DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Jacobs	6-2-08

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000626	[X] Prepare reply for the Director's signature DATE DUE 6-13-08
2. DATE SIGNED BY DIRECTOR	[ ] Prepare reply for appropriate signature DATE DUE
C: Myers EF Cleared 7/17/08, letter attached	[ ] FOIA DATE DUE [ ] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			

Systematic Management Systems

3550 Hobson Road, Suite 104
Woodridge, IL 60517
(630) 512-0700
(630) 512-0760 Fax

May 28, 2008

Ms. Emma Forkner
Director
South Carolina Department
of Health and Human Services
P.O. Box 8206
Columbia, SC 29202

Dear Ms. Forkner:

We are working with a skilled nursing facility client in South Carolina and wanted to obtain appropriate written confirmation from the South Carolina Medicaid Agency as to the appropriate methodology or steps to be followed in the submission of an adjustment/reduction of a Medicaid long-term care resident's monthly "countable income" amount for separately identifiable medical or remedial services that are not payable by a third party in accordance with Section 1902(r)(1) of the Social Security Act.

The applicable federally mandatory required Medicaid Program provisions are contained in the statutes, regulations and CMS instructions as noted below (highlighted copies are enclosed).

Section 1902(r)(1)(A) of the Social Security Act
42 CFR 435.725(c)(4)
42 C.F.R. 435.733(c)(4)
42 C.F.R. 435.832(c)(4)
42 C.F.R. 435.831(e)(f)(h) – which clarifies the required deductions from an institutionalized (SNF) recipient monthly income before the amount of countable income is determined
CMS State Medicaid Operations Manual -- Section 3628 (with emphasis on sub-sections 3628.6 and 3628.7)

We initially identified certain laboratory service procedures for which the Skilled Nursing Facility (SNF) is certified to perform within its facility (under its state/federal CLIA-waived certificate) without the utilization of an outside independent laboratory. These procedures are not covered by Medicare (or other third-party payor) in a SNF. Based on our review of the State Medicaid Manuals and billing systems/procedures, a SNF cannot bill for these CLIA waived laboratory services directly to the State Medicaid Program as these services are currently payable to entities who are enrolled as independent laboratories under the State Medicaid Program.

Accordingly, we ask that you confirm to us in writing whether a SNF must enroll as an independent laboratory in order to be compensated separately for these individually, identifiable laboratory services provided to approved (eligible) Medicaid recipients who do not have any monthly countable income and are residing in a State Medicaid participating SNF.

In relation to the above-referenced laboratory services provided to a Medicaid recipient, residing in a SNF, who has countable monthly income and in accordance with the above-listed mandatory federal laws and regulations, the State Medicaid Program is required to allow the long-term care provider (on behalf of its Medicaid resident) to reduce the subsequent determined reportable countable monthly income to pay for any separately identifiable medical or remedial services provided to the Medicaid recipient during his/her stay in the SNF.

We ask that you confirm to us your agency's concurrence with the availability of this process/procedure under the South Carolina Medicaid Program. We also ask that you provide to us a copy or reference to any existing state administrative rules or regulations including any procedures that may be able to assist in identifying the procedure to be followed to adjust a Medicaid recipient's countable income under your State Medicaid Agency's policies/procedures.

Further, we ask that we be provided a name of an individual from your Medicaid Agency (or related Agency) that we can communicate with should there be any related questions or concerns that might arise. In the alternative, if anyone from your Agency has any questions or concerns, we invite them to call me at (630) 512-0700 any time during normal business hours (CDT).

We thank you in advance for your cooperation in this matter.

Sincerely,

James J. Giger
President

JJG:sk
Enclosures

(r)(1)(A) For purposes of sections 1902(a)(17) and 1924(d)(1)(D) and for purposes of a waiver under section 1915, with respect to the post-eligibility treatment of income of individuals who are institutionalized or receiving home or community-based services under such a waiver, the treatment described in subparagraph (B) shall apply, there shall be disregarded reparation payments made by the Federal Republic of Germany, and there shall be taken into account amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including—

(i) medicare and other health insurance premiums, deductibles, or coinsurance, and

(ii) necessary medical or remedial care recognized under State law but not covered under the State plan under this title, subject to reasonable limits the State may establish on the amount of these expenses.

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[Page 154-156]

TITLE 42--PUBLIC HEALTH

CHAPTER IV--CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES (CONTINUED)

PART 435_ELIGIBILITY IN THE STATES, DISTRICT OF COLUMBIA, THE NORTHERN MARIANA

Subpart H_Specific Post-Eligibility Financial Requirements for the Categorically Needy

Sec. 435.733 Post-eligibility treatment of income of institutionalized individuals in States using more restrictive requirements than SSI: Application of patient income to the cost of care.

(a) Basic rules. (1) The agency must reduce its payment to an institution, for services provided to an individual specified in paragraph (b) of this section, by the amount that remains after deducting the amounts specified in paragraphs (c) and (d) of this section, from the individual's total income.

(2) The individual's income must be determined in accordance with paragraph (e) of this section.

(3) Medical expenses must be determined in accordance with paragraph (f) of this section.

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(b) Applicability. This section applies to the following individuals in medical institutions and intermediate care facilities:

(1) Individuals receiving cash assistance under AFDC who are eligible for Medicaid under Sec. 435.110 and individuals eligible under Sec. 435.121.

(2) Individuals who would be eligible for AFDC, SSI, or an optional State supplement except for their institutional status and who are eligible for Medicaid under Sec. 435.211.

(3) Aged, blind, and disabled individuals who are eligible for Medicaid, under Sec. 435.231, under a higher income standard than the standard used in determining eligibility for SSI or optional State supplements.

(c) Required deductions. The agency must deduct the following amounts, in the following order, from the individual's total income, as determined under paragraph (e) of this section. Income that was disregarded in determining eligibility must be considered in this process.

(1) Personal needs allowance. A personal needs allowance that is reasonable in amount for clothing and other personal needs of the individual while in the institution. This protected personal needs allowance must be at least--

(i) $30 a month for an aged, blind, or disabled individual, including a child applying for Medicaid on the basis of blindness or

disability;

(ii) $60 a month for an institutionalized couple if both spouses are aged, blind, or disabled and their income is considered available to each other in determining eligibility; and

(iii) For other individuals, a reasonable amount set by the agency, based on a reasonable difference in their personal needs from those of the aged, blind, and disabled.

(2) Maintenance needs of spouse. For an individual with only a spouse at home, an additional amount for the maintenance needs of the spouse. This amount must be based on a reasonable assessment of need but must not exceed the higher of--

(i) The more restrictive income standard established under Sec. 435.121; or

(ii) The amount of the medically needy income standard for one person established under Sec. 435.811, if the agency provides Medicaid under the medically needy coverage option.

(3) Maintenance needs of family. For an individual with a family at home, an additional amount for the maintenance needs of the family. This amount must--

(i) Be based on a reasonable assessment of their financial need;

(ii) Be adjusted for the number of family members living in the home; and

(iii) Not exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under Sec. 435.811, if the agency provides Medicaid under the medically needy coverage option for a family of the same size.

(4) Expenses not subject to third party payment. Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including--

(i) Medicare and other health insurance permiums, deductibles, or coinsurance charges; and

(ii) Necessary medical or remedial care recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits the agency may establish on amounts of these expenses.

(5) Continued SSI and SSP benefits. The full amount of SSI and SSP benefits that the individual continues to receive under sections 1611(e)(1) (E) and (G) of the Act.

(d) Optional deduction: Allowance for home maintenance. For single individuals and couples, an amount (in addition to the personal needs allowance) for maintenance of the individual's or couple's home if--

(1) The amount is deducted for not more than a 6-month period; and

(2) A physician has certified that either of the individuals is likely to return to the home within that period.

(e) Determination of income--(1) Option. In determining the amount of an individual's income to be used to reduce the agency's payment to the institution, the agency may use total income received, or it may project total

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monthly income for a prospective period not to exceed 6 months.

(2) Basis for projection. The agency must base the projection on income received in the preceding period, not to exceed 6 months, and on income expected to be received.

(3) Adjustments. At the end of the prospective period specified in paragraph (e)(1) of this section, or when any significant change occurs, the agency must reconcile estimates with income received.

(f) Determination of medical expenses--(1) Option. In determining the amount of medical expenses that may be deducted from an individual's

income, the agency may deduct incurred medical expenses, or it may project medical expenses for a prospective period not to exceed 6 months.

(2) Basis for projection. The agency must base the estimate on medical expenses incurred in the preceding period, not to exceed 6 months, and medical expenses expected to be incurred.

(3) Adjustments. At the end of the prospective period specified in paragraph (f)(1) of this section, or when any significant change occurs, the agency must reconcile estimates with incurred medical expenses.

[45 FR 24884, Apr. 11, 1980, as amended at 48 FR 5735, Feb. 8, 1983; 53 FR 3596, Feb. 8, 1988; 55 FR 33705, Aug. 17, 1990; 56 FR 8850, 8854, Mar. 1, 1991; 58 FR 4932, Jan. 19, 1993]

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TITLE 42--PUBLIC HEALTH

CHAPTER IV--CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES (CONTINUED)

PART 435_ELIGIBILITY IN THE STATES, DISTRICT OF COLUMBIA, THE NORTHERN MARIANA

Subpart I_Specific Eligibility and Post-Eligibility Financial Requirements for the Medically Needy

Sec. 435.831 Income eligibility.

The agency must determine income eligibility of medically needy individuals in accordance with this section.

(a) Budget periods. (1) The agency must use budget periods of not more than 6 months to compute income. The agency may use more than one budget period.

(2) The agency may include in the budget period in which income is computed all or part of the 3-month retroactive period specified in Sec. 435.914. The budget period can begin no earlier than the first month in the retroactive period in which the individual received covered services. This provision applies to all medically needy individuals except in groups for whom criteria more restrictive than that used in the SSI program apply.

(3) If the agency elects to begin the first budget period for the medically

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needy in any month of the 3-month period prior to the date of the application in which the applicant received covered services, this election applies to all medically needy groups.

(b) Determining countable income. The agency must deduct the following amounts from income to determine the individual's countable income.

(1) For individuals under age 21 and caretaker relatives, the agency must deduct amounts that would be deducted in determining eligibility under the State's AFDC plan.

(2) For aged, blind, or disabled individuals in States covering all SSI recipients, the agency must deduct amounts that would be deducted in determining eligibility under SSI. However, the agency must also deduct the highest amounts from income that would be deducted in determining eligibility for optional State supplements if these supplements are paid to all individuals who are receiving SSI or would be eligible for SSI except for their income.

(3) For aged, blind, or disabled individuals in States using income requirements more restrictive than SSI, the agency must deduct amounts that are no more restrictive than those used under the Medicaid plan on January 1, 1972 and no more liberal than those used in determining eligibility under SSI or an optional State supplement. However, the amounts must be at least the same as those that would be deducted in

determining eligibility, under Sec. 435.121, of the categorically needy.

(c) Eligibility based on countable income. If countable income determined under paragraph (b) of this section is equal to or less than the applicable income standard under Sec. 435.814, the individual or family is eligible for Medicaid.

(d) Deduction of incurred medical expenses. If countable income exceeds the income standard, the agency must deduct from income medical expenses incurred by the individual or family or financially responsible relatives that are not subject to payment by a third party. An expense is incurred on the date liability for the expense arises. The agency must determine deductible incurred expenses in accordance with paragraphs (e), (f), and (g) of this section and deduct those expenses in accordance with paragraph (h) of this section.

(e) Determination of deductible incurred expenses: Required deductions based on kinds of services. Subject to the provisions of paragraph (g), in determining incurred medical expenses to be deducted from income, the agency must include the following:

(1) Expenses for Medicare and other health insurance premiums, and deductibles or coinsurance charges, including enrollment fees, copayments, or deductibles imposed under Sec. 447.51 or Sec. 447.53 of this subchapter;

(2) Expenses incurred by the individual or family or financially responsible relatives for necessary medical and remedial services that are recognized under State law but not included in the plan;

(3) Expenses incurred by the individual or family or by financially responsible relatives for necessary medical and remedial services that are included in the plan, including those that exceed agency limitations on amount, duration, or scope of services.

(f) Determination of deductible incurred expenses: Required deductions based on the age of bills. Subject to the provisions of paragraph (g), in determining incurred medical expenses to be deducted from income, the agency must include the following:

(1) For the first budget period or periods that include only months before the month of application for medical assistance, expenses incurred during such period or periods, whether paid or unpaid, to the extent that the expenses have not been deducted previously in establishing eligibility;

(2) For the first prospective budget period that also includes any of the 3 months before the month of application for medical assistance, expenses incurred during such budget period, whether paid or unpaid, to the extent that the expenses have not been deducted previously in establishing eligibility;

(3) For the first prospective budget period that includes none of the months preceding the month of application, expenses incurred during such

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budget period and any of the 3 preceding months, whether paid or unpaid, to the extent that the expenses have not been deducted previously in establishing eligibility;

(4) For any of the 3 months preceding the month of application that are not includable under paragraph (f)(2) of this section, expenses incurred in the 3-month period that were a current liability of the individual in any such month for which a spenddown calculation is made and that had not been previously deducted from income in establishing eligibility for medical assistance;

(5) Current payments (that is, payments made in the current budget period) on other expenses incurred before the current budget period and

not previously deducted from income in any budget period in establishing eligibility for such period; and

(6) If the individual's eligibility for medical assistance was established in each such preceding period, expenses incurred before the current budget period but not previously deducted from income in establishing eligibility, to the extent that such expenses are unpaid and are:

(i) Described in paragraphs (e)(1) through (e)(3) of this section; and

(ii) Carried over from the preceding budget period or periods because the individual had a spenddown liability in each such preceding period that was met without deducting all such incurred, unpaid expenses.

(g) Determination of deductible incurred medical expenses: Optional deductions. In determining incurred medical expenses to be deducted from income, the agency--

(1) May include medical institutional expenses (other than expenses in acute care facilities) projected to the end of the budget period at the Medicaid reimbursement rate;

(2) May, to the extent determined by the State and specified in its approved plan, include expenses incurred earlier than the third month before the month of application (except States using more restrictive eligibility criteria under the option in section 1902(f) of the Act must deduct incurred expenses regardless of when the expenses were incurred); and

(3) May set reasonable limits on the amount to be deducted for expenses specified in paragraphs (e)(1), (e)(2), and (g)(2) of this section.

(h) Order of deduction. The agency must deduct incurred medical expenses that are deductible under paragraphs (e), (f), and (g) of this section in the order prescribed under one of the following three options:

(1) Type of service. Under this option, the agency deducts expenses in the following order based on type of expense or service:

(i) Cost-sharing expenses as specified in paragraph (e)(1) of this section.

(ii) Services not included in the State plan as specified in paragraph (e)(2) of this section.

(iii) Services included in the State plan as specified in paragraph (e)(3) of this section but that exceed limitations on amounts, duration, or scope of services.

(iv) Services included in the State plan as specified in paragraph (e)(3) of this section but that are within agency limitations on amount, duration, or scope of services.

(2) Chronological order by service date. Under this option, the agency deducts expenses in chronological order by the date each service is furnished, or in the case of insurance premiums, coinsurance or deductible charges, the date such amounts are due. Expenses for services furnished on the same day may be deducted in any reasonable order established by the State.

(3) Chronological order by bill submission date. Under this option, the agency deducts expenses in chronological order by the date each bill is submitted to the agency by the individual. If more than one bill is submitted at one time, the agency must deduct the bills from income in the order prescribed in either paragraph (h)(1) or (h)(2) of this section.

(i) Eligibility based on incurred medical expenses. (1) Whether a State elects partial or full month coverage, an individual who is expected to contribute a portion of his or her income toward the costs of institutional care or home and community-based services under

Section

Sec. Sec. 435.725, 435.726, 435.733, 435.735 or 435.832 is eligible on the first day of the applicable budget (spenddown) period--

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(i) If his or her spenddown liability is met after the first day of the budget period; and

(ii) If beginning eligibility after the first day of the budget period makes the individual's share of health care expenses under Sec. Sec. 435.725, 435.726, 435.733, 435.735 or 435.832 greater than the individual's contributable income determined under these sections.

(2) At the end of the prospective period specified in paragraphs (f)(2) and (f)(3) of this section, and any subsequent prospective period or, if earlier, when any significant change occurs, the agency must reconcile the projected amounts with the actual amounts incurred, or with changes in circumstances, to determine if the adjusted deduction of incurred expenses reduces income to the income standard.

(3) Except as provided in paragraph (i)(1) of this section, in States that elect partial month coverage, an individual is eligible for Medicaid on the day that the deduction of incurred health care expenses (and of projected institutional expenses if the agency elects the option under paragraph (g)(1) of this section) reduces income to the income standard.

(4) Except as provided in paragraph (i)(1) of this section, in States that elect full month coverage, an individual is eligible on the first day of the month in which spenddown liability is met.

(5) Expenses used to meet spenddown liability are not reimbursable under Medicaid. To the extent necessary to prevent the transfer of an individual's spenddown liability to the Medicaid program, States must reduce the amount of provider charges that would otherwise be reimbursable under Medicaid.

[59 FR 1672, Jan. 12, 1994]

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TITLE 42--PUBLIC HEALTH

CHAPTER IV--CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES (CONTINUED)

PART 435_ELIGIBILITY IN THE STATES, DISTRICT OF COLUMBIA, THE NORTHERN MARIANA

Subpart I_Specific Eligibility and Post-Eligibility Financial Requirements for the Medically Needy

Sec. 435.832 Post-eligibility treatment of income of institutionalized individuals: Application of patient income to the cost of care.

(a) Basic rules. (1) The agency must reduce its payment to an institution, for services provided to an individual specified in paragraph (b) of this section, by the amount that remains after deducting the amounts specified in paragraphs (c) and (d) of this section, from the individual's total income.

(2) The individual's income must be determined in accordance with paragraph (e) of this section.

(3) Medical expenses must be determined in accordance with paragraph (f) of this section.

(b) Applicability. This section applies to medically needy individuals in medical institutions and intermediate care facilities.

(c) Required deductions. The agency must deduct the following amounts, in the following order, from the individual's total income, as determined under paragraph (e) of this section. Income that was disregarded in determining eligibility must be considered in this process.

(1) Personal needs allowance. A personal needs allowance that is reasonable in amount for clothing and other personal needs of the individual while in the institution. This protected personal needs allowance must be at least--

(i) $30 a month for an aged, blind, or disabled individual, including a child applying for Medicaid on the basis of blindness or diability.

(ii) $60 a month for an institutionalized couple if both spouses are aged, blind, or disabled and their income is considered available to each other in determining eligibility; and

(iii) For other individuals, a reasonable amount set by the agency, based on a reasonable difference in their personal needs from those of the aged, blind, and disabled.

(2) Maintenance needs of spouse. For an individual with only a spouse at home, an additional amount for the maintenance needs of the spouse. This amount must be based on a reasonable assessment of need but must not exceed the highest of--

(i) The amount of the income standard used to determine eligibility for SSI for an individual living in his own home;

(ii) The amount of the highest income standard, in the appropriate category of age, blindness, or disability, used to determine eligibility

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for an optional State supplement for an individual in his own home, if the agency provides Medicaid to optional State

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supplement recipients under Sec. 435.230; or

(iii) The amount of the medically needy income standard for one person established under Sec. 435.811.

(3) Maintenance needs of family. For an individual with a family at home, an additional amount for the maintenance needs of the family. This amount must--

(i) Be based on a reasonable assessment of their financial need;

(ii) Be adjusted for the number of family members living in the home; and

(iii) Not exceed the highest of the following need standards for a family of the same size:

(A) The standard used to determine eligibility under the State's approved AFDC plan.

(B) The medically needy income standard established under Sec. 435.811.

(4) Expenses not subject to third party payment. Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including--

(i) Medicare and other health insurance permiums, deductibles, or coinsurance charges; and

(ii) Necessary medical or remedial care recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits the agency may establish on amounts of these expenses.

(d) Optional deduction: Allowance for home maintenance. For single individuals and couples, an amount (in addition to the personal needs allowance) for maintenance of the individual's or couple's home if--

(1) The amount is deducted for not more than a 6-month period; and

(2) A physician has certified that either of the individuals is likely to return to the home within that period.

(e) Determination of income--(1) Option. In determining the amount of an individual's income to be used to reduce the agency's payment to the institution, the agency may use total income received or it may project total monthly income for a prospective period not to exceed 6 months.

(2) Basis for projection. The agency must base the projection on income received in the preceding period, not to exceed 6 months, and on income expected to be received.

(3) Adjustments. At the end of the prospective period specified in paragraph (e)(1) of this section, or when any significant change occurs, the agency must reconcile estimates with income received.

(f) Determination of medical expenses--(1) Option. In determining the amount of medical expenses to be deducted from an individual's income, the agency may deduct incurred medical expenses, or it may project medical expenses for a prospective period not to exceed 6 months.

(2) Basis for projection. The agency must base the estimate on medical expenses incurred in the preceding period, not to exceed 6 months, and medical expenses expected to be incurred.

(3) Adjustments. At the end of the prospective period specified in paragraph (f)(1) of this section, or when any significant change occurs, the agency must reconcile estimates with incurred medical expenses.

[45 FR 24886, Apr. 11, 1980, as amended at 46 FR 47988, Sept. 30, 1981; 48 FR 5735, Feb. 8, 1983; 53 FR 3596, Feb: 8, 1988; 53 FR 5344, Feb. 23, 1988; 56 FR 8850, 8854, Mar. 1, 1991; 58 FR 4933, Jan. 19, 1993]

3628. DEDUCTION OF INCURRED MEDICAL AND REMEDIAL CARE EXPENSES (SPENDDOWN)

The following definitions are used for purposes of this section.

Financially Responsible Relative--A spouse or parent (including a stepparent who is legally liable for support of stepchildren under a State law of general applicability) whose income is actually used in determining eligibility.

Incurred Expenses--Expenses for medical or remedial services:

- o recognized under State law,
- o rendered to an individual, family, or financially responsible relative, and
- o for which the individual is liable in the current accounting period or was liable in the 3-month retroactive period described in 42 CFR 435.914.

An expense as described above is an incurred expense from the beginning of the accounting period in which the liability arises until the end of the accounting period in which the liability is satisfied. The expense is deductible from income in any accounting period in which it meets the definition of an incurred expense but only to the extent that the amount has not been deducted previously. (See §3628.1.)

Liable Third Party--Any individual, entity or program that is or may be liable to pay all or part of the cost of medical or remedial treatment for injury, disease, or disability of an applicant or recipient of Medicaid.

NOTE: There is no Federal financial participation (FFP) in expenses used to reduce spend down liability.

Projected Expenses--Expenses for services that have not yet been incurred but are reasonably expected to be.

Spenddown Liability--Amounts by which countable income exceeds the MNIL for the budget period.

State or Territorial Public Program--A program that is operated (i.e., administratively controlled) by a State or territory (including a political subdivision thereof).

State or Territorially-Financed Program--A State or territorial public program whose funding, except for deductibles and coinsurance amounts required from program beneficiaries, is either:

- o appropriated by the State or territory directly to the administering agency, or
- o transferred from another State or territorial public agency to the administering agency.

When countable income exceeds the MNIL for the budget period, deduct from that income certain medical and remedial care expenses incurred by an individual, family or financially responsible relative that are not subject to payment by a third party unless the third party is a public program of a State (or territory) or political subdivision of a State (or territory). Deduct incurred medical and remedial care expenses paid by a public program (other than a Medicaid program) of a State (or territory). Once countable income is reduced (by applying these deductions) to an amount equal to the MNIL, the individual or family is income eligible.

Take reasonable measures to determine the legal liability of third parties to pay for incurred expenses. However, do not forestall an eligibility determination simply because third party liability cannot be ascertained or payment by the third party has not been received. 42 CFR 435.911 prescribes a time period for reaching decisions on Medicaid eligibility, i.e., 60 days for applicants who apply on the basis of disability and 45 days for all others. It establishes a time limit for receipt of third party payment or verification of third party intent to pay in order to determine deductible expenses under spenddown. Efforts to determine the liability of a third party must continue through the last day of this period.

3628.1 Expenses That Must Be Deducted.--Deduct from countable income the medical and remedial care expenses listed below that are not subject to payment by a third party. (Such deductions are allowable even if the expenses are paid by a public program (other than the Medicaid program) of a State or territory if the program is financed by the State or territory.)

o Insurance premiums (including Medicare), deductibles or coinsurance charges including enrollment fees, copayments or deductibles imposed under 42 CFR 447.51 or 447.53 subject to any reasonable limits you choose to impose;

o Necessary medical and remedial services recognized under State law but not included in your plan, subject to reasonable limits;

o Necessary medical and remedial services included in your plan (subject to any reasonable limits you choose to impose). For example, you may limit types of services such as cosmetic or podiatrist's services. You are encouraged to restrict exclusions to items of care that can be determined, based on medical advice, not to be essential or necessary;

o Expenses incurred during the month of application and the 3 preceding months described at 42 CFR 435.914 are deducted unless such expenses have been paid by or are subject to payment by a legally liable third party as described in §3628. Expenses incurred by the individual, family or legaly responsible relative and paid by the individual, family or legally responsible relative are deducted; and

o Current payments or unpaid balance on old bills incurred outside the current prospective and 3-month retroactive periods not previously deducted in any budget period are also deducted.

3628.2 Optional Deductions and Limitations on Incurred Medical Expenses.--Optional limits placed on insurance premiums, deductibles or coinsurance charges and necessary medical and remedial care expenses included in your plan must be reasonable. Following are examples of limits that are not reasonable:

o An accumulative dollar limit for all services subject to reasonable limits. For example, a $600 limit; and

o A limit on services included in your plan that is the same as a limit already included in your plan. For example, if your plan limits drugs to three prescriptions per month, you may not impose a combined limit of three prescriptions as covered and noncovered incurred expenses.

Although no accumulative dollar limit may be imposed, dollar limits may be imposed on individual services. Additionally, you may impose limits on the number of visits or items of covered services provided they exceed limits included in your plan.

3628.3 Projection of Expenses.--Do not project medical and remedial care expenses that are not for institutional care services (excluding acute care facility services). For example, insurance premiums are not an institutional service, therefore, such expenses cannot be projected. Nor may you deduct expenses that are included in a prepaid package of services prior to the date the services are rendered (e.g., charges for prenatal care and delivery services and orthodontia).

3628.4 Projection of Institutional Care Expenses.--The agency has the option of projecting institutional care expenses (except for expenses for services rendered in an acute care facility). The amount of the projected expenses is based on the private pay rate or a combination of actual incurred institutional expenses and projected expenses.

Election of the option to project institutional care expenses does not preclude deduction of actually incurred expenses and in some instances requires the use of a combination of actually incurred expenses and projected expenses. Those circumstances are:

o When the projected institutional care expense is less than the individual§s spenddown liability for the budget period; and

o When there is current liability for bills from a period prior to the current retroactive and prospective budget periods. A bill written off as a bad debt is not a current liability.

3628.5 Date of Eligibility.--The total of actually incurred expenses and/or projected expenses are added together and deducted from the spenddown liability for the budget period. If the total of the projected expenses does not exceed the spenddown liability for the budget period, the individual must incur additional expenses in order to be income eligible. Thus, depending on individual circumstances and your election of full or partial month coverage under 42 CFR 435.914, an individual could be eligible on the first day of the budget period or sometime during the budget period. If you elect full month coverage, eligibility begins on the first day of the month in which spenddown liability is met. (You are reminded, however, that although the effective date of eligibility begins on the first day of a month FFP is not available for expenses used to reduce spenddown liability.) If you elect partial month coverage, eligibility begins on the day all conditions of eligibility (including spenddown) are met.

Following are examples that illustrate projection of expenses and the effective date of eligibility.

Example 1: The individual is in the institution as of the first day of the month. His monthly spenddown liability is $2000. The projected private rate is $1,800 per month ($60 per day). Since the projected institutional expense is $200 less than the spenddown liability of $2000, the individual is not eligible based on his projected institutional expense. However, on the 3rd day of a prosthesis costing $200 is purchased. Thus on the 3rd of the month the month the combination of projected and actually incurred expenses equal the spenddown liability and the individual is income eligible.

Example 2: The individual enters the institution on the 16th of the month. The monthly spenddown liability is $500. The individual has incurred $600 in other medical expenses prior to the month of application which remain the individual's current liability. Because the individual has $600 of other medical expenses, the spenddown is met on the first day of the monthly budget period (prior to the first day of institutionalization).

3628.6 Application of Post-Eligibility Rules When Projection of Institutional Care Expenses Is Used.--§§42 CFR 435.733, 435.832 and 436.832 specify how an eligible individual's income is applied to the cost of institutional care. Following are examples of how eligibility rules and post-eligibility rules interface.

Example 1: An individual's monthly income is $925. The monthly private rate is $1,400. The monthly spenddown liability is $600. The individual is in the institution as of the first day of the month. Since the projected monthly institutional expense ($1,400) exceeds the monthly spenddown liability ($600), the individual is considered eligible on the first of the month. Thus, the post-eligibility treatment of income rules apply. At least $25 per month of the individual's income is protected for personal needs. Thus, the State must reduce its payment to the institution by $900 ($925 - $25) and the individual would apply $900 of his income toward the cost of care. The Medicaid rate is $1,200, therefore, the State would pay the institution $300 ($1,200 - $900).

Example 2: An individual's monthly income is $1,820. The monthly private pay rate is $1,200 ($40 per day). The monthly spenddown liability is $1,500. The individual is in the institution as of the first day of the month and the State projects institutional expenses at the private pay rate.

Since projected monthly expenses as of the first day of the month are not sufficient to meet the spenddown liability ($1,500), the individual is not eligible. However, after remaining in the institution for 15 days the individual has actually incurred expenses of $900. The projected institutional expenses for the remaining days in the month are $600 ($40 x 15 days). Thus, as of the 15th day of the month, the individual is eligible and the rules of post-eligibility treatment of income apply.

Under the post-eligibility rules, $25 per month of the individual's income is protected for personal needs. Prorated for the 15 days remaining in the month, the Medicaid rate is $450, the individual's income is $910, and the protected income for personal needs is $12.50. Therefore, the State must reduce its payment at the Medicaid rate to the

institution by $897.50 ($910 - $12.50). The individual would apply this amount toward the cost of care up to the Medicaid rate $450 for the 15 day period and the State would pay $0 toward the cost of care. The individual would retain $320 of his $1,820 income each month.

3628.7 Order of Deduction.--Deduct incurred expenses in the following order:

1. Insurance premiums, deductibles or coinsurance charges including enrollment fees, copayments or deductibles imposed under §§42 CFR 447.51 or 447.53;

2. Necessary medical and remedial services that are recognized under State law but not included in the Medicaid plan;

3. Necessary medical and remedial services that exceed Medicaid plan limitations on amount, duration and scope imposed by the agency;

4. Necessary medical and remedial services that are included in the agency§s Medicaid plan, within the agency's limitations on amount, duration and scope of services.

Section

[Code of Federal Regulations]
[Title 42, Volume 4]
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[Page 205-207]

TITLE 42--PUBLIC HEALTH

CHAPTER IV--CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES (CONTINUED)

PART 436_ELIGIBILITY IN GUAM, PUERTO RICO, AND THE VIRGIN ISLANDS--Table of

Subpart I_Financial Requirements for the Medically Needy

Sec. 436.831 Income eligibility.

The agency must determine income eligibility of medically needy individuals in accordance with this section.

(a) Budget periods. (1) The agency must use budget periods of not more than 6 months to compute income. The agency may use more than one budget period.

(2) The agency must include in the budget period in which income is computed all or part of the 3-month retroactive period specified in Sec. 435.914. The budget period can begin no earlier then the first month in the retroactive period in which the individual received covered services.

(3) If the agency elects to begin the first budget period for the medically needy in any month of the 3-month period prior to the date of application in which the applicant received covered services, this election applies to all medically needy groups.

(b) Determining countable income. The agency must, to determine countable income, deduct amounts that would be deducted in determining eligibility under the State's approved plan for OAA, AFDC, AB, APTD, or AABD.

(c) Eligibility based on countable income. If countable income determined under paragraph (b) of this section is equal to or less than the applicable income standard under Sec. 436.814, the individual is eligible for Medicaid.

(d) Deduction of incurred medical expenses. If countable income exceeds the income standard, the agency must deduct from income medical expenses incurred by the individual or family or financially responsible relatives that are not subject to payment by a third party. An expense is incurred on the date liability for the expense arises. The agency must determine deductible incurred expenses in accordance with paragraphs (e), (f) and (g) of this section and deduct those expenses in accordance with paragraph (h) of this section.

(e) Determination of deductible incurred expenses: Required deductions based on kinds of services. Subject to the provisions of paragraph (g) of this section, in determining incurred medical expenses to be deducted from income, the agency must include the following:

(1) Expenses for Medicare and other health insurance premiums, and deductibles or coinsurance charges, including enrollment fees, copayments, or deductibles imposed under Sec. 447.51 or Sec. 447.53 of this chapter;

(2) Expenses incurred by the individual or family or financially responsible relatives for necessary medical and remedial services that

are recognized under State law but not included in the plan;

(3) Expenses incurred by the individual or family or by financially responsible relatives for necessary medical and remedial services that are included in the plan, including those that exceed agency limitations on amount, duration or scope of services;

(f) Determination of deductible incurred expenses: Required deductions based on the age of bills. Subject to the provisions of paragraph (g) of this section, in determining incurred medical expenses to be deducted from income, the agency must include the following:

(1) For the first budget period or periods that include only months before the month of application for medical assistance, expenses incurred during such period or periods, whether paid or unpaid, to the extent that the expenses have not been deducted previously in establishing eligibility;

(2) For the first prospective budget period that also includes any of the 3 months before the month of application for medical assistance, expenses incurred during such budget period, whether paid or unpaid, to the extent that the expenses have not been deducted previously in establishing eligibility;

(3) For the first prospective budget period that includes none of the months preceding the month of application, expenses incurred during such budget period and any of the 3 preceding months, whether paid or unpaid,

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to the extent that the expenses have not been deducted previously in establishing eligibility;

(4) For any of the 3 months preceding the month of application that are not includable under paragraph (f)(2) of this section, expenses incurred in the 3-month period that were a current liability of the individual in any such month for which a spenddown calculation is made and that had not been previously deducted from income in establishing eligibility for medical assistance;

(5) Current payments (that is, payments made in the current budget period) on other expenses incurred before the current budget period and not previously deducted from income in any budget period in establishing eligibility for such period; and

(6) If the individual's eligibility for medical assistance was established in each such preceding period, expenses incurred before the current budget period but not previously deducted from income, to the extent that such expenses are unpaid and are:

(i) Described in paragraphs (e)(1) through (e)(3) of this section; and

(ii) Are carried over from the preceding budget period or periods because the individual had a spenddown liability in each such preceding period that was met without deducting all such incurred, unpaid expenses.

(g) Determination of deductible incurred medical expenses: Optional deductions. In determining incurred medical expenses to be deducted from income, the agency--

(1) May include medical institutional expenses (other than expenses in acute care facilities) projected to the end of the budget period at the Medicaid reimbursement rate;

(2) May, to the extent determined by the agency and specified in its approved plan, include expenses incurred earlier than the third month before the month of application; and

(3) May set reasonable limits on the amount to be deducted for expenses specified in paragraphs (e)(1), (e)(2), and (g)(2) of this section.

(h) Order of deduction. The agency must deduct incurred medical expenses that are deductible under paragraphs (e), (f), and (g) of this section, in the order prescribed under one of the following three options:

(1) Type of service. Under this option, the agency deducts expenses in the following order based on type of service:

(i) Cost-sharing expenses as specified in paragraph (e)(1) of this section.

(ii) Services not included in the State plan as specified in paragraph (e)(2) of this section.

(iii) Services included in the State plan as specified in paragraph (e)(3) of this section but that exceed agency limitations on amount, duration, or scope of services.

(iv) Services included in the State plan as specified in paragraph (e)(3) of this section but that are within agency limitations on amount, duration, or scope of services.

(2) Chronological order by service date. Under this option, the agency deducts expenses in chronological order by the date each service is furnished, or in the case of insurance premiums, coinsurance, or deductibles charges the date such amounts are due. Expenses for services furnished on the same day may be deducted in any reasonable order established by the State.

(3) Chronological order by bill submission date. Under this option, the agency deducts expenses in chronological order by the date each bill is submitted to the agency by the individual. If more than one bill is submitted at one time, the agency must deduct the bills from income in the order prescribed in either paragraph (h)(1) or (h)(2) of this section.

(i) Eligibility based on incurred medical expenses. (1) Whether a State elects partial or full month coverage, an individual who is expected to contribute a portion of his or her income toward the costs of institutional care or home and community-based services under Sec. 436.832 is eligible on the first day of the applicable budget (spenddown) period--

(i) If his or her spenddown liability is met after the first day of the budget period; and

(ii) If beginning eligibility after the first day of the budget period makes the individual's share of health care expenses under Sec. 436.832 greater than the individual's contributable income determined under this section.

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(2) At the end of the prospective period specified in paragraph (f)(2) or (f)(3) of this section and any subsequent prospective period or, if earlier, when any significant change occurs, the agency must reconcile the projected amounts with the actual amounts incurred, or with changes in circumstances, to determine if the adjusted deduction of incurred expenses reduces income to the income standard.

(3) Except as provided in paragraph (i)(1) of this section, if agencies elect partial month coverage, an individual is eligible for Medicaid on the day that the deduction of incurred health care expenses (and of projected institutional expenses if the agency elects the option under paragraph (g)(1) of this section) reduces income to the income standard.

(4) Except as provided in paragraph (i)(1) of this section, if agencies elect full month coverage, an individual is eligible on the first day of the month in which spenddown liability is met.

(5) Expenses used to meet spenddown liability are not reimbursable under Medicaid. Therefore, to the extent necessary to prevent the

transfer of an individual's spenddown liability to the Medicaid program, States must reduce the amount of provider charges that would otherwise be reimbursable under Medicaid.

[59 FR 1674, Jan. 12, 1994]

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TITLE 42--PUBLIC HEALTH

CHAPTER IV--CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES (CONTINUED)

PART 436_ELIGIBILITY IN GUAM, PUERTO RICO, AND THE VIRGIN ISLANDS--Table of

Subpart I_Financial Requirements for the Medically Needy

Sec. 436.832 Post-eligibility treatment of income of institutionalized individuals: Application of patient income to the cost of care.

(a) Basic rules. (1) The agency must reduce its payment to an institution, for services provided to an individual specified in paragraph (b) of this section, by the amount that remains after deducting the amounts specified in paragraphs (c) and (d) of this section from the individual's total income.

(2) The individual's income must be determined in accordance with paragraph (e) of this section.

(3) Medical expenses must be determined in accordance with paragraph (f) of this section.

(b) Applicability. This section applies to medically needy individuals in medical institutions and intermediate care facilities.

(c) Required deductions. The agency must deduct the following amounts, in the following order, from the individual's total income as determined under paragraph (e) of this section. Income that was disregarded in determining eligibility must be considered in this process.

(1) Personal needs allowance. A personal needs allowance that is reasonable in amount for clothing and other personal needs of the individual while in the institution. This protected personal needs allowance must be at least--

(i) $30 a month for an aged, blind, or disabled individual, including a child applying for Medicaid on the basis of blindness or disability;

(ii) $60 a month for an institutionalized couple if both spouses are aged, blind, or disabled and their income is considered available to each other in determining eligibility; and

(iii) For other individuals, a reasonable amount set by the agency, based on a reasonable difference in their personal needs from those of the aged, blind, or disabled.

(2) Maintenance needs of spouse. For an individual with only a spouse at home, an additional amount for the maintenance needs of the spouse. This amount must be based on a reasonable assessment of need but must not exceed the higher of--

(i) The amount of the highest need standard for an individual without income and resources under the State's approved plan for OAA, AFDC, AB, APTD, or AABD; or

(ii) The amount of the highest medically needy income standard for one person established under Sec. 436.811.

(3) Maintenance needs of family. For an individual with a family at home, an additional amount for the maintenance needs of the family. This amount must--

(i) Be based on a reasonable assessment of their financial need;

(ii) Be adjusted for the number of family members living in the home; and

(iii) Not exceed the highest of the following need standards for a family of the same size:

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(A) The standard used to determine eligibility under the State's Medicaid plan, as provided for in Sec. 436.811.

(B) The standard used to determine eligibility under the State's approved AFDC plan.

(4) Expenses not subject to third party payment. Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including--

(i) Medicare and other health insurance premiums, deductibles, or coinsurance charges; and

(ii) Necessary medical or remedial care recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits the agency may establish on amounts of these expenses.

(d) Optional deduction: Allowance for home maintenance. For single individuals and couples, an amount (in addition to the personal needs allowance) for maintenance of the individual's or couple's home if--

(1) The amount is deducted for not more than a 6-month period; and

(2) A physician has certified that either of the individuals is likely to return to the home within that period.

(e) Determination of income--(1) Option. In determining the amount of an individual's income to be used to reduce the agency's payment to the institution, the agency may use total income received or it may project total monthly income for a prospective period not to exceed 6 months.

(2) Basis for projection. The agency must base the projection on income received in the preceding period, not to exceed 6 months, and on income expected to be received.

(3) Adjustments. At the end of the prospective period specified in paragraph (e)(1) of this section, or when any significant change occurs, the agency must reconcile estimates with income received.

(f) Determination of medical expenses--(1) Option. In determining the amount of medical expenses to be deducted from an individual's income, the agency may deduct incurred medical expenses, or it may project medical expenses for a prospective period not to exceed 6 months.

(2) Basis for projection. The agency must base the estimate on medical expenses incurred in the preceding period, not to exceed 6 months, and medical expenses expected to be incurred.

(3) Adjustments. At the end of the prospective period specified in paragraph (f)(1) of this section, or when any significant change occurs, the agency must reconcile estimates with incurred medical expenses.

[45 FR 24888, Apr. 11, 1980, as amended at 46 FR 47991, Sept. 30, 1981; 48 FR 5735, Feb. 8, 1983; 53 FR 3597, Feb. 8, 1988; 56 FR 8851, 8854, Mar. 1, 1991; 58 FR 4938, Jan. 19, 1993]

Medically Needy Resource Standard

NOTE: To determine if more liberal methods or standards are protected by the moratorium and the effective date(s) of policy within the moratorium period, you must clearly identify on Supplement 5 exactly to whom policies pertain (e.g aged, blind, and disabled and/or AFDC-related medically needy, or all persons under the special income level of institutionalized individuals) and the date the policy was effective or is to be effective in the State. If a policy was in effect in a part of the moratorium period that has passed and you wish to reinstate a policy indicate the prior effective dates and the new effective date. Delete from the appropriate Supplement and approved moratorium policies which (during the moratorium period) become policy under §1902(a)(10). Because moratorium policies will be disapproved as part of the official plan, we recommend that you submit moratorium amendments separate from other plan amendments.

3640.7 Resubmission of Current Plan Policies.--Because of changes in eligibility sections of the State plan preprint, some of you have resubmitted old plan preprint pages to protect previously approved policies which are no longer approvable. The practice of including old plan pages among new plan pages has created confusion as the policies States are applying under their plans. Some of the policies contained on the old pages are protected by the moratorium, others are not.

In order to clarify Medicaid plan policies and to assure States maximum protection under the moratorium you must within 3 months of the date of issuance of this instruction:

- Delete old preprint pages from your plan;

- Annotate Attachment 2.6-A in the manner described in §3640.5, 1.-3. if you are using financial policies which differ from those required under §1902(a)(10) of the Act;

- Describe in an addendum to Supplement 5 financial policies included in your current approved plan that differ from those required under §1902(a)(10). Clearly identify that the policies described are included under the current approved plan, to whom the policies apply and the approved effective date of such policies; and

- Annotate any other pages of the current preprint, as appropriate, to reflect any other approved policies which differ from the Medicaid statute.

Upon submission of the revised plan pages, policies will be reviewed to determine if such policies are within the scope of the moratorium. We will advise you of the status of those policies under the moratorium. Such policies will remain a part of your official plan. However, compliance action may be initiated for policies which do not comply with the Medicaid statute and which are not protected by the moratorium.

Log #0656

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Emma Forkner
Director

July 17, 2008

Mr. James J. Giger, President
Systematic Management Systems
3550 Hobson Road, Suite 104
Woodbridge, Illinois 60517

Dear Mr. Giger:

Thank you for requesting information relative to the agency's policies and procedures for deductions of non-covered medical expenses for nursing facilities.

As required under federal law, South Carolina does allow adjustments to recurring income for expenses recognized by state law as medical expenses but not covered by the Medicaid program or other third-party payer. Non-covered medical expenses also include those items and/or services that exceed the Medicaid maximum allowable. Non-covered medical expenses do not include any items and/or services recognized as allowable cost for Medicaid rate setting purposes.

Non-covered expenses allowed as deductions from monthly recurring income include:

1. Prescription drugs above the four (4) prescriptions-per-month limit, not to exceed $54.00 per additional prescription per month.

2. Eyeglasses not otherwise covered by the Medicaid program, not to exceed a total of $108.00 per occurrence for lenses, frames and dispensing fee. A licensed optometrist or ophthalmologist must certify the necessity for eyeglasses.

3. Dentures
   - A one-time expense
   - Not to exceed $651.00 per plate or $1320.00 for one full pair of dentures
   - A licensed dental practitioner must certify necessity.
   - An expense for more than one pair of dentures must be prior approved by State DHHS.

4. Denture Repair
   - Justified as necessary by a licensed dental practitioner
   - Not to exceed $77.00 per occurrence.

5. Physician and other medical practitioner visits that exceed the yearly limit, not to exceed $69.00 per visit

6. Hearing Aids
    - A one-time expense
    - Not to exceed $1000.00 for one or $2000.00 for both
    - Necessity must be certified by a licensed practitioner
    - An expense for more than one hearing aid must be prior approved by State DHHS.

7. The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty is limited to zero.

Please note that lab fees are not included and that no deduction can be made if the resident has no reported monthly recurring income or expenses that were incurred prior to the resident entering the facility.

Additionally, for Medicaid billing purposes, lab tests performed at the nursing home facility/rest home are not compensable as a separate charge when using facility equipment and test kits. An independently licensed facility located on the premises would not be exempt from this policy. For confirmation, please refer to the Physicians, Laboratories, and Other Medical Professionals Provider Manual 02/01/2005 Edition, pages 2-26 & 2-27, also available at the website noted above.

The policies, procedures and forms for initiating adjustments to recurring income because of non-covered medical expenses are available by accessing the Nursing Facility Services Manual 11/01/2005 Edition online at the SCDHHS website at www.dhhs.state.sc.us/dhhsnew/ResourceLibrary/manuals.asp. Billing procedures are found in Section 3.

Additionally, for Medicaid billing purposes, lab tests performed at the nursing home facility/rest home are not compensable as a separate charge when using facility equipment and test kits. An independently licensed facility located on the premises would not be exempt from this policy. For confirmation, please refer to the Physicians, Laboratories, and Other Medical Professionals Provider Manual 02/01/2005 Edition, pages 2-26 & 2-27, also available at the website noted above.

If you have further questions, please contact Mr. Garnell Cauley, Bureau of Eligibility Policy and Oversight at (803) 898-2851.

Sincerely,

Emma Forkner
Director

EF/