# ARKANSAS REGISTER

## Transmittal Sheet

Sharon Priest
Secretary of State
State Capitol Rm. 026
Little Rock, Arkansas 72201-1094

For Office Use Only: Effective Date 7/4/99 Code Number 016.20.99012

Name of Agency Department of Human Services

Department Division of County Operations

Contact Person Roy D. Kindle, Jr. (501) 682-8251

Statutory Authority for Promulgating Rules 42CFR 435.725(c)(1); AR Code Ann. 20-76-201 et Seq.; AR Code Ann. 20-15-201 et Seq.

| Intended Effective Date | | Date |
|---|---|---|
| ☐ Emergency | Legal Notice Published . . . . . | 5-26-99 |
| ☒ 10 Days After Filing | Final Date for Public Comment . . . . . | 6-24-99 |
| ☐ Other | Reviewed by Legislative Council . . . . | |
| | Adopted by State Agency . . . . . | 7-3-99 |

## CERTIFICATION OF AUTHORIZED OFFICER

I Hereby Certify That The Attached Rules Were Adopted In Compliance with Act 434 of 1967 As Amended.

Ruth Whitney RK
Signature

(501) 682-8375
Phone Number

Director, Division of County Operations
Title

May 20, 1999
Date

FILED
ARK. REGISTER DIV.
99 JUN 24 PM 3:58
SECRETARY OF STATE
STATE OF ARKANSAS
BY

**DEPARTMENT** of Human Services
**DIVISION** of County Operations
**PERSON COMPLETING THIS STATEMENT** Roy Kindle, Assistant Director
Office of Program Planning & Development

**TELEPHONE:** 682-8251 **FAX NO.** 682-1597



## FINANCIAL IMPACT STATEMENT

**To comply with Act 884 of 1995, please complete the following Financial Impact Statement and file with the questionnaire and proposed rules.**

**SHORT TITLE OF THIS RULE** – MS 99-8, Earnings of ICF/MR Residents

**1. Does this proposed, amended, or repealed rule or regulation have a financial impact?**
Although this amended rule will allow all ICF/MR residents to retain more of their earned income, it is not anticipated that any resident will have earnings that exceed the maximum SSI benefit rate. This will result in a larger total Medicaid expenditure annually, but a General Revenue Funds savings to the state of $67,630, as offsetting adjustments to cost reports will no longer be required.

2. **If you believe that the development of a financial impact statement is so speculative as to be cost prohibited, please explain.**
N/A

3. **If the purpose of this rule or regulation is to implement a federal rule or regulation, please give the incremental cost for implementing the regulation.**

| 1999-2000 Fiscal Year | | 2000-2001 Fiscal Year | |
|---|---|---|---|
| **General Revenue** | **$ 40,466.00** | **General Revenue** | **$ 40,466.00** |
| **Federal Funds** | **108,744.00** | **Federal Funds** | **108,744.00** |
| **Cash Funds** | | **Cash Funds** | |
| **Special Revenue** | | **Special Revenue** | |
| **Other** | | **Other** | |
| **Total** | **$ 149,210.00** | **Total** | **$ 149,210.00** |

4. **What is the total estimated cost by fiscal year to any party subject to the proposed, amended, or repealed rule or regulation?**

| 1999-2000 Fiscal Year | 2000-2001 Fiscal Year |
|---|---|
| **None** | **None** |

5. **What is the total estimated cost by fiscal year to the agency to implement this regulation?**

| 1999-2000 Fiscal Year | 2000-2001 Fiscal Year |
|---|---|
| **$ 40,466.00** | **$ 40,466.00** |

NOTICE
OF
RULEMAKING

Pursuant to Arkansas Code Annotated 20-76-201 et Seq., Arkansas Code Annotated 20-15-201 et Seq., and 42 CFR 432.725 (c)(1), the Director, Division of County Operations, issues proposed changes to the Medical Services Policy Manual to allow residents of ICF/MR facilities to keep all of their earnings up to an amount equal to the current SSI SPA.

Copies of the proposed changes may be obtained by writing the Division of County Operations, P.O. Box 1437, Slot 1220, Little Rock, AR 72203, Attention: Office of Program Planning & Development. All comments must be submitted in writing to the address indicated above no later than 30 days from the date of this notice.

If you need this material in a different format, such as large print, contact our Americans with Disabilities Act Coordinator at 682-8920 (voice) or 682-8933 (TDD).

The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and operates, manages, and delivers services without regard to age, religion, disability, political affiliation, veteran status, sex, race, color or national origin.

Ruth Whitney
Director, Division of County Operations
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# MANUAL TRANSMITTAL

## Arkansas Department of Human Services

### Division of County Operations

[X] Policy [ ] Form [ ] Policy Directive

Issuance Number MS 99-8

Medical Services Policy Manual

Issuance Date 07-01-99

From: Ruth Whitney, Director

Expiration Date Until Superseded

Subj: Revised Policy

| Pages to be Deleted | Dated | Pages to be Added | Dated |
|---|---|---|---|
| MS 3000 - 3135 | 11/01/95 | MS 3000 - 3135 | 11/01/95 |
| MS 3140 - 3160 | 07/01/97 | MS 3140 - 3160 | 07/01/99 |
| MS 3160 - 3241 | 11/01/95 | MS 3160 - 3241 | 11/01/95 |
| MS 3341 | 07/01/97 | MS 3341 | 07/01/97 |
| MS 3341 - 3342 | 07/01/97 | MS 3341 - 3342 | 07/01/99 |
| MS 3342 - 3343.1 | 07/01/97 | MS 3342 - 3343.1 | 07/01/99 |
| MS 3343.1 - 3344.1 | 07/01/97 | MS 3343.1 - 3344 | 07/01/99 |
| MS 3344.1 - 3344.5 | 11/01/95 | MS 3344.1 - 3344.5 | 11/01/95 |
| MS 3350.5 - 3352 | 07/01/97 | MS 3350.5 - 3352 | 07/01/97 |
| MS 3400 | 07/01/97 | MS 3400 | 07/01/99 |
| MS 3400 | 07/01/97 | MS 3400 | 07/01/97 |
| MS 3400 - 3401 | 07/01/97 | MS 3400 - 3401 | 07/01/99 |

Summary of Changes

Effective July 1, 1999, ICF/MR residents including residents of State Human Development Centers are allowed to keep all of their earnings up to an amount equal to the current SSI SPA in addition to the $40.00 personal needs allowance. In determining eligibility, the total of gross earned income along with unearned income must continue to be compared to the current long term care income limit. In determining the patient liability in post-eligibility, earned income up to an amount equal to the current SSI SPA is deducted as a protected maintenance.

This change does not affect the treatment of earned income for residents of nursing homes and Benton Services Center. Patients with an intermediate level of care in a nursing facility whose physician's plan of care prescribes an employment activity as a therapeutic or rehabilitative measure will continue to keep up to $100.00 of their earnings in addition to the $40.00 personal needs allowance.

ICF/MR residents who currently show earned income equal to or less than $100.00 on WASM/WNHU will not require any updates until the next reevaluation, since they are currently not paying any earned income toward their cost of care in the facility. Those ICF/MR cases which currently show earned income exceeding $100.00 on WASM/WNHU will need to be adjusted. A listing of these cases will be sent to county offices under separate cover so that an adjustment to the patient liability can be made. Less than thirty cases have been identified statewide.

## 3000 Guidelines for the Long Term Care Program and Other AABD Categories

## 3100 General Information

### 3110 Facilities Which Provide Services

Facilities which provide medically necessary care and services 24 hours per day on a long term basis include private nursing facilities, Benton Services Center, Arkansas Human Development Centers, private intermediate care facilities for the mentally retarded (ICF/MR's), and ICF/MR facilities with both over and under 15 beds.

### 3120 Services Provided Under Medicaid

In addition to facility vendor payments, all services listed in the pamphlet, "Your Guide to Medicaid Services in Arkansas", are available to individuals under the Long Term Care Program, with the following exception: Individuals in the State Human Development Centers are not eligible for the Prescription Drug Program.

### 3130 Licensing and Classification of Facilities

To receive vendor payment under the Medicaid Program, a facility must be licensed and certified by the Office of Long Term Care (OLTC), and must execute a provider agreement with the Division of Medical Services.

The OLTC publishes a directory listing all participating facilities. Changes to the directory are issued periodically. The directory and updates are provided to each county office.

### 3135 Nursing Facility

Section 1919 (a) of the Social Security Act defines a nursing facility as an institution which is primarily engaged in providing:

- Skilled nursing care and related services for residents who require medical or nursing care,
- Rehabilitation services for the rehabilitation of injured, disabled, or sick persons, or
- Health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities,

and is not primarily for the care and treatment of mental diseases.

## 3140 Personal Allowance for Facility Residents

Each recipient in a facility is allowed to retain $40 per month from their income for personal expenses. (EXCEPTION: Recipients whose only income is SSI will have their monthly payment reduced to $30. They are allowed to keep this amount as a personal allowance.) Upon written authorization of a resident, the facility must hold, safeguard and account for the personal funds of the resident deposited with the facility. If the resident's personal funds are in excess of $50, the facility must deposit the funds in excess of $50 in an interest bearing account (or accounts), separate from any of the facility's operating accounts, that credits all interest earned on the resident's account to his or her account. A resident's personal funds may not be commingled with facility funds or with any person's funds other than another resident. The resident's individual financial record must be available on request to the resident or his/her legal representative.

* In addition to the $40 personal needs allowance, ICF/MR residents, including residents of State Human Development Centers, who have income from employment are allowed to keep all of their earnings up to an amount equal to the current SSI SPA.

A resident with earnings who is receiving intermediate care in a nursing facility may keep up to $100 increased personal needs allowance if his/her physician has stated that a period of employment activity is necessary as a therapeutic or rehabilitative measure. If a resident receiving skilled care in a nursing facility becomes employed, the Utilization Review Section of the OLTC should be contacted and requested to reevaluate medical necessity.

Certain SSI recipients whose stay in a nursing facility is not expected to exceed 3 months and who have a home to maintain will be allowed to retain full SSI benefits for personal expenses for three calendar months following the month of entry. The SSI payment, in these instances, will not be considered in eligibility or payment determination (Re. MS 3401).

A $90 personal needs allowance will be given to a veteran receiving a VA pension in a facility who has no spouse or dependent children. A veteran's surviving spouse who has no dependents and who receives a VA pension will also be given a $90 allowance. The full $90 allowance will be allowed only when VA has reduced the pension to $90. (Re. MS 3348.1). Veterans receiving VA compensation do not qualify for the $90 PNA.

## 3150 Special Charges to Recipients in Facilities

The facility must inform the patient prior to or at the time of admission or application, and during his/her stay, of services available in the facility and of related charges, including charges for services not covered by Medicare or the per diem rate. Recipients may be charged only for optional services (services not necessary or consistent with the normal care of the patient). When such services are provided, documentation must be on file with the OLTC. The refusal of a recipient to accept optional services offered by a facility must not effect a decrease or alteration in the services required or necessitated by his/her condition or otherwise considered as normal care. Inquiries from recipients or family members concerning special charges will be referred to the OLTC.

## 3160 Nondiscrimination

The Division of County Operations complies with all provisions of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the

Americans With Disabilities Act of 1990. All facilities authorized to participate in the LTC program must also comply with these provisions. No person will be prevented from participation, denied benefits, or otherwise subjected to discrimination based upon race, color, sex, national origin, disability, age, religion, political affiliation, or veteran status.

The Division of County Operations has the responsibility of informing applicants and recipients that assistance is provided on a nondiscriminatory basis and of their right to file a complaint with the Division, the Department of Health and Human Services, the Department of Justice, and/or the United States Civil Rights Commission if they feel they have been discriminated against on the basis of one of the above.

The OLTC is responsible for securing a statement of compliance from all hospitals and facilities authorized to participate in the Medicaid program, and for assuring that the Statement of Compliance is officially adopted and posted on the premises. The OLTC will also assure that copies of the policy are provided to all employers and staff, and to all referral agencies. The OLTC will conduct annual reviews of facilities to insure compliance with these provisions.

## 3170 Freedom of Choice

Residents of nursing and ICF/MR facilities, and AABD recipients whose primary insurance is Medicare, are not required to participate in the Medicaid Primary Care Physician Managed Care Program.

These recipients will have freedom of choice in the selection of facilities, physicians, pharmacies, and other medical providers. The recipient should be informed that payment under the Medicaid program can be made only to medical providers authorized to participate in the Medicaid program. If the recipient wishes to utilize the services of a personal physician or other medical practitioner who does not participate in the Medicaid program, the recipient will be advised that payment cannot be made by the Agency for these services, and that the cost will be his/her responsibility.

## 3180 Placement

Relatives or friends of a facility applicant should help in making the selection of a Medicaid certified and licensed facility. Names and addresses of facilities that can provide the appropriate care and services will be given to the patient or his/her family.

If the applicant is unable to make this choice and if there are no relatives or friends to assist in the decision, the county office will assist with the placement. If placement cannot be made, a request for assistance should be made to the OLTC.

## 3200 Application Process

## 3210 Initial Application for Facility Payment

An application for facility services may be made by the applicant, designated representative, next of kin, or person(s) acting responsibly for the individual. Applications should be made in the county where the facility chosen by the individual is located. If an application is made in the applicant's home county before facility entry, but the applicant enters a facility in another county, the application will be denied by input to WIMA, using denial Reason 53. A DCO-700 will then be completed, advising the client or the representative that the application has been sent to the appropriate county. All records will then be

transferred to the county where the facility is located. A new application will not be needed by the receiving county, and the original date of application will be entered in ACES when the application is reregistered.

NOTE: If a period of eligibility has been, or will be, established in a facility in the county of initial application, that county will certify the case for the eligible period before transferring the case to the second county.

Applications may be processed for deceased persons. Application may be made by any person with responsibility for the medical debts of the deceased person.

Application for facility services will be made on Form DCO-777. This form will be completed for all applications for facility vendor payment unless the individual is currently receiving assistance as an AFDC, U-18, or Foster Care (Cat. 91 or 92) recipient. No new application is needed for these categories.

### 3220 Reapplication for Facility Payment

Reapplication for facility services is made in the same manner as initial applications. Previous records will be reviewed. If the applicant comes from another county where his case was closed, the record will be secured from that county.

### 3230 Distinction Between Application and Inquiry

Every person has the right to apply for Medicaid. No application or inquiry may be ignored.

The distinction between an application and an inquiry is as follows:

1. An application is the action by which an individual indicates in writing to the Agency his desire to receive services.

2. An inquiry is simply a request for information about eligibility requirements for services. An inquiry may be followed by an application.

### 3240 Steps in Application Process

### 3241 Initial Contact

Initial contact may be made in person, by telephone, or by letter. Contact may be made by the applicant, a designated representative, the next of kin, or another person acting responsibly for him. The following tasks will be completed by the county worker during the initial contact:

1. Completion of Forms DCO-777 and DCO-727 (except for active AFDC, U-18, or Foster Care, Cat. 91 or 92 recipients). If the applicant or his representative is not present at the initial contact, Forms DCO-777 and DCO-727 may be mailed. The county worker will inform the applicant or his representative that he has not officially made application until the signed DCO-777 is received, and that all correspondence is available in different formats, such as large print;

2. Explanation of the process for determining medical necessity by the Long Term Care-Utilization Control Committee for all facility applicants. If the applicant has not selected a facility, a DCO-703 will be given or mailed to the applicant or his representative for him to take to his

in the advance notice that the case will be closed and that a new application will be required to reopen the case.

Anticipated income changes that will not result in case closure may be entered in WNHU no earlier than the month prior to the month of receipt of the income. The vendor payment adjustment will then be made by the Medicaid claims processing agent (Re. DCOUM 3723 for procedure). The recipient or representative should be notified of the increased vendor payment responsibility by DCO-700 at least ten days prior to input of the change.

2. Irregularly Received Non-Monthly Income - When the recipient receives income on an unpredictable basis and in unpredictable amounts, income adjustments and ineligibility resulting from its inclusion in the budget will not be processed until after its receipt. The ten day advance notice of intended action will be given before effecting any case closures or income adjustments. All income adjustments or closures will be made effective the first day of the month in which the income is received (Re. DCOUM 3722, 3723, and 3724). The recipient or person acting on his/her behalf must be fully advised by DCO-700 of the amount of his/her vendor payment responsibility in these cases. Every effort should be made to anticipate non-monthly income receipts so that advance action can be taken as specified under #1.

   As with regularly received non-monthly income, if benefits will be terminated for only one month for receipt of irregular non-monthly income, a new application will not be required and the customer will be so advised. Closures of two or more months will require a new application.

3. SSI/SSA Lump Sum Benefits - SSI lump sum payments will not be counted as income in the month of receipt and will be given a resource exclusion according to the schedule at MS 3332.3 #6. SSA lump sum payments will be counted as income in the month of receipt, but will be given the appropriate resource exclusion. Interest earned on these excluded funds will be counted as income in the month accrued and as a resource, if retained, in the month(s) following.

   When SSA lump sum benefits result in income ineligibility, the case will be suspended in the month of receipt of the lump sum. A new application will not be required to reopen the case in the following month. (Re. MS 3634.1 for procedures).

4. Interest and Dividend Income - Interest and dividends on checking and savings accounts, certificates of deposit, etc. represent a return on an investment or a loan of money, and are considered unearned income when credited to an account. Interest and dividends are considered credited to an account when a financial institution normally reports the income to the customer. The frequency with which interest is computed is immaterial in determining when the income is received (e.g., a bank may compute interest daily, but credit an account only monthly or quarterly).

   Interest and dividends will be considered in both eligibility and net income determinations. An individual will not be allowed to retain interest and dividends for personal needs in addition to the monthly personal needs allowance.

   In determining initial eligibility and at subsequent reevaluations, the latest interest/dividend statement (two if paid quarterly, at least three

if paid monthly) will be used to determine the countable monthly amount. If small interest/dividend amounts paid monthly or quarterly fluctuate slightly, counties may average and use the the average amount until the next scheduled reevaluation, unless an adjustment is necessary sooner due to a reported change. Interest/dividends credited or paid annually will be counted as income in the month of credit or receipt.

The county worker will provide the customer (or authorized representative) with an explanation regarding the consideration of interest/dividend income in the eligibility and net income determinations. Since the monthly interest/dividend amount will be combined with other income before the $40 monthly allowance for personal needs is considered, the recipient will not receive the full $40 monthly allowance unless he/she withdraws the interest/dividends as paid.

NOTE: Interest income of State Human Development Centers and Benton Services Center customers will be used in determining initial eligibility, but will not be considered in determining net income. All recipient interest income will be reported by these facilities in their semi-annual cost reports, and the full amount will be deducted by Central Office at the time of retrospective cost settlement.

* Interest income of customers in 10 bed ICF/MR facilities is counted in BOTH initial and post-eligibility determinations, as semi-annual cost reporting is not done for these facilities.

5. Gross earned income is counted in determining initial eligibility for ICF/MR residents including residents of State Human Development Centers. In posteligibility determinations earnings less mandated deductions up to an amount equal to the current SSI SPA are disregarded.

3342 Consideration of Ineligible Spouse/Parent(s) Income after Initial Eligibility Has Been Established

After initial eligibility has been established, income of the noninstitutionalized ineligible spouse/parent(s) may be considered available to the eligible spouse/child in a facility only to the extent that it is voluntarily contributed either to the eligible spouse/child in a facility or directly to the facility for partial vendor payment.

The ineligible spouse/parent(s) is not required to make a contribution to the eligible spouse/child in a facility or to the facility and may, in fact, choose to make no contributions.

If, however, the ineligible spouse/parent(s) indicates that he/she will voluntarily contribute any income, determine whether the contribution is made directly to the eligible person in the facility or directly to the facility for partial vendor payment.

Contributions made directly to the eligible person in the facility will be considered as unearned income both in determination of eligibility and in determining the net income to be applied to the vendor payment.

Contributions made directly to the facility as partial vendor payment will only be considered for the individual's share of the facility vendor payment, and will not be considered for recipient eligibility. The payment made by the

ineligible spouse/parent(s) must be for covered services under the LTC program to be considered available to apply toward the vendor payment. Payments made by the ineligible spouse/parent(s) for special charges or additional services and items not covered by the facility vendor payment will not be considered. This includes payments made by the family of the facility recipient to the facility for the cost of a private room.

Each ineligible spouse/parent will be advised that income contributions may be made on a voluntary basis to the eligible spouse/child in a facility or to the facility, and of the different ways that the contributions may be considered. The decision of whether to contribute or not is left to the ineligible spouse/parent(s) to make, and no suggestions or recommendations of action will be given. Any questions that the ineligible spouse/parent(s) has regarding the effects of a specific action will be answered.

Non-voluntary contributions can only be effected by court order, and only considered when actually paid by the ineligible spouse/parent(s). The eligible person in a facility is not required to seek support from the ineligible spouse/parent(s) to remain eligible for facility care.

## 3343 Determination and Verification of Earnings from Employment

The monthly gross amount of any earnings from employment will be determined. Monthly gross income is determined by the actual earnings received (or to be received) during the month of application or reevaluation, whether paid weekly, biweekly, semimonthly, or monthly. In cases where 5 pay periods during the month of application result in ineligibility, the application will not be denied (if otherwise eligible) but will be considered for eligibility in the following month when there will be only 4 pay periods. In ongoing cases where earnings are biweekly, the cases will be flagged (by DCO-88 or WALR) to make income adjustments on WNHU during the months when 5 paychecks are to be received.

If the earnings fluctuate, the worker will determine, by averaging or other means, an amount which fairly reflects the income actually currently available to the applicant on a monthly basis. The case narrative will clearly reflect the manner in which the income was determined and the justification for considering it a fair reflection of the actual, current income available to the applicant.

Verification of earnings from employment will be by check stubs, pay slips, or collateral contact with the employer. Sufficient verification must be obtained so that the actual income of the employee can be determined. The worker will not automatically assume that one check stub accurately reflects earnings for an entire month. The latest month's verification will be required. If a person is paid weekly, then the latest 4 (or 5) consecutive check stubs will be required. If the person is paid every other week or twice a month, then the latest two check stubs will be required, and if paid monthly, then the latest check stub will be required. If the customer does not have the required verification, then verification from the employer will be required:

EXCEPTION: For cases in which the applicant/recipient has just begun employment and a month's verification is not available, the county worker will compute the income from the best information available. In this instance the case will be flagged for a redetermination of earnings in the following month using full verification procedures.

## 3343.1 Earnings of ICF/MR Facility Residents

* Residents of ICF/MR facilities, including residents of State Human Development Centers, who have earned income may be given an earnings disregard of up to an amount equal to the current SSI SPA in addition to the $40 personal needs allowance. Nursing facility residents with earnings who receive intermediate care may be given a disregard of up to $100 of their monthly earnings, provided there is documentation that a physician has prescribed employment activity as a therapeutic or rehabilitative measure. If a nursing home resident receiving skilled care reports earnings, the Utilization Control Committee of the OLTC should be contacted and requested to reevaluate medical necessity.

All nursing facility and ICF/MR residents must first pass the gross income test, with no disregards allowed. If found eligible, the consideration of earnings will be as follows.

1. Ten Bed ICF/MR Facilities and State Human Development Centers

* Earnings of residents of these facilities must be taken into consideration for both eligibility and net income determinations. If residents pass the gross income eligibility test, their earnings will be included in the net income determination. In determining the net income to be applied toward the vendor payment, first subtract the mandatory deductions (e.g., federal and state income taxes) from gross income and, from the remaining earned income, up to an amount equal to the current SSI SPA for personal needs. Refer to MS 3400 for consideration of earnings at certification.

2. Fluctuating Earnings

If the earnings of ICF/MR facility residents stay below the SSI SPA, no reporting of fluctuations is needed.

The facility administrator will report to the county any month in which a resident's earnings exceed the SSI SPA.

If earnings consistently stay above the SSI SPA, they may be averaged (MS 3343), provided the facility administrator will agree to report to the county:

a. every 6 months when earnings are fairly stable, or

b. more frequently if the resident loses employment, changes jobs, or has earnings in any month which are more than $15 above the computed average.

## 3344 Determination and Verification of Earnings from Farm, Business or Self-Employment

Generally, it is necessary for the self-employed individual to estimate current income based on a projection from the tax return filed for the previous year and from current records kept in the regular course of business.

Because of the fluctuating nature of income receipts and self-employment expenses, current estimates for net income from self-employment will be based on the entire taxable year.

## 3344.1 Determining Amount of Net Earnings from Self-Employment

The amount of net earnings from self-employment is not always ascertainable from business records. If this is the case, use the first of the following methods that is likely to give the most accurate estimate of current and future net earnings which may be allocated on a monthly basis.

1. When the individual has been carrying on the same trade or business for some time, net earnings from self-employment have been fairly constant from year-to-year, and he/she anticipates no change or gives no satisfactory explanation of why the net earnings for current and future months would be substantially different from what it has been in the past, the estimate of earnings for the current taxable year should be the same as the net profit last year. Monthly income should be determined as one-twelfth of the net profit as shown on the tax return for the preceding year.

2. When the individual is engaged in the same business that he/she had the preceding taxable year and anticipates no change or can give no reason why the net earnings for current and future months would be substantially different from what it has been in the past, determine the ratio between his net profit and gross receipts for the last year (e.g. net profit of $1,200 for $6,000 gross income, or 20%). Determine from his/her records the actual gross receipts for the current taxable year and project for the remainder of the year (e.g. $4,000 in current year's receipts for the first 6 months gives an assumed gross of $8,000 for the entire year). Apply the previously determined gross-net ratio (e.g. 20% of $8,000 is $1,600) and the resulting estimated net profit would be allocated equally into each month of the taxable year. This method would not be suitable for a business which is seasonal or has income peaks at certain times of the year.

3. Have the self-employed individual supply a profit and loss statement or other business records for the taxable year to date so that a net profit can be projected for the year and allocated monthly.

4. Use the individual's best estimate based on his/her business records.

5. Consideration may be given to the individual's explanation as to why he/she believes his/her estimated net earnings for the current year will be substantially different from the information on tax returns for past years or business records for past periods. Some examples of satisfactory explanations include business loss or damage due to fire, flood, burglary, serious illness or disability of the owner, or other such catastrophic event which can be documented. Obtain documentation for the records (newspaper accounts, police reports, medical reports, etc.). With documentation, a lower estimate may be accepted.

After the estimated net income from self-employment has been determined, explain to the individual how it has been determined and the effect it has on eligibility. Advise the individual that he/she may appeal if he/she disputes the estimates, or that he/she may request a change or reapply if new evidence becomes available.

If the allocated amounts of income result in ineligibility, explain to the individual that he/she may reapply if the remaining current year receipts or expenses or a new accounting of net earnings from self-employment result in lower net earnings.

If the individual is eligible for assistance, advise him/her that any substantial variation of net earnings should be reported promptly with appropriate evidence, so that overpayments and underpayments can be prevented. Explain also that he/she must provide a copy of the federal tax return as it becomes available.

When one of the methods under items 3, 4 or 5 has been used to determine net earnings, advise the individual that he/she should maintain monthly records of ongoing receipts and expenditures until the federal tax return is available so that substantial variations of income can be identified and reported immediately to avoid erroneous eligibility.

## 3344.2 Unstated Income

Unstated income is income not reported or otherwise accounted for, but known to exist because living expenses exceed the income that has been reported.

An applicant, recipient or person whose income is subject to deeming may have unstated income.

The amount of unstated income to be considered as unearned income in determining eligibility is the difference between the declared monthly income and the monthly living expenses.

## 3344.3 When to Develop Unstated Income

When an individual's stated income does not appear adequate to cover living expenses, it will be necessary to develop unstated income, unless there is a reasonable explanation to account for the difference; e.g., savings have been used or bills have not been paid.

If the previous year's income tax return of an individual engaging in self-employment activity shows "0" or only a small amount of net income, living expenses and unstated income must be explored.

## 3344.4 Development of Living Expenses

When development of living expenses is required due to unstated income, explain to the individual what information will be needed to develop living expenses and why it is needed. Consider the living expenses of each and every member of the self-employed individual's household, and explain that all expenses must be considered. It is essential that a complete disclosure be obtained.

The following guide should be used in developing living expenses:

1. Prepare on a separate narrative sheet(s) a topical breakdown of pertinent monthly living expenses such as:

   a. Shelter or Living Quarters Cost (rents, taxes, mortgage payments, heating expenses, utility expenses, water expenses, sewer expenses, garbage collection expenses, etc.).

   b. Clothing and Upkeep.

c. Medical Expense Not Reimbursed by Insurance (doctor bills, dentist bills, drugs, health insurance premiums, etc.).

d. Transportation (car loan payments, insurance premiums, gasoline, tires, oil, mass transportation fares, etc.).

e. Food, Meals and Household Supplies (groceries, cleaning supplies, restaurant meals, etc.).

f. Credit Purchases and Loans (furniture bill payments, finance company payments, etc.).

g. Other (life insurance premiums, legal services, traffic fines, cigarettes, alcoholic beverages, etc.).

2. The reported living expenses will be considered as expenses in the actual time periods in which the expenses were paid by members of the household. Take into account the tendency to overlook expenses. Avoid averaging expenses between different months unless the monthly living expense total would be distorted if they were not averaged. If averaging is used, give an explanation of the reason on the narrative sheet.

3. Add the following statement to the narrative sheet(s) of living expenses: "I agree that this is a fair statement of monthly household living expenses".

4. Obtain the signature of the self-employed individual. If the self-employed individual does not provide the information, obtain the signature of the individual who does, and explain why the self-employed individual cannot or will not sign the statement.

## 3344.5 Determination of Unstated Income

1. Reported Income - Reported income may include net earnings from self-employment and income from other sources, including cash or in-kind income. The amount of reported income for a month is determined by adding to the allocated monthly portion of net income from self-employment, the amount of other monthly income for the self-employed individual and any other individual who is an applicant or whose income is being deemed to the applicant, or who is an ineligible child taken into account because of deeming of income.

   Reported income is the aggregate of unearned and earned income of the following people living together as one household.

   a. Applicant(s)

   b. Individual(s) whose income is deemed to the applicant; and

   c. Ineligible children, if any, who would be taken into account in computing the amount of deemed income where there is a deeming situation.

2. Computation of Unstated Income:

   a. Applicant is self-employed - When an applicant or both applicants in a household (in the case of a couple) are self-employed, the computation of unstated unearned income, if any, requires that the

amount of reported monthly income be subtracted from the amount of monthly living expenses, and the result, if greater than zero, be added to the amount of total unearned income of the applicant(s). Such income would be treated as other unearned income in the application.

EXAMPLE: The applicant reports earned income consisting of $100 per month net earnings from self-employment. The spouse, also an applicant, reports a pension of $100 per month. Living expenses are developed and total $400 per month. The total family income of $200 is subtracted from the $400 monthly living expenses, leaving $200 that will be counted as unstated unearned income for the couple to be divided as $100.00 for each member of the couple.

b. Individual whose income is deemed is self-employed - When the self-employed individual(s) in a household with an applicant is an ineligible spouse or parent, the computation of unstated unearned income (reported income subtracted from living expenses) increases the amount of unearned income of the self-employed individual. The effect of the unstated unearned income on the applicant depends on the deeming computation. Refer to MS 2110 for SSI Retroactive Medicaid determinations, and MS 7400-7440 for AABD Medically Needy Determinations.

3. Providing an Opportunity to Explain - When unstated unearned income is determined, discuss the matter with the individual and provide the individual with an opportunity to explain how living expenses are met. If the stated living expenses include obligations which do not represent actual expenditures (because bills are not being paid), adjust the amount of living expenses after obtaining a second (adjusted) statement of living expenses. If there are loans which account for the money used to pay living expenses, obtain a statement of specifics of the loan(s) and verify the loan transaction(s). Verified proceeds from loans received and used for living expenses can be subtracted from the amount of unstated unearned income left after subtracting reported income from living expenses. The use of resources may also be used to explain how living expenses are met.

4. Notice of Determination - When unstated unearned income is counted, explain on the notice of decision (DCO-700) that an inclusion of unstated income was made based on a comparison of living expenses with reported income because of excess living expenses.

eligibility start and stop date for a fixed period. If the level of care review date is not a future date when a case is to be added on WNHU, a later DCO-704 must be requested from the OLTC Utilization Control Committee. When Utilization Control completes another level of care review prior to county request and/or certification of a case, the later DCO-704 will be automatically forwarded to the county office.

Once the level of care, the level of care begin date, and the level of care review date, when appropriate, have been entered in WNHU at certification, the county office will not make any later changes to these fields. Any changes in the level of care, decision date, and review date will be processed centrally by OLTC and the Medicaid claims processing agent.

If a Medicaid recipient in a facility elects hospice care after a case has been certified by the county with a level of care code S, A, B, C, or D, the code will be system changed by OLTC, and the county will not be involved.

The county office is responsible for completing part III of the DCO-704 and distributing the DCO-704 to the appropriate parties at the time facility eligibility is authorized via the DCO-57 or DCO-765.

## 3351 Prompt Notice of Skilled Care Classifications

In any case that the county office cannot complete certification action promptly after the receipt of a DCO-704 which indicates a skilled care classification, the county worker will provide a machine copy of the DCO-704 to the facility where the patient is residing. This copy will be annotated with the following information at the top of the form:

"Information Copy for Utilization Control Requirements Only" and the name of the facility.

## 3352 Appeal of Utilization Control Committee Action

There are two types of appeal in the Utilization Control process:

1. Admission/Continued Stay Not Medically Necessary - The Utilization Control Committee will request comments and opinions from the attending physician in each case where admission/continued stay is determined not to be medically necessary. However, if the committee's decision is that continued stay is not medically necessary, this decision is final. The committee will make notification to the attending physician, the facility administrator and the county office when it has been determined that continued stay in a facility is not medically necessary.

   If the county office has a pending application, it will be denied (MS 3500).

   If the recipient has an active case, the county office will provide advance notice of closure to the recipient and next of kin (when possible) by form DCO-700 and, at the end of the notice period, close the facility case by submitting a DCO-57 and/or DCO-765 with appropriate entries for data entry.

2. Reclassification - If the administrator and attending physician are not in agreement with the assigned level of care, they may appeal the decision within ten (10) days of receipt of Form DCO-704 (for applicants) or review report from OLTC by writing the Administrator, Utilization Control Committee, OLTC. The appeal should indicate why a reevaluation is being requested. It may be signed by the administrator or physician. The reviewing physician(s) in the OLTC will consider this information and, if warranted, the applicant/recipient will be reclassified. During the period of appeal, the facility will be paid at the rate of the latest classification. If the classification is changed by virtue of the appeal, payment adjustment will be made to the date of the previous classification.

## 3400 Determination of Net Income

When categorical eligibility and medical necessity have been established, the county worker will determine the amount of the individual's income that will be applied to the cost of care. Section 3 of the DCO-707 (and the DCO-712 when there is a CS) is used for the determination.

Using Section 3 of the DCO-707, determine the income to be applied to the cost of care as follows:

1. Total Earned and Unearned Income

   In Section 3, enter all income of the recipient by type and amount, with the following exception:

   For State Human Development Centers (HDC) and Benton Services Center (BSC) residents do not enter the interest income. A semi-annual cost accounting will be made by these facilities which will take this income into consideration.

   Enter the unearned income of all recipients. Exclude VA Aid and Attendance payments and VA CME/UME, along with the interest income of HDC and BSC residents.

* From the earned income of all recipients deduct the actual mandatory deductions and work related expenses from gross earnings. From the earnings of 10 bed ICF/MR residents and State Human Development Center residents, an additional amount up to the current SSI SPA may be deducted from earned income as a personal needs allowance.

   Total the unearned income and the net earned income and enter on Line 4.

2. Fees for Income Trusts

   For individuals whose cases were certified prior to November 1, 1995, deduct the fees which were approved - trustee fees, attorney fees, monthly bank services and preparation of income tax returns. Cases certified November 1, 1995, and later may have deducted ONLY the monthly service charges for maintaining the bank account.

3. Personal Needs Allowance

   a. Subtract a $40 personal needs allowance for most facility residents.

   b. Single veterans and spouses of veterans with no dependents whose VA pensions have been reduced to $90 will be given the full $90 as a personal needs allowance. They will not be given an additional $40. **EFFECTIVE 11/1/95, the $90 PNA will NOT BE GIVEN to any individual whose VA pension has not been reduced to $90 by VA.** If VA reduces a pension to $90, an income adjustment will be made on WNHU.

* c. For residents of ICF/MRs and State Human Development Centers with earned income, $40 may be given as a personal needs allowance, in addition to a disregard of earned income up to the current SSI SPA.

   Effective 11/1/1995, it will NOT be the responsibility of the county to attempt to identify individuals who may be eligible for a $90 PNA or to allow a $90

PNA when the VA benefits have not been reduced to $90. If a single veteran or surviving spouse of a veteran with no dependents is receiving VA pension and the benefits have not been reduced to $90 at certification, only a $40 PNA will be given. The case will later be adjusted if the county learns that the pension has been reduced to $90.

Individuals previously given $90 PNA and still receiving the full VA pension amount will be reduced to a $40 PNA at next case change or reevaluation after appropriate notice. They may be instructed to contact the Veterans Administration if they believe they are entitled to a $90 reduced pension.

If the individual has no spouse and/or dependents or noncovered medical expenses, this will be the only allowance given to arrive at net income. If the individual has dependent children only (no spouse), proceed to step 4 below before arriving at net income. If the individual has a spouse or a spouse and other dependents living in the community, refer to MS 3338.3.

4. Protected Maintenance Allowance from NF Eligibles Income for Dependent Children When There Is No Spouse in the Home. In certain cases, an allowance may be given from the eligible individual's income for the protected maintenance of dependent children living in the home, when there is no spouse in the home.

Eligibility for the individual in a facility must be established before consideration is given for protected maintenance. If there are dependent (under 18) children, the combined income of the children must be less than the Medically Needy Income Level for the appropriate number of children in the household (MS 7610) to qualify for protected maintenance.

In addition to meeting the stated income limitations, the countable resources of the dependent children must be within the AABD resource limitations to qualify for protected maintenance. Actual amounts allowed for protected maintenance are determined as follows:

a. Determine the children's maintenance level (i.e. appropriate MNIL for the children);

b. Total any income that the children may have. If the total gross income equals or is greater than the maintenance level established in a., then no protected maintenance from the individual's income will be allowed. If the children's income total is less than their maintenance level, their total gross income will be subtracted from their maintenance level to arrive at the amount that will be given from the individual's income for protected maintenance. Example: Two dependent children each have $75 monthly income; their total income ($150) is subtracted from the 2 person MNIL of $216.66, leaving $66.66.

c. Deduct the figure derived from step b. ($66.66) from the individual's income. If there are no noncovered medical expenses, this net income will be entered in Section 3 of the DCO-707 and will be applied to the cost of facility care. The amount allowed for protected maintenance must be entered on the DCO-57 (In this example, $66.66). If there are noncovered medical expenses, see step 5 below.

5. Noncovered Medical Expenses

After deduction of the personal needs allowance and a maintenance allowance (if any), the total of noncovered medical expenses (for the facility recipient only) will be entered on the DCO-707. For noncovered medical expenses allowable as deductions, refer to MS 3338.3 #4. The remaining amount, after all allowable deductions, is the net income that the individual will be expected to apply to the cost of care.

6. Net Income

* When ready to certify a case, a total of the excluded earnings, income trust fees (when applicable), maintenance allowance(s), and noncovered medical expenses (if any) will be entered in the PROT MAIN Field of the DCO-57 or DCO-765. The net amount remaining will also be entered on the DCO-57 or DCO-765. The actual vendor payment will be determined centrally by the Medicaid claims processing agent, based on the net income that has been entered by the county office.

VA PENSIONS REDUCED TO $90

For active cases, ONLY after the VA pension benefit has been reduced by VA to $90, $90 will be entered on WASM in the VA PENSION field. On WNHU, $50 will be entered in the PROTECTED MAINT. field (plus any additional amount considered for noncovered medical expenses). The system will automatically exclude the $40 PNA so that a total of $90 will be given to the veteran or surviving spouse.

3401 Treatment of Extended SSI Benefits for Institutionalized Recipients

Effective 7/1/88, those SSI recipients entering a medical or nursing facility:

- who have a home to maintain, and
- who obtain a medical statement for SSA to document that the medical confinement will not exceed 3 calendar months after the month of entry to the facility

will be allowed to retain their full SSI benefits for a period up to 3 full months. No extension beyond the 3 months will be allowed.

When aware of the extension of SSI benefits for facility applicant/recipients, the county office will totally disregard the SSI benefits for determination of facility eligibility and vendor payment. If the applicant/recipient has income from any other source (e.g. VA, SSA, RR Retirement, etc.), that income will be included in the facility budget.

At certification of facility applicants receiving the full SSI benefit (who have no other income), only the $30 personal needs allowance will be entered on the DCO-57 (WNHU) and the remaining income will be disregarded.

When certifying recipients with a combination of SSI and other income, all of the SSI benefit will be disregarded. The other income will be entered in the budget section of the DCO-57 (WASM) and DCO-765 (WNHU). The $40 personal needs allowance will be deducted from the countable income, and the remaining income will be entered as NH Net Income (patient liability) on the DCO-57 or DCO-765 (WNHU).

a. Complete the certification (Re. MS 3500 #1)

b. Transfer the case on WASM and WNHU to the county where the recipient now resides (Re. EMSUM 3726).

## 3500.1 Certification of Patients Approved for Medicare

When Medicare approves individuals for skilled nursing care/extended care, the facility receives reimbursement in the form of Medicare per diem and Medicaid coinsurance (if applicable) for up to 100 days, provided the individual continues to meet Medicare criteria.

Applications for Medicare approved admissions will be processed in the same manner as applications for non-Medicare approved admissions, except that nursing home services will not be authorized on WNHU until Medicare benefits have been exhausted. Medicaid for Medicare eligible individuals will be authorized on WASM, however, so that all other Medicaid covered services may be paid. For example, Medicare pays 100% of facility expenses for only 20 days. After this time, the individual becomes liable for coinsurance, which cannot be paid by Medicaid until the case is opened on WASM.

The monthly Medicare per diem amount will not be considered when determining income eligibility, but it will be treated as a third party resource to be applied to the cost of care in a facility.

When Medicare approves an individual for skilled nursing care, the facility should notify the county office of the Medicare admission via the DCO-702.

If at some point the individual fails to meet Medicare criteria or exhausts his/her benefits, Medicare will stop payment. The facility will notify the county office of the change in status via the DCO-702. On the day following termination of Medicare benefits, the Service Representative may authorize facility services on WNHU to be effective on that date, provided the individual continues to meet all LTC requirements.

## 3600 Continuing Eligibility

Reevaluation of facility cases to determine continuing eligibility is required periodically by the county office for all categories of LTC. Once a case has been certified, the county office responsibilities will be limited to completing regularly scheduled reevaluations, making retroactive and current income adjustments on WNHU, transferring cases, and effecting closures due to death, discharge or other eligibility factors.

## 3610 Reevaluation of Eligibility

The time period for review of facility cases will vary according to the category, as shown below. All facility cases, regardless of category, must be reviewed within 30 days of receipt by the receiving county when a case transfer has been made to assure continuing eligibility. However, a new application and full reevaluation is not required unless it is time for the annual reevaluation.

### 3611 Foster Care (Cat. 91 or 92) and U-18 Cases

These cases will be reevaluated every six months. Eligibility will be redetermined according to the current eligibility criteria for the category. Form DCO-95 will be completed (DCO-98 for Cat. 92, IV-E foster children), along with other required forms.

3613 SSI

These facility cases will be reevaluated every twelve months. Form DCO-777 and all other required forms will be completed. Categorical eligibility is established if the individual continues to receive SSI payment.

3614 AA, AB, and AD

These cases will be reevaluated every twelve months. Form DCO-777 and all other required forms will be completed, and eligibility will be redetermined according to the current AABD criteria. NOTE: If the individual has a spouse and/or other dependents in the community and fluctuating noncovered medical expenses, a partial reevaluation will be completed every 6 months, if the county has elected to estimate net income (Re. MS 3338.4).

3615 Completion of Reevaluation

Upon determination of continuing eligibility, the DCO-57 will be completed for data entry into WASM. An "O" action will be shown along with worker number, date of completion of review, and any changes.

WNHU update will be made only if there have been changes in income, NH county or NH number. If income has changed, NL must be entered as the Action Type on WNHU.

If an income change was not previously reported, the retroactive income with start and stop dates will be entered in the retroactive payment section of the DCO-765 or DCO-57 for WNHU update. If the last income change is the current income, however, this change will be entered as a current change with an income start date effective the month the new amount was received (i.e., do not use a retroactive field).

* Residents of the State Human Development Centers will report only current (i.e., past month's) earnings at reevaluation. They will not verify all earnings received since the last reevaluation was completed. No retroactive adjustments will be needed.

If an HDC resident ever has monthly earnings that exceed the SSI SPA, the facility will report this to the county office so an adjustment can be made on WNHU.

The DCO-87 will be coded for next anticipated change/reevaluation, and the DCO-88 will be marked to show the reevaluation was completed.

3620 Utilization Control

The Utilization Control Committee of the Office of Long Term Care will periodically review and redetermine patient classification and necessity for continued stay in a facility when required. Classification and medical necessity reviews will be made only for individuals whose medical condition changes and for those admitted for convalescent care.

When the need for continued stay in a facility has been determined to be medically necessary, a new review date is assigned and the approval/patient classification is valid through that date. The county office will not receive notice of change in classification, unless a change in medical necessity will require case closure, or transfer to another facility. The change in classification (if any), the decision date, and the new review date will be system entered by OLTC.

## 3343.1 Earnings of ICF/MR Facility Residents

* Residents of ICF/MR facilities, including residents of State Human Development Centers, who have earned income may be given an earnings disregard of up to an amount equal to the current SSI SPA in addition to the $40 personal needs allowance. Nursing facility residents with earnings who receive intermediate care may be given a disregard of up to $100 of their monthly earnings, provided there is documentation that a physician has prescribed employment activity as a therapeutic or rehabilitative measure. If a nursing home resident receiving skilled care reports earnings, the Utilization Control Committee of the OLTC should be contacted and requested to reevaluate medical necessity.

All nursing facility and ICF/MR residents must first pass the gross income test, with no disregards allowed. If found eligible, the consideration of earnings will be as follows.

### 1. Ten Bed ICF/MR Facilities and State Human Development Centers

* Earnings of residents of these facilities must be taken into consideration for both eligibility and net income determinations. If residents pass the gross income eligibility test, their earnings will be included in the net income determination. In determining the net income to be applied toward the vendor payment, first subtract the mandatory deductions (e.g., federal and state income taxes) from gross income and, from the remaining earned income, up to an amount equal to the current SSI SPA for personal needs. Refer to MS 3400 for consideration of earnings at certification.

### 2. Fluctuating Earnings

If the earnings of ICF/MR facility residents stay below the SSI SPA, no reporting of fluctuations is needed.

The facility administrator will report to the county any month in which a resident's earnings exceed the SSI SPA.

If earnings consistently stay above the SSI SPA, they may be averaged (MS 3343), provided the facility administrator will agree to report to the county:

a. every 6 months when earnings are fairly stable, or

b. more frequently if the resident loses employment, changes jobs, or has earnings in any month which are more than $15 above the computed average.

## 3344 Determination and Verification of Earnings from Farm, Business or Self-Employment

Generally, it is necessary for the self-employed individual to estimate current income based on a projection from the tax return filed for the previous year and from current records kept in the regular course of business.

Because of the fluctuating nature of income receipts and self-employment expenses, current estimates for net income from self-employment will be based on the entire taxable year.