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17.9 INCOME

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

NOTE: The post-eligibility process does not apply to the MAGI Medicaid coverage groups – Adult Group, Parents/Caretaker Relatives, Pregnant Women, Children Under Age 19. MAGI Medicaid coverage groups do not contribute to the cost of their nursing facility care.

A. EXCLUDED INCOME SOURCES

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

B. BUDGETING METHOD

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

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

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

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

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

- Determine the number of days the client resided or expects to reside in the facility in the calendar month and multiply the number of days by the daily contribution rate. The result is the client's total cost contribution for the partial month. After all computations have been completed, any cents calculated as part of the result are dropped.

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

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

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

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

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

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

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

C. FINANCIAL ELIGIBILITY PROCESS

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

1. QMB Eligible

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

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

2. Client Is Medicaid Recipient

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

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

NOTE: Individuals already receiving full-coverage Medicaid in the Adult Group, who become eligible for Medicaid payment of nursing facility services, must be dually coded in the data system as receiving nursing home coverage, code MLTN.

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

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

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

When an applicant is not a recipient of full Medicaid coverage, the following test is made to determine eligibility.*.3

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3. Gross Income Test

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

- Determine the client's gross non-excluded monthly income.
- Compare the income to 300% of the current maximum SSI payment for one person.

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

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

EXAMPLE: When the current maximum SSI payment is $721, the client's gross, non-excluded monthly income is compared to $2,163.

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

Certain individuals who meet the gross income test but are ineligible for Medicaid due to being over the allowable asset limit, may be eligible for the LTCIP Asset Disregard. See Section 17.10.

4. SSI-Related Medicaid Test

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

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

EXCEPTIONS:

- Income is not deemed.
- The MNIL for one person is always used. See Chapter 10, Appendix A.

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- The spenddown amount is determined on a monthly basis.

When the monthly Medicaid rate for the facility in which the client resides equals or exceeds his monthly spenddown amount, the spenddown is assumed to be met and Medicaid eligibility is established. In addition, if the monthly spenddown amount exceeds the monthly Medicaid rate for the facility, the client may become eligible for Medicaid based on a 6-month POC, but not for payment of nursing facility services. The Medicaid daily rate for the facility is multiplied by 30 to determine the average monthly rate. The daily rates for all Medicaid are found only on the DFA intranet page. The rates are updated semi-annually.

NOTE: The Medicaid rates for nursing facilities are provided only for DHHR staff who must determine eligibility for Medicaid. The rates cannot be released by local DHHR staff to the public. Any requests for the rates must be made under the Freedom of Information Act (FOIA) to the DHHR Office of the Deputy Secretary, Division of Accountability and Management Reporting.

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

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

D. POST-ELIGIBILITY PROCESS

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

NOTE: The post-eligibility process does not apply to the MAGI Medicaid coverage groups – Adult Group, Parents/Caretaker Relatives, Pregnant Women, Children Under Age 19. MAGI Medicaid coverage groups do not contribute to the cost of their nursing facility care.

EXCEPTION: The one-time $250 payment and tax credits/refunds issued under the American Recovery and Reinvestment Act of 2009 and excluded. This includes post-eligibility determinations for institutionalized individuals.