LONG TERM CARE SERVICES

F-300 PERSONS INSTITUTIONALIZED LESS THAN 30 CONSECUTIVE DAYS

A client in this group must have countable income below SSI payment levels and must be an inpatient in a skilled nursing facility (SNF), intermediate care facility (ICF or ICF/MR), or hospital and meet all eligibility requirements.

In determining the number of days in a medical institution for eligibility purposes, include the day of admission, but not the day of discharge/death.

An "outpatient" stay is less than a 24–hour period regardless of the hour of admission, whether or not a bed is used or whether or not the patient remains in the facility past midnight.

F-305 ELIGIBILITY EXCEPTIONS

a. All individuals under age 65 who are inpatients in an institution for mental disease (IMD), i.e., freestanding psychiatric hospital, **are not** eligible for Medicaid in this category.

   An IMD is defined as a hospital, nursing facility or other institution of more than 16 beds which is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Individuals are severely psychotic, emotionally ill, suicidal and a danger to themselves, others or property. In Nevada IMDs are commonly referred to as "psychiatric hospitals." **An institution for the mentally retarded IS NOT an institution for mental disease.**

b. An inmate of a public institution is ineligible for Medicaid UNLESS the institution is a medical institution. An inmate of a penal institution is NEVER eligible for Medicaid while in the custody of law enforcement officials, UNLESS admitted as an inpatient to a hospital, nursing facility, juvenile psychiatric facility, or intermediate care facility. This individual is eligible for any Medicaid covered services provided to them while an **inpatient** in these facilities and they are Medicaid-eligible. If this individual becomes an inpatient of a long-term care facility, they must meet level of care and plan of care assessments to become eligible.

c. Individuals under 22 receiving inpatient psychiatric services in a residential treatment center (RTC) **are** eligible for Medicaid in this category.

   RTCs specialize in treating children with conduct, personality and emotional disorders, depression, hyperactivity, academic failure, and/or mild learning disabilities. Medicaid will pay for services provided in a RTC if the referral resulted from a "Healthy Kids" screening and the admission was prior authorized/certified by Medicaid's Peer Review Organization (PRO).

These cases must also be evaluated for QMB eligibility.

F-310 DEFINITIONS

SSI Eligible Spouse - The client's spouse who meets the requirements in both a. and b. below:

a. Is pending SSI, received SSI or would have been eligible for SSI;

   To determine if the spouse would have been eligible for SSI, the spouse:

   1. must have been aged, blind or disabled. Blindness and disability is established when the spouse has been determined eligible for any type of permanent disability/blind benefits (e.g., SSA, VA, or retirement disability benefits); and

   2. must be determined financially eligible.

b. Is living with the client or has not been separated longer than the specified time frames:

Consider the client a **member of a couple with an eligible spouse** only for the month they ceased living together.

SSI Ineligible Spouse - The client's spouse who is not pending SSI, not receiving SSI and would not have been eligible for SSI.

When the spouse is not aged or has not been determined eligible for some type of permanent disability/blindness benefits consider the spouse an SSI ineligible spouse.

The ineligible spouse's income must always be considered when the client is living with the spouse. When the client and ineligible spouse are separated, the ineligible spouse's income is only considered the month of separation.

Individual - Consider clients as individuals when they are:

a. NOT married;

b. Married but have been separated from their SSI ELIGIBLE spouse for a specified time frame:

   The client will be considered an individual beginning the month after the month they cease living together.

c. Married but have been separated from their SSI INELIGIBLE spouse for a specified time frame:

   Consider the client an individual the month FOLLOWING the month they ceased living together;

d. Had an SSI INELIGIBLE spouse who received TANF, VA pension or other assistance based on need for the month Medicaid is requested.

Monthly Maintenance Needs Allowance - An amount determined by adding together the federal minimum maintenance need standard (150% of poverty for 2 persons) and an excess shelter allowance. This amount cannot exceed the federal maximum maintenance needs standard except when authorized by findings of an administrative review/hearing.

Housing Costs (principal place of residence) - The community spouse's expenses for rent or mortgage payment (including principal and interest), property taxes and mortgage/rental insurance. In situations where a maintenance charge is required, allow only that portion which does not include personal or individual utility expenses.

Standard Utility Allowance (SUA) - An amount established under SNAP which is the statewide average of total monthly utility costs.

Do not allow SUA if utilities are included with the rent and cannot be separately identified.

If the telephone service is the only utility, allow the telephone allowance instead of the full SUA.

Excess Shelter Allowance - An amount (if any) determined by subtracting the federal excess shelter deduction (30% of 150% poverty for two persons) from the community spouse's housing costs plus the SUA.

Verification of the community spouse's gross income and housing costs must be obtained. If income verifications are not returned by the required date, the case will be completed without allowing a maintenance allowance. If verification of housing costs and/or utility expense is not provided, compute the spousal income allowance without it.

The client will be notified on the Notice of Decision, the patient liability was determined without a maintenance allowance deduction. If, however, the verifications are received after the required date, the maintenance allowance deduction will be allowed beginning the month the verification was received.

The community spouse monthly income allowance deduction will be discontinued if information is received the spouse is not receiving the maintenance allowance.

F-315 BUDGETING PROCEDURES FOR SSI FINANCIAL ELIGIBILITY SSI BUDGET FORM 2646-EE (Spouse to Spouse Deeming)

F-315.1 Income Consideration

Determine whether the client is considered an individual or a member of a couple with an SSI eligible or ineligible spouse by applying the definitions in this section.

When the client is considered an individual, only the client's income is counted. Additionally, when the client is considered a member of a couple, the spouse's income is counted for a specified time period.

Spouses **separated temporarily,** for economic (employment) or emergency reasons (hospitalization), vacations or visits are NOT considered "separated" (ceased living together) for purposes of income consideration. The separation must be expected to continue. A temporary absence is one where the individual leaves and returns to the household in the same month or the following month.

When income of the spouse must be considered, the income will be verified. If impossible to verify the spouse's income, document the circumstances and accept the client's statement.

F-315.2 SSI Budget Form 2646–EE – General Instructions

F-315.2.1 Member of Couple with Eligible Spouse

Any time the spouse appears potentially SSI eligible, treat as an eligible spouse until determined ineligible.

Use the **member of a couple, with eligible spouse** column.

a. If ineligibility results, consider the spouse ineligible and go through the deeming computation by using the **member of a couple, with ineligible spouse** column, to determine if deeming applies.

b. If deeming doesn't apply, proceed to Part B using the **individual** column.

c. If deeming does apply, proceed with the budget under the **member of a couple with ineligible spouse** column. If this process also results in ineligibility, the client is ineligible for Medicaid.

F-315.2.2 Member of Couple with Ineligible Spouse

Use the **member of a couple, with ineligible spouse** column, items A–1 through 3 to determine if deeming applies.

a. If deeming doesn't apply, proceed to the **individual** column of the budget.

Deeming never applies when the SSI ineligible spouse receives TANF, VA pension or other federal or state assistance based on need.

F-315.2.3 Individual

Use the **individual** column, when the person meets the definition of an individual.

F-315.3 SSI Budget Form 2646-EE - Specific Instructions

F-315.3.1 Deeming Computation

Deeming never applies when the SSI ineligible spouse receives TANF, VA pension or other federal or state assistance based on need.

a. Determine the ineligible spouse's total unearned income.

b. Determine if an SSI ineligible child(ren) allocation is applicable. The allocation is applicable if there are any dependent children who are:

   1. Under age 18 OR under age 22 and are students regularly attending a school, college or university or a course of vocational or technical training to prepare for gainful employment; **and**

   2. The child(ren) are not receiving TANF, VA pension or other federal or state assistance based on need.

c. If the allocation deduction is applicable, for each ineligible child, subtract the child's income from the child allocation amount. Subtract the remainder from the ineligible spouse's unearned income.

d. Determine the ineligible spouse's gross earned income.

e. Subtract the balance of any allocation for ineligible children not offset by unearned income.

f. Add the remaining unearned income to the remaining earned income, after the allocation deductions.

g. Compare the total income after allocations to the deeming indicator amount.

   If less than the deeming indicator amount, deeming does not apply, proceed to Part B, **individual** column of the SSI budget using only the client's income.

If equal to or more than the deeming indicator amount, deeming DOES APPLY. Proceed to Part B **member of a couple with an ineligible spouse** column adding the unearned income after allocations to the client's unearned income and the remaining earned income to the client's earned income.

F-315.3.2 SSI Eligibility Determination

In this section of the budget, use only the client's income when using the **individual** column. Use combined incomes of the client and eligible or ineligible spouse when using the **member of a couple with an eligible or ineligible spouse** column.

a. Determine unearned income.

b. Subtract the general income exclusion of $20 to arrive at the remaining unearned income.

c. Determine total gross earned income.

d. Subtract any balance of the general exclusion not offset by unearned income.

e. Subtract the work expense exclusion of $65.

f. Impairment–Related Work Expenses (IRWE). This exclusion is applied to earned income of disabled (but not blind) individuals under age 65.

The expense must be reasonable; for items/services which are directly related to enabling an impaired individual to work, and which are necessarily incurred by the individual because of a physical or mental impairment.

IRWEs are excludable when the cost is paid by the disabled individual and is not reimbursable from another source.

g. Subtract 1/2 of the remaining earned income after the above deductions.

h. Determine the total countable income by adding Items B–1–b and B–2–e.

i. Compare the total countable income (Item B–3) to the appropriate SSI payment amount (SPA).

If the amount is equal to or greater than the SPA in the **member of a couple with ineligible spouse** or **individual** columns, the client is ineligible for Medicaid.

If ineligible in the **member of a couple with eligible spouse** column, proceed to the **member of a couple with ineligible spouse** column to complete the eligibility determination.

F-320 BUDGETING PROCEDURES FOR SSI FINANCIAL ELIGIBILITY OF CHILDREN – PARENT TO CHILD DEEMING BUDGET – FORM 2646–EE/A

F-320.1 General Deeming Provisions

If the child is under age 18 **or** under age 21 and regularly attending school, college, university or technical training designed to prepare him/her for gainful employment **and** living in the same household with the natural/adoptive parent(s) or natural/adoptive parent and a stepparent; all income of the ineligible parent(s) will be considered in determining eligibility for the child.

a. Deeming applies from a parent to a child when they live together in the same household.

b. Deeming stops the month following the month of institutionalization in a medical facility.

c. Deeming begins the month following the month the child returns home from a medical facility.

d. Deeming applies even when the child is temporarily absent from the home. A temporary absence exists when:

1. The child leaves the household but intends to, and does, return in the same month or the following month; or

2. The child is away at school but returns home on some weekends, holidays, or vacations **and** is subject to parental control.

Consider the parent(s) or stepparent an ineligible parent when they are not pending SSI, receiving SSI or would not have been eligible for SSI.

To determine if the parent would have been eligible for SSI, the parent must be aged, blind or disabled. Blindness and disability is established when the parent has been determined eligible for any type of permanent disability/blind benefits, such as SSA, VA, or Retirement Disability Benefits, and is determined financially eligible.

When the parent is not aged or has not been determined eligible for some type of permanent disability/blindness benefits, consider the parent an SSI ineligible parent.

If the child is only living with a stepparent (natural/adoptive parent is not in the home) deeming does not apply. If the child is living with a natural/adoptive parent and a stepparent, deeming will apply.

F-320.2 Parent to Child Deeming Budget – General Instructions

The following types of parental income are excluded when determining the amount of deemed income:

a. Any portion of a grant, scholarship or fellowship used to pay tuition or fees;

b. Money received for providing foster care to an ineligible child;

c. Any income used to comply with the terms of court–ordered support or support payments enforced under Title IV–D;

d. Disaster Assistance.

Deeming never applies when the parent(s) or stepparent receives TANF, VA pension or other federal or state assistance based on need.

F-320.3 Deeming Computation

a. Determine the ineligible parent/stepparent's total unearned income.

b. Determine if an SSI ineligible child(ren) allocation is applicable. The allocation is applicable if there are a dependent (natural or adoptive) child(ren) who are:

1. Under age 18 OR under age 21 and are students regularly attending a school, college or university or a course of vocational or technical training to prepare for gainful employment; **and**

2. The child(ren) are not receiving TANF, VA pension or other federal or state assistance based on need.

c. If the allocation deduction is applicable, for each ineligible child, subtract the ineligible child's income **(includes the total child support for the ineligible child)** from the child allocation amount. Subtract the remainder from the ineligible parent/stepparent's unearned income.

d. Determine the ineligible parent/stepparent's gross earned income.

e. Subtract the balance of any allocation for ineligible children not offset by unearned income.

f. Subtract $20 (general income exclusion) from the remaining unearned income.

g. Subtract any balance of the general income exclusion not offset by unearned income from earned income.

h. Subtract the work expense exclusion of $65.

i. Impairment–Related Work Expenses (IRWE). This exclusion is applied to earned income of disabled (but not blind) individuals under age 65.

The expense must be reasonable; for items/services which are directly related to enabling an impaired individual to work, and which are necessarily incurred by the individual because of a physical or mental impairment.

IRWEs are excludable when the cost is paid by the disabled individual and is not reimbursable from another source.

j. Subtract 1/2 of the remaining earned income after the above deductions.

k. Add the countable unearned and earned income to arrive at total countable income.

l. Then subtract the parent allocation amount.

m. The net amount (if any) is the deemed income to the child.

F-320.4 Eligibility Determination

a. Add the child's own unearned income to the deemed income from the ineligible parent/stepparent.

b. Subtract $20 (general income exclusion).

c. If the child has earnings subtract any balance of the general income exclusion not offset by the child's unearned income from the child's earned income.

d. Subtract the work expense exclusion of $65.

e. Impairment–Related Work Expenses (IRWE). This exclusion is applied to earned income of disabled (but not blind) individuals under age 65.

The expense must be reasonable; for items/services which are directly related to enabling an impaired individual to work, and which are necessarily incurred by the individual because of a physical or mental impairment.

IRWEs are excludable when the cost is paid by the disabled individual and is not reimbursable from another source.

f. Subtract 1/2 of the remaining earned income after the above deductions.

g. Add countable unearned and earned income to arrive at total countable income.

h. Compare the total countable income to the individual SSI Payment Amount (SPA). If the amount is equal to or greater than the SPA, the child is ineligible for Medicaid.

F-325 PATIENT LIABILITY

Patient liability is determined for eligible persons in a medical facility. There is no patient liability for any portion of institutionalization in a VA hospital, AGCF, FCH, freestanding psychiatric hospital or RTC.

F-325.1 Treatment of Income, Deductions and Expenses

When determining patient liability for initial and ongoing cases, budget income for the month it is received and deductions/expenses for the month in which they are paid/incurred.

When unanticipated income is received, patient liability will be adjusted for the month in which it was received.

Regular unearned income deposited directly into a financial institution is considered received in the month for which it is intended to be received.

F-325.2 Partial Month Proration

The amount of patient liability is prorated according to the number of days the client was in a facility when the person is institutionalized less than a full calendar month due to:

a. Date of admission

b. Discharge to independent living, VA hospital, AGCF, FCH, freestanding psychiatric hospital or RTC.

c. Death

Determine what the patient liability would be for a full month. Divide that full month amount by the number of days in the month of partial institutionalization to determine the daily amount of patient liability. Multiply this daily amount by the number of days the client was institutionalized in that month (include the day of admission but not the day of discharge/ death).

The result is the amount of patient liability due for the partially institutionalized month.

F-325.3 Effective Date of Patient Liability

a. State Institutional

Patient liability is effective the first month of eligibility (this includes requested months prior to the application month).

b. State Institutional/QMB (SLMB)

Hospital Stay Only: For inpatient hospital stays under 90 consecutive days, do not calculate or send notice of patient liability. This is because Medicare will cover up to 90 days in a hospital and Medicaid must pay the hospital deductible and co–pay charges. If hospitalized beyond the 90 day time period, begin patient liability the first of the month following the 90 days.

c. Deceased Clients

The facility is notified of the patient liability amount due for the month of death. The facility will collect only for charges actually incurred. Any unused patient liability will be deposited in the patient trust fund account.

F-325.4 Notification of Patient Liability/Case Status

When a case is approved or patient liability changes, the client, facility and authorized representative (if applicable) are notified on a Notice of Decision of the amount and effective date.

When the client moves from one facility to another, notify the facilities of the current case status and MONTHLY patient liability when this information has not already been provided them in or for that month.

F-325.5 Patient Liability Budgeting Procedures – Form 2220–EM

a. Determine the client's **total** gross countable monthly income

1. Subtract income excluded in patient liability

b. Subtract the following items from **total monthly income** in the following order:

1. Personal Needs Allowance

   a) Deduct $35 personal needs allowance (PNA) for each month of institutionalization.

   b) Additional personal needs – Institutionalized individuals with **no** community spouse living in the home but with other dependent family members in the home are allowed an additional personal needs allowance based on household size. The additional personal needs amount is determined by subtracting the 1996 needs standard of $459 from the current TANF need standard for the household size.

   Note: this requires a NOMADS work around.

2. Community Spouse Monthly Income Allowance

   Income allocated to the community spouse for maintenance. This amount (if any) is determined by subtracting the community spouse's income which is considered available (including need based assistance like TANF, SSI, etc.) from the monthly maintenance allowance.

   DO NOT count VA UME as income considered available to the community spouse.

   Clients do not have to request the maintenance allowance for their spouse/dependents. The case manager will automatically request the information necessary to determine the maintenance allowance when there is a spouse or dependents at home.

3. Family Allowance (Spousal Impoverishment)

   Family members must be a dependent child, dependent parent(s) or dependent sibling(s). The child, parent or sibling must be residing in the home of the community spouse AND claimed by the community spouse or institutionalized spouse as dependents for federal income tax purposes.

   The amount determined to be the family allowance is deducted from the institutionalized spouse's countable income effective with the first month in which the continuous period of institutionalization is met OR if this deduction was not previously allowed the deduction will be allowed effective the first month following the month in which the change is reported.

   The family allowance deduction need not be determined IF the $35 personal needs allowance in combination with the community spouse monthly income allowance zero's out the patient liability.

Verification of each family member's gross income must be obtained.

a) Subtract the family member's gross income from minimum needs allowance (150% of poverty).

b) Divide the amount from (a) above by three. This is one family member's allowance.
Repeat this calculation for each family member. If there is only one family member, the amount from (b) will be the family allowance deduction. If there is more than one family member, add each family member's allowance to determine the family allowance deduction.

4. Dependent Allowance (Non-Spousal Impoverishment)

A monthly income allowance for each dependent family member living in the Institutionalized individual's home with **no** community spouse living in the home. Calculated by subtracting the dependents total income from the need standard (100% Need Standard) for the household size.

5. Expenses Incurred For Health Insurance Premiums, Deductibles and Co–Insurance Charges

Deduct health insurance premiums, deductibles and co–insurance expenses incurred by the client. Clients/Representatives must advise the agency of medical insurance and provide proof of expenses. These expenses must not be paid or subject to payment by a third party.

Medicare premiums are subject to payment by a third party.

Any institutional case where the client is not a SSI recipient and will not receive a reimbursement for Medicare cost from any source, may have the Medicare premium deducted as an expense for months immediately preceding the second month after the month of approval.

Example #1 (Medicaid Only): Client applied June 2nd and requests 3 months prior medical. Case is approved July 10th. Medicare premiums may be deducted from March through August. Beginning September, we cannot deduct the Medicare premium as it is then subject to third–party payments.

Example #2 (Medicaid/QMB): Client applied for Medicaid/QMB on June 2nd and requests 3 months prior medical. In June, QMB eligibility is established and benefits begin effective July 1st. Then Medicaid eligibility is established July 20th back to March. Medicare premiums may be deducted for March, April, May and June only. Effective July and ongoing, the premiums are subject to third–party payments as QMB coverage began in July.

6. Expenses Incurred For Medical Care

   Deduct expenses incurred by the client for necessary medical care recognized under the state law but not covered under the Medicaid Program. This includes medical expenses incurred more than three months prior to the date of application. Client/Representatives must advise the agency and submit proof of the expenses.

   The case manager will attach a copy of the medical bill plus all related medical records to Form 2536 and submit to DHCFP for approval. These expenses must not be paid or subject to payment by a third party. DHCFP approval is required to assure the deduction is for necessary care payable to reasonable limits.

c. The deficit, if any, is the client's share of facility cost (PATIENT LIABILITY).