DEPARTMENT POLICY

Medicaid (MA) Only

This item completes the Group 2 MA income eligibility process.

Income eligibility exists for the calendar month tested when:

- There is no excess income.
- Allowable medical expenses (defined in **EXHIBIT I**) equal or exceed the excess income.

When **one** of the following equals or exceeds the group's excess income for the month tested, income eligibility exists **for the entire month**:

- Old bills (defined in EXHIBIT IB).
- Personal care services in client's home, (defined in Exhibit ID), Adult Foster Care (AFC), or Home for the Aged (HA) (defined in EXHIBIT ID).
- Hospitalization (defined in EXHIBIT IC).
- Long-term care (defined in EXHIBIT IC).

When **one** of the above does **not** equal or exceed the group's excess income for the month tested, income eligibility begins either:

- **The exact day of the month** the allowable expenses **exceed** the excess income.
- **The day after the day of the month** the allowable expenses **equal** the excess income.

In addition to income eligibility, the fiscal group must meet all other financial eligibility factors for the category processed. However, eligibility for MA coverage exists only for qualified fiscal group members. A qualified fiscal group member is an individual who meets all the nonfinancial eligibility factors for the category processed.

Group 2 for Pregnant Women

The deductible for a pregnant woman is usually met at the first office visit because the woman incurs the full cost of obstetric (OB) services (including labor and delivery) at their first OB visit. The

total cost of the OB services must be equal to or greater than the amount of the deductible in order to open. She is Medicaid eligible for the remainder of the pregnancy and twelve months post-partum.

RULES FOR MA GROUP 2 INCOME ELIGIBILITY

Use the following rules to determine MA Group 2 income eligibility.

The individual must be given the most advantageous use of their old bills (also known as incurred expenses). The individual may request coverage for the current month, up to six future months (see eligibility based on old bills in this item), and for any prior months.

1. Use the budgeting rules in BEM 530. Determine income eligibility in calendar month order, starting with the oldest calendar month.
2. Use BEM 546 to determine the post-eligibility patient-pay amount (PPA) for each L/H month that a beneficiary is Group 2 eligible.
3. Determine Medicare Savings Program eligibility separately for Group 2 beneficiaries entitled to Medicare Part A (see BEM 165).
4. Request information about **all** medical expenses incurred during and prior to each month with excess income.
5. Notify the group of the outcome of each determination. **NOTIFICATION** explains which forms to use and when.

MONTHS WITHOUT EXCESS INCOME

Income eligibility exists for the entire month tested when the group does **not** have excess income.

For **L/H months,** also go to BEM 546 to determine the post-eligibility PPA.

MONTHS WITH EXCESS INCOME

Income eligibility exists for all or part of the month tested when the **medical group's** (defined in BEM 544, **EXHIBIT I**) allowable medical expenses (BEM 545, EXHIBIT I) equal or exceed the fiscal group's excess income. The **NON-L/H** and **L/H** sections that follow list the exact order in which to subtract specific types of these allowable expenses.

NON-L/H PAST AND PROCESSING MONTHS

Use these instructions to determine Group 2 income eligibility for each non-L/H past and processing month with excess income.

Old Bills

1. Compare the **medical group's** allowable old bills (defined in EXHIBIT IB) to the excess income.

   - If there are no old bills, go to 2.
   - If there are old bills and they total **less** than the excess income, subtract the old bills to get the remaining excess income. Go to 3.
   - If the old bills **equal** or **exceed** the excess income, subtract the excess income from the allowable old bills to get the **unused old bills**.

     Income eligibility exists for the entire month tested, **and**:

     - If this is a **past** month, stop.
     - If this is the **processing** month, go to NON-L/H FUTURE MONTH.

Personal Care Services

2. If a group member is/was receiving personal care services in his/her home, AFC, or HA does income eligibility exist based on “EXHIBIT ID"?

   - If **no**, go to 3.
   - If **yes**, income eligibility exists for the entire month.

- If this is a **past** month, stop.
- If this is the **processing** month, income eligibility may be ongoing **unless** you project a change(s); see Exhibit II.
- If you project a change, go to NON-L/H FUTURE MONTH.

LTC Expenses

3. Determine each qualified fiscal group member's LTC (or hospice care in LTC) expenses for the month.

   - If expenses incurred by **one qualified fiscal group member equal or exceed** the excess income, income eligibility exists for the entire month. If expenses incurred by **one qualified fiscal group member** are **less** than the excess income, go to 4.

Inpatient Hospital

4. Determine each qualified fiscal group member's allowable hospital expenses for the month.

   - If expenses incurred by **one qualified fiscal group member** for one admission **equal or exceed** the excess income, income eligibility exists for the entire month.
   - If expenses incurred by **one qualified fiscal group member** for one admission are **less** than the excess income, go to 5.

All Medical Expenses

5. Determine the medical group's allowable medical expenses for the month.

   - If **less** than the remaining excess income, income eligibility does not exist for this month.
     - If this is a **past** month, stop.
     - If this is the **processing** month, the group has or continues to have a deductible. Go to “deductible.”
   - If **equal to or more** than the remaining excess income, income eligibility exists starting on:

- The **day after the day the expenses equaled** the excess income.
- The **exact day the expenses exceeded** the excess income. However, MA may only be billed for the amount that exceeds the group's liability; go to *identifying a group's liability* in this item.

IDENTIFYING A GROUP'S LIABILITY

Use these instructions to determine a fiscal group's liability for all or part of a medical expense incurred on the first day of MA coverage. A fiscal group is not responsible for liabilities of less than $1.00.

1. Identify a group's liability on the date allowable medical expenses exceeded its excess income as follows:

   - The group's excess income for the month tested.
   - **MINUS** allowable medical expenses for the month tested through the day before the date MA coverage begins.
   - **EQUALS** the group's liability.

   If the group's liability is less than $1.00, stop. If it is $1.00 or more, go to 2.

2. Total the group's non-qualified expenses (defined below) incurred on the date expenses exceeded the excess income.

   A **non-qualified expense** is an allowable expense used to meet a deductible but not billable to MA. Such expenses include those incurred:

   - For services not covered by MA.
   - By fiscal or medical group members who are not eligible for MA coverage for this date.

   Go to 3.

3. Subtract the group's total non-qualified expenses from the **group's liability**. Is the remainder less than $1.00?

   If **yes**, stop.
   If **no**, the remainder is the **group's liability balance**. Go to 4.

4. Arrange the rest of the expenses incurred on the date expenses exceeded excess income as follows:

   a. Largest to smallest paid expenses.
   b. Largest to smallest unpaid expenses.

   Go to 5.

5. Subtract the first (next) expense in the order arranged in step 4 above from the group's liability balance. Is there a remainder?

   - If **no**, enter the **group's liability balance** on the DHS-114 as the client payment for this expense. Stop.

   - If **yes**, enter the entire amount of this expense on the DHS-114 as the client payment. The remainder becomes the group's liability balance. Go to 6.

6. Is the group's liability balance less than $1.00?

   - If **yes**, stop.
   - If **no**, repeat step 5.

NON-L/H FUTURE MONTH

Use these instructions to determine ongoing income eligibility for non-L/H months with excess income.

Old Bills

1. Compare the **medical group's** allowable old bills (**EXHIBIT IB**) to the excess income.

   - If there are no old bills, go to 2.
   - If there are old bills and they total **less** than the excess income, the group has or continues to have a deductible. Go to deductible. If the old bills **equal or exceed** the excess income, go to *eligibility based on old bills* in this item to determine whether one or more future month(s) of income eligibility exists.

Personal Care Services

2. If a group member is receiving personal care services (Exhibit ID) in their home, AFC, or HA, does income eligibility exist based on “EXHIBIT II”?

- If **no**, the group has or continues to have a deductible. Go to deductible.
- If **yes**, income eligibility exists for the entire month and continues.

L/H PAST AND PROCESSING MONTHS

See BRG for the definitions of **L/H patient** and **L/H month**.

For L/H months, the L/H patient is the **only** medical group member. Use only his medical expenses to establish income eligibility. Do not recalculate a PPA for the month of death.

Use these instructions to determine Group 2 income eligibility for each L/H past and processing month with excess income.

LTC and Hospital Expenses

1. Determine the beneficiary's allowable LTC and hospital expenses for the month.
   - If **less** than his excess income, go to 2.
   - If **equal to or more than** his excess income, income eligibility exists for the entire month; go to *post eligibility* in this item.

Old Bills

2. Compare the beneficiary's allowable old bills (see EXHIBIT IB) to the excess income.
   - If they are **less** than his excess income, subtract the old bills to get the remaining excess income. Go to 3.
   - If the beneficiary's allowable old bills **equal or exceed** the excess income, income eligibility exists for the entire month; go to *post eligibility* in this item.

All Medical Expenses

3. Determine the beneficiary's allowable medical expenses for the month.

- If **less** than the remaining excess income, income eligibility does not exist for the month.

  - If this is a **past** month, stop.
  - If this is the **processing** month, this client has or continues to have a deductible; go to Deductible in this item. If **equal to or more** than the remaining excess income, income eligibility exists for the entire month. Go to *post eligibility* in this item.

L/H FUTURE MONTH

Use these instructions to determine ongoing income eligibility for L/H patients with excess income.

LTC Expenses

1. Determine the L/H patient's allowable LTC expenses for the month.

   - If **less** than his excess income, go to 2.
   - If **equal to or more** than his excess income, income eligibility exists for the entire month; go to *post eligibility* in this item.

Old Bills

2. Compare the L/H patient's allowable old bills to his excess income.

   - If the old bills are **less** than his excess income, he has or continues to have a deductible; go to **Deductible in this item.** If the beneficiary's old bills **equal** his excess income, income eligibility exists for the entire month.

     If his old bills **exceed** his excess income, income eligibility may exist for more than one month; go to *eligibility based on old bills* in this item.

     Also, go to *post eligibility* in this item to determine the post-eligibility PPA.

POST-ELIGIBILITY

You determined the L/H patient is income eligible for the entire month.

You now must calculate the amount of the beneficiary's liability to the hospital or LTC provider by completing a separate

determination. The result of this second determination is called the **post-eligibility patient-pay amount (PPA).**

Go to BEM 546 to determine the post-eligibility PPA, then:

1. Authorize MA coverage:
   - for the month tested if this is a past month or the processing month, **or**
   - on an ongoing basis if this is a future month.
2. If this is a **past month**, stop.

   If this is the **processing month**, determine continued income eligibility as follows:
   - If the client is still in a hospital or LTC facility on the processing date, go to *L/H future month*.
   - If not, go to *non-L/H future month*.

   If this is a **future month**, and the client was income eligible based on old bills, go to *eligibility based on old bills*.

ELIGIBILITY BASED ON OLD BILLS

A group with excess income can delay deductible for one or more future months based on allowable old bills; see EXHIBIT IB in this item.

Determining the Number of Months to Delay Deductible

1. Do the total old bills equal or exceed the group's excess income?
   - If **yes**, go to 2.
   - If **no**, go to 5.
2. Divide the total old bills by the group's excess income. Drop any fractions. The result equals the number of months the group may delay deductible.
   - If the result is more than one month, go to 3.

- If not, authorize MA for the future month. Go to 5.

3. Authorize MA for the additional months, but not more than a total of six future months. Go to 4.

4. Set a follow-up for whichever is **earliest**:

   - The fifth future month, **or**
   - The month before the last month of MA coverage. Go to 5.

5. Transfer the case to active deductible effective the month following the last month the group's old bills exceeded its excess income.

   Go to Deductible in this item.

Old Bills Follow-up

At follow-up:

- Re-verify the group's liability for old bills, if any.
- Authorize up to six additional months of MA if the group is eligible.
- Notify the group of:
  - Additional MA coverage, or
  - Transfer to active deductible (see step 5 above).

DEDUCTIBLE

Deductible is a process which allows a client with excess income to become eligible for Group 2 MA if sufficient allowable medical expenses are incurred.

Active Deductible

Open an MA case **without ongoing Group 2 MA coverage** on Bridges as long as:

- The fiscal group has excess income, **and**
- At least one fiscal group member meets all other Group 2 MA eligibility factors.

Such cases are called active deductible cases. Periods of MA coverage are added each time the group meets its deductible.

Deductible Period

Each calendar month is a separate deductible period.

Starting the First Deductible Period

The first deductible period:

- Cannot be earlier than the processing month for applicants.
- Is the month following the month for which MA coverage is authorized for recipients.

Deductible Amount

The fiscal group's monthly excess income is called a deductible amount.

Meeting a Deductible

Meeting a deductible means reporting and verifying allowable medical expenses (defined in “EXHIBIT I) that equal or exceed the deductible amount for the calendar month tested.

Use the NON-L/H PAST AND PROCESSING MONTHS section for non-L/H months and the L/H PAST AND PROCESSING MONTHS section for L/H months to determine both:

- The order in which to deduct expenses.
- When to identify a group's liability.

IDENTIFYING A GROUP'S LIABILITY explains how to determine the group's share of its expense(s) on the first day of MA coverage.

Example: The client incurs a medical expense in January 2016. The expense was **reported** and verification turned in to DHHS in August 2016.

- As the expense was reported later than the last day of the third month (April 30, 2016) after the expense, it cannot be used for January 2016.

- The expense can be used as an old bill.

    - When eligibility determination is done in August 2016 the old bill (Jan 2016 expense) can be used for May 2016, June 2016, July 2016, August 2016 or future months. To

allow the client to choose the most advantageous month(s) in which they want to use the old bill, enter the "Apply to Deductible Determination From/To Dates" Most Advantageous does not mean they can turn in an expense at any time and eligibility can be determined for the month the expense was incurred. If the client had **reported** the January 2016 expense between January 1 and April 30th 2016 but had not verified, then the expense can be used for the January 2016 expense when the verifications are received. It is important for the specialist to **document** when the client reports an expense even if the client does not yet have the bill to verify the expense. The expense does not need to be verified before using as an expense.

Example: The client applies for Health Care Coverage in January 2016. Determination of eligibility is not completed until August 2016 and results in the determination of a deductible case for January 2016 ongoing. The client has until the last day of the third month (that is November 2016) following the notification that they client has a deductible case (notice sent August 2016) to report the expense.

Remember: to use an old bill the group/individual's current liability for the expense must be verified by the specialist.

Adding MA Coverage

Add periods of MA coverage each time the group meets its deductible; see INSTRUCTIONS for details.

Renewal

Renew eligibility for active deductible cases at least every 12 months regardless of whether a group has met its deductible.

Processing Changes

The group must report changes in circumstances within 10 days. Redetermine the group's eligibility when a change that may affect eligibility is reported.

Apply changes for the corresponding period as follows if MA coverage has been authorized:

Reductions in MA Coverage

A **reduction** in MA coverage means:

- Higher hospital or LTC patient-pay amount.
- Transfer from MA coverage to active deductible.
- Later MA eligibility begin date.

Do not reduce MA coverage already authorized on Bridges for the processing month or any past month.

Increases in MA Coverage

An **increase** in MA coverage means**:**

- Lower hospital or LTC patient-pay amount.
- Transfer to ongoing MA coverage from active deductible.

Increase MA coverage for any month(s) with coverage already authorized on Bridges.

- Start increased coverage the calendar month the change occurred, if reported within 10 days.

- Start increased coverage the calendar month the change was reported, if not reported within 10 days.

Expenses Reported After Coverage Authorized

A group may report additional expenses that were incurred prior to the MA eligibility begin date you calculated for that month.

Do not alter the MA eligibility begin date if you have already authorized coverage on Bridges. However, any expenses the group reports that were incurred from the first of such a month through the day before the MA eligibility begin date might be countable as old bills.

See EXHIBIT IB and EXAMPLE 7 in EXHIBIT IV.

Closures

Close an active deductible case when **any** of the following occur:

- No one in the group meets **all** nonfinancial eligibility factors.
- Countable assets exceed the asset limit.
- The group fails to provide needed information or verification.

Exception: Do not close the case just because the group fails to verify sufficient allowable medical expenses to meet its deductible.

- The group does not return the redetermination form.
- You cannot locate any of the group members.

Use **adequate notice** to close the case.

NOTIFICATION

This section contains a list of the form(s) you need to notify groups about MA Group 2 eligibility determinations and tells you when to send them.

Send the group a DHS-1606, Health Care Coverage Notice when you:

- Approve or deny MA.
- Add periods of MA coverage to an active deductible case.
- Transfer an active deductible case to ongoing MA coverage.

DHS-114, Deductible Notice

Use a DHS-114 or its Bridges equivalent to notify the group of:

- The start of or transfer to active deductible.
- A change in its deductible amount.
- The begin and end date(s) of MA coverage, when added.
- Its share of the expenses incurred on the date it meets its deductible.
- The names of all providers notified to collect payment from the group for all or part of an expense used to meet deductible.

When a group is liable for all or part of any expense(s) incurred on the first day of MA coverage, send a copy of the DHS-114 (or Bridges equivalent) to **each** provider(s) who must collect all or part of an expense from the group.

DHS-114A, Deductible Report

Send a DHS-114A to the group with every Deductible Notice. At their option, groups may use the DHS-114A to report:

- Incurred medical expenses.
- Changes in circumstances.

MSA-Pub. 617, Medicaid Deductible Information

Give the group a MSA-Pub. 617 or send one with the deductible notice when an active deductible starts and at each redetermination.

VERIFICATION REQUIREMENTS

Verify the following **before** using an allowable medical expense to determine eligibility:

- Date expense incurred.
- Amount of expense.
- Current liability for an old bill.
- Receipt of personal care services provided in a home, an adult foster care home, or home for the aged; see EXHIBIT ID or Exhibit II if verifying ongoing eligibility.

Verify both of the following when you authorize MA based on a personal care co-payment:

- Amount DHHS has authorized for personal care services.
- Amount required but not covered by DHHS payment.

See EXHIBIT II in this item.

Note: Verify continuing residence in a long-term care facility / AFC home at application and redetermination as verification of allowable medical expenses when determining on-going eligibility.

Verification Sources

Sources to verify an incurred expense include:

- Bill from medical provider.
- Receipt from medical provider.
- Contact with medical provider or the provider's billing service.

Sources to verify current liability for an old bill include:

- Current billing or statement from provider.
- Contact with medical provider or provider's billing service.

EXHIBIT I - MEDICAL EXPENSES

A **medical expense** must be incurred for a medical service listed below. Except for some transportation, the actual charge(s) minus liable third-party resource payments counts as an allowable expense. However, not all sources of payment are considered liable third-party resources; see THIRD PARTY RESOURCES, EXHIBIT IA.

Note: A charge cannot be incurred until the service is provided.

You will need additional information to calculate the costs of some medical services. Such information is detailed in separate exhibits. You will be referred to the necessary exhibit where these services are listed.

Count allowable expenses incurred during the month you are determining eligibility for, whether paid or unpaid. You may also count certain **unpaid** expenses from prior months that have not been used to establish MA eligibility; see OLD BILLS, EXHIBIT IB.

Medical Services

Medical services include the following:

- Cost of a diabetes patient education program.
- Service animal (such as a guide dog) or service animal maintenance. In Michigan the animal must be fully trained and cannot be for emotional support, companionship, therapy for others, or crime deterrence.
- Personal cares services in home, AFC, or HA; see EXHIBIT ID.
- Transportation* for any medical reason.
- Medical service(s) provided by any of the following:

- Anesthetist.
- Certified nurse-midwife.
- Chiropractor.
- Christian Science practitioner, nurse or sanatorium.
- Clubhouse psychosocial rehabilitation programs.
- Dentist.
- Family planning clinic.
- Hearing aid dealer.
- Hearing and speech center.
- Home health agency.
- Hospice; see EXHIBIT III.
- Hospital; see EXHIBIT IC.
- Laboratory.
- Long-term care facility; see EXHIBIT IC.
- Maternal support services provider.
- Medical clinic.
- Medical supplier. **
- Mental health clinic.
- Nurse.
- Occupational therapist.
- Ophthalmologist.
- Optometrist.
- Oral surgeon. Orthodontist.
- Pharmacist. ***
- Physical therapist.
- Physician (MD or DO).
- Podiatrist.
- Psychiatric hospital; see EXHIBIT IC.
- Psychiatrist.
- Psychologist.
- Radiologist.
- Speech therapist.
- Substance abuse treatment services provider.
- Visiting nurse.

* Includes ambulance at actual cost and other transportation for medical services at the rates in BAM 825. Includes clients driving themselves for episodic and pharmacy trips at the rate they are paid in BAM 825 for chronic ongoing trips.

** Includes purchase, repair and rental of supplies, such as:

- Prosthetic devices.
- Orthopedic shoes.
- Wheelchairs.

- Walkers.
- Crutches.
- Equipment to administer oxygen.
- Personal response system (for example Lifeline Emergency Services).

*** Includes:

- Legend drugs (that is, can only obtained by prescription).
- Aspirin, ibuprofen and acetaminophen drug products which are prescribed by a doctor and dispensed by a pharmacy.
- Non-legend drugs and supplies, such as:
  - Insulin.
  - Needles.
  - Syringes.
  - Drugs for the treatment of renal (kidney) diseases.
  - Family planning drugs and supplies.
  - Ostomy supplies.
  - Oxygen.
  - Surgical supplies.
  - Nicotine patches and gum.
  - Incontinence supplies.

It does not include medicine chest and first aid supplies, such as:

- Band-Aids.
- Alcohol.
- Cotton swabs.
- Nonprescription cold remedies.
- Ointments.
- Thermometers.

EXHIBIT IA - THIRD PARTY RESOURCES

Third party resource payments are payments from any liable third party for medical care. They include payments Medicare, other health insurers or any liable third party made or will make.

Payments made by any third party cannot be included as part of the beneficiary's medical expense for **any** of the medical service(s) listed in EXHIBIT I. Therefore, you must try to find out if any liable third-party resource payment has been, or will be made to

determine a beneficiary's costs. Count **only** the beneficiary's cost as a medical expense. However, do not delay the eligibility determination just because third party payment information is not readily available.

Exceptions: Payments made by the following are not third-party resource payments:

- Indian health service.
- Payments made by a state- or locally-funded government program are not third-party resource payments. State- and locally-funded government programs include those administered by:
  - County health departments.
  - Community Mental Health.
  - State and county DHHS.

  Any program that receives federal funds is not a state- or locally-funded program.

Such payments can be used to meet the beneficiary's deductible as follows:

- Count the entire expense for the month during which the service was provided.

- Count **only** the portion of the expense the client must actually pay when using an expense as an old bill; see EXHIBIT IB.

Example: Community Mental Health (CMH) provides $300 in services to a client in February 2016. CMH determines the beneficiary's ability to pay is $30. Therefore, CMH will not attempt to collect more than $30 from the client for February's services.

The client applies for MA on May 31, 2016, and requests MA for February, March and April.

This medical expense could be counted in one of two ways:

A. **The month being tested is February.**

Count the entire expense ($300) for February.

B. **The month being tested is March or April or May.**

The client was not eligible for February and verifies:

- His February CMH bill is unpaid, and

- He is still liable for the $30 for February.

  Count the $30 the client is still liable for as an old bill; see **EXHIBIT IB** in this item.

Note: All services and supports provided by a CMH program, including case management services, are considered medically necessary and all charges for these services should be applied fully to the beneficiary's monthly deductible obligation.

EXHIBIT IB - OLD BILLS

Medical expenses listed under **Medical Services** in EXHIBIT I can be used as **old bills** if they meet **all** of the following criteria:

- The expense was incurred in a month prior to the month being tested.
- During the month being tested:
  - The expense is/was still unpaid, **and**
  - Liability for the expense still exists (existed).
- A third-party resource is **not** expected to pay the expense.
- The expense was **not** previously used to establish MA income eligibility.
- The expense was one of the following:
  - Incurred on a date the person had no MA coverage.
  - **Not** an MA covered service.
  - Provided by a non-MA enrolled provider.
- A member of the medical group incurred the expense. This includes expenses incurred by a deceased person if both:
  - The person was a medical group member's spouse or unmarried child under 18.
  - The medical group member is liable for the expense.

Note: An expense which has been turned over for collection is still a medical expense until the provider has written off the expense.

You must give groups that have excess income the opportunity to verify old bills before you start an active deductible case.

Use old bills in chronological order by date of service.

EXHIBIT IC - HOSPITAL AND LONG-TERM CARE EXPENSES

A person cannot incur hospital care or long-term care expenses until he is actually admitted to the facility.

A person may receive **hospice** care in a hospital or long-term care facility. Do not consider the expense of such care a hospital or long-term care expense; see EXHIBIT III, HOSPICE CARE, in this item.

Hospital Care

Calculate the expense of inpatient hospital care or inpatient care in a private psychiatric facility as follows:

Actual charge for inpatient care
- Liable third-party resource payments*

= Countable expense of hospital care

Long-term Care

Calculate the expense of long-term care as follows:

LTC facility's charge at the private rate
- Liable third-party resource payments*

= Countable expense of long-term care

Medicare Part A may cover up to 100 days of care per episode of illness. If so, the first 20 days the Medicare beneficiary's LTC expenses are zero, because there is no coinsurance. Beneficiaries must pay coinsurance for days 21 through 100.

*Liable third-party resource payments are explained in EXHIBIT 1A.

EXHIBIT ID - PERSONAL CARE SERVICES

Allowable medical expenses (EXHIBIT I) include amounts the medical group **incurs** for personal care services in their home or AFC, or Home for the Aged. Clients may receive personal care services

while living in their own home, an adult foster care (AFC) home or a home for the aged (HA).

Personal care expenses in their home, AFC or HA are incurred monthly regardless of when services are paid for.

In addition, the client may be liable for the employer's portion of FICA taxes. This FICA liability is an allowable medical expense. If the client claims this expense, use the current percentage for the employer's portion of the FICA tax on the incurred cost rather than the actual FICA payment. The services specialist has information about the current percentage for the employer's portion of the FICA tax.

Allowable Services

Personal care services in their home, AFC or HA must be services related to activities of daily living. Activities of daily living include:

- Eating/Feeding.
- Toileting.
- Bathing.
- Dressing.
- Transferring.
- Grooming.
- Ambulation.
- Taking medication.

Household services provided in the beneficiary's home must be services essential to the ill person's health and comfort. Such services include:

- Personal laundry.
- Meal preparation/planning.
- Shopping/errands.
- Light housecleaning.

Excluded Services

The following services are **not** allowable as personal care:

- Heavy housecleaning.
- Household repairs.
- Yard work.

The following services are **not** allowable as personal care for clients residing in an AFC or HA:

- Room.
- Board.
- Supervision.
- Household services.
- Remedial services; see BEM 544.

Personal Care Services in Beneficiary's Home, AFC, or HA

The personal care services provider **cannot** be a responsible relative of the person requiring care if the client lives in his own home. Responsible relative means:

- A person’s spouse.
- The parent of an unmarried child under age 18.

A physician (MD or DO) must verify the need for personal care services in their home, AFC, or HA and the estimated duration of need. At the end of the estimated duration of need, a physician must verify continued need.

If available, use the verifications obtained by Adult Services for the Home Help eligibility determination or the Adult Community Placement (ACP).

Verifications

The personal care services provider must verify all of the following:

- Date the service was provided.
- The charge for that day for the services provided.
- That the services rendered are services related to activities of daily living.
- That household services rendered in the beneficiary's home are services essential to the ill person's health and comfort. See Exhibit ID.

EXHIBIT II - MA ELIGIBILITY AND PERSONAL CARE

Beneficiary's with excess income who are receiving personal care Home Help Services in their home, AFC, or HA may be eligible for

ongoing MA coverage. MA coverage can be authorized or continued at the beneficiary's option provided all conditions in this Exhibit are met.

The beneficiary's option to pay a portion of his personal care cost works much the same as paying a patient-pay amount to a hospital or long-term care facility. When a client chooses this option, his services specialist subtracts his excess income from the MDHHS payment for personal care services. The client is then responsible for paying his excess income amount directly to his personal care provider. This ensures MA does not pay the beneficiary's liability.

Discuss this policy option with the client. Advise the client that he will be responsible for paying his excess income to his Home Help Services personal care provider, AFC provider, or HA provider. This cost may include the employer's portion of FICA taxes. The services specialist has information about what portion of the beneficiary's excess income is for the provider and what portion, if any, is for FICA taxes.

Sometimes personal care costs exceed the maximum amount services will pay. In such cases the client is responsible for the amount services will not pay. If the client chooses the policy option described in this Exhibit, he will be responsible for the amount services will not pay in addition to his excess income. Under these circumstances, this option may not be advantageous to the client.

Conditions of Eligibility

1. The client must meet all nonfinancial eligibility factors and all financial eligibility factors **except** income.

2. The client must have an active Adult Services case with Home Help or ACP services **and** be receiving personal care services in his home, AFC, or HA. Consider the services case active as soon as the services specialist begins to work with the client.

   The services specialist is responsible for obtaining verification of the need for personal care services and making the ACP or Home Help eligibility determination.

3. The amount DHHS has or will approve for personal care services must exceed the beneficiary's excess income. Contact the services specialist for the following information:

- The amount DHHS has or will approve for personal care services.
- The amount of personal care services required but not approved by MDHHS (ACP determines the need for personal care, AFC determines the cost for the personal care).

4. The beneficiary must agree to pay his excess income to his provider.

If **all** of the above conditions exist, income eligibility begins the month DHHS reduces or will reduce its payment for personal care services by the amount of the beneficiary's excess income. The beneficiary's excess income becomes his **personal care co-payment.**

Within two working days of determining the client is eligible under this option, notify the services specialist in writing of the MA effective date and the amount of the beneficiary's personal care co-payment.

Income eligibility does not exist if **any** of the above conditions are not met. Return to the procedure that sent you to this Exhibit.

Changes in Circumstances

MA eligibility cannot continue based on this policy option if the beneficiary's circumstances change for reasons including, but not limited to, the following:

- The beneficiary no longer needs personal care services in their home, AFC, or HA.
- The cost of personal care no longer exceeds his excess income.
- The beneficiary enters LTC.

Notify the services specialist in writing **within two working days** when a change(s) in the beneficiary's circumstances changes the amount of his personal care co-payment. Send a memo to the services specialist for SSI-related cases.

If the personal care co-payment **decreases**, use adequate notice. The begin date for the lower personal care co-payment is the first day of the month in which you make the determination.

If the personal care co-payment **increases**, use timely notice (see BAM 220). The begin date for the higher personal care co-payment is the first day of the month following the month in which the negative action period ends.

Do not close a case eligible under this option because the beneficiary does not pay the provider. MA funds will not be used to pay the beneficiary's liability because the beneficiary retains responsibility for that portion of his incurred expenses. The issue of payment of these expenses remains between the individual, services and the personal care services provider.

EXHIBIT III - HOSPICE CARE

A terminally ill person may receive hospice care. Hospice organizations provide or arrange for all care related to the person's terminal illness. Hospice organizations do not provide or arrange other medical services (such as dental care).

A person is eligible for hospice care under MA when all of the following are true: He knows of the illness and his life expectancy. He chooses to receive hospice services. A doctor (MD or DO) certifies he has six months or less to live.

The hospice notifies the Michigan Department of Health and Human Services (MDHHS) when an MA beneficiary enrolls. MDHHS authorizes the appropriate PET code on Bridges.

Hospice Services

Hospice services fall under five categories:

1. **Routine home care** - Non-continuous at-home care.

2. **Continuous home care** - Predominantly nursing care provided at home as short-term crisis care. May also include home health aide or homemaker services.

3. **Inpatient respite care** - Short-term inpatient care for the terminally ill individual to give the at-home caregiver relief. Inpatient respite care is usually five continuous days or less in

a hospital, nursing facility, intermediate care facility or freestanding hospice facility.

4. **General inpatient care** - Usually for pain control or acute or chronic symptom management. May be provided in a hospital, nursing facility or freestanding hospice facility.

5. **Routine at-home care in a nursing facility** - Individuals who do not have a home or family member or friend who can care for them may stay in a nursing facility and receive routine home care from the hospice.

EXHIBIT IV - MA GROUP 2 CASE EXAMPLES

EXAMPLE 1

Deductible Delayed with Old Bills

10/15/16 - Mr. B. applies for MA. He also requests MA coverage for July, August and September 2016.

Mr. B. verifies an old bill for $315.00.

11/22/16 - Process Mr. B's application and determine the excess income is $30.00.

Mr. B. is eligible for MA coverage for 10 months based on old bills. You set a follow-up for 3/17.

After the MDHHS-176 Deadline Date you send Mr. B. a MDHHS-176, DHS-114, DHS-114A and MSA-Pub. 617 to notify him his case will have a $30.00 monthly deductible effective 5/1/17.

4/1/17 - Any day on or before the MDHHS-176 Deadline Date, transfer Mr. B's case to active deductible:

EXAMPLE 2

Deductible Met with Old Bill Balance and Current Bills

5/3/16 - Mr. B. contacts you, indicating he has met his $30.00 deductible for May 2016. He drops off copies of a prescription charge for $14.71 for 5/2/16 and a doctor's office visit on 5/3/16 for $25.00. You also verify he still owes the $315.00 old bill he reported at application. $300.00 of the old bill was used to establish 10 months of initial income eligibility, leaving a $15.00 balance.

5/10/16:

- Allow the $15.00 unused old bill, $14.71 prescription and $25.00 office call.
- Calculate a new budget.
- Determine Mr. B. met his deductible on 5/3/16.

Authorize MA coverage:

Send Mr. B. a DHS-1606, DHS114 and DHS-114A. The DHS-114 notifies Mr. B. that:

- He has MA coverage for 5/3/16 - 5/31/16, and
- His monthly deductible is $30.00.

Mr. B.'s liability for 5/3/16 is less than $1.00. Therefore, Mr. B. doesn't have to pay it.

EXAMPLE 3

Deductible Met With Incurred Expenses

7/8/16 - Ms. J. submits a DHS-114A and attaches the following verification:

- Office call 7/2/16 - $35.00.
- X-rays 7/316 - $60.00.
- Prescriptions 7/5/16 - $34.93.

Ms. J.'s monthly deductible amount is $115.00.

7/12/16 - Calculate a budget on Bridges. The beneficiary is liable for $20.00 for 7/5/16.

Send the beneficiary a DHS-114 and a DHS-114A. The DHS-114 indicates Ms. J. is eligible for MA coverage for 7/5/16 through 7/31/16 but is responsible for $20.00 to the pharmacist for services rendered 7/5/16.

Send the pharmacist a copy of the notice to verify the beneficiary's $20.00 liability for services rendered 7/5/16.

Authorize MA:

EXAMPLE 4

Ongoing MA to Active Deductible

Mrs. N. has received MA coverage for five years.

10/8/16 - Mrs. N. reports additional continuing income that results in excess income of $43.00 per month.

10/11/16 - Request incurred medical expense information. Mrs. N. states that she has no old bills.

10/12/16 - Start timely negative action procedures to transfer the case from ongoing Group 2 MA to active deductible, effective 11/1/16.

Send the beneficiary a DHS-114, DHS-114A and MSA-Pub. 617. The DHS-114 informs Mrs. N. that her case is being transferred to active deductible effective 11/1/16, with a deductible amount of $43.00 per month.

EXAMPLE 5

Excess Assets

2/4/16 - Mr. M. has an active deductible case. His monthly deductible amount is $456.00. He reports $95,000 from the sale of his apartment building (previously excluded as income-producing property).

2/7/16 -Send Mr. M. adequate notice (DHS-417, Excess Assets Notice) and close the case based on excess assets.

EXAMPLE 6

Deductible Not Met in Three Months

Jodi H. has an active deductible case. Her annual renewal is due 1/17.

12/6/16 - Jodi's case appears on the 12/16 RD-093. You review the case and determine that Jodi has not met her deductible in 9/16, 10/16 and 11/16.

Bridges automatically generates a negative action notice.

EXAMPLE 7

Expenses Reported After MA Coverage Added

Mr. C. has a $55.00 deductible amount.

10/7/16 - Mr. C. reports the following allowable medical expenses:

- 10/1/16 Dentist for filling - $37.50.
- 10/6/16 Outpatient blood test - $52.00.

10/14/16 - Authorize full MA coverage effective 10/6/16 with Mr. C's liability = $17.50.

10/28/16 - Mr. C. verifies the following additional allowable medical expenses:

- 10/2/16 Specialist exam - $75.00.
- 10/2/16 Prescription - $18.75.

Determine that the specialist exam is unpaid. However, Mr. C. paid for the prescription.

Coverage cannot be backdated to an earlier date in 10/16. Therefore, you complete a budget on Bridges for 11/16, counting the $75.00 expense as an old bill. The paid prescription cost cannot be counted.

Mr. C. meets his deductible for 11/16, based on the $75.00 old bill. $20.00 remains as an unused old bill.

Authorize MA coverage for 11/1/16 through 11/30/16 and send Mr. C. a DHS-1606, DHS-114 and DHS-114A.

EXAMPLE 8

Changes in the Deductible Amount

Tina has a $45.00 deductible.

On 9/3/16, Tina submits the following:

- A DHS-114A, indicating a change in income for 7/16 and 8/16 due to overtime.
- Check stubs for 7/16 and 8/16. A statement of expected hours for 9/16.

On 9/6/16, calculate budgets for 7/16, 8/16 and 9/16. You determine Tina's deductible amounts are:

- $61.00 for 7/16.
- $57.00 for 8/16.
- $42.00 for 916.

Send Tina a DHS-114 to notify her of her new deductible amounts for 7/16, 8/16 and 9/16.

Deductible and SLMB

Mr. A. applies for MA on 3/12/16. You process the application on 3/26/16 and determine Mr. A.:

- Is eligible for limited-coverage QMB (SLM), but
- Has $342.00 excess income for Group 2 MA.

Mr. A. submits proof of the following medical expenses:

- Doctor's Office 3/2/16 - $200.00.
- Prescription 3/2/16 - $142.00.

Mr. A.'s expenses on 3/2/16 equal his excess income, so Group 2 MA eligibility exists starting 3/3/16.

Send Mr. A. a DHS-1606, DHS-114, DHS-114A, DHS-4660 and MSA-Pub. 617 to notify him of **all** of the following. He:

- Is eligible for SLMB starting 3/1/16.
- Is eligible for Group 2 MA 3/3/16 - 3/31/16.
- Has an active deductible case with a deductible amount of $342.00, starting 4/1/16.

Send a copy of the QMB memo to DHHS-MSA.

3/26/16**,** authorize MA coverage:

EXAMPLE 11

Deductible and ALMB

Mr. C. applies for MA on 3/4/16. Process the application on 3/25/16 and determine that Mr. C.:

- Has $572.00 excess income for Group 2 MA, and
- Has incurred expenses equaling his deductible on 3/3/16, and
- Would have qualified for ALMB except for his March MA eligibility.

On 3/25/16, authorize MA coverage:

Send Mr. C. a DHS-1606, DHS-114, DHS-4660, DHS-114A and MSA Pub. 617 to notify him that he:

- Is eligible for MA 3/4/16 - 3/31/16, and
- Has an active deductible case with a $572.00 deductible amount starting 4/1/16, and
- Is qualified for ALMB starting 4/1/16.

  Note: You did a future month (April 2016) budget on Bridges to show Mr. C. ALMB-qualified and to get the ALMB notice.

Bridges updates the scope coverage.

LEGAL BASE

MA

42 CFR 435.831(b)-(d)
MCL 400.106, .107