within 90-days. On May 22nd the CS is notified via DOM-307 that excess spousal resources must be transferred from the IS to the CS by August 19th in order for the IS to remain eligible. IS resources that must be transferred include the Money Market Account, the CD owned by the IS, the life insurance owned by the IS and money in the joint IS/CS checking account. The CS is informed that resources remaining in the name of the IS cannot exceed \$4,000. Action taken by the CS in this example is as follows:

- The CS closes the jointly owned Money Market Account and deposits the money into a new Money Market Account in the CS's name only.
- The CD owned by the IS matures in July and is cashed in and deposited into the CS's checking account.
- The life insurance owned by the IS is irrevocably assigned to a funeral home, creating burial provisions for both the IS and CS.
- The joint account owned by the IS/CS is left alone since both of their income is deposited into the account. The CS removes \$19,000 from the joint account and deposits it into her checking account.

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The rearranged resources (by August 19th) are as follows, allowing the CS to remain eligible:

IS Countable Resources	CS Countable Resources	Verification Required
\$2,000 - Existing Checking Account Balance	\$20,000 - New Money Market Account	Closing balance of joint Money Market Account. Balance of New Money Market Account with CS' name.
\$1,000 - Joint Checking Account (new balance)	\$5,000 - Existing CD	Current Bank statement for joint checking account.
	\$29,000 - Existing Checking Account with new balance	Closing balance of CS' CD. Bank statements showing transfer of \$19,000 from joint checking account to CS' checking account. Current Bank statement for CS checking account.
\$3,000 – total for IS	\$54,000 – total for CS	
\$6,000 CSV of Life Insurance now excluded		

The exception for requiring resources to be transferred to the CS is when the IS in a nursing facility or ICF/IID dies within the 90-day protected period and the death occurs prior to the time resources were transferred out of the name of the IS. Assume resources would have been transferred had the IS lived for the full 90-day period.

500.07.04 SEPARATION OF THE SPOUSAL SHARE – INCOME

Unless evidence to the contrary is presented, the following rules regarding ownership of income apply to income of an IS and CS:

- 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

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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.
- If income is paid from a trust, use the terms of the trust and applicable trust policy to determine any income or spousal share of income paid from a trust. When a trust instrument is not specific as to the couple's ownership interest in the trust income, follow the rules for non-trust income outlined above.

There is no deeming of income from a CS to an IS for the purpose of determining eligibility for the IS in any month of institutionalization, including the month of entry into long term care. If the CS applies for Medicaid under an at-home COE or HCBS COE, do not deem or combine income of the IS and CS in the month of entry or any month thereafter.

NOTE: A CS Income Allocation from income of the IS counts as income to the CS in determining Medicaid eligibility of the CS. Refer to 500.10.04, CS Income Allocation.

500.07.05 SEPARATED SPOUSES

The following applies regardless of the length of the separation for spouses who are separated but not divorced at the time the IS enters long term care either in a nursing facility, hospital, swing bed or enrolls in a HCBS waiver program. These spousal rules apply even if the couple considers themselves separated after the IS enters long term care or a prenuptial agreement exists.

- A good faith effort must be taken to verify CS resource and income information. Contact the CS for the needed verifications unless:
 - The CS receives SSI and resource, and income information can be obtained through electronic data sources (SVES, BENDEX, SDX).
 - The CS receives Medicaid in an at-home COE or HCBS COE and income and resource information is available in the CS case record.
 - If current resource information for the CS is not available, request it from the CS in order to get verification of total resources as of the month of institutionalization for the IS.

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- If the CS is not a Medicaid recipient and his/her whereabouts are known, issue a Request for Information to the CS requesting resource and income information and verification.
 - Verification of the CS' income is not required unless a spousal allocation will be budgeted. Do not allow a spousal allocation of income if unable to verify income of the CS.
 - If the CS has good cause for not cooperating with spousal rules, obtain a written or verbal statement from the CS, IS or the authorized representative for the IS detailing the reasons for not cooperating. The statement will be considered under undue hardship reasons outlined below.
 - If the CS refuses to cooperate with the request for resource information, any known excess resources will continue to count toward the IS unless undue hardship is established.
 - If contact is made with the CS, explain Spousal Impoverishment rules to the CS and determine his/her ability or desire to cooperate. If good cause exists for not cooperating or if the CS expresses refusal, review the situation under undue hardship rules.
- If the whereabouts of the CS are unknown, attempt to locate the CS through such processes as telephone directory listings, property search records or online Internet searches. If unable to locate the CS, count only the resources of the IS.

Undue Hardship for Separated Spouses

If the CS holds resources at the time of application for the IS that exceeds the CS maximum and refuses to make the resources available to the IS or if the CS refuses to verify his/her resources in order to assist in the eligibility process for the IS, then handle as follows:

- If a denial of Medicaid eligibility will result in life sustaining services for the IS being denied through a discharge from the medical institution or a termination of HCBS services, consideration of the spousal share may be waived.
- Undue hardship situations must be reviewed individually. Submit the written or verbal statement of the CS or IS or his/her authorized representative (converted

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to a written statement) through supervisory channels to the Central Office for a review of the circumstances and a decision.

CS Lives Out of State

There is no requirement for a CS to live in Mississippi; however, spousal share rules continue to apply regardless of where the CS lives. Spousal rules are more restrictive for a CS living out of state in that:

- Home property located out of state must be transferred to the CS within the 90-day protected period for transferring resources. The IS cannot be eligible while owning property out of state unless the property can be excluded under some other provision.
- Any income allocated to the CS must be closely monitored to ensure the allocation is actually sent to the CS.

500.07.06 ASSESSMENT OF RESOURCES

When requested by either member of a couple or by a representative acting on behalf of either an IS or CS, an “assessment” of spousal resources must be provided under the following conditions:

- An assessment is a snapshot of the couple’s resources in the month of institutionalization. If one spouse has not yet entered long term care 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. An assessment provides an evaluation of spousal resources only and is not a full eligibility determination.
- In order to provide an assessment, the value of all countable resources owned by the IS and the CS, either jointly or individually, or the proportionate share of any resource owned with other individuals, must be verified.
- The overall time period allowed for an assessment is 45 days. All of the couple’s resources must be verified within the allotted time and a written notice must be provided to the couple advising:
 - The total value of countable resources owned by the couple,
 - The basis for the determination,

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- The CS share based on the maximum standard in effect at the time of the assessment,
- A statement advising whether the IS would be currently resource eligible if an application was filed.
- Use the “Resource Assessment Notice” located in the Appendix page by the same name for issuing the written findings of a completed assessment.

The assessment completed to document resources remains intact unless:

- The agency obtains proof that accurate information was not provided at the time of the assessment,
- The couple alleges that the initial assessment was inaccurate and provides proof to show otherwise,
- The IS leaves the institution for 31 days or longer and then re-enters an institution in which case a new review of resources is required.

If the IS applies within 90 days after an assessment has been completed, use the assessment as the basis for verified spousal resources and allow 90-days to arrange spousal shares.

500.07.07 WHEN SPOUSAL RULES NO LONGER APPLY

Spousal impoverishment rules no longer apply when a change in circumstances occurs, resulting in a couple who are no longer an IS with a CS. Spousal rules under this provision no longer apply the first full month following:

- The death of either the IS or CS,
- The divorce of the IS/CS,
- The IS is discharged from long term care,
- The CS enters long term care
 - the exception is for a CS who qualifies for HCBS while living in a private living arrangement while his/her spouse is in an institution. Spousal rules will continue to apply under these conditions.
 - It is not permissible for both spouses to be eligible in a HCBS coverage group. If this happens, both are evaluated separately under institutional rules as individuals.

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NOTE: if the IS/CS are not legally married at the time of institutionalization, spousal rules are not allowed. Legal marriage for spousal impoverishment purposes includes only couples married under State law or a legal common law marriage (prior to 1956). “Holding out” prior to institutionalization is not a form of legal marriage.

500.07.08 POST-ELIGIBILITY BUDGETING – SPOUSAL INCOME ALLOCATION

The IS has his/her income eligibility determined using only the IS’ income or proportionate share of income. The IS must be income eligible based on total income below the 300% maximum institutional limit or the Income Trust provision. Income producing resources owned in total or in part by the IS may be transferred to the CS in order to maximize income available to the CS if the spousal share allows. Excluded income producing resources do not count against the spousal share so those can be transferred to the CS without any impact on CS resources.

If the IS is eligible based on income and his/her share of spousal resources that have or will be transferred within the 90-day protected period and if all other factors of eligibility have been met, the IS is eligible. The income that may be allocated to the CS from the IS’ monthly income is a post-eligibility decision that is part of the Medicaid Income computation, described in 500.10 later in this section.

NOTE: Only the income the IS actually makes available to the CS is allowed as a deduction from his/her income in determining cost of care, known as Medicaid Income. An IS can refuse to make the income allocation available to the CS and can request that it be denied or discontinued at any time during his/her eligibility as an IS. A written statement by the IS or representative is needed for the case record to deny or discontinue a CS allocation.

The monthly CS income allocation is based on the Monthly Maintenance Needs Allowance or MMNA and the income of the IS. The MMNA is based on a federally issued amount subject to annual adjustment. The MMNA maximum allowance is located in the “Chart of ABD Need Standards and Resource Limits” in the Appendix page by the same name and is subject to an annual updated amount.

The monthly CS allocation amount that is available to the CS is determined as follows:

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Step 1 – Determine the CS MMNA maximum amount.

- Income of the CS must be verified. Once verified, use the gross income of the CS from all sources. Income disregards and unearned and earned income exclusions are not allowed in the MMNA allocation process. CS income that varies or is infrequent should be averaged to obtain the monthly CS income amount. NOTE: VA payments for A&A and/or UME made available to the CS from the IS count as income to the CS.
- Subtract the CS income from the MMNA amount in effect for the time period under consideration.
- The difference is the CS MMNA maximum amount; however, this amount may not be the actual CS allocation amount. The CS allocation may be less if the income of the IS is less than the MMNA maximum calculated. This step determines the maximum MMNA. If the income of the IS would allow a higher amount, the CS MMNA can be no more than the maximum calculated in this step unless a court orders a higher MMNA.

Step 2 – Determine the Maximum CS Allocation Amount Based on Income of the IS

- Using the income of the IS, subtract the Personal Needs Allowance (PNA). This is usually \$44 but could be higher depending on the income of the IS. Refer to the PNA discussion in 500.10, Medicaid Income.
- The remaining income of the IS is the maximum CS allocation available to the CS.
 - If the remaining income of the IS is less than the Step 1 maximum amount, the CS allocation amount is limited to the **Step 2 result** (based on income of the IS).
 - If the remaining income of the IS is more than the Step 1 maximum amount, the CS allocation amount is limited to the **Step 1 result** (the maximum MMNA).
 - Examples are provided below that illustrate the process.

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- A lower amount may be allocated if the CS wants to maintain or establish eligibility for SSI or Medicaid under another “non-institutional” COE. **Exception:** The CS who is eligible or applying for a HCBS COE is considered a CS for the purpose of an income allocation, provided the IS is in a nursing facility and is not applying or eligible in a HCBS COE. The CS eligible or applying for a HCBS COE may also adjust his/her MMNA to keep income at/below the HCBS income limit.
- **The Medicaid Specialist must assist the CS** in the decision as to how much income to accept as a CS Spousal Allocation in order to maintain or establish his/her own Medicaid eligibility in another COE. The Specialist must consider the income of the CS using the budgeting rules of the COE for which he/she is applying or is eligible and determine how much, if any, of the income of the IS would bring the CS to a safe level that would allow eligibility or continued eligibility.

Example #1 – IS has income of \$1,955. IS has a reduced pension of \$90 so his PNA is \$90, reducing his income to \$1,865. His CS has income of \$880 in Social Security benefits and has Medicare, Parts A/B. Application is filed in March 2024.

CS MMNA Maximum Calculation			Maximum CS Allocation – IS Income		
MMNA Max	CS Income	Max MMNA	IS Income	PNA	Max CS Allotment based on IS Income
\$3,853.50	\$880	\$2,973.50	\$1,955	\$90	\$1,865

In this example, the CS could qualify for the lesser amount of \$1,865 based on the IS income. The possibilities for the CS, using 2024 income limits, are as follows:

Effective Month: July 2025

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- The CS could qualify for QMB-only with income of \$880.00 and accept up to \$424.00 as an allocation (QMB limit of \$1,255.00). CS income of \$880 less \$50 disregard reduces the CS countable income to \$830, which is \$424.00 difference between her income and the limit of \$1255.00. To be safe, the CS allocation could be set at \$424.00, and the CS could qualify as QMB with a \$1 cushion.
- The CS could opt to take the entire IS allocation of \$1,865 to raise her income level to \$2,745 (\$880 + \$1,865).
- The CS could opt to take \$675.00 as an allocation and qualify as a SLMB (\$1,506.00 SLMB limit in effect less \$830, countable income of the CS with a \$1 cushion for safety).
- It is up to the CS to choose what she wants to do regarding the allocation, but it is up to the Specialist to educate the CS and assist the CS in explaining the possibilities.

Example #2 – IS qualifies under an Income Trust with total income of \$3,800 with a PNA of \$44. CS income is \$1,200. The CS has Medicare Parts A/B.

CS MMNA Maximum Calculation			Maximum CS Allocation – IS Income		
MMNA Max	CS Income	Max MMNA	IS Income	PNA	Max CS Allotment based on IS Income
\$3,853.50	\$1,200	\$2653.50	\$3,800	\$44	\$3,756

In this example, the CS could qualify for the lesser maximum MMNA of \$2653.50 since the income of the IS is greater than the maximum MMNA. The possibilities for the CS, using 2024 limits, are as follows:

- The CS could qualify for a HCBS waiver program that uses the institutional limit of 300% FBR, which is \$2829 for the period in effect in this example. As a result, the CS could accept up to \$1628 in an

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allocation and still qualify for HCBS based on income of \$1,200 + \$1628 = \$2828 which would put the CS \$1 under the 300% limit.

- The CS could accept the full MMNA of \$2653.5 to bring the CS income up to \$3853.50, but the CS could not qualify for HCBS without an Income Trust (which would require a monthly payment of \$1,025.50 to fund the trust each month.) The CS may prefer the extra income rather than applying for Medicaid.
- The CS could qualify as an SLMB based on income of \$1,200 and accept a very low CS allotment of \$355 (SLMB limit of \$1506 less countable income of \$1,150 and a \$1 cushion for safety).
- It is up to the CS to choose what she wants to do regarding the MMNA, but it is up to the Specialist to educate the CS and assist the CS in explaining the possibilities.

500.07.09 POST-ELIGIBILITY BUDGETING – ALLOWANCE FOR OTHER FAMILY MEMBERS

An allowance for other dependent family members that reside with the CS is permissible if income remains after allocating to the CS. Other family members include:

- Children under age 21 who live with the CS. NOTE: An allowance is also permissible for a dependent child under age 18 who does not live with the CS, as outlined in 500.10, Medicaid Income policy.
- Children age 21 and over who depend on the IS or CS for meeting physical, medical or financial needs,
- A dependent adult family member includes a mother, father, grandmother, grandfather, brother, sister, aunt or uncle ***living with the CS*** who depends on the IS or CS for meeting physical, medical or financial needs. A signed statement completed by the IS, CS or authorized representative indicating the relationship of the dependent adult and the nature of the dependency is acceptable verification to provide the allowance.

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The monthly “Other Family Member Needs Allowance” is based on a federally issued amount subject to annual adjustment. The allowance amount is located in the “Chart of ABD Need Standards and Resource Limits” in the Appendix page by the same name and is normally updated annually.

The allowance is determined as follows:

- Determine the gross income of each dependent family member,
- Subtract the total gross income of each family member from the “Other Family Member Needs Allowance” for the time period under consideration. Each family member’s allowance is calculated separately based on the dependent’s own income.
- The remaining income for each dependent family member is then divided by 1/3 to obtain each family member’s allowance amount.
- The calculation for each family member’s allowance is:

Other Family Members Needs Allowance

Less Family Member’s Own Income

Difference divided by 1/3 = that family member’s allowance

The dependent family member has the same option as the CS to arrange the allowance amount so that the family member can maintain or establish Medicaid eligibility.

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500.08 RESOURCE AND INCOME RULES – SINGLE INDIVIDUALS & BOTH MEMBERS OF MARRIED COUPLE IN LONG TERM CARE

Individuals entering long term care who are single, or not legally married or both members of a married couple are entering long term care are treated as individuals in determining income and resource eligibility effective with the month of entry:

- A child entering long term care seeking eligibility under an institutional COE, including an HCBS COE or the DCLH COE, do not have parental income or resources deemed to the child in any month under consideration for long term care coverage. Resource and income eligibility is based on the child's own income or resources or the child's proportionate share of jointly owned resources or income. Income eligibility is based on the institutional 300% limit and resources are tested against the appropriate resource limit for an individual.
- Each individual age 18 and over entering long term care and seeking Medicaid eligibility in an institutional COE has income eligibility tested against the institutional 300% limit based on the individual's own income and resources tested against the individual limit. The individual's own income and resources or their proportionate share of jointly owned income or resources are used to determine eligibility.
- Married couples who enter long term care at the same time, including couples enrolling in a HCBS waiver program in the same month, 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 and resources or his/her proportionate share of jointly owned income/resources. Each member of a couple is treated as an individual for Medicaid Income purposes for the month of entry also.

If the couple enters long term care in different months, the month of entry and all prior months are handled under spousal impoverishment provisions.

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500.09 INSTITUTIONAL BUDGETING AND OTHER REQUIREMENTS

Individuals who need coverage in an institutional COE have eligibility determined based on their own income and resources or his/her proportionate share of jointly owned income/resources. Total income is used to determine income eligibility using the institutional income limit. In addition, there are other requirements applicable to eligibility in a long-term care setting that are addressed below.

500.09.01 ELIGIBILITY BASED ON TOTAL INCOME

Total income for institutional eligibility is determined differently than for countable income for an at-home ABD individual or for gross income for a MAGI individual. Total income:

- Does not include any averaged income that may have been used for at-home eligibility. Income subject to averaging is counted in its entirety in the month received for eligibility purposes.
- Does not include any VA Aid & Attendance or VA payments for Unreimbursed Medical Expenses (UME) received by a veteran or his/her spouse while in an institution.
- Net rental income is counted as unearned income rather than counting gross rental receipts.

Total income is tested against the “Federal Maximum” institutional income limit that is equal to 300% of the individual SSI FBR. This amount is subject to change on an annual basis at the time the SSI need standards are adjusted. The limit is found in the Appendix page entitled “Chart of Institutional Limits and Transfer of Assets Divisors.”

Total income must be less than the 300% limit in order for eligibility to be established or maintained. If the institutional COE is one that allows the use of an Income Trust, an individual with income that exceeds the 300% limit may qualify under the terms of an Income Trust if all criteria is met regarding the use of an Income Trust. Refer to Section 304.04.04, Income Trusts, for a complete policy discussion.

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An individual must meet the requirements of being eligible based on total income or through the use of an Income Trust before moving to the post-eligibility budgeting process of calculating Medicaid Income and associated income deductions and allowances.

500.09.02 30-CONSECUTIVE DAY REQUIREMENT

Long term care is defined as 30-consecutive days or more in a medical facility. Day one is the date of admission continuing through the end of the 30th day. Thus, 30-consecutive days translates into 31 days or more of continuous admission to or residence in a medical facility. The 30-consecutive day requirement can be met in a hospital or nursing facility or a combination of the two. Time spent in a medical facility that is located out of state or in a non-title XIX medical facility (such as a VA hospital) immediately preceding a stay in a Mississippi hospital or nursing facility will count toward the 30-consecutive day requirement provided there was no break in continuous institutionalization.

Example: An individual enters a hospital on 04/17 and is transferred to a nursing facility on 05/01, with no break in institutionalization. The admission to the nursing facility is presumed to last for more than 31 days. The 30-consecutive day requirement is met for April and May unless the individual discharges from the nursing facility prior to 05/18. The 31st day falls on 05/18 so the individual would have to remain in the NF until 05/18 to meet the 30-consecutive day requirement.

Example: An individual is a patient in an out of state VA medical facility from 01/10 to 01/29 at which time the individual is transferred directly to a MS acute care hospital. The individual remains in the MS hospital until 02/14. The time spent in the out of state VA medical facility counts toward meeting the 30-consecutive day requirement needed to qualify for Long Term Hospitalization. The initial date of institutionalization is 01/10 even though the out of state facility is not a Medicaid provider.

NOTE: The 30-consecutive day requirement is applicable to individuals who need eligibility under the 300% institutional limit. When the 30-consecutive day requirement is met and the individual is otherwise eligible, eligibility can extend back to the first of

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the month of institutionalization, but Medicaid services are subject to payment only in a title XIX facility enrolled as a MS provider of medical services.

500.09.02A EXCEPTIONS TO THE 30-CONSECUTIVE DAY REQUIREMENT

The following are exceptions to meeting the 30-consecutive day requirement:

- The individual dies prior to the 31st day in continuous institutionalization,
- The individual is determined to have income that does not exceed 135% FPL, as described below.

500.09.02B ADMISSIONS OF LESS THAN 30-CONSECUTIVE DAYS

For long term hospitalization admissions that are less than 31-days, the individual must be determined eligible in an at-home full-service COE (ABD or MAGI) or a QMB-Only to get coverage for partial month(s) of admission. Refer back to 500.04.01 for a full discussion of eligibility in the Long-Term Hospitalization (LTH) COE's.

Eligibility for LTH admissions cannot be approved prior to the end of the 30-consecutive day period.

For admissions to a nursing facility or ICF/IID, the stay is presumed to be for 31-days or longer. Eligibility can be approved prior to the end of the 30-consecutive day period under the assumption that the admission will be longer than 31 days. If however, the 30-consecutive day requirement is not met, then the system will determine eligibility using 135% FPL as the eligibility threshold for placement in the "would be eligible if at home" category that does not require a 30-consecutive day stay.

If income exceeds 135% FPL and the 30-consecutive day requirement is not met, the individual is ineligible for the partial month(s) of admission unless eligibility can be determined under an alternate COE. Refer to 500.04.02 for a full discussion of COE placement under these conditions.

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500.09.03 MEDICARE COVERED DAYS IN A NURSING FACILITY

Under certain conditions, Medicare Part A will cover an individual's costs in a skilled nursing facility (SNF). After a qualifying hospital stay, Medicare pays in full for services in a SNF for up to 20 days. Beginning with the 21st day, a co-insurance charge is imposed by Medicare. Medicare will pay up to 100 days in a SNF, which includes the 20-day full coverage period and the 80 day co-insurance charge period.

A Medicare covered individual in a SNF within his/her 100 days of Medicare coverage may apply for Medicaid and, if determined eligible, Medicaid will pay the Medicare co-insurance charges (provided there is no other third-party coverage paying the expense). During the time an individual is within the 100 days of Medicare-covered care in a SNF, no Medicaid Income is payable. During this time period, MEDS will calculate and report Medicaid Income, but no cost of care is collected by the facility during Medicare covered days. As a result, income may accumulate and result in excess resources. If the Specialist is aware that an applicant is initially being covered by Medicare in the nursing facility, an explanation must be made to the applicant, spouse or representative that income must not be allowed to accumulate and result in resources that exceed \$4,000 and that any excess income must be spent appropriately, i.e., for the recipient's benefit or given to the CS (if applicable or appropriate, depending on the Medicaid status of the CS).

500.09.04 TEMPORARY LEAVE DAYS IN A NURSING FACILITY (BED HOLD DAYS)

Medicaid will continue to pay the per diem cost for an eligible recipient who is on allowed/permitted leave from a facility, which includes:

- Inpatient hospital days – a recipient is allowed to be absent from a nursing facility while admitted to a hospital under certain conditions. The facility must hold the recipient's bed during the absence and Medicaid will continue to pay the per diem cost unless or until the recipient exhausts their allowed days. Current policy allows 15 days per each hospital stay with no maximum hospital leave days per year.

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- Home/therapeutic leave days – a recipient is allowed to be absent from a nursing facility in order to return home for holidays and/or other special events or occasions. The facility must hold the recipient's bed during the absence and Medicaid will continue to pay the per diem cost unless or until the recipient exhausts their allowed days. Current policy allows up to 42 days per state fiscal year, not to exceed 15 days per absence, plus the following holidays
 - Christmas, including the day before and after
 - Thanksgiving, including the day before and after
- Other leave may be allowed that is not mentioned in eligibility policy. The Division of Medicaid's Administrative Code specifies the type of leave allowed and the limits placed on the leave, if applicable.

Temporary leave is not an eligibility issue; however, eligibility staff must know that a nursing facility is required to discharge a recipient from the facility and notify the regional office via DOM-317 Form when allowed leave days have been exhausted.

- If a recipient is discharged due to a hospitalization that lasts more than 15 days, the recipient may be moved to a Long-Term Hospitalization COE.
- If a recipient exhausts their home/therapeutic leave days, the recipient must be evaluated for eligibility under at-home coverage before terminating eligibility.

500.09.05 ESTATE RECOVERY PROVISION

The estate recovery provision applies to certain individuals eligible for Medicaid in a:

- Nursing facility,
- ICF/IID,
- Swing bed
- Home & Community Based Services waiver program.

It is not applicable to individuals eligible for Medicaid in a:

- Long Term Hospitalization COE,
- Katie Beckett Program COE.

The estate recovery provision is discussed in its entirety in Chapter 102, Non-Financial Requirements at 102.09.06, Estate Recovery Requirements.

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The agency provides a “Estate Recovery Fact Sheet” on the agency website. The items on the fact sheet are to be discussed with the long-term care applicant, spouse or authorized representative of the applicant at the time of the interview. Provide a copy of the Estate Recovery Fact Sheet after discussing the provision with the person being interviewed.

500.10 RECIPIENTS ELIGIBLE UPON ENTRY TO LONG TERM CARE

The following discusses the handling of adults and children eligible for Medicaid upon entry to a medical institution that includes the following:

- Nursing Facility and ICF/IID
- Swing-Bed
- PRTF (Psychiatric Residential Treatment Facility)
- Hospital

An individual who enters a medical institution can have Medicaid eligibility from one of the following sources.

- SSI,
- Foster child whose eligibility source is the Department of Child Protection Services or DCPS or a former foster child who is guaranteed eligibility to age 26 (COE-007),
- MAGI adult or child,
- ABD at-home eligible.

Although Medicaid eligibility exists for the above-named recipients, payment for room and board in the facility, referred to as the per diem payment, must be authorized by the regional office. The per diem payment is authorized only after the RO places the required liability (Medicaid Income) and long-term care information in MEDS.

The type of action needed for an individual eligible upon entry to a medical institution depends on whether the stay will be short or long term and whether the source of the eligibility will continue. The regional office will usually know of an eligible individual’s

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entry to a medical facility upon receipt of the DOM-317 form submitted by the facility through LTSS. Receipt of the DOM-317 form indicates the need for the regional office to authorize the per diem payment to the facility, with the exception of a hospital. Covered hospital admissions are paid through processing of claims submitted to DOM by the hospital.

The Medicaid Regional Office is responsible for authorizing the per diem payment to a NF, ICF/IID, Swing-Bed and PRTF, regardless of the individual's source of Medicaid eligibility. The per diem payment cannot be paid to the facility until the liability and long-term care information is authorized in MEDS by the regional office. Before the per diem payment can be authorized by a regional office, certain actions are required to determine that the individual who is eligible at home is also eligible for long term care services, including payment of room and board in the facility.

Admissions to a Nursing Facility, ICF/IID and Swing Bed are subject to the following long term care policy provisions, regardless of the source of the recipient's Medicaid eligibility:

- Transfer of assets provision - the 5-year lookback period as well as any months subsequent to the 5-year period must be reviewed for possible transfers that would disqualify the individual from eligibility for the Medicaid per diem payment.
- Spousal impoverishment provision – if an eligible individual is married with a spouse in the community, the spousal rules regarding resource and income ownership applies.
- Substantial Home Equity provision – this provision applies to home property owned by the recipient.
- Medicaid Income – is payable if income allows. The exception is for months in which a recipient is eligible under a MAGI source of eligibility that includes MAGI COE's and Foster Children COE's. This exception is effective December 1, 2016.
- Estate Recovery provision – limited to recipients age 55 or older at the time of death who own real or personal property that can be considered an estate who do not have a legal surviving spouse or surviving dependent child, as defined in estate recovery policy.

Admissions to a PRTF are subject to payment of Medicaid Income, if applicable. MAGI-related eligibility is an exception to payment of Medicaid Income, even if the MAGI-

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related recipient has income. None of the other institutional provisions apply to a child in a PRTF. Admission to a PRTF is considered a temporary placement; therefore, the Regional Office that handles the MAGI or ABD case of the child entering a PRTF will handle the PRTF admission.

Admissions to an acute care hospital are subject to spousal impoverishment provisions if the recipient is married with a spouse in the community. None of the other institutional provisions apply to a hospitalized recipient.

CHIP Eligible Child Enters a Facility

In general, CHIP coverage for a child placed in a PRTF, NF or ICF/IID is contingent on each of the following:

- The facility must be in the CHIP insurer's network of covered providers, and
- Prior authorization of the admission is required.
- If the admission is covered, the coverage is subject to limits, as defined by the CHIP insurer. The CHIP Member Handbook issued by the CHIP insurer defines coverage for the plan in which the child is enrolled.

NOTE: There may be other CHIP requirements for placement. The CHIP insurer must address any/all such prerequisites for coverage in a facility. The parent, guardian or representative for the CHIP child must be referred to the CHIP insurer for any specific questions about a CHIP child's placement in a PRTF or other long term care facility.

If an admission to a facility will not be covered by CHIP or if CHIP limits are exhausted for an admission, an ABD application is required for the CHIP child to determine if Medicaid can cover the admission.

In general, CHIP covers short term admissions to an in-network PRTF and may also cover up to 60-days in a skilled nursing facility. However, CHIP is not designed to pay for long term admissions to any long-term care facility or PRTF. As a result, the following action is required of a Specialist upon receipt of a 317 form from a PRTF, NF or ICF/IID on a child whose current source of eligibility is CHIP:

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1. Contact the CHIP child's parent, guardian or representative to determine if the CHIP insurer is aware of the placement and will cover the admission.
2. Explain that a Medicaid application for coverage of the CHIP child using ABD criteria will be required if the admission will not be covered under CHIP due to one of the requirements listed above not being met, i.e., the facility is not in the CHIP insurer's network or prior authorization was not obtained or limits on the admission will likely be exhausted.
3. Explain ABD application requirements such as an interview (the applicant or representative can come into the office or opt for a telephone interview), a disability determination and other non-financial and financial requirements for ABD.
4. Explain that timely filing of an ABD application combined with the CHIP to Medicaid transition date determines the starting date of Medicaid coverage, if the child is approved. A critical factor to explain is that Medicaid cannot cover any month in which the child is eligible for CHIP. The purpose of making contact with the parent or other appropriate person is to ensure that a child can be transitioned from CHIP to Medicaid as quickly as possible when Medicaid is needed to cover any month of a long-term care admission.

NOTE: the parent can opt for CHIP to close in advance of an ABD application decision if prolonging CHIP eligibility will prevent Medicaid coverage for needed month(s). A request for early termination of CHIP requires a written request for the record. Use the manual form "Request for Early Closure of CHIP – Admission to Long Term Care" to obtain the parent or other appropriate person's written request. The form is needed so that the parent will understand that Medicaid cannot cover any month in which the child is eligible for CHIP in a long-term care facility; however, Medicaid eligibility is not guaranteed since all ABD requirements must be met.

5. Contact with the parent or other appropriate person must be documented in the case record.

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500.10.01 SSI ELIGIBLE ENTERS LONG TERM CARE

An SSI recipient who enters a Nursing Facility, ICF/IID or Swing-Bed may continue to be eligible for SSI, depending on the length of the admission and the income of the SSI recipient.

SSI recipients with income less than \$50 generally remain eligible for SSI while in a Medicaid (title XIX) facility. These SSI recipients are identified in the system by their SSI Living Arrangement on the SDX of "D," which indicates living in an institution, i.e., a nursing facility, ICF/IID or Swing-Bed. The MMIS system then transitions the recipient to COE-005. Upon receipt of a DOM-317 form submitted by the facility through LTSS, handle as follows:

- No separate application for Medicaid is needed to continue the SSI-related Medicaid; however, a review of the SSI recipient's financial factors of eligibility is required prior to authorizing the per diem payment to the facility, as discussed below.
- Create a MEDS record and upload the 317 to MEDS. COE-005 is a worker-entered COE for the purpose of entering needed liability (Medicaid Income) and long-term care dates required to authorize payment to the facility.
- Conduct a financial review of the SSI recipient's income and resources and a transfer of resource review prior to authorizing the per diem payment to the facility.
 - If the applicant is SSI only (draws only SSI income with no social security or other income), use SDX to complete the financial review of income and resources prior to approval for COE 005 SSI in Institution coverage. No information should be requested from the SSI only client unless they voluntarily report a transfer or income or resources that were not indicated on the SDX.
 - FAM is not used to determine eligibility for 005 coverage and should not be requested on SSI only applicants. It is permissible to request FAM for clients who receive both SSI and social security (or other income) once a signed application is received because their 005 coverage will end.

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- Any income or resources that are discovered that would affect SSI eligibility must be reported to SSA. An example of unknown income may be sheltered workshop earnings or trust or conservatorship income/resources that should be available to the SSI recipient. Report excess income or resources to SSA by using form DOM-319, Report or Referral to District or Branch Social Security Office.
 - If income/resources become known to the RO that would make the SSI recipient ineligible for SSI but would allow eligibility for Medicaid-only using Medicaid LTC income/resource limits, allow the per diem payment to be authorized after reporting the income/resource(s) to SSA via DOM-319. A Medicaid application must be initiated by the RO after SSA takes action to terminate SSI, as discussed in the "SSI Terminates in a Facility" below, if appropriate.
 - If the recipient is determined eligible for payment to the facility, enter liability and LTC dates as needed to authorize the per diem payment. The SSI payment is not counted as income in computing Medicaid Income for the SSI recipient, but any other income received that is countable under ABD rules is counted in the post-eligibility process. A Notice of Approval and DOM-317 Form generated by MEDS or manually is required advising the recipient or their representative of the approval of long-term care Medicaid coverage and the facility of the approval and Medicaid Income amount, if applicable. The form must be uploaded to LTSS.
 - If the recipient (adult or child) is determined ineligible for the per diem payment due to a transfer of resources, excess resources or some other factor of ABD eligibility, issue a Notice of Action to the recipient advising of the denial of the per diem payment and issue Form DOM- 317 to the facility through LTSS denying the per diem payment for the SSI recipient.
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- An annual review of SSI-only cases is required using the Administrative Ex Parte Renewal process described in Chapter 101 at 101.15, Redetermination or Renewal Process.

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- If SSI eligibility ends due to death, action must be taken to close the SSI-only record in the system thereby closing out the liability and long-term care data on file. If SSI closes for any other reason, a Medicaid application must be initiated by the RO in order to continue Medicaid eligibility in the facility.

An SSI recipient entering a hospital or PRTF is handled as follows:

- SSI recipients in an acute care hospital setting are not placed in COE-005. Instead, they remain in COE-001 as regular SSI recipients. No action is needed for these SSI recipients unless or until the SSI recipient enters a NF, ICF/IID or Swing-Bed.
- A PRTF facility will issue a DOM-317 form to the RO through LTSS for SSI recipients admitted. The only action needed by the RO is to enter the Medicaid Income of the child, if any, and long-term care dates in a timely manner upon receipt of the DOM-317. The DOM-317 response by the RO with the needed liability and long-term care information must be returned to the PRTF through LTSS within 30 days of receipt of the DOM-317 from the facility.

SSI Terminates in a Facility

If an SSI recipient enters a nursing facility, ICF/IID or Swing-Bed for 31 days or longer and SSI eligibility will terminate due to income that exceeds the SSI institutional limit, an application for ABD Medicaid must be initiated by the regional office upon receipt of the DOM-317 Form submitted by the facility through LTSS:

- Mail the ABD application form to the responsible person identified on the DOM-317 form or to the SSI recipient if no other responsible person is named. If the SSI recipient is acting on his/her own, work with facility staff to ensure the application is completed. NOTE: a completed SSI Review Form submitted by the SSI recipient or representative is also acceptable to use to establish Medicaid-only eligibility.

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- Upon receipt of the signed ABD application form or SSI Review Form, all factors of eligibility and institutional eligibility must be independently verified. Use SVES, SDX, and BENDEX data to verify non-financial factors to the extent possible. Medicaid-only eligibility cannot be approved, if otherwise eligible, until the month after SSI/Medicaid eligibility ends, at which time the ABD application can be registered and approved. Request FAM when the signed ABD application is received. If the former SSI recipient is determined ineligible for Medicaid-only, the ABD application must be appropriately registered in MEDS and denied, issuing notice to the applicant and the DOM-317 form to the facility through LTSS.
- If FAM does not verify bank accounts, request 3 months bank statements. SSI has already done the 5 year asset lookback for SSI clients.
- Any SSI-only month(s) of eligibility must be handled in MEDS as a worker-entered SSI-only (COE-005) time period. The Medicaid-only time period is created for the month after SSI/Medicaid closes. The SSI-only time period requires application of the same eligibility criteria as the Medicaid-only time period.
 - If the SSI recipient is eligible for the per diem payment for SSI month(s) needed, a notice must be issued advising of the approval of the per diem payment and the DOM- 317 sent through LTSS will notify the facility of the approval of the per diem payment.
 - If the SSI recipient is ineligible for the per diem payment for any SSI month(s), a notice and DOM-317 sent through LTSS must be issued accordingly.
 - If a child under age 19 has a future SSI end date posted on MESA and Medicaid-only ABD eligibility needs to be approved prior to the posted end date, the Specialist must work through supervisory channels to have the SSI/Medicaid end date changed so that the ABD Medicaid-only eligibility can begin prior to the posted end date.
- If SSI terminates while the SSI recipient is in a hospital or PRTF, take action as follows:

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- No action is needed for someone in a hospital other than if the RO is contacted about the SSI termination, initiate an ABD application that must be completed or accept an SSI Review Form to start the ABD eligibility determination process.
- Since a PRTF facility sends the RO a DOM-317, the RO will be aware of the current SSI status of the child admitted to the PRTF. If an SSI termination date is on file, the RO must initiate an ABD application by mailing the form to the responsible party identified on the DOM-317. Authorize a per diem payment for any SSI/Medicaid month(s) needed within the required 30-day time period and process the ABD application in the normal manner.

500.10.02 CHILDREN IN CUSTODY OF DCPS OR FORMER FOSTER CHILD ENTERS LONG TERM CARE

A child under age 21 whose source of eligibility is the Department of Child Protection Services (DCPS) or a former foster child eligible in COE-007 who enters a Nursing Facility, ICF/IID or Swing-Bed is eligible for a per diem payment to the facility for short term admissions, defined as 90-days or less. For admissions that exceed 90-days, an ABD application is required, as discussed below.

Foster Child in Custody of DCPS or Former Foster Child Enters Facility for 90-Days or Less

If an admission to a nursing facility, ICF/IID or Swing Bed is anticipated to be for no more than 90-days, a DCPS/Medicaid eligible child will generally remain eligible for DCPS-related Medicaid and a former foster child will remain eligible in COE-007. Contact with the facility may be required in order to determine the anticipated length of stay. While DCPS-related Medicaid or COE-007 Medicaid continues, handle as

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follows upon receipt of the DOM-317 from the facility through LTSS notifying the RO of the admission:

- No separate application for Medicaid is needed.
- Create a MEDS record and upload 317. COE's 003, 026 and 007 are worker-entered COE's for foster children and former foster children needing liability and long-term care data to be entered in order to authorize a per diem payment to the facility. Refer to the MMIS Recipient File to determine the appropriate COE of the foster child.
- Address any relevant income or resource information that becomes known to the RO that could be used if the admission extends beyond 90-days.
- Medicaid Income is not payable for a foster child whose eligibility source is DCPS or former foster child whose eligibility source is COE-007. Since foster care income eligibility is based on MAGI rules, a short-term admission is based on MAGI-related income eligibility rather than ABD income eligibility and Medicaid Income is not payable. If ABD eligibility is needed because the admission is extended beyond 90-days, Medicaid Income would be payable, if applicable, under ABD rules.
- Notice must be issued to the DCPS address on file regarding the foster child's approval of the per diem payment to the facility or to the former foster care adult or his/her representative.

When a child in COE-003 or 026 or an adult in COE-007 is discharged from the facility or becomes ineligible for foster care/former foster care Medicaid, take action to close the liability and long-term care data on file in MEDS. If the child or adult remains in the facility upon closure of foster care related Medicaid, review the case for Medicaid-only long-term care eligibility, as outlined below.

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Foster Child in Custody of DCPS or Former Foster Child Enters Facility for Extended Stay

If a foster child in COE-003 or 026 or a former foster child eligible in COE-007 enters a nursing facility, ICF/IID or Swing-Bed and the admission will be for an extended stay of greater than 90-days, an ABD application is required.

- Contact the social worker or county office identified in MESA to request that the appropriate DCPS staff person file an ABD application on behalf of the foster child. For a former foster child eligible in COE-007, issue the ABD application form to the responsible party indicated on the DOM-317 form or send an ABD application form to the recipient if no responsible party is named. If the former foster child is acting on his/her own, work with facility staff to ensure the application is completed.
- It is permissible to begin the ABD application process at the time the DOM-317 is received by the RO if the facility indicates to the Specialist that the admission will be an extended stay. Begin the process as described above, i.e., contact the county social worker or issue the ABD application to the former foster child or the responsible party. Allow the DCPS-related Medicaid or COE-007 Medicaid eligibility to remain open while the ABD application is being requested and processed.
- If ABD long term care eligibility is approved, the foster child or former foster child can be transitioned to an ABD COE. The ABD begin date must be coordinated with the ending date of DCPS-related Medicaid or COE-007 Medicaid eligibility. Refer the request to end COE-003, 026 or 007 eligibility through supervisory channels and begin ABD eligibility in the month following the end date of foster care eligibility.
- If a foster care child or former foster care adult is determined to be ineligible for ABD Medicaid, refer the case to the Benefit Program Manager for review. Central Office staff must review the circumstances of the case to determine the appropriate handling of an ABD denial of a foster care related adult or child in long term care. Do not take action to terminate the per diem payment; instead, hold the case for further instructions.

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Foster Child Enters a PRTF or Foster Child or Former Foster Child Enters an Acute Care Hospital

Hospital or PRTF admissions do not have a limitation imposed on the length of stay. No action is needed for an acute care hospital admission for a foster/former foster care child/adult.

For a PRTF admission, the RO must respond to the DOM-317 through LTSS from the PRTF within 30 days from the date of receipt of the form to report that no Medicaid Income is payable while the child remains eligible for DCPS-related Medicaid.

500.10.03 MAGI ELIGIBLE CHILD OR ADULT ENTERS LONG TERM CARE

A MAGI eligible child or adult may enter a nursing facility, ICF/IID or Swing-Bed for a temporary or indefinite period of time. The source of eligibility may remain as MAGI if the absence from the MAGI household is temporary, as discussed below. For temporary admissions, whereby MAGI-related eligibility is allowed to continue in any of the situations described below, handle as follows:

- The DOM-317 form submitted to the RO through LTSS becomes part of the MAGI case record.
- Medicaid Income is not payable for a MAGI child or adult while eligible under MAGI rules.
- Prior to authorizing a per diem payment on a MAGI-related eligible in a nursing facility, ICF/IID or Swing Bed, review for any possible transfers of assets within the 5-year lookback period and any subsequent months.

MAGI Pregnant Woman Enters NF, ICF/IID or Swing Bed

MAGI eligibility is allowed to continue through the end of the pregnant woman's post-partum period. If the woman remains in the facility beyond the end date of her post-partum period, an ABD application must be initiated by the RO by mailing the ABD application form to the recipient or her representative. It is permissible to begin the ABD application process at the time the DOM-317 is received from the facility through LTSS if it is likely that the admission will continue beyond the ending date of MAGI

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eligibility. Contact with the facility may be necessary to determine the anticipated length of stay.

- If ABD eligibility is approved, transition the pregnant woman to the appropriate ABD long term care COE prior to the MAGI end date.
- If ineligible for ABD Medicaid, do not terminate MAGI-related eligibility prior to the end of the woman's post-partum period. When the post-partum period ends, the ABD application must be appropriately registered and denied in MEDS and notice issued to the applicant and a DOM-317 issued to the facility through LTSS.

MAGI Eligible Child Enters NF, ICF/IID or Swing Bed

A child eligible in any MAGI-related COE is allowed to maintain MAGI eligibility for up to 90-days after entering a NF, ICF/IID or Swing Bed. If the admission to the facility will be a short-term stay, enter the needed long term care dates and liability (\$0 while MAGI eligible) in MEDS. If the stay in the facility will exceed 90-days, take action to determine ABD institutional eligibility for the child, leaving the MAGI case open while ABD is pending. It is permissible to begin the ABD application process at the time the DOM-317 Form is received from the facility.

- If ABD is approved, the MAGI child can be transitioned to an ABD COE prior to the end of the 12-month protected period.
- If ineligible for ABD, refer the case to the Benefit Program Manager for review. Central Office staff must review the circumstances of the case to determine the appropriate handling of an ABD denial of a MAGI child in long term care. Do not take action to terminate the per diem payment; instead, hold the case for further instructions.

MAGI Eligible Child/Adult Enters an Acute Care Hospital or MAGI Child Enters PRTF

Hospital admissions for an adult or child or PRTF admission for a child do not have a limitation imposed on the length of the stay in either type of facility. No action is needed for an acute care hospital admission. For a PRTF admission, the RO must respond through LTSS to the DOM-317 from PRTF within 30 days from the date of receipt of the form to report that no Medicaid Income is payable while the child remains eligible for MAGI-related Medicaid.

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500.10.04 ABD ELIGIBLE CHILD OR ADULT ENTERS LONG TERM CARE

An ABD recipient (adult or child) eligible in any ABD at-home COE may enter a nursing facility, ICF/IID or Swing Bed but it is not possible for a Medicaid per diem payment to the facility to be authorized by MEDS while the recipient is in an ABD at-home COE. MEDS requires that the recipient be changed to a long-term care COE, even for partial month or other short-term admissions to a NF, ICF/IID or Swing Bed. See below for PRTF admissions for a child.

PRTF Admissions for an ABD At-Home Eligible Child

The exception to the rule that prohibits a recipient from remaining in an ABD at-home COE while in a facility is for an ABD child in a PRTF. A child eligible in either of the COE's identified below can have a per diem payment authorized to a PRTF while remaining in either:

- COE-019 – Katie Beckett Program
- COE-045 – Healthier MS Waiver

Note the following clarifications:

- Medicaid Income for a child in either COE-019 or 045 is payable to the PRTF if the child has income that exceeds allowable Medicaid Income deductions.
- If a child in COE-019 or COE-045 enters a NF, ICF/IID or Swing Bed, transition to an appropriate long term care COE is required, as explained below.
- If a child is eligible in any other ABD at-home COE (other than COE-019 or 045) and enters a PRTF, place the child in the appropriate institutional COE as outlined below. This would be a rare occurrence since ABD-eligible children are primarily placed in COE-019 or 045.

NF, ICF/IID and Swing Bed Admissions for an ABD At-Home Eligible Adult or Child

For all ABD recipients eligible in an at-home COE, entering long term care in a NF, ICF/IID or swing bed requires development and a decision on the individual's LTC eligibility. Within 10-days from receipt of the 317 from the facility, action must be initiated to develop long term care eligibility as outlined below.

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The Medicaid Specialist must review the case to determine if a redetermination or special review is needed and enter the correct contact type in MEDS. Change the living arrangement to LTC (nursing home, ICF/IID or Swing bed). If the recipient does not have a spouse or representative, do not send correspondence to the recipient in the nursing facility without knowing whether the individual will be able to act in his/her own behalf.

1. If a special review is applicable, use of the partial ABD application will collect the information needed. Issue pages 6-14 of the DOM-300 with DOM-307 directing the recipient or spouse/representative to respond to the LTC questions and resource questions, if needed. Specific questions that need a response include:
 - Community spouse allowance (if appropriate), receipt of sheltered workshop earnings, transfer of income question, all questions about resources (if resources have not been declared or if declared resources exceed the limit) and the transfer of resource within the last 5 years question.
 - Request that the individual or spouse or representative sign on page 14.
 - Schedule a phone interview. Review and confirm reported information during the interview, resolve discrepancies and discuss all LTC provisions applicable, such as spousal impoverishment, transfer of assets, home equity, Medicaid Income and allowable deductions, the Income Trust provision, if applicable, Estate Recovery and any other pertinent topics.
 - Issue a 309, as needed. If the 309 does not result in the needed information being submitted, refer to #3 below.
2. If a full review is due, issue DOM-300 with DOM-307, highlighting the pertinent questions needed for LTC eligibility. Schedule a phone interview to discuss all LTC provisions, review and confirm reported information and resolve any discrepancies. Issue DOM-309 as needed but if it does not result in the needed information being submitted, refer to #3 below.
3. For both special and full reviews of an ABD at-home eligible entering LTC, the following is also required:
 - If there is no response to the DOM-309 or only a partial response, determine if there are extenuating circumstances involved, such as no community spouse and no representative or there is a representative that is non-responsive. Refer to 101.03.07, Reasonable Efforts to Assist, for specific action to take.

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- If the situation cannot be remedied locally, route the case through normal supervisory channels to attempt a solution. The individual can remain eligible in the at-home COE while a decision is pending next steps for the Specialist or supervisor to take.
- 4. A decision on the outcome of the LTC eligibility is required. The decision to approve, deny or terminate eligibility or impose a penalty due to a transfer of assets or home equity disqualification must be issued in a notice to the individual and a 317 response to the facility through LTSS. If the individual is ineligible due to excess resources but eligible in a Medicare cost-sharing COE, the LTC eligibility must be denied and the reduced coverage either approved or reapproved. An individual in a LTC living arrangement cannot have eligibility in any other at-home COE other than a Medicare cost-sharing COE.
 - If the ABD at-home recipient is eligible using LTC rules and has income equal to or less than 135% FPL, the 30-consecutive day requirement does not have to be met.
 - If the ABD at-home recipient is eligible using LTC rules and has income greater than 135% FPL, the 30-consecutive day requirement must be met. Failure to meet the 30-consecutive day requirement, as described in 500.09.02, will result in a MEDS denial of LTC.

Hospital Admissions for an ABD At-Home Eligible Adult or Child

ABD at-home recipients eligible in any full-service COE or eligible as QMB-only admitted to an acute care hospital receive covered inpatient Medicaid services without changing their COE. If the recipient is eligible in any other COE (such as SLMB or QI), then the recipient would need to meet the 30-consecutive day requirement and qualify under long term hospitalization rules in order to qualify for Medicaid while hospitalized.

500.11 MEDICAID INCOME (POST-ELIGIBILITY BUDGETING)

After an individual has been determined eligible for Medicaid in a long-term care facility, the amount the individual must pay toward the cost of their care must be determined. This is referred to as Medicaid Income or patient liability. Medicaid Income is the amount the recipient must pay to the nursing facility after allowable deductions have been subtracted from the recipient's total income, as outlined in this section. This is a post-eligibility process calculated to determine the recipient's cost of care.

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When an individual is eligible for Medicaid in a nursing facility, including an ICF/IID, the individual receives full Medicaid covered services plus a per diem payment (vendor payment) to the facility for room and board. The room and board payment includes all of the covered services listed below. Refer to Title 23 of the Miss. Administrative Code Part 207, Chapter 2, Rule 2.6, Per Diem, for a more detailed discussion of per diem policy.

Items Included in the Medicaid Per Diem

- Room/bed maintenance services,
- Nursing and respiratory therapy services,
- Meals and dietary services, including nutritional supplements,
- Activity services and medically related social services,
- Laundry services, including the recipient's personal laundry,
- Over the counter drugs and legend drugs not covered by any other source,
- Medical supplies such as diabetic supplies, diapers and pads, oxygen supplies and supplies required to deliver nutrition directly into the stomach by a tube bypassing the mouth.
- Certain durable medical equipment appropriate for use in a nursing home, such
- Non-emergency transportation as a wheelchair.
- Personal hygiene items such as bath soap, shampoo, comb and brush, razor and shaving cream, toothbrush and toothpaste, towels/washcloths, hair and nail hygiene services, bathing, routine grooming care.
- Private room coverage as medically necessary. The Medicaid per diem rate includes reimbursement for a resident's placement in a private room if medically necessary and ordered by a physician. The Medicaid reimbursement is considered payment in full for the private room and the resident cannot be charged for the difference between a private and semi-private room if medically necessary.

Items Not Included in the Medicaid Per Diem

The following are not included in the Medicaid per diem, but the items or services may be provided by a separate Medicaid provider or otherwise paid by a third-party insurer, such as Medicare. NOTE: Medicaid will cover most of the following with the appropriate prior authorization.

- Laboratory and X-ray services,
- Drugs covered by Medicaid, Medicare, VA or any other payor source,

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- Physical therapy, occupational therapy and speech-language pathology services,
- Ostomy supplies, CPAP or BiPAP devices,
- Individualized, resident specific custom wheelchairs,
- Emergency transportation

500.11.01 INCOME USED IN THE MEDICAID INCOME (MI) COMPUTATION

The individual's total income is used to determine MI. Do not count SSI payments as income in the MI computation. Since MI is a post-eligibility process, income averaging is allowed as described below. Whether or not income can be counted in the MI computation depends on whether the income is being considered during the application process or reported as a change. Increases in MI are based on advance notice issued at least 10-days before the date Medicaid makes its payment to the facility, as described in Chapter 101, Coverage Groups and Processing Applications and Reviews, at 101.19, Other Changes – ABD Programs.

500.11.01A COUNTING LUMP SUM PAYMENTS IN THE MI COMPUTATION

In determining whether lump sum payments should be counted or excluded in the MI computation depends on whether the payment has previously been counted as income for MI purposes:

1. Non-recurring lump sum payments – If a lump sum payment has not been previously counted as income, it is counted as income in the month received.

Example – A former SSI recipient in a nursing home receives a retroactive title II payment that has been reduced due to an SSI offset as described in Chapter 200, Income, at 200.07.02A. The lump-sum Social Security payment has never been previously counted as income for MI purposes so it is counted in its entirety in the month received for MI purposes although for eligibility purposes it may be counted as income in the month regularly due, as specified in the award letter.

Example – A recipient in a nursing facility receives a VA pension but it is suspended for failure to verify medical expenses. The recipient remains entitled to his full VA payment; therefore, his full basic pension amount continues to count as income in the MI computation. When the recipient complies with the VA in verifying medical expenses, a lump sum payment is issued from VA for all payments previously suspended. The lump sum VA payment is not income for

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MI purposes because the payment represents income that has previously been counted as income in the MI computation.

2. Recurring lump sum payments – If a payment is recurring, such as annual land rent payments, the recurring payment is subject to averaging as infrequent income, which is outlined below.

500.11.01B AVERAGING INCOME IN THE MI COMPUTATION

Recurring income that varies in amount and/or frequency is averaged in the MI computation **provided** the payment allows eligibility based on income in the month the payment is received without averaging. If the individual is eligible when counting the payment for eligibility purposes, averaging the income for MI purposes applies. Income averaging is allowed in the Medicaid Income computation for infrequent and/or irregular income received by:

- the eligible individual,
- the CS in determining the income allocation for the CS.

The process for averaging income of the eligible individual is described below. If any step is completed manually, it must be documented in the case record. Averaging infrequent income received by the CS is a manual process and must be documented in the case record.

Infrequent Income – Testing for Income Eligibility and Averaging

This process must be handled in 2 steps; with either both steps entered in MEDS or a combination manual and automated process:

1. Eligibility test – since a recurring lump sum payment (infrequently received) must allow eligibility before averaging, the Specialist must:
 - Enter a time period in MEDS using the month of receipt as the begin date and enter the full amount of the payment as a one-time payment allowing MEDS to determine if the recipient remains eligible.

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- If ineligible, MEDS will terminate eligibility after allowing for advance notice.
- Set a tickler or enter appropriate time period(s) to count the recurring lump sum payment as income in the appropriate month(s).

OR

- Prepare a manual budget testing the payment with other income against the institutional limit of 300% to ensure the recipient remains eligible.
 - If ineligible, the full payment amount must be entered in MEDS as a one-time payment so that MEDS can count the payment as income in the month received and terminate eligibility after allowing advance notice.
 - Use the month of receipt as the begin date of the time period entered.
 - Whether Step 1 is done entirely in MEDS or a combination manual and MEDS process, it is necessary for the Specialist to verify resources and the spend down of the lump sum payment prior to reinstating eligibility. Take action to anticipate receipt of the recurring lump sum payment in the next month of receipt and repeat Step 1 and Step 2, if appropriate.
2. Medicaid Income Computation – if the individual is eligible in Step 1 when counting the full payment as income in the month received, then the payment is subject to averaging as follows:
- If a time period was entered in MEDS in Step 1 above so that MEDS determined the recipient to be eligible, take the following action:
 - retract the pending eligibility decision,
 - enter the full payment and the correct frequency and MEDS will average the payment in the MI computation accordingly.

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- If a manual budget was prepared in Step 1, enter the full payment amount and the correct frequency in MEDS and the averaged amount will be calculated accordingly for MI purposes.

500.11.01C AVERAGING INFREQUENT INCOME REQUIREMENTS

Infrequent income is averaged over the period of time the payment is intended to cover. Payments received annually are averaged over 12 months and payments received quarterly are averaged over 3 months, etc. MEDS will calculate the correct average based on the frequency entered for the payment. Keep in mind that non-recurring income is not subject to averaging, but MEDS must be manipulated to treat a recurring lump sum as a one-time payment in order to have eligibility determined in the month of receipt. If eligible, entry of the correct frequency in MEDS will result in a correct average.

- Lump sum payments (one-time or recurring) received prior to a month under consideration for eligibility is not subject to averaging.

For example: An applicant enters a nursing facility in June and requests eligibility effective with June. The applicant received an annual land rent payment in May. The May payment is not counted or averaged since May is not a month of requested eligibility. The payment received the following May must be anticipated and counted as income in May and averaged if the individual is eligible when counting the full payment.

- The Specialist must explain to the applicant or representative that recurring lump sum payments are counted when received and if eligible when counting the lump sum, the payment will then be averaged. The averaged payment amount must be available for payment as Medicaid Income if applicable.

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500.11.01D AVERAGING INCOME THAT VARIES

Irregular income or income that varies in amount each month is also averaged if the individual is eligible when counting the payment(s) in the month received. The purpose of averaging irregular income is to enter one averaged amount as income over the

review period, unless a known change is anticipated, as described below. In each instance of averaging, the Specialist must explain to the applicant or representative that the income will be averaged, and the averaged amount must be available for payment as Medicaid Income, if applicable.

Income That Varies Each Month

Income such as interest, dividends, royalty payments, etc. may vary monthly. To obtain an average, verify the 3 most recent month's payments available (if representative of normal payments, otherwise, verify additional payments to obtain a realistic average).

The payment is then averaged according to the number of payments verified and entered as an averaged amount over the 12-month review period, allowing for any known changes.

Example: A nursing home applicant enters the facility on June 20th and requests eligibility beginning June 1. The applicant verifies the last 3 royalty payments received: March payment = \$150; April payment = \$200; May payment = \$125. The applicant has documented proof that his monthly royalty payments are never less than \$125 and never higher than \$200 in any month over the last year. The payments are totaled (\$475) and divided by 3 (total payments verified). An average payment amount of \$158.33 is entered in MEDS as the royalty payment, beginning with the month of entry (June). Medicaid Income, if not protected for the month of entry, is prorated by the facility.

Example: Same example as above but at first annual review, the individual verifies that his royalty payments will end in December. A new 3-month average is verified and used as royalty income from June through November of the current year. The payment is removed from the budget effective with the month of December.

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Income That Varies Each Day

If a payment that is counted as income is paid based on a daily rate, such as long-term care insurance payments paid directly to the individual rather than the facility, the payments are subject to averaging based on the daily rate and the days in each month of the review period and/or payment period. The daily rate must be verified.

Example: A nursing home applicant enters the facility on January 4th and requests eligibility for January. The applicant will receive a daily rate of \$150 each day in the facility through the month of September, at which time the payment will be terminated. An Income Trust is allowable since the insurance payment is excess monthly income that will be reduced at a future date.

- Income for January (28 days) and February: $\$150 \times 28 = \$4,200 \times 2 = \$8,400$.
- Income for March, May, July and August: $\$150 \times 31 = \$4,650 \times 4 = \$18,600$.
- Income for April, June and September: $\$150 \times 30 = \$4,500 \times 3 = \$13,500$.
- Total payment for the 9-month period = $\$40,500/9 = \$4,500$
- The average monthly amount of \$4,500 is entered as income beginning in January through September. The payment is removed as income for October.

Net Rental Income

Although rental income may be a stable amount, known allowable expenses may result in income that varies in one or more months of the review period, which results in income subject to averaging. When expenses are claimed from rental income and can be reasonably anticipated as an incurred expense each year, such as taxes and insurance on the rental property, then these expenses can be annualized, and an average amount used as rental income.

Example: A nursing home recipient begins to rent out her home property for \$800 per month, beginning in July. An annual tax payment is due each January and an annual insurance payment is due in March. Taxes and insurance for the prior year are verified as \$2,100 total. Divide the allowable tax and insurance payment by 12.

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Deduct the average amount of \$175 in allowable, known expenses from the \$800 rental income, counting \$625 as monthly rental income.

Expenses that are unknown or cannot be anticipated, such as allowable upkeep or repairs to the property, are allowed deductions from rental income when verified as paid.

500.11.02 PROTECTION OF INCOME IN MONTH OF ENTRY

Individuals entering a long-term care setting where Medicaid Income is payable, i.e., nursing facility, ICF/IID, swing-bed, PRTF (if appropriate), are entitled to protection of income in the month of entry into long term care. Income protection:

- Reduces Medicaid Income to \$0 if the individual was in a community setting at any point during the month of admission into long term care,
- Is meant to allow for essential expenses incurred by the applicant in the month of entry,
- Does not apply when the individual transfers into long term care from another medical facility when there was no point during the month of entry when the individual was at-home or in another community setting.
- A community setting includes the individual's home, the home of another person, an assisted living facility or a community residential care facility.
- MEDS uses the date of institutionalization to determine if protection of income is applicable for the month of entry.
- Income Trust cases have income protected only up to an amount that is \$1 less than the institutional limit if income protection applies for the month of entry. Refer to the policy for Income Trusts in Chapter 304, Trusts, at 304.04.04, Income Trusts.

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Example #1 – Applicant enters a hospital on April 3rd and is transferred directly to a nursing facility on April 6th. The partial month of April qualifies for income protection so the applicant will not have MI payable to the NF in April if otherwise eligible.

Example #2 – Applicant enters a hospital on April 28th and transfers to a nursing facility on May 1st. Medicaid Income is payable for May. April is the first month of institutionalization and MI is not payable in a hospital.

Example #3 – Applicant enters a hospital on April 5th and is discharged home April 30th. On May 1st, individual enters a nursing facility directly from home. The first day of institutionalization is May 1st so income is protected for May.

NOTE: For the month of discharge from a NF or the month of death in a NF there is no protection of income. Medicaid Income is prorated over the number of days the recipient was in the NF prior to discharge or death. MI is payable on a prorated basis, computed by the NF, in the month of death or discharge from the facility.

500.11.03 PERSONAL NEEDS ALLOWANCE (PNA) DEDUCTION

The first deduction from an eligible individual's total income for Medicaid Income purposes is the deduction of the applicable personal needs allowance or PNA. There are 3 types of allowable PNA:

- \$44 PNA – the basic PNA that each person is entitled to receive for a MI deduction unless the person qualifies for a higher PNA.
- Work Deduction equal to ½ the SSI FBR less \$44 applied to earnings – limited to individuals enrolled in work therapy programs or those otherwise engaged in paid activity while in a facility. For recipients that work, a work deduction is allowed from earnings and a \$44 PNA is allowed from remaining earned and unearned income.
- \$90 PNA – limited to veterans or their dependents whose reduced pension payment is \$90.

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Basic PNA of \$44

Each recipient of long-term care Medicaid with MI payable is entitled to at least \$44 in monthly income that the recipient gets to keep each month for clothing or other personal needs of the individual not covered by Medicaid while residing in the nursing facility. Recipients whose income is less than \$44, such as SSI recipients who receive a \$30 SSI payment in the facility, get to keep the full amount of their income up to \$44 to meet their personal needs.

Work Deduction

Each recipient engaged in paid work activity or work therapy programs, such as enrollment in a sheltered workshop, are entitled to a higher PNA allowed due to increased personal needs related to their work.

Recipients with earnings receive a work deduction from earnings that is 1/2 the SSI FBR in effect at the time less \$44. Any excess earnings are counted as income for MI purposes. The \$44 is then allowed as a deduction from remaining earned and unearned income. See example below:

Example: Individual in a sheltered workshop is paid no more than \$40.00 in a month and receives \$900 in Social Security. All of the individual's wages are disregarded because earnings are less than ½ the SSI Federal Benefit Rate (FBR) and do not count in the MI computation. When the \$40.00 is entered in MEDS as wages, the full \$40.00 is disregarded as a work deduction. The \$44 PNA is deducted from unearned income of \$900, resulting in Medicaid Income of \$856.

Example: Individual in a nursing facility sews quilts that are sold at a local flea market. The quilts are sold for \$100 each. In the last 3 months since the quilt making activity began, the individual has sold an average of 5 per month. Wages entered in MEDS is \$500 per month. Other income of the individual is \$1,522 in Social Security. The PNA is determined as follows:

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Gross Earned Income	\$500
½ Federal Benefit Rate (FBR)	\$471.50 - ½ of \$943 FBR in 2024
Less \$44	\$44.00 - subtracted from ½ FBR (but allowed as a PNA deduction below)
Total Work Deduction	\$427.50- subtracted from wages
Countable Earned Income	\$28.50 (\$500 less \$323.50)
Unearned Income	\$1,522.00
PNA	less \$44
Total Medicaid Income (assuming no other deductions from MI)	\$1506.50

For 2024, the maximum Work Deduction PNA is \$427.50, which is \$471.50 less \$44. Individuals with earning greater than \$44 get the full \$427.50 work deduction; thus, earnings up to this amount are kept by the working recipient. Each calendar year, based on the SSI FBR, the maximum work deduction is ½ the current SSI FBR for an individual less \$44. The individual also gets the \$44 PNA deducted from any remaining earned and total unearned income.

VA Reduced Pension of \$90

For single veterans and surviving spouses of veterans in nursing facilities who are subject to the \$90 reduced VA pension, the PNA is equal to the reduced pension payment. When a VA pension is reduced, the \$90 PNA is effective with the month the \$90 VA pension is payable. Do not adjust the PNA retroactively in the event a retroactive lump sum VA reduced pension is payable. The retroactive VA payment is not counted as income if a VA pension payment was previously counted as income in the retroactive period.

Effective Month: July 2025

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500.11.04 COMMUNITY SPOUSE (CS) INCOME ALLOCATION

The policy provision for allowing a spousal income allocation is addressed in detail in 500.07.08. If there is a Community Spouse (CS) and the IS wishes to make an income allocation available to the CS, the CS income allocation is the 2nd deduction allowed in determining Medicaid Income. To recap, the CS allocation is:

- Based on total income belonging to the CS. There are no earned or unearned income disregards deducted from the CS income. Income that is received irregularly or infrequently is averaged to obtain a monthly amount that is counted along with all other monthly income of the CS. Income that is not countable to the IS, such as VA Aid & Attendance, that is made available to the CS is countable income to the CS in determining overall total income of the CS.
- The CS income allocation is the **lesser** of:
 - The CS MMNA maximum calculation (MMNA less CS income), or
 - The maximum allocation based on the IS income after deducting his/her PNA (IS income less the applicable PNA).
- The CS can opt to reduce his/her CS income allocation amount in order to establish or maintain his/her own Medicaid eligibility. A CS can have Medicaid eligibility as SSI, MAGI, ABD at-home and HCBS. If the CS opts for a reduced income allocation amount, obtain a written statement from the CS or his/her representative requesting the reduction in order to qualify for Medicaid. NOTE: Both spouses cannot be in a HCBS waiver. One spouse can be in a HCBS waiver, but no CS income allocation is allowed since there is no Medicaid Income for an IS eligible in a HCBS waiver.
- The Notice of Action that is issued to the IS and/or CS must state the amount of the CS income allocation.

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- The CS may not qualify for an income allocation due to his/her own income that exceeds the maximums allowed or may refuse an income allocation. In either case, no income allocation would be allowed.

500.11.05 OTHER FAMILY MEMBERS ALLOWANCE

The “other family members” allowance is the 3rd deduction allowed in determining Medicaid Income if there is a CS that is allowed an income allocation. If the CS does not get an income allocation or if there is no CS but there are dependent children living in the community, the deduction is the 2nd deduction after allowing for the PNA of the institutionalized individual.

Other Family Member Living with the CS

The policy provision for deducting an allowance for other family members living with the CS is addressed in detail in 500.07.09. The IS must have income remaining after allocating to the CS (if applicable) before an “other family member” allowance can be calculated.

To recap this policy:

- An adult child or other specified adult family member must be dependent on the IS or CS for meeting physical, medical or financial needs of the family member as evidenced by a signed statement completed by the IS, CS or authorized representative. A minor child gets an allowance without a statement.
- The “other family member allowance is determined separately for each dependent family member. The calculation is:

Other Family Members Needs Allowance

Less Family Member's Own Income

Difference divided by 1/3 = that family member's allowance

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- Each dependent family member that qualifies for an allowance can opt for a reduced amount (or no allowance) in order to establish or maintain his/her own Medicaid eligibility.

Other Family Member – No CS

If there is no CS (due to death, divorce or abandonment) but the institutionalized individual has a dependent child or children under age 18 living in the community, the child(ren) can qualify for an allowance. Each child's allowance is determined using the same calculation cited above for dependents living with a CS. When a child reaches age 18, the allowance must be discontinued.

500.11.06 NON-COVERED MEDICAL EXPENSE (NCME) DEDUCTIONS

Allowable Non-Covered Medical Expenses (NCME's) are amounts deducted in the Medicaid Income calculation for medical or remedial care recognized under state law and verifiable as medically necessary. NCME deductions include:

1. Health Insurance premiums, deductibles and co-insurance charges that are the responsibility of the applicant or recipient, and
2. Medically necessary care, services and items incurred by the applicant or recipient, within specified limits.

Effective January 1, 2019, NCME policy is revised as addressed below. Any request for a NCME deduction submitted 01/01/2019 or after must be reviewed under NCME policy effective on and after 01/01/2019.

NCME's are Medicaid Income deductions limited to individuals in the types of nursing facilities that require Medicaid Income. NCME's are:

- Allowed as a deduction only in months of LTC eligibility when Medicaid Income is otherwise payable.
- Not subject to payment by Medicaid, Medicare or other third-party insurance.

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- Classified as pre-eligibility and post-eligibility expenses and are handled accordingly as described in policy below.
- Expenses that are the liability of the recipient, meaning the expenses were incurred by the recipient and payment of the expenses are the responsibility of the recipient.

NCME's, including health insurance premiums and medically necessary care, services and items, can be considered for allowance except under the following conditions:

1. A deduction is not allowed if the individual has no income or income has been depleted in allowing the PNA, CS allowance and/or Other Family Member allowance deductions. Incurred expenses that would otherwise have been allowed during periods of \$0 Medicaid Income are forfeited. This includes expenses that would have been allowed but for:
 - Protection of income in the month of entry that results in \$0 Medicaid Income. An expense that would have otherwise been allowed in the month of entry but for protection of income is a forfeited expense. Any remaining balance of the expense will be allowed in subsequent month(s).
 - An ongoing NCME that is carried over into future months until the expense is depleted may result in forfeiting current timely submitted expense(s) that would have been allowed had income been available. NCME's are not held or delayed until income becomes available.
2. Deductions for NCME's are not allowable during a transfer of assets penalty period, including a partial month penalty period, or a home equity disqualification period. An applicant or recipient has to be completely out of a penalty period imposed to begin or resume allowable NCME deductions. NCME's that would have been deducted during a penalty period are forfeited and not allowed at a later date.
3. A deduction is not allowed if the applicant was not residing in a NF when the service was rendered. NCME's received prior to entering LTC are not allowed.

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Verification Required for NCME's

All non-covered medical expenses must be verified prior to allowing the cost as a deduction from Medicaid Income and/or entering the expense in MEDS. In addition, NCME's submitted require a notice informing the individual of the outcome of submission of the expense. Refer to Notice Requirements below.

Verification is required to show:

- The applicant or recipient is the person who received the service, care or medical item or equipment and incurred the expense,
- The applicant or recipient is liable for payment of the expense,
- The amount of the expense.
- Verification of medical necessity from a physician or other licensed medical practitioner when policy requires it, such as expenses for services or procedures which are normally considered cosmetic or elective or are included in the nursing home per diem.

Verification can be in the form of a bill from a provider that verifies the recipient's liability for charges after all third-party payments have been applied, an Explanation of Benefits from Medicare and/or other health insurance provided it confirms the recipient's final liability amount, or other official notices of amount(s) owed for the incurred expense.

A NCME must be incurred in order to be allowed, meaning the service was received or the premium is due, but the expense can be paid or unpaid at the time the expense is allowed, unless otherwise noted. If the expense has been paid, determine the impact a refund will have on the individual's eligibility.

Order of Allowing NCME

Allow NCME's in the following order:

1. Health insurance premiums, including allowable Medicare premium(s). NOTE: Health insurance premiums are converted to monthly deductions, regardless of the billing frequency.
2. Pre-eligibility NCME's, if applicable, and

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3. Post-eligibility NCME's.

NOTE: NCME's are allowed based on income that is available in the Medicaid Income calculation for the upcoming months of the current review period and beyond.

Deductions may be fully or partially allowed based on remaining income or disallowed due to no available income or other valid reasons.

500.11.06A – HEALTH INSURANCE PREMIUM(S) ALLOWED AS A NCME DEDUCTION

Non-covered medical expenses, as stated above, include the allowance of Health Insurance premiums provided the payment is not subject to payment by a third party. Multiple premiums may be allowed as NCME's provided:

- the premium(s) is otherwise allowable, as defined below,
- the applicant or recipient is the insured and is liable for the payment,
- income is available in the Medicaid Income calculation to allow the premium, and
- the expense is submitted and verified timely at application and review.

Types of Allowable Health Insurance Premiums

The types of health insurance premiums allowed include, but may not be limited to, the following plans:

- Medicare-related health plans:
 - Medicare supplement (Medigap) plans – these are policies that helps pay some of the health care costs remaining after original Medicare pays for covered charges. This type of plan covers Medicare co-payments, coinsurance and deductible charges not covered by Medicare.
 - Medicare Part C plans (Medicare Advantage Plans) – DOM does not pay the premiums for Medicare Part C plans so if a Medicaid recipient is enrolled in a Part C plan, the premium is an allowable type of health insurance premium deduction. Part C plans differ from original Medicare. Enrollees get their Medicare Part A/B coverage through the Part C plan.

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- Medicare Part A premiums for individuals who have income above the 100% FPL benchmark for DOM to pay the Part A premium and who have a Part A premium payable. If an applicant for long term care with Medicaid Income payable does not have free Part A, he/she should be advised that DOM will allow the Part A premium as a deduction from Medicaid Income at the point the premium is withheld from the Social Security check or the recipient otherwise pays the premium, provided income is available to allow the deduction.
 - Medicare Part B premiums are allowed for:
 - QMB dual individuals until the month after the month of disposition of the application (effective date DOM will begin Buy-In), and
 - Dually eligible individuals with income greater than 120% FPL until such time as DOM begins payment of the Part B premium, which is the 2nd month following approval of the long-term care case, i.e., approved in May, buy-in begins July.
 - Medicare Part D premiums incurred (pre-eligibility and post-eligibility) until such time as the individual is able to transition to a \$0 premium Part D plan. If there are extenuating circumstances that would make transitioning to a \$0 premium Part D plan a punitive move, such as costly drugs that would not be covered under the \$0 premium plan, supervisory clearance is needed to allow the recipient to remain in a Part D plan with a premium allowed as a NCME.
- Employer or union plans, including the Federal Employees Health Benefits Program,
 - Tricare,
 - Indian Health Service, Tribal and Urban Indian Health plans, or
 - Any other type of health insurance that offers a type of health insurance coverage, including limited health policies that cover only dental or vision coverage.

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Types of Policies Not Allowed

Premiums for the following types of coverage are not allowable as a Health Insurance deduction:

- In general, premiums for Medicare Part D plans are not an allowable deduction since \$0 premium Part D plans are available to each dually eligible LTC recipient; however, as stated above, if extenuating circumstances exist for not transitioning to a Part D plan, the premium may be allowed with supervisory clearance.
- Premiums for policies providing payment for loss of earnings, or loss of life, limb, sight, etc.
- Premiums for disability income policies or policies that guarantee a payment each week for a stated number of weeks due to hospitalization for sickness or injury.
- Part B Medicare premiums for individuals with income greater than 100% FPL to 120% FPL are not allowable. Medicaid pays the Part B premium from application month, and when applicable, up to 3 months prior to the application month for these individuals.
- Premiums paid by DOM for Medicare, as specified in 102.13, Medicaid/Medicare Requirements and Coordination.

Verification Required

Verification of each health insurance premium claimed is required to show:

- The applicant or recipient is the insured and is liable for payment of the premium, and
- The amount and frequency of the premium(s) due.

Accept copies of the following types of documentation that confirm the name of the insured and the frequency and amount due of the premium(s):

- Premium notices,
- Health insurance policy(s),
- Bank statements verifying a draft provided the frequency and insured status is verified separately,
- Other official notices issued by the health insurance company.

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500.11.06B – PRE-ELIGIBILITY NCME'S

For NCME purposes, the pre-eligibility period is the three (3) months prior to the month of the current application, i.e., the current 3-month retroactive period. The applicant may be determined Medicaid eligible for all, some or none of the retroactive months; however, Medicaid eligibility does not impact whether an expense can be allowed as a pre-eligibility NCME in a subsequent month of Medicaid eligibility. Non-covered services received or health insurance premium(s) due during this 3-month period can be considered for a pre-eligibility NCME deduction, provided the applicant resided in a NF during the pre-eligibility month the service was received, or the health insurance premium was incurred/due. Pre-eligibility expenses are referred to as remedial expenses in MEDS.

Example: An individual enters a NF on January 20th and applies for Medicaid on March 1st. The pre-eligibility period for NCME's in this example is January and February only since the individual was not in a NF in the month of December. At the time of application in March, the individual has paid the NF for January and February. Eligibility is requested for March 1st and continuing. A NCME for allowable denture repair was incurred (received) on January 30th, after entry into the NF. The bill for the repair verifies the date of service. Medicare is not billed because it will not cover any of the expense. The NCME received in January will be an allowable NCME subject to a maximum limit placed on denture repair in the first month of eligibility. Since this is a pre-eligibility expense received in a month in which the individual was ineligible, the expense is permissible because the individual was in the NF at the time the service was rendered and denture repair is an allowed NCME, but with a limit set on the deduction amount. The actual or maximum allowable expense, whichever is less, is allowable as a NCME effective March 1st or the first month of eligibility.

NOTE: The Pre-Eligibility period may be extended if the applicant is not eligible in the month of application. Using the above example, if the applicant was not eligible in March (month of application) but was eligible in April or May, the pre-eligibility period would have been extended through the month prior to the month eligibility begins on the current application. The beginning date of the pre-eligibility is not subject to change. It is always the 3-months prior to the current application date.

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Earmarking Exception

Liberalized resource policy allows excess resources to be disregarded in the eligibility decision for the current or retroactive month(s) if resources are earmarked for payment of private pay in a NF in month(s) prior to the begin date of Medicaid eligibility. If the applicant elects to earmark excess resources for payment of private pay in any of the pre-eligibility month(s), the private pay amount owed cannot subsequently be allowed as a NCME. The election to earmark must be obtained in writing using the "Excess Resources Declaration Form" designed for this purpose.

Example #1: Applicant enters the NF on November 10th but does not apply until the following March. Applicant is ineligible for the pre-eligibility period of December, January and February due to excess funds in the applicant's bank account. The excess funds remain available at the time of application in March. The excess resources are earmarked for payment of the nursing facility's private pay rate for all 3 months of the pre-eligibility period, thus allowing eligibility for March forward. Using this example, the funds used to pay for December through February cannot subsequently be used as an allowable pre-eligibility deduction since funds were used to establish eligibility for the current month of application. In addition, any private pay expense incurred from the date of entry on November 10th through November 30th is not an allowable NCME since it is a service received in a month prior to the pre-eligibility period.

NOTE: If earmarking does not pay the entire private pay expense for any month in which earmarking is applicable, the remaining balance can be an allowable NCME beginning in the first month of eligibility. Verification must be provided to document that the remaining balance was for services received in the pre-eligibility period. Any expense for a month prior to the pre-eligibility period cannot be allowed.

Example #2: Applicant enters a NF in January and applies in April. The applicant has total countable resources of \$6,500 in the retroactive months of January – March and at the time of application in April. During the month of April, the applicant pays the NF \$3,000 for partial payment of his unpaid NF bill. The NF provides verification that the \$3,000 was applied to the month of January with a balance due of \$3,500 for January plus unpaid balances for February and March. Eligibility is established for the month of February using earmarking of excess resources for payment of the partial month of January. The January remaining balance of \$3,500 is allowed as a NCME

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beginning in the first month of eligibility, which is February. The remaining balance is allowed as a NCME until the expense is depleted.

Allowance of Pre-Eligibility NF Expense

If earmarking does not apply, the cost of NF expense(s) received in the pre-eligibility period can be considered for NCME purposes.

Example #1: Applicant enters a NF in December and applies in March. The applicant has excess resources valued at \$4,500 for December, January, and February and at the time of application in March. The applicant has not paid the bill for the NF since entering in December. During the month of March, the \$500 in excess resources is used to purchase personal items needed by the applicant, allowing eligibility to begin March 1st. The NF unpaid balance verified for the months of December – February is an allowable NCME beginning in March with the deduction continuing until the NF expense(s) are completely allowed.

Example #2: Applicant enters a NF in January and applies in April. In January, applicant had \$30,000 in a bank account. In March, the \$30,000 was used to pay off the mortgage on his excluded home property. At the time of application, only his income has been paid to the NF. Eligibility is established March 1st. The months of January and February are denied due to excess resources. The unpaid balance for NF private pay for Jan-Feb is allowable as a pre-eligibility NCME beginning March 1st.

The pre-eligibility period is tied to the current application date. The current application date does not change if:

- An application is denied but is later reinstated under the provision of Compliance After Denial described in 101.08.06.
- A case is closed at renewal but is later reinstated as required under policy provisions addressed in 101.17, Reinstatements. This includes reinstatements required due to:
 - Information that is provided prior to the effective date of closure (101.17.01),

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- Case closures due to failure to return a signed renewal form or requested information when the client complies within the 90-day period following the effective date of closure (101.17.02),
- Corrective actions required due to agency error (101.17.03),
- A fair hearing decision mandates reinstatement (101.17.04), or
- A known temporary closure occurs (101.17.05).

NOTE: In instances where a reinstatement results in a gap in eligibility, such as a known temporary closure, pre-eligibility NCME's are allowed to continue upon reinstatement without interruption. If a NCME was allowed prior to closure, the remaining balance would continue to be allowed upon reinstatement. If additional NCME's were incurred during the gap month(s), these will also be allowable NCME's.

Example: A LTC case with an ongoing pre-eligibility NCME for unpaid NF bills in the initial pre-eligibility period closes for the month of December due to receipt of the State retiree's 13th check. The case is reinstated for January 1st. The 13th check was insufficient to pay the entire private pay cost for December. The remaining balance of the December private pay expense is entered in MEDS as a pre-eligibility NCME which has the effect of adding the new balance to the existing balance.

Gap months of eligibility created by reinstatements are the only exception which allows NCME's to be considered under pre-eligibility rules. The NCME must have been incurred in the gap month(s) while in a NF or PRTF.

If reinstatement of a LTC application or renewal is not appropriate using reinstatement provisions, then a new application date results in a new pre-eligibility period.

Timely Submission of Pre-Eligibility NCME's

Pre-eligibility NCME's must be verified, and the verifications must be submitted timely in order for the expense(s) to be considered as a Medicaid Income deduction. See below for "Verification Required for Pre and Post Eligibility NCME's" for details on verification.

Expenses for services, care, or items received or health insurance premiums due in the Pre-Eligibility period must be declared and verified during the application processing period.

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- During the interview, the NCME provision that allows deductions for health insurance premiums due and other expenses for care, service and items that were received during the pre-eligibility period must be explained to the applicant or spouse or representative. If expenses are declared, a request for verification of the expense(s) must be included on the DOM-307 (and DOM-309, if applicable). NCME's for the month of application and continuing must also be discussed and verified, as outlined in 500.11.06C below.
- Verification(s) will be accepted at any time prior to the disposition of the application.
- If timely submitted and verified, expense(s) will be allowed effective with the first month of eligibility. Deductions for allowable expense(s) will continue as a Medicaid Income deduction until fully allowed or as an ongoing expense (such as a HI premium).
- The first month of eligibility may be in one of the pre-eligibility month(s) or the month of application or a subsequent month. If eligibility is approved after the month of application, the pre-eligibility period is extended to include the month of application and any subsequent month prior to the first month of eligibility. The key factor is the expense is timely submitted and allowed as a deduction in the first possible month, provided income is available.
- Pre-eligibility NCME's that are declared but not verified during the period of time the application is being processed are forfeited unless there is a reasonable explanation for not submitting the verification needed, such as a final bill for the service after third party payments were finalized had not been received by the time the application was approved. In this event, use the post-eligibility timeframes for verifying and allowing the expense.
- Timely submitted and verified pre-eligibility NCMEs may be received late in the application approval process. If the expense cannot be feasibly handled at eligibility approval, a special review will be completed and if allowable, the expense will be deducted from Medicaid Income beginning with the first month of eligibility.

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500.11.06C – POST ELIGIBILITY NCME'S

The post-eligibility period begins with the month of the current application forward, provided the individual is a resident of a NF and eligible in the month of application. If the applicant is not eligible in the month of application, the post eligibility period begins with the first month of eligibility following the month of application.

NOTE: If an applicant is not eligible in the month of application, it does not change or alter the pre-eligibility begin date or forfeit any pre-eligibility NCME's allowable. Ineligibility in the month of application (or subsequent month) extends the pre-eligibility period and delays the effective date that allowable pre-eligibility expense(s) begin since a deduction is not possible in a month in which there is no eligibility.

Post-eligibility NCME's are allowed when the financial liability of the applicant or recipient is known and verifiable. The expense must have been incurred (received) in a month of eligibility beginning with the month of application or any subsequent month and timely submitted in order to be an allowable NCME. NOTE: As stated above, a pre-eligibility expense that is timely declared but is not verifiable until a post-eligibility month is treated under the timeliness standards of a post-eligibility NCME.

Timely Submission of Post-Eligibility NCME's

All NCME's must be verified, and the verification must be submitted timely in order for the expense(s) to be considered as a NCME deduction.

Expenses incurred (received) during the first month of eligibility which includes or follows the month of application for LTC are Post-Eligibility NCME's. If a NCME is reported no later than the month following the month the expense is known and verifiable, i.e., the final billing that verifies the recipient's liability, the NCME is considered to have been timely reported.

- If verification of the expense is not provided, or is not fully provided, at the time the expense is reported, written requests for the verification needed is required via DOM-307, and DOM-309 if needed.

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- NCME's reported timely and verified within the allotted time permit the NCME to be allowed as a deduction effective with the current month. There is no need to reprocess any prior month; allow the full expense in the current month for timely reported post-eligibility NCME's. The expense will be continued until fully allowed, provided income is available to allow the expense(s).

The Reporting Pamphlet that is issued with each approval notice informs a recipient eligible in a nursing facility of the NCME provision and the time limit for reporting the NCME. The Reporting Pamphlet is the notice to the recipient that certain post-eligibility NCME's are allowed as deductions from Medicaid Income.

Post-eligibility NCME's that are not reported timely are forfeited or result in only a portion of the expense allowed:

- The remaining balance of a NCME that would otherwise have been allowed had the expense been reported timely will be allowed in the current month.
- The amount that would have been allowed as a deduction from the month the expense was incurred through the month prior to the month the expense is reported is forfeited.
- Example: An eligible LTC recipient with monthly Medicaid Income of \$500 purchases a pair of hearing aids on March 20th. The final billing of \$3,000 (less than the maximum allowed) is dated April 20th. The deadline for reporting and verifying the expense is May 31st. If the expense is verified by May 31st, the full \$3,000 expense is entered in MEDS with an effective date of May 1st (current month). MEDS will allow the full \$3,000 as a deduction for May – October. Failure to timely report post-eligibility NCME's results in a minimum of 2 or more months being forfeited, as follows:
 - If verified to the RO in June, the NCME amount that would have been allowable for April and May (\$1,000) is forfeited. The remaining balance of \$2,000 is entered in MEDS with an effective date of June. MEDS will allow the expense for June – September.
 - If verified to the RO in July, the NCME amount that would have been allowed for April, May and June is forfeited (\$1,500). The remaining balance of \$1,500 is entered in MEDS with an effective date of July. MEDS will allow the expense for July – September.

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- If verified to the RO in August, \$2,000 is forfeited (the allowance for April, May, June and July); only the remaining balance of \$1,000 is allowed for August and September.
- Each month in which reporting is delayed results in lost month(s).

500.11.06D – NCME'S INCURRED BETWEEN THE APPLICATION AND APPROVAL MONTH(S)

There may be NCME's that are incurred between the month of application and the month the application is approved. These NCME's must be considered for allowance under post-eligibility timeliness rules, i.e., the month following the month the NCME is known and verifiable which is the month of the billing after all third parties have paid, if applicable.

Example: An applicant enters a NF in March and files the Medicaid application on March 12th. The application is approved on April 26th with eligibility starting March 1st. The individual incurs an expense for dentures on April 15th (subject to the denture maximum). The billing that verifies the individual's full and final liability is dated May 15th and submitted to the RO for allowance as a NCME on June 28th. The expense, although incurred prior to the time the application was approved, was not verifiable until a post-eligibility month and was timely submitted. The expense is allowed for June and continuing until the expense has been fully allowed, provided income is available for the deduction.

500.11.06E – NCME'S INCURRED IN GAP MONTHS OF ELIGIBILITY

If a recipient case closes and reinstatement is not possible, a new application is required that creates a new pre and post eligibility period for NCME's purposes. Any NCME's submitted for consideration must be carefully reviewed to ensure that it is not duplication of expense(s) previously allowed.

500.11.06F – NCME'S IN THE PRE AND POST ELIGIBILITY PERIODS

The following provides a listing of NCME's that are allowed or are allowed within prescribed limits or disallowed in the pre-eligibility and post-eligibility periods that are for medically necessary care, service and items.

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Types of NCME's Allowed

Pre-Eligibility Expenses Not Allowed	Post-Eligibility Expenses Not Allowed
Expenses incurred earlier than the 3-months prior to the current application month, including unpaid NF Room & Board expenses.	If pre-eligibility expenses deplete income in month(s) in which post-eligibility expenses would have otherwise been fully allowed, the post-eligibility expense is forfeited. Example: A \$5,000 pre-eligibility NF expense will be allowed from the recipient's \$500 available income from Jan to Oct, which results in \$0 Medicaid Income for the 10-month period. A NCME for denture expenses of \$1,300 timely submitted in April cannot be allowed because there is no income in April, May or June to allow the expense. (\$1,300 allowed at \$500 each month would need 3 months to allow.) Using the same example, if the \$1,300 NCME is timely submitted in Oct., the remaining \$800 can be allowed for Nov/Dec. (The \$500 that would have been allowed for Oct is forfeited due to no available income; but the remaining balance of \$800 is allowable for Nov/Dec.)
Cosmetic or elective surgical expenses except when medically necessary and prescribed by a medical professional.	Cosmetic or elective surgical expenses except when medically necessary and prescribed by a medical professional.
Expenses incurred in the pre-eligibility period when the applicant was not a resident of a LTC nursing facility.	A duplication of expenses previously authorized as a deduction in the pre or post eligibility period.
	Any cost associated with an item or service included in the per diem cost of the NF (refer to 500.11), unless the expense is determined medically necessary and not otherwise covered by Medicaid through the prior authorization process.

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Pre-Eligibility Expenses Not Allowed	Post-Eligibility Expenses Not Allowed
	Deductibles, co-payments and co-insurance charges for a dually eligible recipient (Medicaid will pay all associated cost-sharing expenses for Medicare Parts A and B).

Types of NCME Allowed – Subject to Maximum Limits on Each Service

Service	Limits on Allowable Deduction(s)
Eyeglasses	Expense must not be otherwise covered by Medicaid. For each fiscal year the allowable expense cannot exceed a total set by DOM per occurrence for lenses, frames and dispensing fee. Current limits are available on Appendix A-2
Dentures	For each fiscal year the allowable expense cannot exceed a total set by DOM. Current limits are available on Appendix A-2.
Denture Repair	For each fiscal year the allowable expense cannot exceed a total set by DOM. Current limits are available on Appendix A-2.
Hearing Aids	For each fiscal year the allowable expense cannot exceed a total set by DOM. Current limits are available on Appendix A-2.

Maximum allowable expenses are subject to change effective July 1st of each year.

Allowable NCME's with No Maximum Limits

The following list may not be inclusive of all possible NCME's allowed. For recipients with Medicare and/or other health insurance, do not allow the charge(s) until Medicare and/or third-party payment is verified and the recipient's liability is verifiable:

- Charges for prescription drugs not covered by Medicaid for a LTC recipient without Medicare.
- Charges for prescription drugs not covered by Medicare, Part D for a dually eligible LTC recipient.
- Private duty nursing provided in the LTC NF if a physician prescribes this care for a specific duration and no other third party is liable for this expense.

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- Other charges for services, care, items or durable medical equipment that are not subject to payment by a third party and are medically necessary as evidenced by a physician's order or prescription.
- NOTE: Before allowing an expense as a NCME, ensure that proper steps have been taken to determine if Medicaid will cover the expense. For example, wheelchairs are included in the per diem cost paid to the facility, but individualized custom wheelchairs are not. However, Medicaid will cover a resident specific custom wheelchair with prior authorization. If there is any question about an allowable NCME, the matter should be routed to the Central Office for clearance.

500.11.06G – ALLOWANCE AND CALCULATIONS OF NCME DEDUCTIONS

1. Health Insurance Premium(s)

The Specialist must enter certain information in MEDS to allow health insurance premiums as a NCME, as follows:

- Carrier Name
- Premium Amount - All premiums must be converted to monthly by the Specialist, regardless of the actual frequency, before entering the premium amount in the system.
- Begin and End Dates (terminating premiums) – Enter a begin and end date when the premium is not an allowable ongoing deduction, or the policy is terminating. MEDS will allow the premiums within the confines of the date range entered. Begin and end dates will be applicable to Medicare premiums allowed until buy-in begins. In some instances, a policy may be terminating, and the applicable end date must be entered to stop the deduction.
- Begin and End Dates (ongoing premiums) – The defaults dates in the system should not be changed if the monthly premium is allowed ongoing. MEDS will allow the premium deduction(s) based on available monthly income.

Verify health insurance premiums at each regular renewal to continue the deduction. Adjust the premium in MEDS only if the amount and/or frequency changes; otherwise, allow the current deduction to remain.

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2. Incurred Medical Expense(s)

- Pre-eligibility expenses are “remedial care” expenses, meaning they were incurred in a period that is no more than 3 months prior to application or were incurred in a period that precedes an eligible or reinstated period, i.e., ineligible application month or gap month. All pre-eligibility expenses are subject to “remedial” processing in MEDS. For each expense, enter type, provider, amount, verification and first month to apply. The first month to apply is the same for all pre-eligibility expenses involved in the action, i.e., the first eligible month upon approval of the application or upon reinstatement. The system will allow the expense(s) based on available income and display a projection with the anticipated date the expense will be fully allowed (unless there are changes) on the Medicaid Income tab.
- Enter post-eligibility expenses which can be fully allowed within a month as current, one-time expenses in MEDS. The Specialist must enter the expense type, provider, amount, verification, frequency of “one-time” and applied date, which is the month in which the expense was timely submitted or month in which an expense that is not timely submitted can be allowed considering forfeited amounts discussed under “Timely Submission of Post-Eligibility NCMEs” in Section 500.11.06C.
- When any post-eligibility expense cannot be allowed in full one-time, but there is some Medicaid Income available for it, enter the expense for remedial processing by MEDS. The expense will be allowed in full based on system remedial processing rules.
- Expenses subject to remedial processing in MEDS are allowed as deductions in full based on available Medicaid Income provided the case remains active. When a case terminates and reinstatement is not possible, all recurring NCMEs are lost, and a new pre-eligibility period is established.
- At renewal, verify that any recurring NCME’s are being used for their stated purpose rather than re-verifying the NCME’s.
 - For example, if a deduction is ongoing for private pay of nursing home expenses in pre-eligibility month(s), verify that the allowed

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deduction for private pay is being used to pay the NF. If recipient funds are not being used to pay the stated expense, determine if excess resources exist due to the non-payment or if a transfer of the funds has occurred and take appropriate action.

- A NCME that is not used for its intended purpose is no longer an allowable NCME.

500.11.06H – NOTICE REQUIREMENTS FOR NCME DEDUCTIONS

Approval notices generated in MEDS for applications, renewals and/or special reviews that include the allowance of NCME's will display the total amount of all NCME's for each eligibility segment addressed on the notice. The Specialist can view the allowable expenses on the Decision Details screen which shows the budget calculations.

Any NCME that is reported and verified to the RO but not allowed as a deduction from Medicaid Income for any reason must be documented in the Remarks section of an approval notice, specifying the expense and the reason for the disallowance. Valid reasons include:

- No income available to allow the expense in the month(s) in which the expense should have been allowed, or
- Verification was only partially submitted, or
- The expense was outside the pre-eligibility period, or
- The expense was not submitted timely and there is no remaining expense to allow.
- The expense does not comply with policy, i.e., it is an expense included in the Medicaid per diem or no evidence is provided that the expense was prescribed by a medical professional, or it is an expense that is covered by a third party, etc.

Medicaid Income changes that occur after approval of a LTC case are addressed in 101.18.01, Other Changes – ABD Programs, which specifies the effective date of decreases and increases in Medicaid Income. The allowance of post-eligibility NCME's is subject to these provisions. However, if a verified NCME cannot be allowed due to any of the valid reasons shown above, the recipient must be notified of the specific expense disallowed and the reason(s) for the disallowance. Since Medicaid Income will

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not change due to the disallowance of an expense, it is not an action that requires advance notice, but it is a decision that requires a notice and is appealable.

The “No Change in Medicaid Income” notice must be completed by the Specialist to inform the recipient of any NCME that are disallowed and the reason for the disallowance.

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500.12 CHART OF INSTITUTIONAL CRITERIA BY TYPE OF LTC FACILITY OR LIVING ARRANGEMENT

Factor of Institutional Eligibility	Nursing Facility (NF)	ICF/IID	Swing Bed	HCBS	Long Term Hospital	PRTF	Katie Beckett Program
30-Consecutive Days	Yes, if needed to establish Eligibility under 300% group. No, if eligible at-home.			Presumed	Yes, if needed to establish eligibility. No, if eligible at-home.		Presumed
Level of Care	Yes – DOM-317	Yes – DOM-317	Yes – DOM-317	Yes – 2-way form	No	Yes – DOM-317	Yes – contractor
Transfer of Assets & 5 Year Lookback	Yes	Yes	Yes	Yes	No	No	No
Income Trust	Yes	Yes	Yes	Yes	No	No	No
Spousal Impoverishment Spousal Shares of Income/Resources	Yes	Yes	Yes	Yes	Yes	N/A	N/A
Spousal Income Allocation (deduction from Medicaid Income)	Yes	Yes	Yes	No	No	N/A	N/A
Substantial Home Equity	Yes	Yes	Yes	Yes	No	N/A	N/A
Medicaid Income	Yes	Yes	Yes	No	No	Yes	N/A
NCME Deduction	Yes	Yes	Yes	No	No	Yes – for ABD	N/A
Estate Recovery	Yes	Yes	Yes	Yes	No	No	No