POLICY

Medicaid (MA) Only

Use this item to determine post-eligibility patient-pay amounts. A post-eligibility patient-pay amount is the L/H patient's share of the cost of LTC or hospital services.

First determine MA eligibility.

Then determine the post-eligibility patient-pay amount when MA eligibility exists for **L/H patients** eligible under:

- A U19 Healthy Kids category.
- A Group 2 (G2U, G2C) category.
- An SSI-related Group 1 or 2 category ***except:***
  - QDWI.
  - Only Medicare Savings Program (with **no** other MA coverage).

MA income eligibility and post-eligibility patient-pay amount determinations are **not** the same. Countable income and deductions from income often differ. Medical expenses, such as the cost of LTC, are never used to determine a post-eligibility patient-pay amount. Do **not** recalculate a patient-pay amount for the month of death.

PATIENT-PAY AMOUNT

The post-eligibility patient-pay amount is total income minus total need.

Total income is the client's countable unearned income plus his remaining earned income; see *Countable Income* in this item.

Total need is the sum of the following when allowed by later sections of this item:

- Patient allowance.
- Home maintenance disregard.
- Community spouse income allowance.
- Family allowance.
- Children's allowance.
- Health insurance premiums.
- Guardianship/conservator expenses.

TOTAL INCOME/ COUNTABLE INCOME

For all persons in this item, determine countable income as follows:

- RSDI, Railroad Retirement and U.S. Civil Service and Federal Employee Retirement System.
- Non-SSI income for SSI recipients.

Calculate countable income using policy in BEM 500, 501, 502, 503, 504 and 530.

Exception: Do **not** use the following special exclusion policies regarding RSDI. These policies only apply to eligibility, **not** post-eligibility patient-pay amounts. VA Aid and Attendance income is not excluded from the Patient Pay Calculation.

- BEM 155, 503 COUNTABLE RSDI.
- BEM 157, COUNTABLE RSDI.
- BEM 158, COUNTABLE RSDI.
- BEM 503, Countable VA PENSION.

Note: The benefits of clients on buy-in increase about three months after buy-in is initiated. Recompute the patient-pay amount when the client's benefits actually change. BAM 810 has information about buy-in.

- **Earned and Other Unearned Income.**

  Use BEM 500, 501, 502, 503, 504 and 530. For clients, use MAGI- or SSI-related policy as appropriate. Use SSI-related policies for all other persons.

  For the **client only**, disregard $65 + 1/2 of his or her countable earned income. Earned income minus the disregard is **remaining earned income**.

NEED ITEMS

Patient Allowance

The patient allowance for clients who are in, or are expected to be in, LTC and/or a hospital for the entire L/H month is $60. Deduct $60 as a need item for the client in the nursing home.

Exception: The patient allowance for a veteran is $90 per month.

Note: The VA determines who receives the Improved Pension and therefore the $90 allowance. The VA may give the Improved Pension to a widow or other member of the veteran's family, see exhibit in this item. Deduct $90 as a need item for the veteran.

Use the appropriate protected income level for one from RFT 240 for clients who enter LTC and/or a hospital but are not expected to remain the entire L/H month.

Reminder: The patient-pay amount is not reduced or eliminated in the month the person leaves the facility.

Home Maintenance Disregard (HMD)

Medicaid beneficiaries who will be residents of a long-term care facility for less than six L/H months may request a disregard to divert income for maintenance of their home for a maximum of six months. Deduct the HMD as a need item for up to six months.

Beneficiaries who have been or are expected to remain in long-term care for longer than six months do not meet the criteria for this disregard.

The PPA will be reduced when all of the following are true:

- A physician has certified the beneficiary is medically likely to return home in less than six months from the date of admission.
- The request is being made for an individual who is a current Medicaid beneficiary and responsible for a patient pay amount.
- The beneficiary is a current resident of a long-term care facility.
- The beneficiary has a legal obligation to pay housing expenses and has provided verification of the expenses. The housing expenses must be in the beneficiary’s name. A foreclosure, eviction or bankruptcy proceedings must not have begun.

- The home is not occupied by a community spouse or children eligible for a family allowance income deduction.
- The written or verbal request is being made by the beneficiary or an individual authorized to act on behalf of the Medicaid beneficiary.

The effective date of the disregard is the first day of Medicaid eligibility as a nursing facility resident. The disregard is for a maximum of six months but may be granted multiple times if the total months do not exceed six months.

Community Spouse Income

L/H patients can divert income to meet the needs of the community spouse as a need item. The **community spouse income allowance** is the maximum amount they can divert. However, L/H patients can choose to contribute less. Divert the **lower** of:

- The community spouse income allowance.
- The L/H patient's intended contribution; see *Intent to Contribute* in this item.

Compute the community spouse income allowance using steps one through five below. An L/H client can transfer income to the spouse remaining in the home even if that spouse no longer meets the definition of a community spouse because they are in a Medicaid waiver program such as PACE, MIChoice, or others listed in the BEM manual.

That is because without the transfer of income the spouse would not be able to remain in the home and avoid also becoming an L/H client.

1. Shelter Expenses

Allow shelter expenses for the couple's principal residence as long as the obligation to pay them exists in either the L/H patient's or community spouse's name.

Include expenses for that residence even when the community spouse is away (for example, in an adult foster care home). An adult foster care home or home for the aged is **not** considered a principal residence.

Shelter expenses are the total of the following monthly costs:

- Land contract or mortgage payment, including principal and interest.
- Home equity line of credit or second mortgage.
- Rent.
- Property taxes.
- Assessments.
- Homeowner's insurance.
- Renter's insurance.
- Maintenance charge for condominium or cooperative.

Also add the appropriate heat and utility allowance if there is an obligation to pay for heat and/or utilities. The heat and utility allowance for a month is $706.00.

Convert all expenses to a monthly amount for budgeting purposes.

2. Excess shelter allowance.

Subtract the appropriate shelter standard from the shelter expenses determined in step one. The shelter standard for a month is $811.50.

The result is the **excess shelter allowance**.

3. Total allowance.

Add the excess shelter allowance to the appropriate basic allowance. The basic allowance for a month is $2705.00. The result, up to the appropriate maximum, is the **total allowance**. The maximum allowance for a month is $4066.50.

Exception: In hearings, administrative law judges can **increase** the total allowance to divert more income to an L/H patient's community spouse; see BAM 600.

4. Countable income.

Determine the community spouse's countable income; see COUNTABLE INCOME in this policy.

5. Community spouse income allowance.

Subtract the community spouse's countable income from the total allowance. The result is the **community spouse income allowance**.

Exception: Use court-ordered support as the community spouse income allowance if:

- The L/H patient was ordered by the court to pay support to the community spouse, **and**
- The court-ordered amount is **greater** than the result of step five.

Intent to Contribute

DHS-4592, Intent to Contribute Income:

- Determines the amount of income an L/H patient intends to contribute to his community spouse.
- Instructs the L/H patient to report how much income he intends to make available.
- Should be returned within 10 days.

If the DHS-4592 is **not** returned within 10 days:

- Do **not** delay case actions, and
- Budget the entire community spouse income allowance.

The entire allowance will be budgeted **until** the DHS-4592 is returned indicating the L/H patient intends to contribute **less**.

When the DHS-4592 indicating an intent to contribute **less** income is received:

- **Decrease** the income diverted to the community spouse to the indicated amount.
- Do **not increase** the income diverted to the community spouse without a new DHS-4592.
- **Decrease** the income diverted if:
  - The community spouse's circumstances change, **and**

- The change reduces the community spouse income allowance **below** the amount indicated on the DHS-4592.

- Use timely negative action procedures to increase the patient-pay amount.

Do **not** use amounts from previous DHS-4592s when diverting income again after stopping a diversion for one of these reasons:

- An L/H patient is discharged to a non-L/H setting for 30 or more days.
- An L/H patient's ongoing Medicaid case (including active deductible) terminates.
- An L/H patient's spouse is hospitalized or in LTC for 30 or more consecutive days.

Start the diversion process from the beginning.

Family Allowance

An L/H patient's income is diverted to meet the needs of certain family members as a need item. The amount diverted is called the **family allowance**.

Family members must**:**

- Live with the community spouse, **and**
- Be **either** spouse's:
  - Married and unmarried children under age 21.
  - Married and unmarried children age 21 and over if they are claimed as dependents on either spouse's federal tax return.
  - Siblings and parents if they are claimed as dependents on either spouse's federal tax return.

The **basic allowance** for each dependent is the monthly amount **minus** the dependent's countable income, divided by 3. The monthly amount is $2705.00.

The **family allowance** is the sum of the dependents' basic allowances.

Children's Allowance

L/H patients without a community spouse can divert income to their unmarried children at home who:

- Are under age 18, **and**
- Do **not** receive FIP or SSI.

The amount diverted is called the **children's allowance**. It is the children's protected income level from RFT 240 **minus** their net income. **Net income** is:

- 80 percent of countable earned income, **plus**
- Countable unearned income.

Do **not** divert income if information concerning the children's income is **not** provided.

Health Insurance Premiums

Include as a need item the cost of any health insurance premiums (including vision and dental insurance) the L/H patient pays for another member of their fiscal group, regardless of who the coverage is for. Include Medicare premiums that a client pays for their own coverage until the buy-in is complete. See Bridges Glossary for the definition of health insurance. See BEM 211 to determine the fiscal group.

Example: L/H patient pays Blue Cross health insurance premiums for two (self and spouse). Allow health insurance premiums for the other members of the fiscal group as a need item.

Do **not** include premiums paid by someone other than the L/H patient as a need item. The community spouse's own Medicare premium is included in the CSIA budget standards. Verify who pays the premium if questionable.

Convert the cost of all premiums to a monthly amount for budgeting purposes.

Note: Allow the $5 deduction paid by GM retirees which includes LTC insurance coverage as an insurance expense deduction.

Guardianship/Conservator Expenses

Allow $83 per month when an L/H patient pays for his court-appointed guardian or conservator as a need item.

Guardianship/conservator expenses must be verified and includes:

- Basic fee.
- Mileage.
- Other costs of performing guardianship/conservator duties.

DHS-3227, TENTATIVE PATIENT-PAY AMOUNT NOTICE

Send a DHS-3227, Tentative Patient-Pay Amount Notice, within five working days of application when:

- The applicant is in LTC, **and**
- A final determination will **not** be made within five working days from date of application.

Send the DHS-3227 to the client and the LTC facility.

NOTIFICATION

Notify both L/H patients and their community spouses **in writing** of:

- Their hearing rights, **and**
- The amount of and method for computing the:
  - Community spouse income allowance, **and**
  - Family allowance.

Provide notice when:

- First calculating community spouse income or family allowance.
- The amount of either allowance changes.
- L/H patients, their community spouses, or representatives of either spouse request it.

Use the following forms to provide notice:

- DHS-4587, Community Spouse and Family Income Allowance Notice.
- DHS-4584, Community Spouse and Family Income Allowance Record.

Send a DHS-4592, Intent to Contribute Income, when the community spouse income allowance is greater than zero.

POST ELIGIBILITY PATIENT PAY OFFSETS

Long-term Care (LTC) facilities may deduct the following post eligibility expenses from a resident's patient pay amount:

- The cost of certain medically necessary services not covered by MA such as chiropractic, podiatry, dental (other than emergency dental and oral surgery) and hearing aid dealers.
- The MA co-payments for covered services.

The remainder of the patient-pay amount is then applied to the cost of care provided by the LTC facility.

MDHHS determines if an offset is allowable.

The post eligibility patient-pay amount is **not** off-set by local office staff.

Note: If an LTC applicant requests an offset of the patient pay to cover old medical bills, see PEME in the glossary and this item. Assist the applicant by forwarding the unpaid bills to:

Medical Services Administration
Michigan Department of Health and Human Services
PO Box 30479
Lansing, MI 48909-9634
Attn: PEME

PRE-ELIGIBILITY PATIENT PAY OFFSETS(PEME)

Long-term care (LTC) facilities may deduct the following from a person's patient-pay amount:

- The cost of certain medically necessary services **not** covered by MA such as chiropractic, podiatry, dental (other than emergency dental and oral surgery) and hearing aid dealers, and
- The MA co-payments for covered services.

The remainder of the patient-pay amount is then applied to the cost of care provided by the LTC facility. The Department of Health and Human Services determines whether an offset is allowable.

Patient-pay amounts are **not** offset by local office staff. Contact the PEME unit at MDHHS-MSA-PEME@michigan.gov with requests to offset a patient pay to cover old medical bills, see PEME in glossary and in this policy.

MSA will determine whether an offset is allowable.

Pre-Eligibility Medical Expenses (PEMEs) are unpaid medical expenses incurred in the three months prior to the application for Medicaid.

The offset of the PPA is only allowed if the money is used to pay the provider(s) for the incurred medical expense and will be terminated if the recipient fails to pay the provider.

Offsets will be applied to the months following an approval. In general, the allowable expenses are the same as allowed for a group 2 deductible case.

In addition, the medical expense(s):

- Must be unpaid, and an obligation still exists to pay.
- The expenses were incurred in the three months prior to the initial approved application for Long Term Care Medicaid.
- Cannot be from a month where Medicaid eligibility existed.
- Cannot be covered by a third-party source (public or private).
- Cannot be from a month in which a divestment penalty has been imposed.
- Cannot have been used previously as a pre-eligibility medical expense to offset a patient-pay amount.

- Can include cost of room and board for Medicaid LTC facilities, remedial care, and other medical expenses recognized by Michigan law but not covered under the Michigan state plan.
- Request for PEME must be made within one year after eligibility for LTC Medicaid has been established and prior to the first Long Term Care Medicaid redetermination following the approved LTC application.

Note: MSA will terminate offsets if there is a failure to pay the medical provider with the funds.

VERIFICATION REQUIREMENTS

Verify income per BEM 500, 501, 502, 503, 504.

Clients must verify the following before the cost can be used to determine excess shelter:

- Shelter obligation and amount.
- Heat and utility obligation but **not** amount.

These must be verified at application, redetermination or change.

Verify the cost of health insurance premiums before allowing the expense at application, redetermination or change.

Verification Sources

Shelter Obligation and Amount:

- Mortgage or rental contracts.
- Statement from mortgage company, bank or landlord.
- Tax or assessment bill or a collateral contact with the appropriate government department.
- Insurance policy, receipt or bill for premium or collateral contact with the insurance company.

Heat and Utility Obligation:

- Current bill or receipt or a written statement from the heat/utility provider.

- Collateral contact with the heat/utility provider.

Home Maintenance Disregard:

- Physician statement signed by a M.D. or D.O.

Health Insurance Premiums:

- Insurance policy (not an application for insurance).
- Receipt or bill for premium.
- Contact with insurer.

Guardian/Conservator Expenses:

- Court Documents.

EXHIBIT - VA NOTICE

This is a portion of an April 1991 letter announcing reduced VA benefits. Key wording is highlighted.

You have been **a patient in a Medicaid-approved nursing home and covered by a Medicaid** plan for services since (Date) . **Because you have no dependents and are receiving Improved Pension, the law requires that we limit your pension to $90.00 monthly** while you are receiving this type of care.

For that reason, we propose to reduce your benefits from (Date) . No overpayment will be created.

This $90.00 monthly payment is for your incidental needs, such as toilet articles, snacks, etc. and **no part of this payment should be used by Medicaid to cover your medical expenses.** You should notify your state Medicaid office that your Improved Pension is being reduced.

LEGAL BASE

MA

Social Security Act, Section 1924
42 CFR 435.725,.726 and.832