2151 – ABD MEDICALLY NEEDY FOR NURSING HOME RESIDENTS/ HOSPICE CARE RECIPIENTS

POLICY STATEMENT	ABD Medically Needy (AMN) eligibility for a resident of a nursing home or hospice care recipient **residing in a nursing home** is determined by applying the projected monthly nursing home/hospice care private pay billing rate to the A/R's monthly AMN spenddown.

BASIC CONSIDERATIONS

De Facto Eligibility

When the projected monthly nursing home/hospice care private pay billing rate exceeds the monthly spenddown amount, eligibility and vendor payment are approved as of the first day of the month. There is no vendor payment for Hospice Care recipients.

Spenddown Eligibility

When the projected monthly nursing home private pay billing rate does **not** exceed the monthly spenddown amount, eligibility is determined by deducting actual medical expenses in chronological order. Eligibility begins the day the projected nursing home/hospice care billing rate for the remainder of the month is greater than or equal to the remaining spenddown amount.

Budget Period

The budget period for **all** residents of nursing homes or recipients of hospice care applying for ABD Medicaid under AMN is one month.

The **private** pay nursing home/hospice care billing rate is the only medical expense that can be projected.

For an A/R eligible using projected expenses, Medicaid is approved for six month periods if there are no changes anticipated in income or projected medical expense that would affect Medicaid eligibility.

An A/R who is **not** eligible using projected expenses may incur a bill during the month that reduces the spenddown to an amount that can be satisfied by projecting the private pay nursing home/hospice care billing rate for the remainder of the month. If this occurs, Medicaid is approved for one month only, using the day the expense was incurred as the Begin Authorization Date (BAD).

For an A/R eligible as of the first day of the month using projected expenses, patient liability is determined using the same procedures used for recipients approved under the Nursing Home COA.

BASIC CONSIDERATIONS (cont.)	For an A/R eligible using projected and actual expenses, patient liability is determined by allowing **all** medical expenses used to meet spenddown as an IME deduction if they are incurred in the same month for which patient liability is calculated.

PROCEDURES

Follow the steps below to determine AMN eligibility for a nursing home resident or hospice care recipient residing in a nursing home:

Step 1 Determine that the A/R is **ineligible** under the Nursing Home/Hospice Care COA. Refer to **Section 2141, Nursing Home or Section 2135, Hospice Care**.

Step 2 Determine that the A/R meets all basic eligibility criteria, including Level of Care. Refer to **Chapter 2200, Basic Eligibility Criteria**.

Step 3 **EXCEPTION:** Length of Stay is **not** a requirement under this COA.

Step 4 Determine resource eligibility. Refer to **Chapter 2500, ABD Financial Responsibility and Budgeting**, and **Chapter 2300, Resources**.

Step 5 Complete an Individual Budget to determine the A/R's AMN spenddown amount, using the Medically Needy Income Level (MNIL) for one and a one month budget period. Refer to the **Section 2506, Individual Budgeting.**

Step 6 Project the cost of nursing home/hospice care for the month for which Medicaid eligibility is being determined.

- Use the private pay per diem billing rate for the nursi home/hospice care agency in which the A/R resides/receives services.
- Multiply the per diem billing rate by the number of days the A has resided/received services (or is expected to reside/receive services) in the nursing home during the month.

NOTE: Do **not** include days prior to the date of admission or the date of discharge and afterward.

Subtract the cost of nursing home/hospice care determined in Step 5 from the A/R's spenddown for the month determined in Step 4.

- If the spenddown is met (there is a deficit), the A/R is eligil from the first day of the month. Proceed to Step 7.
- If a portion of the spenddown remains (there is a surplu determine eligibility by deducting actual expenses chronologically. Proceed to Special Considerations in this section.

PROCEDURES (cont.)

Step 7 Approve the A/R on the system for Medicaid from the first day of the first month for which eligibility has been established. In SUCCESS, use **L95** for de facto AMN NH. For Hospice recipients, register a **W01** AU, enter **HP** as the institution type on the **INST** screen, and code the LOC and waiver type codes as **H** as additional indicators that the A/R is a hospice recipient. Enter **NH** as the living arrangement on **DEM1**.

For all de facto AMN Hospice AUs:

- Enter the A/R's total gross income in the system.
- Enter a deduction code of "OB" in the system.
- Enter a deduction amount which when subtracted from the A/R's income will bring the A/R within the Medicaid Cap.

NOTE: There is no first day liability (FDL) and Form 400 is **not** required.

Step 8 Determine the A/R's NH patient liability using the procedures used for an A/R determined eligible under the Nursing Home COA. Refer to Section 2559, Patient Liability/Cost Share**.** **NOTE:** There is no Cost Share for HC.

NOTE: Do **not** allow the nursing home billing rate projected to meet the spenddown as an incurred medical expense (IME) deduction in the patient liability budget.

Step 9 For AMN NH COA, authorize the vendor payment using the same procedures used for an A/R approved under the Nursing Home COA. Refer to **Section 2576, Vendor Payment Authorization.**

Step 10 Determine whether changes are anticipated in the A/R's income (other than regularly scheduled cost of living adjustments) or nursing home/hospice care billing rate in the next six months that would affect eligibility.

Step 11 If no change is anticipated, complete a review on the case in the sixth month after the month of initial Medicaid approval.

If a change is anticipated, enter an alert in the system to review the case in the month prior to the month of change. Also, complete the special review described above in the sixth month after the month of initial Medicaid approval.

SPECIAL CONSIDERATIONS

Follow the steps below when the projected monthly nursing home/hospice care billing rate does not meet the spenddown **and** the A/R incurs another medical expense(s) during the month.

Step 1 Deduct all allowable medical expenses from the spenddown chronologically by date incurred as they are presented. When any medical expense is deducted, deduct the private pay nursing home/hospice care billing rate per diem that has already been incurred in the month, up through the day prior to the day of the month that the medical expense was incurred.

Step 2 Project the nursing home/hospice care billing rate for the days remaining in the month, beginning with the day the medical expense was incurred.

- If the projection meets the remaining spenddown amount, appro the A/R as Medicaid eligible for the remainder of the month, using the day the expense was incurred as the BAD. Refer to Chart 2151.1, Determining FDL for an AMN Nursing Home Recipient, for procedures on determining the first day liability (FDL) amount and rules on issuing Form 400. Proceed to Step 3
- If the projection does **not** meet the remaining spenddown amou continue the spenddown process in Step 1.

Step 3 For NH COA, determine the A/R's NH patient liability. Refer to IMEs in Medically Needy Patient Liability Budgets in the Procedures portion of the Section 2555, Incurred Medical Expenses, for rules on allowing the IME deduction in the patient liability budget.

NOTE: Do **not** prorate the A/R's patient liability based on the number of days in the month s/he is Medicaid eligible.

Step 4 For NH COA, authorize the nursing home vendor payment to begin on the BAD. Refer to Special Considerations in Section 2576, Vendor Payment Authorization.

Step 5 Process the case in the system and notify the A/R of the vendor payment via system generated notice.

Step 6 Review the case as medical expenses are presented each month to determine whether the A/R can meet the spenddown for the new budget period.

SPECIAL CONSIDERATIONS (cont.)

Use the following chart to determine how to report first day liability (FDL) on an AMN Nursing Home/Hospice Care recipient who meets the spenddown with a combination of projected and actual expenses or only actual expenses. The chart assumes that an expense other than the projected nursing home/hospice care per diem is always applied to the spenddown on the BAD **before** the projected nursing home/hospice care per diem is applied.

Chart 2151.1 - Determining FDL for an AMN Nursing Home/Hospice Care Recipient

IF	THEN
the break-even bill is the projected nursing home/hospice care per diem **AND** the entire amount of a Medicaid covered medical expense incurred on the BAD (other than the nursing home/hospice care per diem) has been applied to meet the spenddown **AND** there are no Medicaid covered medical expenses incurred on the BAD other than the expense(s) applied to meet the spenddown	Do **not** issue Form 400. Enter the amount of the Medicaid covered expense that was applied in its entirety to meet the spenddown as the FDL on Form 964.
the break-even bill is the projected nursing home/hospice care per diem **AND** the entire amount of a Medicaid covered medical expense incurred on the BAD (other than the nursing home/hospice care per diem) has been applied to meet the spenddown **AND** there are other Medicaid covered medical expenses incurred on the BAD other than the expense(s) applied to meet the spenddown	Do **not** issue Form 400 for the Medicaid covered expense that was applied in its entirety to meet the spenddown. Issue Form 400 for each of the other Medicaid covered expenses incurred on the BAD that were not applied to the spenddown. Enter a client liability of $0 on each form. Enter the amount of the Medicaid covered expense that was applied in its entirety to meet the spenddown as the FDL on Form 964.
the break-even bill is a Medicaid covered medical expense other than the nursing home/hospice care per diem **AND** there are Medicaid covered medical expenses incurred on the BAD other than the expense(s) applied to meet the spenddown	Issue Form 400 for the break-even bill. Enter on the form as the client liability the amount of the expense that was applied to the spenddown. Issue Form 400 for each of the other Medicaid covered expenses incurred on the BAD that were not applied to the spenddown. Enter a client liability of $0 on each form. Enter the client liability listed on Form 400 for the break-even bill as the FDL on Form 964.
the break-even bill is a Medicaid covered medical expense other than the nursing home/hospice care per diem **AND** there are no Medicaid covered medical expenses incurred on the BAD other than the expense(s) applied to meet the spenddown.	Issue Form 400 for the break-even bill. Enter on the form as the client liability the amount of the expense that was applied to the spenddown. Enter the client liability listed on Form 400 for the break-even bill as the FDL on Form 964.

Chart 2151.2 - SUMMARY: DE FACTO VS SPENDDOWN

	DE FACTO	SPENDDOWN
Level of Care	Must have a DMA-6(NH) or Hospice Communicator to approve	Same
Length of Stay	Not required	Same
Budget Periods	1 month - May approve for 6 months if no anticipated changes - Do a review 6 months after approval	1 month Approve month by month on Form DMA 964 or on SUCCESS.
Classes of Assistance	SUCCESS: L95	SUCCESS: L99 The FDL is 0.
Projected Expense	Only private pay NH/HC billing rate	Same
BAD	First day of month of eligibility	Date spenddown is met
FDL	$0	Medical bills (other than NH/HC) used to meet SD on BAD
Forms 400 Required	None	See Chart 2151.1
Patient Liability, IMEs, and Income	Only averaged medical expenses not covered by Medicaid (same as regular NH COA A/Rs); do **not** deduct projected NH billing rate used to meet SD. Average income and IMEs.	All medical expenses used to meet SD, including NH/HC private pay per diem incurred prior to BAD each month **NOTE:** If patient liability exceeds DMA billing rate, enter DMA monthly billing rate plus any deductions or IMEs as the patient liability on the SUCCESS "INST" screen. Watch for excess resources. Do **not** average income/IMEs.
Beginning Date of NH VP	Month of admission: DMA-6 payment date if: - eligible, and - in NH, and - no VA contract, OR 1st day of the 1st month of eligibility if not in month of admission	BAD: the date SD is met or DMA-6 payment date, whichever is later