

Health Care Finance and Administration	Section: Institutional Medicaid
Policy Manual Number: 125.020	Chapter: Post-Eligibility Treatment of Income

POST-ELIGIBILITY TREATMENT OF INCOME

Legal Authority: 42 CFR 435.725; Tenn. Code Ann. § 71-5-147; Tennessee Medicaid State Plan, Attachment 2.6-A, Supplement 3

1. Policy Statement

Individuals determined eligible for Institutional Medicaid are required to contribute to the cost of their care as a resident in a nursing facility or as a Home and Community Based Services (HCBS) recipient. Patient liability is determined by allowing the following deductions from the individual's gross income:

- A Personal Needs Allowance (PNA) for clothing and other personal needs while residing in the institution;
- A monthly fee for maintenance of a Qualified Income Trust (QIT), if applicable;
- A Community Spouse Income Maintenance Allowance (CSIMA), for institutionalized individuals with a spouse residing in the community;
- A Dependent Income Maintenance Allowance (DIMA), for institutionalized individuals with a dependent residing in the community;
- Health insurance premiums, coinsurance and deductibles; and
- Expenses for medical services and items not covered by TennCare Medicaid (Item D Expenses).

2. PNA

The PNA is provided to cover the institutionalized individual's personal needs and incidentals while residing in the nursing facility or receiving HCBS waiver services. Apply the appropriate PNA based on the type of long-term services and supports (LTSS) the individual receives.

- **Nursing Facility**

Subtract a \$50 PNA from the available income of an individual in a nursing facility.

- **HCBS (including ECF CHOICES), PACE and Self-Determination ID Waivers**

Subtract 300% of the Supplemental Security Income Federal Benefits Rate (SSI-FBR) from the gross income of an individual receiving HCBS, PACE or Self-Determination ID Waiver services.

- **Statewide ID and Comprehensive Aggregate Cap Waivers**

Subtract 200% of the SSI-FBR from the gross income of an individual receiving Statewide ID and Arlington ID Waiver services.

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3. QIT Allowance

A QIT is a trust established for individuals seeking LTSS who are ineligible for TennCare Medicaid due to excess income. See the *Qualified Income Trust (QIT) or Miller Trust* section in the *ABD Trusts* policy.

Individuals who establish a QIT for the purposes of becoming TennCare Medicaid eligible in Institutional Medicaid are allowed a QIT allowance. The purpose of the QIT allowance is to cover any bank fees associated with maintaining the QIT.

Subtract a \$20 QIT Allowance from gross income after the PNA deduction for individuals who establish a QIT for TennCare Medicaid eligibility purposes, if applicable.

4. CSIMA

When determining an institutionalized individual's patient liability, an allowance is deducted from his or her income for the needs of the community spouse. The CSIMA is allowed unless specifically refused by the institutionalized spouse. Funds must actually be transferred to the community spouse to be deducted.

a. When to Allow a CSIMA

- The CSIMA is allowed unless specifically refused by the institutionalized spouse.
- Funds must actually be transferred to the community spouse in order to be deducted.
- A CSIMA is not allowed if both spouses are institutionalized.
- A CSIMA is allowed when one spouse is institutionalized in a nursing facility and the other is eligible for HCBS in the community.
- If the community spouse applies for TennCare Medicaid, the CSIMA will be counted as unearned income.
- A community spouse receiving SSI, Families First (FF), Veteran's Affairs (VA) Pension, TennCare Medicaid or means-tested benefits does not have to accept the total or any of the income allocation if it will result in the termination or decrease of those benefits.
- If a couple is married but living separately, and considers themselves to be separated, the CSIMA may be allowed if both individuals agree to the allocation and the community spouse is not institutionalized.
- If the community spouse lives out of state, the CSIMA is allowed if the community spouse can be located and the couple is still married.

b. CSIMA Calculation

i. Terms and Standards

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Standard Maintenance Amount: The minimum monthly amount of income, as determined by the Centers for Medicare and Medicaid Services (CMS), that the Community Spouse must receive to meet basic needs.

The standard maintenance amount is \$2,002.50, effective July 1, 2015.

Maximum Maintenance Amount: The maximum monthly amount of income, as determined by CMS, that the Community Spouse can receive as a CSIMA.

The maximum maintenance amount is \$2,980.50, effective January 1, 2015.

Standard Utility Allowance (SUA): The SUA is used when the community spouse is responsible for heating and/or cooling costs. If the SUA is used, then it is considered to cover all utilities, including garbage, water, lighting, etc.

The SUA is \$308, effective October 1, 2015.

Standard Housing Allowance (SHA): The SHA is used to determine whether the community spouse requires an Excess Allowance.

The SHA is \$600.75, effective July 1, 2016.

ii. CSIMA Calculation

The CSIMA is calculated using three steps:

1. Determine Excess Shelter Allowance (ESA)

An ESA is allowed when the total shelter costs for rent, mortgage, taxes and insurance, maintenance charges and utility costs exceed the SHA. The SHA is 30% of the Standard Maintenance Amount.

The SUA is used when the community spouse is responsible for heating and/or cooling costs. If the SUA is used, it is considered to cover all utilities (no additional allowance for garbage, telephone, etc.) When there is no or reduced cost to the community spouse because the cost of a particular utility is paid by a third party (in cash or in kind), reduce the amount of the SUA by the third party payment.

Determine ESA:

$$\begin{array}{r}
 \text{Rent, mortgages, taxes, insurance, etc.} \\
 + \text{SUA} \\
 - \text{SHA} \\
 \hline
 \text{ESA}
 \end{array}$$

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2. Determine Community Spouse Net Income

Determine the Community Spouse's total net income, including Supplemental Security Income (SSI) and FF payments. The Community Spouse net income is defined as income over which the Community Spouse has control over and which is actually available. Income which is not considered available to the Community Spouse includes child support payments and other types of court-ordered payments made by the community spouse.

3. Calculate CSIMA

The CSIMA is calculated by adding the Standard Maintenance Amount and the ESA, and then subtracting the Community Spouse's net income.

Standard Maintenance Amount (\$2,002.50)
+ ESA (Amount determined in Step 1 of CSIMA budget)
– Community Spouse Net Income (Amount determined in Step 2 of CSIMA budget)
= Community Spouse Maintenance Allowance

iii. CSIMA Example

Casey Jones is approved for Institutional Medicaid. Shannon Jones, the community spouse, remains in the community and resides at home. Casey receives \$800 per month in Social Security benefits, and \$200 in monthly pension. Shannon receives \$600 per month in Social Security benefits.

Shannon Jones pays the mortgage of \$400 per month, which includes taxes and insurance. She is responsible for all monthly heating and cooling costs.

Step 1: Determine ESA

\$400.00	Mortgage, taxes, insurance
+ \$308.00	SUA
– <u>\$600.75</u>	SHA
= \$107.25	ESA

Step 2: Determine Community Spouse Net Income

Countable income is determined according to the *ABD Earned Income* policy and *ABD Unearned Income* policy. The community spouse's net income is defined as income over which the community spouse has control over and which is actually available to him or her.

Step 3: Calculate CSIMA

\$2002.50	Standard Maintenance Amount
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+ \$107.00	ESA
<u>- \$600.00</u>	Community Spouse Net Income
= \$1,509.50	CSIMA

Casey's monthly income is \$1,000. Since the income is less than the calculated CSIMA, all of the income (less \$50 PNA) will be allocated to Shannon.

NOTE: In the event that the institutionalized spouse does not have enough income to provide the community spouse with the allowed CSIMA, and the couple has additional resources above the Community Spouse Resource Maintenance Allocation (CSRMA), there may be an allocation of additional resources to the community spouse to make up for the income shortfall. This must be done by appeal, and a HCFA Appeals Officer will determine whether the additional resource allocation is needed. See *Resource Assessment* policy.

5. DIMA

When determining patient liability, an allowance is deducted from the individual's income for the needs of his or her dependents.

a. General Rules

- Dependent relatives include all persons who can be or are being claimed as tax dependents. This includes adult dependent children, parents and siblings, as well as minor children.
- A DIMA is not allowed for any dependent receiving HCBS or who is institutionalized.
- A dependent does not have the option of declining all or a portion of the income allocation for any reason according to the HCFA interpretation of the Medicare Catastrophic Coverage Act (MCCA), even if needs-based benefits may be decreased or lost because of the allocation.
- The total of both the CSIMA and DIMA combined cannot exceed the Maximum Income Allocation Amount.
- The Maximum Maintenance Needs Allowance for each additional dependent family member is equal to one-third of the difference between the Standard Maintenance Amount and the dependent's gross income.

i. Calculate DIMA

The dependent allocation(s) equals the Standard Maintenance Amount for the community spouse minus the dependent's own gross countable income divided by 3 (standard maintenance amount – gross countable income = deficit/3 = dependent allocation).

1. Determine Dependent's Gross Income

Earned Income
+ Self-Employment Income

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- + Unearned Income (other than Child Support)
- + Gross Child Support
- = Dependent Gross Income

2. Calculate DIMA

Standard Maintenance Amount	\$2,002.50
– Dependent Gross Income	Determined in Step 1
÷ 3	1/3 of the difference of the subtotal
<hr/>	
= DIMA	

6. Health Insurance Premiums

Health insurance premiums may be deducted when determining an individual's patient liability. When health insurance premiums for several coverage months are due in a given month, the premiums paid in that given month cannot be prorated over the coverage period. Any premium amount which exceeds the individual's income can be applied against his or her patient liability in following months.

Premiums are deducted for health insurance policies that meet the following criteria:

- The policy is reported to HCFA as third party liability (TPL);
- Benefits are assignable and the individual has agreed to assign them to the State of Tennessee (HCFA); and
- Premiums are paid by the individual, and not by a third party.

Life insurance premiums are not allowed as a deduction.

7. Medicare Premiums

Medicare Parts A, B, C or D premiums are deductible as health insurance premiums, unless:

- The individual is SSI eligible; or
- The individual is enrolled as an SSI Pass Along; or
- The individual is enrolled in any of the following Medicare Savings Programs: QMB, Specified Low Income Beneficiary (SLMB), Qualifying Individual (QI) or Qualified Disabled Working Individual (QDWI).

8. Item D Deductions for Institutionalized Individuals

The law allows for the deduction of expenses incurred by the eligible individual for medical or remedial care that are recognized by state law as medical or remedial care items but are not included in Tennessee's TennCare Medicaid State Plan. Tennessee calls these non-covered expenses Item D.

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Item D medical expenses also include expenses incurred during the three (3) months immediately prior to application for coverage of institutional care.

Institutional charges incurred during an institutional coverage ineligibility period due to an uncompensated transfer of assets may not be used as Item D deductions.

Cost items are those medical or remedial services and goods that must be provided by the nursing care providers. Cost items cannot be charged to the patient or allowed as an Item D deduction.

Criteria for Deduction of an Expense

- The expenses(s) must not be subject to payment by a third party not expecting reimbursement, e.g., medical or health insurance, medical trust fund, Medicare, etc.
- The expense may be unpaid or paid by the client during the month(s) of eligibility determination or paid by a member of the client's family and reimbursement is expected by the family member.
- The expense must not have been allowed previously as a necessary item.
- The expense must be outstanding and considered collectible by the party who provided the medical service and one for which the client is legally liable. Debt sent to a collection agency is still considered collectible by the original party for purposes of this Item D policy.
- Medical expenses incurred up to three months prior to the month of application during TennCare Medicaid ineligibility do not impact whether the bill is an allowable medical expense, e.g. while an applicant is spending down resources to become eligible.

Example: Mrs. Carter applied for TennCare Medicaid for the month of January. She did not meet TennCare Medicaid eligibility for that month due to exceeding the resource limit. She reapplied on April 1, 2016. She incurred charges for the facility stay from January, February, and March. The facility charges may be used as an allowable expense as they occurred during the three months prior to eligibility.

9. Item D Expenses in the Budget

Item D deductions are allowed from patient liability for qualifying paid medical expenses. Item D medical expense deductions are allowed until the full unpaid balance has been deducted, or until the expenses are paid in full, whichever comes first.

10. Qualifying Expenses

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Payments for the following types of medical or remedial care recognized under state law, but are not encompassed within Tennessee's State Medicaid Plan, are subject to the following criteria:

a. Eyeglasses and necessary related services

Deductions can only be made for the following services and must be the least of the provider's usual and customary charges, billed charges or the Medicaid fee schedule:

- Examination and refraction;
- Frame;
- Lenses (bifocal); and
- Lenses (single).

No deductions should be made for the first pair of eyeglass or contact lenses after cataract surgery, since those are allowed by HCFA.

b. Hearing aids and necessary related services

Deductions can only be made for the following services and must be the least of the provider's usual and customary charges, billed charges or the Medicaid fee schedule:

- Audiogram;
- Ear mold;
- Hearing aid;
- Batteries; and
- Hearing aid orientation.

c. Dental services

Deductions can be made for routine and emergency dental services and in accordance with HCFA's dental fee listing, whether such services are provided at a dental office, on-site at the LTCF, or through a mobile dental services provider that contracts with the long-term care facility (LTCF).

d. Other medical service recognized under state law but not covered by TennCare Medicaid

Deductions for any other medical service recognized under state law but not covered by TennCare Medicaid will be made at the least of the provider's usual and customary charges, billed charges or 80% of the Medicare fee schedule. Deductions will be allowed only for services that are determined by the State to be medically necessary for the particular individual on whose behalf the services are being requested.

e. Charges for nursing home days incurred as the result of bed-holds or therapeutic leave days

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Charges for nursing home days incurred as the result of bed-holds or therapeutic leave days that are in excess of the number of days covered under the Medicaid State Plan for the type of facility in question are not allowable deductions.

f. Prescription Drugs

There are four criteria that a prescription drug must meet to be an allowable Item D expense.

- It must not be subject to a payment by a third party (e.g., Medicare or private insurance)
- It must be recognized under State law
- It must not be covered by Medicaid
- It must be determined by the state to be medically necessary

Here are the Item D coverage policies for four frequently requested drugs:

Drug	Covered by Medicare?	Covered by Medicaid/TennCare?	Status as an allowable Item D deduction?	Reasoning
Medically necessary benzodiazepines	Yes	Yes	Not allowed	Drug is covered by both Medicare and TennCare
Medically necessary cough and cold products	Yes, EXCEPT products used for symptomatic relief of cough and colds	Yes, EXCEPT products used for symptomatic relief of cough and colds	<i>Only if</i> the products are used for the symptomatic relief of cough and colds	Item D can only be applied to drugs not covered by TennCare and Medicare
Medically necessary prescription vitamin and mineral products	Yes, but ONLY IF the items are prenatal vitamins and fluoride preparations	Yes, but ONLY IF the items are prenatal vitamins and fluoride preparations	<i>Only if</i> the items are NOT prenatal vitamins and fluoride preparations	Item D can only be applied to drugs not covered by TennCare and Medicare
Medically necessary smoking cessation products	Prescription-only smoking cessation products are COVERED; non-prescription drugs are NOT COVERED	Yes	Not allowed	Prescription-only smoking cessation products are covered by Medicare and TennCare; non-prescription drugs are covered by TennCare

HCFA does not cover prescription drugs for individuals who are dually eligible for both Medicare and TennCare. These individuals are considered to have access to Medicare Part D for their prescription drug coverage, regardless of whether they choose to enroll in Medicare Part D or not.

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g. Dental Services Provided in a LTCF

There are certain requirements that must be met by the mobile dental service providers in order to have their services covered as an Item D deduction.

These are the requirements of the mobile dental service:

1. To obtain a signed consent form from the responsible party prior to performing any dental services. If the responsible party fails or refuses to sign the consent form and has not made any arrangements for alternative dental care, the LTCF is authorized to sign the form on behalf of the resident. The consent will remain valid for the length of the resident’s stay (only one form per patient, not one per procedure), unless otherwise revoked by the responsible party.
2. To deliver the consent form, along with the verification of services form, via hand delivery, mail or facsimile to Tennessee Health Connection (TNHC).
3. To contract with a dentist licensed in the State of Tennessee who is a Medicare/Medicaid provider. A licensed dentist must perform all services. The dentist’s name and provider number must be entered on the Item D request form prior to submitting the bill to HCFA.
4. To create and supply all new forms that are submitted from the mobile dental service provider and the LTCF. The facility should ensure that a copy of these forms is kept on file in the patient records at the facility, along with proof that the services were provided by a licensed dentist.

These are the requirements for HCFA Member Services:

1. Prior to authorizing any Item D expense received from a mobile dental services provider, the Eligibility Specialist must view and document in the data base that the consent form, the Item D request form, and the verifications of service form have been provided.
2. Any services related to the provision of dentures deemed medically necessary must be thoroughly documented in the electronic case record. Process the Item D request within thirty (30) days after receipt in the county office.
3. Once the bills have been processed, the Eligibility Specialist must notify the responsible party and the LTCF of any action taken to approve or deny the expense as an Item D deduction. These expenses will be deducted from the patient’s countable income. This will reduce the patient liability.

Note: Payment can only be made from the patient liability amount, not from the patient’s trust account or the PNA. If the patient liability is already zero, then payment cannot be allowed.

11. Information Needed with Item D Submission

The Item D submission must include the following information:

- a verification of service/item received,

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- consent for receipt of service/item,
- information relating to medical necessity, and
- other identifiers relating to the Item D, including the provider number and a description of the service/item received.

12. Items Ds which Exceed Income

When the total of Item D expenses (and health insurance premiums) is greater than the individual's net income less PNA, QIT, CSIMA and DIMA deductions for the month, deduct only the amount equal to the available income. Item D medical expenses in excess of the individual's net income are carried over into the next month as Medical Expense Carry Over from the previous month.

Expenses will be carried over until the full amount of the expense is deducted or the expense is paid in full, whichever occurs first.

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7.1.2016	4-b-iii	CSIMA-CSIMA Calculation-CSIMA Example	4-5	Standards Update	LW
7.1.2016	5-a-i	DIMA-General Rules-Calculate DIMA	5-6	Standards Update	LW
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7.1.2016	10-f	Qualifying Expenses	9	Policy Change	LW
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7.1.2016	11	Item D Request Form	11	Section Removal	LW
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