H-800 INDIVIDUALS IN INSTITUTIONS - SPECIAL INCOME LEVEL

H-800.1 General Information

Medicaid coverage is available to individuals in institutions whose income is less than or equal to the special income level (SIL). This includes individuals in a:

- Nursing facility; or
- Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).

The special income level is also used to determine income eligibility for:

- Home and community-based services (HCBS) waiver; or
- Program of All-Inclusive Care for the Elderly (PACE).

Determine income eligibility by comparing the individual's gross earned and unearned income, before deductions, to the SIL standard. The SIL standard is equal to three times the SSI Federal Benefit Rate (FBR) for an individual.

Note:
For individuals applying for nursing facility care or HCBS waiver (Adult Day Health Care (ADHC), Community Choice Waiver (CCW), New Opportunities Waiver (NOW), Supports Waiver (SW) and Residential Options Waiver (ROW)) whose income exceeds the SIL, continue reviewing eligibility under the Spend-Down Medically Needy program.

Eligibility under the SIL is applicable to a period of institutionalization likely to be at least 30 consecutive days. Refer to I-400 Continuity of Stay.

H-810 LONG TERM CARE (LTC) PROGRAM

An applicant/beneficiary may be eligible for Medicaid services in the LTC program if he/she is a resident of:

- A Medicaid certified nursing facility (NF);
- A Medicare certified skilled nursing facility (SNF); or
- A Medicaid certified ICF/IID facility.

H-810.1 Coverage

Medicaid will pay all or part of the facility fee, in addition to a full range of Medicaid services**,** for eligible applicants. The Medicaid facility fee payment is referred to as the vendor payment.

The amount of vendor payment is determined by the fiscal intermediary using the patient liability amount and the level of care.

Medicare Part A

Medicare Part A covers Medicare skilled nursing care facility (SNF) services. Refer to H-840.

H-810.2 Medical Certification

The medical certification determination is not a disability determination. Refer to I-1000 Medical Certification.

Care is given and vendor payment is made to the nursing or ICF/IID facility according to the medical needs of the resident.

ICF/IID facilities are certified to provide ICF/IID services only.

Before LTC vendor payment can be authorized for any applicant/beneficiary an evaluation of the individual's medical needs is completed by the facility and the applicant's/beneficiary's physician in order to recommend a level of care (LOC).

An evaluation of the recommended level is made by Office of Aging and Adult Services (OAAS), Office for Citizens with Developmental Disabilities (OCDD) or its designee to determine the need for facility care and the level of care required. The decision may be for a different LOC than the recommended level or that nursing care is not the appropriate placement for the applicant/beneficiary**.**

All individuals seeking admission to a *nursing facility* require a medical certification from the OAAS and/or the appropriate Level II authority prior to admission. If the individual meets nursing facility LOC, OAAS

issues the Form 142 Notice of Medical Certification. Once the approved Form 142 has been obtained, the individual must be admitted to the facility within 30 calendar days of the date of the approval.

If the Form 142 expires before admission to the nursing home, a new Form 142 is required. Medicaid vendor payment shall not begin prior to the date that medical and financial eligibility is established, and shall only begin once the individual is actually admitted to the facility.

An approved Form 142 is required each time there is a change in LOC or when there is a change in ICF/IID facility.

The Form 142 is issued by the OAAS, OCDD or its designee.

The Form 142 documents the:

- Approval or disapproval of the level of care;
- Effective date of the level of care approval; and
- Expiration date, if applicable.

  NOTE:
  For nursing facility residents needing services beyond the expiration date on the Form 142, the nursing facility must submit a continued stay request to the OAAS NFA Unit in accordance with the timelines set by OAAS.

H-810.3 Patient Liability

After determining the applicant/beneficiary is financially eligible for payment of nursing home or ICF/IID services, the applicant/beneficiary becomes subject to the post-eligibility treatment of income (PETI) calculation rules.

Patient liability (PLI) is a post-eligibility calculation used to determine the amount the applicant/beneficiary must pay the LTC facility towards their monthly cost of care. It is based on the amount of monthly income remaining after allowable deductions. Refer to I-1536 Deductions.

Income is counted in the month of receipt; therefore, the PLI is based on the income received in that month. When a payor (Social Security Administration (SSA), Veterans Administration (VA), or retirement

benefits) advance dates a check because the regular payment falls on a weekend or holiday, consider as income in the month of normal receipt.

H-810.4 Optional State Supplement

The Optional State Supplement (OSS) is a state funded payment of up to $8.00, which is made to certain LTC beneficiaries to help meet their personal care needs.

This payment is not available to:

- Medicare SNF beneficiaries;
- Modified Adjusted Gross Income (MAGI)-based beneficiaries in an LTC facility;
- Beneficiaries not eligible for vendor payment because of:
  - A transfer of resource penalty; or
  - Equity interest in the home exceeds the established limit;
- SSI recipients temporarily in a facility for up to three months who continue to receive full SSI benefits; or
- Beneficiaries of home and community-based services (HCBS).

An OSS payment is issued to LTC beneficiaries whose gross income is less than the $38.00 personal care needs amount. Refer to J-300 Optional State Supplement (OSS) Payments.

H-810.5 Categories F (06), V (22), I (08), and O (15)

The Department of Children and Family Services (DCFS) is responsible for determining eligibility for LTC and patient liability for children in state custody who are certified in Categories F, V, I, and O.

H-810.6 Incurred Medical Expense Deduction

The deduction for incurred medical expenses may be allowed in the LTC post-eligibility PLI determination. The medical expense deduction is for medical expenses that an LTC applicant/beneficiary incurs that are not covered by third party insurance or Medicaid, and are not the responsibility of the facility.

Note:
Beneficiaries who do not owe a monthly PLI will not be allowed a deduction.

H-820 MAGI-BASED LONG-TERM CARE

H-820.1 General Information

Applicants/beneficiaries residing in a long-term care (LTC) facility may be certified for MAGI-based LTC. There is no patient liability for an individual eligible for MAGI-based LTC.

Individuals eligible for MAGI-based LTC fall into these groups:

- Individuals whose Medicaid eligibility has already been determined using MAGI-based rules and are certified for Parent and Caretaker Relatives Group, Children Under Age 19 Group, or Pregnant Women Group or Regular Medically Needy (MNP) at the time of admission to the facility.

  Note:
  Individuals whose eligibility has or has not been established in the Adult Group cannot be considered for MAGI-based LTC. Eligibility must be considered for Non-MAGI LTC.

  Note:
  Temporary absence policy allows for a temporary absence from the household for up to 90 days with continued Medicaid eligibility**.**

- Individuals whose Medicaid eligibility has not been determined using MAGI-based rules, but would be eligible in Parent and Caretaker Relatives Group, Children Under Age 19 Group, or Pregnant Women Group or Regular Medically Needy (MNP) had they applied prior to admission to the facility.

Income eligibility is based on the MAGI income and household composition prior to admission to the facility. The countable income is compared to the applicable MAGI-based program. Refer to Z-200 Federal Poverty Income Guidelines. If eligible, the individual may remain in the MAGI-based eligibility determination for the month of admission and three additional months before determining eligibility for

MAGI-based LTC or Non-MAGI LTC.

Individuals who are not eligible for MAGI-based LTC must be evaluated for Non-MAGI LTC (e.g. adult group, aged, blind or disabled). Refer to **H-830 Non-MAGI Long Term Care**.

H-821 ELIGIBILITY DETERMINATION PROCESS

Determine eligibility by applying the following criteria. The elements have been listed in the most logical order, but work on all steps simultaneously.

Cases in categories F, V, O, I are the responsibility of DCFS. Refer a case certified in one of these categories to DCFS for the LTC determination of eligibility.

H-821.1 Determine Assistance/Benefit Unit

Refer to the MAGI-based assistance/benefit unit that the institutionalized applicant/beneficiary was or could be included in.

Note:
Individuals whose eligibility has or has not been established in the Adult Group cannot be considered for MAGI-based LTC. Eligibility must be considered for Non-MAGI LTC.

H-821.2 Establish Categorical Requirements

Verify the institutionalized applicant is certified for a MAGI-based program or Regular MNP.

If the institutionalized applicant is not included in an active certification, verify the individual meets all the eligibility criteria for a MAGI-based program or Regular MNP if he/she had applied.

H-821.3 Establish Non-Financial Eligibility

Verify eligibility for the applicant/beneficiary with regard to the following factors:

- Age – MAGI-based I-100
- Assignment of Third Party Rights I-200
- Citizenship/Identity and Qualified Non-Citizen Status I-300

- Enumeration I-600
- Medical Certification I-1000
- Residence I-1900
- Support Enforcement Services (SES) I-2000
- Creditable Health Insurance I-2200

H-821.4 Establish Need

Household composition continues to include those of the existing case for the month of admission and three (3) additional months.

Institutionalized Children under age 19 and Pregnant Women

Beginning with the fourth month through the sixth month, for institutionalized children under age 19 and pregnant women, determine eligibility for MAGI-based LTC. The income unit consists of only the institutionalized individual.

Remove the institutionalized individual from the existing MAGI-based certification and certify the individual in MAGI-based LTC. If the individual remains institutionalized more than six months, determine eligibility in Non-MAGI LTC.

Institutionalized Parents/Caretaker Relatives

Beginning the fourth month for parents/caretaker relatives who remain institutionalized, remove the institutionalized individual from the existing MAGI-based certification and determine their eligibility in Non-MAGI LTC (e.g. aged, blind, or disabled). Refer to **H-830 Non-MAGI Long Term Care.**

H-821.5 Eligibility Decision

Evaluate all categorical and eligibility requirements and verification received to make the eligibility decision to reject or certify.

H-821.6 Determine Patient Liability

There is no patient liability for an individual who is eligible for MAGI-based LTC.

H-821.7 Certification Period

The certification period cannot exceed six (6) months for children under age 19 and pregnant women. If the applicant/beneficiary remains institutionalized for more than six (6) months determine their eligibility in Non-MAGI LTC.

The certification cannot exceed three (3) months for PCR.

H-821.8 Notice of Decision

Send the notice of decision to the applicant/beneficiary and a copy to the facility.

H-821.9 Post Certification

The applicant/beneficiary is required to apply for other benefits they are potentially eligible to receive. The applicant/beneficiary is not required to apply for SSI but should be encouraged to do so.

H-830 NON- MAGI LONG TERM CARE

H-830.1 General Information

Applicants/beneficiaries residing in an LTC nursing facility may be certified for Non-MAGI LTC.

Persons eligible in the Non-MAGI LTC program fall into these groups:

- Those who are eligible for SSI at the time of admission;
- Those who are not certified for SSI but meet all eligibility criteria;
- Those who are not income eligible for SSI in the community, but have income equal to or below the SIL; or
- Those whose income is above the SIL, but have enough incurred medical expenses to spend-down their excess income. A vendor payment will be made if the post-eligibility process results in a PLI below the facility fee.

H-830.2 Special Income Level

Income eligibility is based on the applicant/beneficiary's gross income, excluding Veterans Administration (VA) aid and attendance.

The applicant/beneficiary's gross earned and unearned income is compared to the SIL rate. The SIL is three (3) times the monthly SSI Federal Benefit Rate (FBR) for an individual. The couple SIL is double the individual SIL. Refer to Z-700 LTC/HCBS SIL Rate, Resource Limits and Personal Care Needs Allowance.

Applicants/beneficiaries whose income exceeds the SIL, continue reviewing eligibility under the Spend-Down MNP. Refer to H-1030 Spend-Down Medically Needy - SSI Related or H-1040 Spend-Down Medically Needy - Long Term Care - SSI Related.

H-830.3 Personal Care Needs

Applicants/beneficiaries are allowed to keep a protected amount of money from their monthly income to spend on personal care needs items not covered by the facility fee.

Allowances for personal care needs (PCN) are as follows:

- $38.00 for an individual;
- $76.00 for a couple; or
- $128.00 for certain veterans who do not have a surviving spouse or dependents and receive VA Improved Pension of $90.00.

  Note:
  The $90.00 VA Improved Pension may not be used to reduce the Medicaid payment to the facility and does not replace the $38.00 PCN**.**

H-830.4 SSI Recipients

SSI recipients who enter a LTC facility remain eligible for Medicaid if they continue to receive an SSI payment while in the facility and may be eligible for nursing facility vendor payment.

There are three (3) circumstances under which vendor payment to an LTC facility may be denied for an individual who receives SSI and has

been medically certified to receive nursing facility services. They are:

- A Medicaid Qualifying Trust (MQT) exists;
- An OBRA '93 trust exists; or
- There has been a transfer of resources for less than fair market value (FMV).

  Note: Refer to I-1700 Trust to determine if the Trust is a countable resource to the SSI recipient or if it will be treated as a transfer of resources.

Transfer of resources for less than FMV made by the SSI recipient must be explored before determining eligibility for vendor payment. Refer to I-1670 Transfer of Resources For Less Than Fair Market Value.

For SSI recipients found eligible for LTC vendor payment, count the entire SSI payment received in the month of admission or in the month the individual converts from Medicare to Medicaid pay status.

Individuals who are entitled to the maximum SSI benefit, and reside in a facility for a whole month and Medicaid pays more than half of their cost of care, will usually have their SSI payment reduced to $30.00 a month while they remain in the facility. SSI may lower the benefit if the individual has other income.

Although the SSI payment change may not be made immediately by SSA, SSI overpayments are subject to recoupment. Any SSI payment received in excess of the personal care needs amount after the first month the individual is entitled to vendor payment shall be excluded from all computations.

H-830.5 Continued SSI Benefits For Recipients Expected To Be Temporarily Institutionalized

SSI benefits paid under section 1611(e)(1)(E) to an individual who is eligible for medical assistance and is in a skilled nursing facility or intermediate care facility at the time such benefits are paid, will be excluded from the PLI calculation for up to two full months of medical confinement. The rule applies to SSI recipients who perform substantial gainful activities section 1619(a) or (b) of the Social Security Act in the month prior to institutionalization. The month of institutionalization is one of the first 2 full months of a continuous period of confinement.

SSI benefits paid under section 1611(e)(1)(G) to an individual who is eligible for medical assistance and is in a skilled nursing facility or intermediate care facility at the time such benefits are paid, will be excluded from the PLI calculation for up to 3 full months of medical confinement. The month of institutionalization is one of the first 3 full months of a continuous period of confinement.
Continuation of SSI benefits will be determined by SSA.

Only disregard the SSI payments made under 1611(e)(1)(E) and (G) in the patient liability determination. There is no disregard for other income such as SSA Title II benefits Retirement, Survivors and Disability Insurance (RSDI).

Note:
These SSI recipients are not eligible for an OSS payment.

H-830.6 Persons With Little Or No Income

Individuals with income at or below the FBR who have been, or are expected to be, continuously institutionalized thirty (30) days or longer may be considered for Medicaid. Applicants who allege a disabling condition shall have a disability determination made by MEDT, if disability has not been established by the SSA.

Applicants are required to apply for any annuity, pension, retirement, and disability benefits for which they are entitled. Refer to I-1532, Potential Income. Should SSA subsequently determine that the individual does not meet the disability criteria, take action to close the case.

These individuals may be eligible for an OSS payment.

H-831 ELIGIBILITY DETERMINATION PROCESS

Determine eligibility by applying the following criteria. The elements have been listed in the most logical order, but work on all steps simultaneously.

Consider possible eligibility under policy for grandfathered beneficiaries if the case was grandfathered and/or converted. Refer to Z-1000 Maximum Resource Limits as of 12-73 for Grandfathered/Converted SSI Recipients.

H-831.1 Determine Assistance/Benefit Unit

The assistance/benefit unit consists of the applicant/beneficiary.

H-831.2 Establish Categorical Requirement

Verify that the applicant/beneficiary is:

- Aged;
- Blind; or
- Disabled.

Refer to E-0000 Category.

H-831.3 Establish Non-Financial Eligibility

Verify eligibility for the applicant/beneficiary with regard to the following factors:

- Assignment of Third Party Rights I-200
- Citizenship/Identity/Qualified Non-Citizen Status I-300
- Continuity of Stay I-400
- Enumeration I-600
- Medical Certification I-1000
- Residence I-1900

H-831.4 Establish Need

Verify that the applicant/beneficiary is medically certified and receiving LTC services from a Medicaid enrolled provider.

A. Determine Composition of the Income Unit

The income unit consists of:

- The applicant/beneficiary;

- Applicants/beneficiaries who are a couple (legally married) residing in the same facility; or

- For the month of admission, the applicant/beneficiary who is a minor child and the parent(s) with whom they lived during the month. Refer to I-1420 Need - Deeming. After the first month of eligibility, the income/resource unit consists of the applicant/beneficiary.

Note:
Never consider the income of the community spouse/legal dependent(s) at home in determining eligibility for an institutionalized applicant/beneficiary. Refer to I-1537 Spousal Impoverishment Income Provisions.

B. Determine Need/Income

Determine the gross income of the applicant/beneficiary including any income deemed from the parent(s). Refer to I-1530 Need - SSI-Related Income.

The applicant/beneficiary must be income eligible based on gross income. If the gross income before any deductions or allowances is greater than the SIL consider eligibility for Spend-down MNP. Refer to H-1030 Spend-Down Medically Needy - SSI-Related or H-1040 Spend-Down Medically Needy - Long Term Care – SSI-Related.

Note:
Exclude any income received from VA Pension for Aid and Attendance from the gross income computation.

Add the gross earned and the gross unearned income, including any income deemed from the parent(s), and compare the total to the SIL. If the applicant/beneficiary is an individual, including a minor child who has income deemed from the parent(s), use the individual SIL.

If the total gross income of the applicant/beneficiary is greater than the SIL, the applicant/beneficiary is income ineligible. Consider eligibility for Spend-down MNP. Refer to H-1030 Spend-Down Medically Needy - SSI-Related or H-1040 Spend-Down Medically Needy - Long Term Care - SSI Related.

If the total gross income is equal to or less than the SIL, the

applicant/beneficiary is income eligible. Continue the determination of need.

Reminder:
Consider QMB or SLMB eligibility for all LTC applicants. Refer to H-1100 Qualified Medicare Beneficiary (QMB) or H-1300 Specified Low-income Medicare Beneficiary (SLMB).

Couples in the Same Facility

Beginning with the month that both the applicant/beneficiary and legal spouse reside in the same facility, determine whether it is to their advantage to have need considered:

- As a couple; or
- As individuals.

First, consider eligibility for each member of the couple as an individual.

If one member of the couple has gross countable income greater than the SIL, consider eligibility as a couple.

If need is considered for the applicants/beneficiaries as a couple, use the couple SIL.

If the combined total gross income of the couple is equal to or less than the couple SIL, the applicants/beneficiaries are income eligible. Continue the determination of need using the couple resource limit.

If need is considered for the applicant/beneficiary as a couple, ** eligibility for Qualified Medicare Beneficiary (QMB) and/or Specified Low-Income Medicare Beneficiary (SLMB) should be reviewed using the couple QMB/SLMB standard.

If the combined gross income of the couple exceeds the couple SIL, the couple is income ineligible. Re-evaluate the eligibility of each member as an individual using the individual's income and comparing it to the individual SIL. If the individual's total gross income is equal to or less than the SIL, the individual is income eligible.

If one or both members of the couple remain income ineligible when considered as an individual, determine individual eligibility in Spend-down MNP. Refer to H-1030 Spend-Down Medically Needy

- SSI-Related or H-1040 Spend-Down Medically Needy - Long Term Care - SSI Related.

C. Determine Composition of the Resource Unit

The resource unit consists of:

- The applicant/beneficiary;
- The applicant/beneficiary and the community spouse;
- Applicants/beneficiaries who are a couple (legally married) residing in the same facility; or
- For the month of admission, only the applicant/beneficiary who is a minor child and the parent(s) with whom he lived during the month. Refer to I-1420 Need - Deeming. After the first month of eligibility, the resource unit consists of the applicant/beneficiary.

D. Determine Countable Resources

Determine eligibility with regard to resources.

Determine the total countable resources of the applicant/beneficiary. Refer to I-1630 Need - SSI-Related Resources.

If resources were disposed of or a trust was established within 60 months prior to application, refer to I-1670 Transfer of Resources for Less Than Fair Market Value. If the applicant/beneficiary is ineligible for vendor payment because of a transfer of resources for less than the fair market value (FMV), consider eligibility for Medicaid benefits without vendor payment.

If the applicant/beneficiary's equity interest exceeds the allowable home equity limit, consider eligibility for Medicaid benefits without vendor payment. Refer to I-1634 Types of Resources (SSI-Related), Individuals with Substantial Home Equity.

For an applicant/beneficiary who entered the facility on or after September 30, 1989, and has a spouse in the community, refer to I-1660 Spousal Impoverishment Resource Provisions (LTC/HCBS).

Compare the total countable resources to the resource limit for an

individual (or couple). Refer to Z-900 Resource Limits by Program .

If the countable resources are greater than the resource limit, the applicant/beneficiary is resource ineligible for LTC.

If the countable resources are equal to or less than the resource limit, the applicant/beneficiary is resource eligible for LTC.

If the resources of a couple are greater than the couple resource limit, consider eligibility for each member of the couple as an individual.

Note:
If considered as an individual for resource purposes, the applicant/beneficiary shall also be considered as an individual for income purposes.

H-831.5 Eligibility Determination

Evaluate all eligibility requirements and verification received to make the eligibility determination.

Consider QMB or SLMB eligibility for all LTC applicants. Refer to H-1100 Qualified Medicare Beneficiary (QMB) or H-1300 Specified Low-income Medicare Beneficiary (SLMB).

If ineligible based on income, consider for Spend-down MNP. Refer to H-1030 Spend-Down Medically Needy - SSI-Related or H-1040 Spend-Down Medically Needy - Long Term Care - SSI Related.

If the applicant/beneficiary is LTC eligible, determine the OSS payment and patient liability.

If the applicant/beneficiary is not eligible for vendor payment because of transfer of resources or equity interest in the home exceeds the established limit, the applicant/beneficiary is responsible for the entire LTC payment and he is not eligible to receive an OSS payment.

H-831.6 Post Eligibility Determination

Determine OSS Payment (Refer to H-810.4 Optional State Supplement)

The OSS payment is for an applicant/beneficiary residing in a nursing

or ICF/IID facility who has gross income of less than $38.00.

The maximum OSS payment amount is $8.00.

The minimum OSS payment is $1.00. If the gross income is such that the OSS payment amount due is $0.50 to $1.00, the applicant/beneficiary is eligible for a payment of $1.00.

If the gross income is such that the OSS payment amount due is $0.49 or less, the applicant/beneficiary is not eligible for an OSS payment.

Refer to J-300, Optional State Supplement (OSS) Payments, and H-810.4, Optional State Supplement.

Determine Patient Liability

Determine patient liability for the month of admission and following months.

Income is counted in the month of receipt; therefore, PLI is based on the income received in that month.

If the applicant/beneficiary has a community spouse, refer to I-1537 Spousal Impoverishment Income Provisions.

> **Note:**
> After eligibility for a couple has been established using the couple SIL, income may be divided to the advantage of the couple but not to the disadvantage of the agency in determining the PLI for each applicant/beneficiary.

Determine the total countable monthly income. Refer to I-1530 Need - SSI-Related Income.

Step 1. Determine the total unearned income.

> For the month of entry to an institution or the month the individual converts from Medicare to Medicaid pay status include the entire SSI payment.
>
> For the following months, exclude any SSI payment received over $30.00 for personal care needs.
>
> Include all VA Pension for Aid and Attendance payments.

Step 2. Determine the total gross earned income.

The earned income deduction is applicable to only ICF/IID residents:

Subtract $65.00 and one-half of the remainder.
The difference is the total countable earned income.

Step 3. Add the total countable unearned income and countable earned income.

Step 4. Deduct the personal care needs allowance. Refer to Z-700 LTC/HCBS SIL Rate, Resource Limits and Personal Care Needs Allowance.

Note:
The reduction of the VA Improved Pension to a maximum of $90 is protected as the personal care needs allowance. Allow the $90 PCN when the VA actually reduces the pension to $90.

Step 5. Subtract all allowable medical insurance premiums. Refer to I-1536 Deductions; H-810.6 Incurred Medical Expense Deduction.

Step 6. Deduct any allowance for the community spouse and/or dependents living in the home prior to admission. Refer to I-1536 Deductions.

The remainder is the patient liability owed by the applicant/beneficiary for their cost of care.

If the patient liability is:

- Equal to or greater than the facility fee, certify the applicant/beneficiary for Medicaid without vendor payment to the facility; or

- Less than the facility fee, certify the applicant/beneficiary for Medicaid with vendor payment to the facility.

H-831.7 Certification Period

The certification period cannot exceed 12 months beginning with the first month of eligibility.

H-831.8 Notice of Decision

Send the notice of decision to the applicant/beneficiary/authorized representative.

Send a copy of the decision notice to the facility.

H-831.9 Post Certification

Applicant/beneficiaries are required to apply for any annuity, pension, retirement, and disability benefits for which they are entitled. They should be encouraged, but not required to apply for SSI cash benefits.

H-840 MEDICAID COINSURANCE—MEDICARE SNF

H-840.1 General Information

Original Medicare Part A covers skilled nursing facility (SNF) care provided to an applicant/beneficiary on a short-term basis if the following conditions are met. The applicant/beneficiary:

- Has Medicare Part A;
- Has a 3-day qualifying hospital stay; and
- Receives skilled nursing facility (SNF) services.

Original Medicare Part A covers SNF care for up to a total of 100 days per Medicare benefit period:

- Days 1 – 20: Medicare pays the full cost. Medicaid has no responsibility for payment.
- Days 21 – 100: Medicare pays all but the daily coinsurance. Medicaid may assist with payment of the daily coinsurance.

Medicare is a third party payor and is billed first in this situation. Medicaid is the payor of last resort.

When the reimbursement from Medicare exceeds the maximum allowable by Medicaid, Medicaid will make an approved payment of $0.00. This claim is considered payment in full and the provider may not seek payment from the applicant/beneficiary.

Applicant/beneficiary income shall not be considered in determining vendor payments for a period of up to 100 days provided he/she remains eligible for Medicare. This also includes the period for which coinsurance is being paid by the Medicaid Program. Refer to LAC 50:II.10147(B).

H-841 ELIGIBILITY DETERMINATION PROCESS

Determine eligibility by applying the following criteria. The elements have been listed in the most logical order, but work on all steps simultaneously.

H-841.1 Determine Assistance/Benefit Unit

The assistance/benefit unit consists of the applicant/beneficiary.

H-841.2 Establish Categorical Requirement

Verify that the applicant/beneficiary is:

- Aged;
- Blind; or
- Disabled.

Refer to E-0000 Category.

H-841.3 Establish Non-Financial Eligibility

Verify eligibility for the applicant/beneficiary with regard to the following factors:

- Assignment of Third Party Rights I-200
- Citizenship/Identity and Qualified Non-Citizen Status I-300
- Continuity of Stay I-400
- Enumeration I-600
- Medical Certification I-1000
- Residence I-1900

H-841.4 Establish Need

A. Determine Composition of the Income Unit

The income/resource unit consists of:

- The applicant/beneficiary;
- Applicants/beneficiaries who are a couple (legally married) residing in the same SNF; or
- For the month of admission only, the applicant/beneficiary who is a minor and the parent(s) with whom he lived during the month. Refer to I-1420 Need - Deeming.

B. Determine Need/Income

Determine the gross income of the applicant/beneficiary including any parental deemed income. Refer to I-1530 Need - SSI-Related Income.

The applicant/beneficiary must have gross income which is equal to or below the SIL to be eligible for Medicaid coinsurance. If his/her income before any deductions or allowances is greater than the SIL, consider for Spend-down MNP. Refer to H-1030 Spend-Down Medically Needy - SSI-Related.

Note:
Exclude any income received from VA Pension for Aid and Attendance from the gross income computation.

Add the gross earned and the gross unearned income, including any income deemed from the parent(s), and compare the total to the SIL. If the applicant/beneficiary is an individual, including a minor child, who has income deemed from the parent(s), use the individual SIL.

If the total gross income is greater than the SIL, the applicant/beneficiary is income ineligible. Consider eligibility in Spend-down MNP.

If the total gross income is equal to or less than the SIL, the applicant/beneficiary is income eligible. Continue the determination of need.

Couples in the Same Facility

Beginning with the month that both the applicant and legal spouse reside in the same facility, determine whether it is to their advantage to have need considered:

- As a couple; or
- As individuals.

If the applicants/beneficiaries are a couple, use the couple SIL.

If the total gross income of the couple is equal to or less than the couple SIL, the applicants/beneficiaries are income eligible. Continue the determination of need.

If the combined gross income of the couple exceeds the couple SIL, the couple is income ineligible. Re-evaluate the eligibility of each individual using the individual's income and comparing it to the individual SIL. If the individual's total gross income is equal to or less than the SIL, the individual is income eligible.

If one or both members of the couple have income above the individual SIL, determine eligibility in the Spend down MNP. Refer to H-1030 Spend-Down Medically Needy - SSI-Related.

If need is considered for the applicants/beneficiaries as a couple, consider eligibility for QMB/SLMB using couple QMB/SLMB limit.

C. Determine Composition of the Resource Unit

The resource unit consists of:

- The applicant/beneficiary;
- The applicant/beneficiary and the community spouse;
- Applicants/beneficiaries who are a couple (legally married) residing in the same facility; or
- For the month of admission (the month of eligibility listed on the BHSF Form 142), only the applicant/beneficiary who is a minor and the parent(s) with whom he lived during the

month. Refer to I-1420 Need - Deeming. After the first month of eligibility, the resource unit consists of the institutionalized individual.

D. Determine Need/Countable Resources

Determine total countable resources of the applicant/beneficiary. Refer to I-1630 Need - SSI-Related Resources.

Transfer of resources or substantial home equity only applies to LTC vendor payment and does not apply to Medicaid coinsurance eligibility determination.

If the applicant/recipient entered the facility on or after September 30, 1989, and has a spouse living in the community, refer to I-1660 Spousal Impoverishment Resource Provisions (LTC/HCBS).

Compare the total countable resources to the resource limit for an individual (or couple). Refer to Z-900 Resource Limits by Program.

If the countable resources are greater than the resource limit, the applicant/beneficiary is resource ineligible for Medicaid coinsurance.

If the countable resources are equal to or less than the resource limit, the applicant/beneficiary is resource eligible for Medicaid coinsurance.

If the resources of a couple are greater than the couple resource limit, consider eligibility for each as an individual.

Note:
If considered as an individual for resource purposes the applicant/beneficiary shall also be considered as an individual for income purposes.

H-841.5 Eligibility Decision

Evaluate all eligibility requirements and verification received to make the eligibility decision.

Note:
Consider income eligibility in QMB or SLMB. Refer to H-1100 Qualified Medicare Beneficiary (QMB) or H-1300 Specified Low-income Medicare Beneficiary (SLMB).

H-841.6 Certification Period

The certification period cannot exceed three (3) months beginning with the first month of eligibility for Medicaid coinsurance because coinsurance is limited to up to 80 days.

The facility is responsible for notifying Medicaid of the first day of the coinsurance.

Eligibility for coinsurance cannot extend beyond the month in which the Medicare payment ends. The facility is responsible for notifying Medicaid of the last day of Medicare payment.

Note:
Because the beneficiary has no PLI while on Medicare/Medicaid coinsurance, he may retain all or most of his income, which may cause an increase in resources. At certification, notify the applicant/responsible person that:

- Resource eligibility is a factor for continued eligibility in coinsurance, and for LTC vendor payment after the coinsurance period ends; and
- It is their responsibility to report if resources exceed the resource limit as of the 1st moment of the month.
- It is the responsibility of the analyst to verify resources prior to the start of vendor payment.

H-841.7 Notice of Decision

Send the notice of decision to the applicant/beneficiary.

Send a copy to the facility.

Note:
If the Medicare skilled determination originally made by the Facility Utilization Committee is later denied by Medicare, change the type case on MEDS and issue notification of Medicaid eligibility.

H-850 RESERVED

H-860 UNDUE HARDSHIP AND UNDUE HARDSHIP EXCEPTION

H-860.1 General Information

An undue hardship may exist when a penalty is determined due to a transfer of assets or equity in home property being over the limit. The penalty would be the denial of vendor payment for nursing facility or home and community-based waiver services. An exception to the penalty may be requested if it is determined that imposing the penalty would cause undue hardship. The exception is for the applicant/beneficiary, not the community spouse. An applicant/beneficiary shall be informed in writing of the opportunity to apply for an undue hardship exception.

H-865 UNDUE HARDSHIP

An undue hardship exists when the applicant/beneficiary's denial of eligibility for vendor payment results in:

- Denial of necessary medical care such that the individual's health or life would be endangered; or
- Loss of food, clothing, permanent residence and other necessities of life.

Undue hardship does not exist when application of the transfer of assets or excess equity in home property merely causes the individual inconvenience or restricts his or her lifestyle but would not put him/her at risk of serious deprivation as described above.

Undue hardship does not exist in the following instances:

1. When transfers are made to the following persons:
   - Blood relatives to a third degree cousin;
   - Mother-in-law;
   - Father-in-law;
   - Brother-in-law; or
   - Sister-in-law.
2. Undue hardship does not exist if the individual who transferred the assets, or on whose behalf the assets

were transferred, has not exhausted all lawful means to recover the assets or the value of the transferred assets.

3. Undue hardship does not exist if the applicant/beneficiary's health or age indicated a need for LTC services was predictable at the time of the transfer.

H-870 UNDUE HARDSHIP EXCEPTION

An undue hardship exception is the dismissal of the penalty, either in whole or in part, which otherwise would have been imposed against an applicant/beneficiary after finding that an undue hardship exists.

H-870.1 Request for Undue Hardship Exception

Prior to imposition of a penalty the applicant/beneficiary must be sent a notice (Notice of the Right to Apply for a Hardship, BHSF Form 2-Hardship) that explains the penalty, their right to apply for an exception and how to apply for the exception. The notice must clearly state:

- That the request for consideration of the exception must be postmarked within seven (7) business days following receipt of the notice;
- That documentation supporting the request for the exception must be provided; and
- The address for the Medicaid office to which the request must be sent.

The Department of Health (LDH) may extend the request period if it determines that extenuating circumstances require additional time.

The request for the exception may be made by the applicant/beneficiary, his representative, or the facility in which he resides.

The individual must provide to the department sufficient documentation to support, by a preponderance of the evidence, the claim that application of the penalty will result in an undue hardship to the applicant/beneficiary; not to the community spouse.

Note:
The community spouse is not protected by the hardship exception.

The exception is for the applicant/beneficiary not to be deprived.

An undue hardship exception may be requested at any time during the penalty period if new circumstances leading to undue hardship arise during the duration of the penalty period. If granted, the undue hardship request shall be prospective from the date of the request.

All requests for exceptions shall be referred to the Eligibility Policy Section with detailed documentation. If additional information is needed to make the exception determination, a notice shall be sent to the person making the request specifying the type of additional information needed and the time within which to provide the additional information.

Once LDH determines that it has received complete documentation, it shall inform the individual within ten (10) business days of the undue hardship decision.

If a request for undue hardship is not received within seven (7) days after notification of transfer penalty, or if the request is denied, LDH shall issue an eligibility determination specifying the applicable penalty period. If the individual is a beneficiary, the notice shall include the date of the Medicaid LTC termination. The notice shall include the right to request a fair hearing and continuing benefits while their appeal is pending.

LDH shall have no obligation to pay for long-term care services during the penalty period unless it grants an undue hardship exception or the applicant/beneficiary prevails in a fair hearing.

H-880 RESULTS OF FINDINGS

If undue hardship is determined to exist and an exception granted, the transferred assets or equity value in the home shall not be considered in the eligibility process.

If a request for an undue hardship exception is denied, the applicant is notified of the decision in writing. The applicant has the right to appeal the denial decision.

If the individual is a beneficiary, the notice shall include the date of the Medicaid LTC termination. The notice shall include the right to request a fair hearing and continuing benefits.

H-885 ENDING UNDUE HARDSHIP EXCEPTION

The undue hardship exception shall end if the individual, the spouse of the individual, or anyone with authority on behalf of the individual, makes any uncompensated transfer of assets after the undue hardship exception is granted.

Deny any requests for an undue hardship exception when it is to reconsider a previous hardship denial, or is a request to reconsider termination of a hardship exception.