477-000-045 – Share of Cost

If net income for the month exceeds the medically needy income level, a client may be determined eligible for medical assistance with a share of cost (SOC) if:

1. A medical need exists or can reasonably be anticipated which meets or exceeds the SOC amount;
2. The client has paid or obligated the SOC for medical care or services for anyone in the unit. If the income of a parent in the home but not in the unit has been considered on the budget, his/her medical expenses (including insurance premiums) may be applied to the child's SOC;
3. The medical care or services have occurred during SOC period; and
4. Obligations or expenditures are substantiated on Form DSS-160.

Note: Medical expenses paid by another state, county, or city program may be used toward the client's obligation if no federal funds are used to pay the medical expense. This would include programs such as county general assistance, the Renal Disease Program or the Medically Handicapped Children's Program. Questions on other programs may be submitted to the Central Office for review.
If an MILTC-53 was submitted an MILTC-63 is needed to determine a SOC budget.

SOC Allowable Obligations:

Medical Service or Supply:
Any medical service or supply is an allowable obligation of an SOC amount, whether or not the service or supply is allowed by Medicaid. This includes the cost of:

1. Transportation to obtain medical care. Mileage is allowed if the client travels by car; if the client uses another form of transportation, the actual cost is allowed; and
2. Meals and lodging when the expense is necessary to obtain approved health services and only if the client is away from home for 12 hours or more per day. The allowance for cost of meals is $12 per day. Additionally, the cost of lodging will be allowed if reasonable and if the client provided receipts. The allowance for meals and lodging may be allowed for an attendant if one is needed to accompany the client.
3. Actual fees for case management services provided by an Area Agency on Aging or a Medicaid provider who is approved to provide case management services. If the client is receiving case management services from some other source, the worker shall outline the circumstances and submit it as a policy question to the Central Office.

The amount the client is responsible for paying toward medical and remedial services while in an alternate living arrangement is an allowable SOC obligation. To arrive at the amount that the client is paying for medical and remedial services, the worker shall subtract the medically needy income level from the applicable consolidated standard of need. If the client is in a long term care facility, his/her SOC should first be applied to the cost of care.

The worker shall inform the client that any expense incurred which is not covered by Medicaid will have to be paid totally by him/her.

Ineligibility for Medicare, Part B Buy-In: When a client has an SOC for ABD, s/he is no longer eligible to receive the state buy-in of Medicare, Part B premium if their income is 120% FPL or above. The Medicare premium will be deducted from the SOC even though a delay of two to three months is usually encountered before the client's benefit check reflects the actual Medicare deduction (net). The Medicare premium may be recouped for these months for which the client was responsible from one month's RSDI benefit.

Medicare Part A Premium: If a client is enrolled in premium Part A Medicare and is paying his/her own premium, this is an allowable SOC.

Pre-placement Visits:
When it has been determined that an individual residing in a nursing home no longer requires nursing home care, the local office has 60 days to arrange for alternate care. In some instances, it may be necessary to arrange for a pre-placement visit to determine the appropriateness of placement in an alternate care facility.
Based on the number of days for the pre-placement visit, the prorated amount for the alternate care facility is deducted from the SOC for the month of the pre-placement visit.
The client shall provide a listing of providers, dates, and amounts for transportation, meals, and lodging.

SOC and Medical Insurance:
When a client with an SOC has medical insurance (including Medicare, worker's compensation, etc.), the following procedures apply:

1. The client or medical provider submits a claim for payment to the insurance company before consideration of the SOC amount;
2. The client or medical provider provides to the worker verification of allowance or disallowance of the claim by the insurance company (i.e., Medicare EOB's, or other insurance benefit explanation forms);
3. The amount that the insurance company allowed must not be counted toward the individual's SOC; and
4. The amount of the claim for which the client is responsible is counted toward the SOC amount.

This procedure applies to all persons whose medical expenses are being used to meet the client's SOC.

Monitoring Client's SOC Obligation

In order for the client to meet his/her SOC obligation, the client will take his/her monthly SOC form (DSS-160) to medical providers as s/he receives medical services for the month noted on the form. The medical provider that provides the last service necessary to meet the SOC will send the completed DSS-160 to Central Office.

When the client has met his/her monthly SOC obligation, the Central Office makes appropriate changes to N-FOCUS.

Medical coverage is effective the first of the month for medical bills not used to meet the SOC obligation for covered services.

If the client never meets the obligation, no medical bills are paid for that month. The client may meet that obligation at a later time.

When the case is reviewed, the worker re-evaluates the case to determine if a medical need will continue. The worker then -

1. Closes the case and send a Notice of Action if there is no medical need. The Notice of Action notifies the client that s/he may reapply if there is a medical need at a later date. Claims incurred after the close date are not paid; or
2. The case remains SOC if there is a continuing medical need.

Spenddown Procedures for Institutionalized Individuals

Reduction of Standard of Need

If an ongoing recipient who is on Medicaid enters a long term care facility, the standard of need must be reduced to $60 the first full month of institutionalization in which there is no Medicare involvement. This requires adequate notice only.

If an ongoing recipient who is in an SOC period enters a long-term care facility, the standard of need must be reduced to $60 the first full month of institutionalization in which there is no Medicare involvement.

Exception: The standard of need for a SSI client in their own household is used up to three months when SSI notifies the agency that the client will receive their full SSI payment for three months as the individual is likely to return to his/her previous living arrangement. Use non-SSI budgeting procedures for individuals in long-term care when SSI does not make a change in living arrangement at the end of three full continuous months and income exceeds the FBR for a single individual in an institution.

Change in Facilities

If the client moves from one facility into another during the same month, the SOC is applied to the care received in the first facility. If the SOC is greater than the cost of care, the SOC is split and the remainder applied to the second facility.

If the client leaves the facility and enters another type of facility in the same month where the service is completely covered by insurance, e.g., Medicare extended, any income that is not obligated to the first facility becomes a resource. If, in the following month(s), the insurance coverage continues and the client is unable to obligate the SOC to the care facility the income is treated as regular SOC and set up in an SOC period.

Computation When Income Exceeds Per Diem Rates

When a client who is in a long term care facility or institution has income that exceeds Medicaid's per diem rates, the client must pay his/her full cost of care at Medicaid rates on a monthly basis. In addition, s/he must obligate income that exceeds the full cost of care at Medicaid rates for other medical services.

The following occurs:

1. The worker computes a medical budget for the SOC amount;
2. N-FOCUS calculates any additional SOC amount to be paid. This additional amount may be used for private pay days or other medical. N-FOCUS only calculates this additional SOC amount if the Medicaid per diem expense has been entered by the Long Term Care interface or the worker.
3. If the worker wants N-FOCUS to calculate the private pay days, s/he must enter the private pay per diem as an expense.
4. Technical help for N-FOCUS may be obtained from Production Support; and
5. The worker completes the prior authorization document, when appropriate.

Computation for Changes in Income or Reimbursement Rate

When the client's income or the Medicaid reimbursement rate for the facility increases or decreases during an SOC period, the worker shall -

1. Compare the resulting income figure to the cost of care;

2. Notify the client if there is a change in the amount of the cost of care at Medicaid rates that the client must obligate and determine the amount of SOC that exceeds the cost of care by subtracting the total income from the total cost of care.

   a. If the SOC increases or decreases, notify the client of the new amount; and
   b. Document in the case record.

Note: If the cost of care at Medicaid rates increases after the client's obligation has been met, the client is not responsible for the increase in the cost of care. Because the client's total income has already been obligated, the worker continues to enter the original care rate on N-FOCUS.

Monitoring Client's SOC Obligation

In addition to being responsible for his/her full cost of care at Medicaid rates, the client must obligate the SOC.

The client may use the following to meet his/her SOC obligation:

1. The difference between the private per diem rate and the Medicaid rate;
2. Other medical services or supplies (see above SOC allowable obligations); or
3. A combination of items 1 and 2.

The system generates Form DSS-160. When the client has met his/her total obligation, the Central Office makes the necessary system changes. The worker completes the prior authorization document, when appropriate, and continues to monitor the client's obligation. The worker shall document in the case record.