INCOME
EXCESS

SIX-MONTH

(2) Determine the percentage of the hospital stay to be covered by Medicaid (100% minus the percentage covered by the A/R's liability);

(3) Multiply the DRG case payment amount by the Medicaid percentage to arrive at the Medicaid payment amount;

(4) Subtract the Medicaid payment amount from the DRG case payment amount. Enter this amount as the Net Available Monthly Income (NAMI) in the Principal Provider Subsystem (PPS). Please note: the amount entered in the PPS will be different from the client's actual liability. Local districts must ensure that the case record, client notices, and the notice to the hospital reflect the actual liability;

(5) Enter the actual dates of service in the Principal Provider Subsystem (PPS);

(6) Instruct the hospital to enter the adjusted client liability as the surplus on the claim form, and complete the rest of the claim form according to normal procedures.

90 ADM-46 contains a more detailed description of "Watkins" cases using the Medicaid per diem rate, or Diagnostic Related Groups (DRG) case payment amount and includes some case examples.

When to Verify: When an SSI-related, ADC-related, under age 21 or pregnant A/R, has income in excess of the Medically Needy level or Medicaid Standard whichever is higher and:

(1) Declares in the application that s/he has unpaid acute in-patient expenses; or

(2) Indicates in the application that any member of the family household is in,or will require acute in-patient care, or has acute in-patient expenses.

INCOME
EXCESS

SIX-MONTH

Verification Process: Expenses for acute in-patient care may be verified by:

(1) Seeing hospital bills;

(2) Seeing Medicare or insurance explanation of benefits;

(3) Clearing with the medical provider.

Documentation: Sufficient to establish an audit trail:

(1) Date, length of stay, amount of charge and name of medical facility;

(2) Date and type of service, amount of charge and name of provider;

(3) If a third party insurer is involved, the amount of the third party payment or the denial of benefits, and the net amount of the A/R's responsibility.

Disposition: Once an A/R with excess income has paid or incurred a charge for acute in-patient care, his/her six-month excess income is computed. Medicaid is authorized for all or any part of the cost of acute in-patient care, which is greater than the A/Rs' spenddown amount. Once the A/R has incurred expenses equal to or greater than his/her excess income for a six-month period, s/he is eligible for Medicaid coverage during this period.

If income and/or household composition (See **OTHER ELIGIBILITY REQUIREMENTS** HOUSEHOLD COMPOSITION) changes during this six-month period, the amount of the excess is recomputed prospectively and the appropriate notice is sent to the A/R.

NOTE: If the A/R is covered by Third Party Health Insurance (e.g., Medicare, Blue Cross/Blue Shield, etc.) the amount of health insurance available for medical bills does not reduce the liability of the A/R. S/he is personally liable for medical bills equal to the amount of his/her excess.

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INCOME
EXCESS

PAY-IN

Policy: Local social services districts are required to offer individuals with excess income the opportunity to reduce their excess income by pre-paying to the district the amount by which their income exceeds the Medically Needy Income level or Medicaid Standard, whichever is higher.. Participation in the Pay-In program is optional on the part of the A/R. The A/R may elect to pay-in for periods of one to six months. When the pay-in period is longer than one month, the individual may pay the full excess income amount at the beginning of the period or may pay in monthly installments.

References:

SSL. Sect. 366(2)(b)

Dept. Reg. 360-4.8

ADMs 96 ADM-15
94 ADM-17

Interpretation: In order to obtain coverage, the participant pays to the local social services district the amount by which his or her net available income exceeds the Medically Needy Income level or Medicaid Standard, whichever is higher, for the appropriate period. In determining this amount, the district deducts from income any necessary medical expenses incurred during the period which are not payable by the Medicaid program. The A/R may elect to pay-in for periods of one to six months.

For pay-in periods of less than six months, full community coverage will not be authorized; instead outpatient coverage will be authorized. When the A/R pays the full excess income liability for a six-month period, full community coverage will be authorized for that period.

If the individual has paid his/her liability to the local district and subsequently incurs expenses during the covered period for services not covered by the Medicaid program, the local district either refunds to the recipient the amount of the medical expense from the recipient's account, or may credit the amount to the recipient's account in a subsequent excess income period.

INCOME
EXCESS

PAY-IN

NOTE: Once the individual has paid in the amount of his/her excess income to the local social services district, s/he is treated like any other Medicaid recipient. Thus, the recipient must receive services from Medicaid providers in order for Medicaid payment to be made. Expenses paid or incurred from non-participating providers will not provide credit or refunds for covered services rendered to the recipient.

The local district establishes a special account to safeguard the funds paid by the individuals. Such amounts are not retained in interest-bearing accounts.

Local districts periodically reconcile the amount in the Medicaid recipient's account with the amount of Medicaid payments made on the recipient's behalf. The amount in the account is compared to the Medicaid payments made for services provided during the covered period. Any unused pay-in amounts are refunded to the recipient or credited to a subsequent excess income period.

NOTE: When reconciling the individual's Pay-In account, local districts take into consideration any off-line payments made on behalf of a participant, since these payments will not be reflected in the Adjudicated Claims history report.

Verification Process: Expenses for outpatient medical care, including prosthetic appliances, may be verified by:

(1) Seeing medical bills;

(2) Seeing cancelled checks or receipts;

(3) Seeing Medicare or insurance explanation of benefits;

(4) Clearing with the medical provider.

Documentation: Sufficient to establish an audit trail:

(1) Date and type of services, amount of charge and name of provider; and
(2) If a third party insurer is involved, the amount of the third party payment or the denial of benefits and the net amount of the A/R's responsibility.