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).

In determining income eligibility under the SIL, the individual's gross earned and unearned income before deductions is compared to the SIL standard.

Note:
For individuals who are 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)) and have income which exceeds the SIL, their eligibility will continue to be reviewed 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/enrollee 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 skilled nursing care services. Refer to H-840 Medicaid Coinsurance – Medicare SNF.

H-810.2 Medical Certification

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

Care is given and payment is made in nursing facilities according to the specific medical needs of the resident. Medical needs are grouped into separate levels:

- SNF, including SNF/ID (Infectious Diseases), SNF/TDC (Technology Dependent Care), and SNF/NRTP (Neurological Rehabilitation Treatment Program); or
- Nursing facility (Medicaid).

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

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

An evaluation of the recommended level is made by Office of Aging and Adult Services (OAAS) or Office for Citizens with Developmental

Disabilities (OCDD) to determine the need for nursing care and the level of care required. The decision may be for a different level of care than the recommended level or that nursing care is not the appropriate placement for the applicant/enrollee**.**

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.

An approved medical certification and a *148 Notice of Admission, Status Change, or Discharge for Nursing Facility Care* is required each time there is a change in level of care or when there is a change in ICF/IID facility.

The medical certification form (BHSF Form 142) is issued by the OAAS, OCDD or its designee.

The medical certification form documents the:

- Approval or disapproval of the level of care; and
- Effective date of the level of care approval.

H-810.3 Patient Liability

Patient liability (PLI) is a post-eligibility calculation used to determine the amount the applicant/enrollee 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 enrollees to help meet their personal care needs.

This payment is not available to:

- Medicare SNF enrollees;
- Modified Adjusted Gross Income (MAGI)-related enrollees in an LTC facility;
- Enrollees 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 three months who continue to receive full SSI benefits; or
- Enrollees of home and community-based services (HCBS).

An OSS payment is issued to LTC enrollees 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 a LTC applicant/enrollee incurs that are not covered by third party insurance or Medicaid, and are not the responsibility of the facility.

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

H-820 LONG TERM CARE - MAGI-RELATED

H-820.1 General Information

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

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

- Enrollees whose Medicaid eligibility has already been determined using MAGI-based income 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-related LTC. Eligibility must be considered for Non-MAGI LTC.

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

- Individuals whose Medicaid eligibility has not been determined for a MAGI-based program or Regular MNP but would be eligible in Parent and Caretaker Relatives Group, Children Under Age 19 Group, or Pregnant Women Group 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-Related LTC or Non-MAGI related LTC.

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

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-related assistance/benefit unit that the institutionalized applicant/enrollee 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-related 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/enrollee with regard to the following factors:

- Age – MAGI-Related I-100

- Assignment of Third Party Rights I-200
- Citizenship/Identity and Alienage 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-related 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 type case 03-90. If the individual remains institutionalized more than six (6) months, determine eligibility in Non-MAGI-related 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 related LTC (e.g. aged, blind, or disabled). Refer to H-830 Long Term Care – SSI-Related.

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-related 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/enrollee remains institutionalized for more than six (6) months determine their eligibility in non-MAGI related LTC.

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

H-821.8 Notice of Decision

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

H-821.9 Post Certification

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

H-830 LONG TERM CARE - NON-MAGI RELATED

H-830.1 General Information

Applicants/enrollees residing in a LTC nursing facility may be certified for non-MAGI related LTC.

Persons eligible in the non-MAGI related 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 can 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/enrollee's gross income, excluding Veterans Administration (VA) aid and attendance.

The applicant/enrollee's gross earned and unearned income is compared to the SIL rate. The SIL is three (3) times the annual 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/enrollees who have income above the SIL will continue to have their eligibility reviewed 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/enrollees 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 a 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 a 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 For Three Months Or Less

Special rules apply to SSI recipients who expect to reside in a LTC nursing facility for ninety (90) days or less if:

- The physician certifies that the SSI recipient's stay in the facility is not expected to exceed ninety (90) days; and
- The SSI recipient needs to continue to maintain their home or living arrangements while in the facility.

Eligibility for continued regular SSI benefits will be determined by SSA. The physician's certification must be received by or postmarked to SSA prior to discharge or by the 90th day of medical confinement, whichever is earlier.

Count the SSI payment received for the month of entry in computing patient liability if the individual did not admit on the first day of the month.

Exclude from patient liability the entire SSI payment for the three-month period following the month of admission.

SSA Title II benefits Retirement, Survivors and Disability Insurance (RSDI) for every month are countable and must be budgeted in computing the applicant/enrollee's PLI.

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.

If disability has not been established by the SSA, a MEDT decision is required for all non-MAGI related applications under these provisions.

Referrals shall continue to be made to SSI. Should SSA subsequently determine that the individual does not meet the disability criteria, take action to close the case.

If SSA approves the individual for SSI benefits, the active case will be changed by LaMEDS from a non-SSI type case to a SSI type case for the appropriate setting. Example: Type Case (TC) 04-90 to TC 04-05.

These individuals may be eligible for an OSS payment. Follow-up with SSA on the SSI referrals is required every ninety (90) days.

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 enrollees 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/enrollee.

H-831.2 Establish Categorical Requirement

Verify that the applicant/recipient is:

- Aged;
- Blind; or
- Disabled.

Refer to E-0000 Category.

H-831.3 Establish Non-Financial Eligibility

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

- Age – MAGI-Related I-100

- Assignment of Third Party Rights I-200
- Citizenship/Identity and Alienage 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/enrollee is receiving or plans to receive LTC services from a Medicaid enrolled provider.

A. Determine Composition of the Income Unit

The income unit consists of:

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

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

B. Determine Need/Income

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

The applicant/enrollee 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 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/enrollee 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/enrollee is greater than the SIL, the applicant/enrollee 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/enrollee is income eligible. Continue the determination of need.

Couples in the Same Facility

Beginning with the month that both the applicant/enrollee 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/enrollees 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/enrollees are income eligible. Continue the determination of need using the couple resource limit.

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 need is considered for the applicant/enrollee as a couple, consider eligibility for Qualified Medicare Beneficiary (QMB)**/** Specified Low-Income Medicare Beneficiary (SLMB) using the couple QMB/SLMB standard.

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/enrollee;
- The applicant/enrollee and the community spouse;
- Applicants/enrollees 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/enrollee 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 applicant/enrollee.

D. Determine Countable Resources

Determine eligibility with regard to resources.

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

If resources were disposed of or a trust was established within sixty (60) months prior to application, refer to I-1670 Transfer of Resources for Less Than Fair Market Value. If the applicant/enrollee 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 (TC 21, 23, 24, or 51).

If the applicant/enrollee'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/enrollee 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/enrollee is resource ineligible for LTC.

If the countable resources are equal to or less than the resource limit, the applicant/enrollee 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/enrollee 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/enrollee is LTC eligible, determine the OSS payment and patient liability.

If the applicant/enrollee is not eligible for vendor payment because of transfer of resources or equity interest in the home exceeds the established limit, the applicant/enrollee 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/enrollee 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/enrollee 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/enrollee 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/enrollee 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/enrollee.

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 received.

For the following months, exclude any SSI payment received over $30.00 made for personal care needs.

Include all VA Aid and Attendance payments.

Step 2. Determine the total gross earned income.

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 for the applicant/enrollee.

If the patient liability is:

- Equal to or greater than the facility fee, certify the applicant/enrollee for Medicaid without vendor payment to the facility; or
- Less than the facility fee, certify the applicant/enrollee 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 for LTC vendor payment.

H-831.8 Notice of Decision

Send the notice of decision to the applicant/enrollee.

Send a copy of the decision notice to the facility.

H-831.9 Post Certification

Refer potentially eligible applicants/enrollees to SSI.

H-840 MEDICAID COINSURANCE—MEDICARE SNF

H-840.1 General Information

Medicaid coinsurance provides Medicaid coverage to an eligible applicant/enrollee who:

- Has Medicare Part A; and

- Receives skilled nursing facility (SNF) services.

Medicaid coverage begins on the first day of the month in which the 21st day falls. There is also shared payment with Medicare for the SNF fee after the first twenty (20) days of care.

Medicare is the third party payor in this situation. Medicaid is the payor of last resort and will only pay costs that are not covered by the Medicare payment.

Medicare Part A covers care in a SNF if certain criteria are met.

Original Medicare may pay up to a total of 100 days per Medicare benefit period:

- The first twenty (20) days are paid by Medicare at 100 percent. Medicaid has no responsibility for payment.

- Days 21 - 100 may be paid by Medicare and Medicaid, if the Medicare payment does not cover the entire facility fee. The Medicaid payment is called coinsurance. Eligibility for coinsurance may begin no earlier than the 21st day of Medicare SNF care.

An applicant/enrollee who is certified for Medicare/Medicaid coinsurance payments does not:

- Owe a patient liability; or
- Have a personal care needs allowance.

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/enrollee.

H-841.2 Establish Categorical Requirement

Verify that the applicant/recipient is:

- Aged;
- Blind; or
- Disabled.

Refer to E-0000 Category.

H-841.3 Establish Non-Financial Eligibility

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

- Assignment of Third Party Rights I-200
- Citizenship/Identity and Alienage 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/enrollee;
- Applicants/enrollees who are a couple (legally married) residing in the same SNF; or
- For the month of admission only, the applicant/enrollee 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/enrollee. Refer to I-1530 Need - SSI-Related Income.

The applicant/enrollee must be income eligible based on his/her gross income 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 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/enrollee 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/enrollee is over the SIL, the applicant/enrollee is income ineligible. Consider eligibility in Spend-down MNP.

If the total gross income is equal to or less than the SIL, the applicant/enrollee 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/enrollees 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/enrollees 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 need is considered for the applicants/enrollees as a couple, consider eligibility for QMB/SLMB using couple QMB/SLMB limit.

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.

C. Determine Composition of the Resource Unit

The resource unit consists of:

- The applicant/enrollee;
- The applicant/enrollee and the community spouse;
- Applicants/enrollees 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/enrollee 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/enrollee. 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/enrollee is resource ineligible for Medicaid coinsurance.

If the countable resources are equal to or less than the resource limit, the applicant/enrollee 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/enrollee 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 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 eighty (80) days.

Eligibility for Medicaid coinsurance payment can begin no earlier than the 21st day of Medicare payment. The start date will be the first day of the month of certification. 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 enrollee has no PLI while on 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 approach the resource limit.

H-841.7 Notice of Decision

Send the notice of decision to the applicant/enrollee. 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 HOSPICE SERVICES PROVIDED IN NURSING FACILITIES – [section removed]

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/enrollee, not the community spouse. An applicant/enrollee 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/enrollee'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/enrollee'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/enrollee after finding that an undue hardship exists.

H-870.1 Request for Undue Hardship Exception

Prior to imposition of a penalty the applicant/enrollee 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/enrollee, 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/enrollee; not to the community spouse.

Note:
The community spouse is not protected by the hardship exception. The exception is for the applicant/enrollee 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 an enrollee, 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/enrollee 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 an enrollee, 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.