POST-ELIGIBILITY TREATMENT OF INCOME

Legal Authority: 42 CFR 435.725; Tenn. Code Ann. § 71-5-147; State Plan, Attachment 2.6-A, Supplement 3; State Plan, Attachment 2.6-A, Supplement 13; 42 USC 1396a(r)(1)(B); Tenn. Comp. R. & Regs. 1200-13-20

1. Policy Statement

Individuals determined eligible for Institutional Medicaid and receiving Long-Term Services and Supports (LTSS) or hospice are required to contribute to the cost of care. Patient liability, the individual's required monthly contribution, is calculated based on the individual's total income after certain allowable deductions.

2. Determination of Total Income

While countable income is used to determine eligibility for Medicaid, total income is used in the post-eligibility process. Total income includes all income available to an individual whether counted or excluded in the eligibility determination. Total income does not include items which are not considered to be income. See the *ABD Income Overview* policy.

a. Income not Included in Total Income

The following income is not included in total income:

- **i.** Supplemental Security Income (SSI) benefits paid under section 1611(e)(1)(E) and (G) of the Social Security Act to individuals who receive care in a hospital, nursing home, skilled nursing facility (SNF), or intermediate care facility (ICF);
- **ii.** Austrian Reparation Payments made under sections 500-506 of the Austrian General Social Insurance Act;
- **iii.** German Reparations Payments made by the Federal Republic of Germany;
- **iv.** Japanese and Aleutian Restitution Payments;
- **v.** Netherlands Reparation Payments based on Nazi persecution;
- **vi.** Payments from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement;
- **vii.** Radiation Exposure Compensation; and
- **viii.** VA pensions limited to $90 per month.

b. VA Pensions Limited to $90 Per Month

VA pension payments are limited to $90 per month for the following individuals who receive Medicaid-covered nursing home care in a Medicaid-approved nursing facility:

- **i.** Veterans who do not have a spouse or a dependent child;
- **ii.** Surviving spouses of veterans who do not have a dependent child; and

iii. Surviving children of veterans.

When the VA pension payment is limited to $90 per month, the payment is aid and attendance and is not included in total income. The VA pension is not limited to $90 per month when the individual receives Home and Community-Based Services (HCBS) or is in a state veterans home. If a veteran or the surviving spouse of a veteran is in a state veterans home and receives more than $90 per month in VA pension, the VA pension, including any payment made for aid and attendance or for unreimbursed medical expenses, is counted in total income and applied to the state veterans home's cost of providing nursing home care to the veteran or surviving spouse.

3. PETI Deductions from Total Income

a. Allowable Deductions

The following are deducted from total income to determine patient liability:

i. A Personal Needs Allowance (PNA) for clothing and other personal needs while residing in the institution;
ii. Mandatory expenses, such as garnishments, conservatorship or guardianship fees, court-ordered bankruptcy, court-ordered child support, court-ordered alimony, and Qualified Income Trust (QIT) fees;
iii. A Community Spouse Income Maintenance Allowance (CSIMA), for institutionalized individuals with a spouse residing in the community;
iv. A Dependent Income Maintenance Allowance (DIMA), for institutionalized individuals with a dependent residing in the community;
v. Health insurance premiums, coinsurance and deductibles;
vi. Incurred medical expenses not covered by TennCare Medicaid and allowed under the State Plan; and
vii. An Incurred Medical Expenses Carry Forward Amount, for allowable medical expenses not previously deducted.

b. PNA

The PNA is provided to cover the institutionalized individual's personal needs and incidentals while residing in the nursing facility or receiving HCBS waiver services. Apply the appropriate PNA based on the type of LTSS the individual receives.

i. Nursing Facility

Subtract a $50 PNA from the total income of an individual in a nursing facility or in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). For an individual with greater need who participates in a sheltered workshop, subtract up to $100 of earnings plus $50 for the PNA.

ii. HCBS (including ECF CHOICES), PACE and Self-Determination ID Waivers

Subtract 300% of the Supplemental Security Income Federal Benefits Rate (SSI-FBR) from the total income of an individual receiving HCBS, PACE or Self-Determination ID Waiver services.

iii. Statewide ID and Comprehensive Aggregate Cap Waivers

Subtract 200% of the SSI-FBR from the total income of an individual receiving Statewide ID and Comprehensive Aggregate Cap (CAC) Waiver services.

c. Mandatory Expenses

Mandatory expenses are expenses an individual is legally obligated to pay. Verified mandatory expenses may be deducted from total income when determining patient liability. Mandatory expenses include but are not limited to: garnishments and other withholdings, conservatorship or guardianship fees, court-ordered bankruptcy, court-ordered child support, court-ordered alimony, and QIT fees.

i. Garnishments and Other Withholdings

A garnishment is a withholding from earned or unearned income to satisfy a debt or legal obligation. Most garnishments are court-ordered. A court order is not required for collection of unpaid taxes owed to the IRS or non-tax debts owed to other federal agencies. When an institutionalized individual's income is being garnished, a deduction for the garnishment is allowed in the patient liability calculation until the debt has been paid in full or the garnishment has been withdrawn.

Other withholdings that are required by law, such as federal income tax, FICA, state and/or local taxes are subtracted from total income when determining patient liability. A deduction is not allowed when the withholding is voluntary.

ii. Conservatorship or Guardianship Fees

A conservator or guardian is a third party appointed by a court to manage the property, financial affairs, and well-being of an individual. A conservatorship or guardianship fee paid by an individual may be deducted if the individual has a legally appointed guardian or conservator, the guardian or conservator charges a fee, and the fee is court-ordered.

iii. Court-Ordered Bankruptcy

Bankruptcy is a legal procedure by which a debtor seeks relief from all or part of his debt. When a debtor, who has regular income, files a petition through a bankruptcy court, he may propose a plan to repay his creditors over a period of time, usually three to five years. The

debtor must begin making plan payments to the trustee within 30 days after filing the bankruptcy case, even if the plan has not yet been approved by the court. Payments are made directly to the trustee or through payroll deduction. Payments made by an institutionalized individual as a part of a repayment plan may be deducted when determining patient liability until the individual is released from all dischargeable debts provided for by the plan.

iv. Court-Ordered Child Support Payments

A child support payment is a payment from a parent to or for the child to meet the child's needs for food and shelter. In order to be allowed as an expense, child support must be court-ordered.

When an individual verifies that he is paying court-ordered child support for a child who is not living in his household, the amount actually paid, up to the full court-ordered obligation is deducted as a mandatory expense.

A child support arrearage payment is a payment that was past due, but not paid in a timely manner for the appropriate period. The arrearage is being paid to comply with an unfulfilled past obligation to support the child. If the individual is making a payment that includes both current support and an amount applied toward arrears, the entire amount may be allowed as a deduction, as long as the arrears were also part of the court-ordered support order when incurred.

A deduction for court-ordered child support is not allowed for the same child for whom a DIMA is allowed in the post-eligibility budget.

v. Court-Ordered Alimony Payments

Alimony is a payment for a spouse or former spouse under a divorce or separation instrument. Alimony expenses do not include voluntary payments. The payments must be in cash, including checks and money orders, to be considered alimony. Alimony is an expense to the payer of the alimony and is allowed when alimony is paid.

When an individual verifies that he is paying court-ordered alimony to a spouse or former spouse, the amount actually paid, up to the full court-ordered obligation is deducted as a mandatory expense.

A deduction for court-ordered alimony is not allowed for the same spouse for whom a CSIMA is allowed in the post-eligibility budget.

vi. QIT Fees

A QIT is a trust established for individuals seeking LTSS who are ineligible for TennCare Medicaid due to excess income. See the *Qualified Income Trust (QIT) or Miller Trust* section in the *ABD Trusts* policy.

Individuals who establish a QIT for the purpose of becoming TennCare Medicaid eligible in Institutional Medicaid are allowed a QIT allowance. The purpose of the QIT allowance is to cover any bank fees associated with maintaining the QIT.

Subtract a $20 QIT Allowance, or other verified amount, from total income for individuals who establish a QIT for TennCare Medicaid eligibility purposes, if applicable.

d. CSIMA

When determining an institutionalized individual's patient liability, an allowance is deducted from his or her income for the needs of the community spouse. The CSIMA is allowed unless specifically refused by the institutionalized spouse. Funds must actually be transferred to the community spouse to be deducted.

i. When to Allow a CSIMA

1. The CSIMA is allowed unless specifically refused by the institutionalized spouse.
2. Funds must actually be transferred to the community spouse in order to be deducted.
3. A CSIMA is not allowed if both spouses are institutionalized.
4. A CSIMA is allowed when one spouse is institutionalized in a nursing facility and the other is eligible for HCBS in the community.
5. If the community spouse applies for TennCare Medicaid, the CSIMA will be counted as unearned income.
6. A community spouse receiving SSI, Families First (FF), Veteran's Affairs (VA) Pension, TennCare Medicaid or means-tested benefits does not have to accept the total or any of the income allocation if it will result in the termination or decrease of those benefits.
7. If a couple is married but living separately, and consider themselves to be separated, the CSIMA may be allowed if both individuals agree to the allocation and the community spouse is not institutionalized.
8. If the community spouse lives out of state, the CSIMA is allowed if the community spouse can be located and the couple is still married.

ii. CSIMA Calculation

1. Terms and Standards

a. Standard Maintenance Amount (SMA): The poverty level standard used to determine the community spouse's monthly maintenance needs. The SMA is 150% of the Federal Poverty Level (FPL) for a household of 2.

The SMA is $2,465.00, effective July 1, 2023.

b. Maintenance Needs Standard: The minimum amount of monthly income necessary to meet the community spouse's maintenance needs and prevent impoverishment. The Maintenance Needs Standard is determined by adding the SMA and Excess Shelter Allowance (ESA).

c. Utility Allowance: The utility allowance under the Supplemental Nutrition Assistance Program (SNAP) used in lieu of the community spouse's actual utility expenses.

i. The **Standard Utility Allowance** (**SUA**) is used when the community spouse is responsible for heating or cooling costs. If the SUA is used, then it is considered to cover all utilities, including garbage, water, lighting, etc.

The SUA is $430, effective October 1, 2023.

ii. The **Basic Utility Allowance** (**BUA**) is used when the community spouse is responsible for at least two utility expenses, but is not responsible for heating or cooling costs.

The BUA is $164, effective October 1, 2023.

iii. The **Standard Telephone Allowance** is used when the community spouse is responsible for a telephone expense, but is not entitled to any other utility allowance.

The Standard Telephone Allowance is $35, effective October 1, 2023.

d. Standard Housing Allowance (SHA): The SHA is used to determine whether the community spouse requires an Excess Shelter Allowance.

The SHA is $739.50, effective July 1, 2023.

2. CSIMA Calculation

The CSIMA is calculated using three steps:

a. Determine Excess Shelter Allowance (ESA)

An ESA is allowed when the total shelter costs for rent, mortgage, taxes and insurance, maintenance charges and utility costs exceed the SHA. The SHA is 30% of the SMA.

The SUA is used when the community spouse is responsible for heating and/or cooling costs. If the SUA is used, it is considered to cover all utilities (no additional allowance for garbage, telephone, etc.) When there is no or reduced cost to the community spouse because the cost of a particular utility is paid by a third party (in cash or in kind), reduce the amount of the SUA by the third party payment.

Determine ESA:

Rent, mortgages, taxes, insurance, etc.
+ SUA
– SHA
ESA

b. Determine Community Spouse Net Income

Determine the Community Spouse's total net income, including SSI and FF payments. The Community Spouse net income is defined as income over which the Community Spouse has control over and which is actually available. Income which is not considered available to the Community Spouse includes child support payments and other types of court-ordered payments made by the community spouse.

c. Calculate CSIMA

The CSIMA is calculated by adding the SMA and the ESA, and then subtracting the Community Spouse's net income.

SMA ($2,465.00)
+ ESA (Amount determined in Step 1 of CSIMA budget)
– Community Spouse Net Income (Amount determined in Step 2)
= Community Spouse Maintenance Allowance

3. CSIMA Example

Casey Jones is approved for Institutional Medicaid. Shannon Jones, the community spouse, remains in the community and resides at home. Casey receives $800 per month in Social Security benefits, and $200 in monthly pension. Shannon receives $600 per month in Social Security benefits.

Shannon Jones pays the mortgage of $400 per month, which includes taxes and insurance. She is responsible for all monthly heating and cooling costs.

a. Determine ESA

$400.00	Mortgage, taxes, insurance
+ $430.00	SUA
– $739.50	SHA
$ 90.50	ESA

b. Determine Community Spouse Net Income

Countable income is determined according to the *ABD Earned Income* policy *and ABD Unearned Income* policy. The community spouse's net income is defined as income over which the community spouse has control and which is actually available to him or her.

c. Calculate CSIMA

$2,465.00	SMA
+ $ 90.50	ESA
– $ 600.00	Community Spouse Net Income
= $1,955.50	CSIMA

Casey's monthly income is $1,000. Since the income is less than the calculated CSIMA, all of the income (less $50 PNA) will be allocated to Shannon.

Note: In the event that the institutionalized spouse does not have enough income to provide the community spouse with the allowed CSIMA and income that may be generated from the Community Spouse Resource Maintenance Allowance (CSRMA) is inadequate to raise the community spouse's available income to the Maintenance Needs Standard, there may be an allocation of additional resources to the community spouse to make up for the income shortfall if the couple has additional resources above the CSRMA. This must be done by appeal and a TennCare Appeals Officer will determine whether the additional resource allocation is needed. See the *Resource Assessment* policy.

e. DIMA

When determining patient liability, an allowance is deducted from the individual's income for the needs of her dependents.

i. General Rules

1. Dependent relatives include the individual's or spouse's adult dependent children, parents, siblings, and minor children who are residing with the community spouse.
2. A DIMA is not allowed for any dependent receiving HCBS or who is institutionalized.
3. A dependent does not have the option of declining all or a portion of the income allocation for any reason according to the TennCare interpretation of the Medicare Catastrophic Coverage Act (MCCA), even if needs-based benefits may be decreased or lost because of the allocation.
4. The DIMA for each additional dependent family member is equal to one-third of the difference between the SMA and the dependent's gross income.

ii. Calculate DIMA

The dependent allocation(s) equals the SMA for the community spouse minus the dependent's own gross countable income divided by 3 (SMA – gross countable income = deficit/3 = dependent allocation).

1. Determine Dependent's Gross Income

Earned Income
+ Self-Employment Income
+ Unearned Income (other than Child Support)
+ Gross Child Support
= Dependent Gross Income

2. Calculate DIMA

SMA	$2,465.00
– Dependent Gross Income	Determined in Step 1
÷ 3	1/3 of the difference of the subtotal
= DIMA	

iii. Dependent Relatives Living in the Home Without a Community Spouse

When determining patient liability, an allowance is deducted from the individual's income for the needs of dependent relatives living in the home without a community spouse.

1. Calculate DIMA

An amount equal to the Medically Needy Income Standard (MNIS) may be allocated to dependent relatives living in the home without a community spouse if the total net countable income of the dependent(s) is less than the MNIS for the household size. To determine a dependent's net countable income, first subtract $65 from the dependent's gross earned income and divide the remainder in half. The result is the dependent's net earned income. Add the dependent's net earned income and gross unearned income together. The result is the dependent's net countable income.

a. Determine Dependent's Net Countable Income

Gross Earned Income
– Earned Income Disregard ($65)
– ½ Remainder
= Net Earned Income

Gross Unearned Income
+ Net Earned Income
= Net Countable Income

b. Calculate DIMA

Add the net countable income of all dependents together.
Compare the combined total to the MNIS for the household size. See the MNIS chart in the *Child Medically Needy* policy.

If the combined total is more than the MNIS, no dependent allocation is given. If the combined total is less than the MNIS, the dependent allocation is the amount of the MNIS for the household size.

f. Health Insurance Premiums

Verified health insurance premiums may be deducted when determining an individual's patient liability. When health insurance premiums for several coverage months are due in a given month, the premiums paid in that given month cannot be prorated over the coverage period. Any premium amount which exceeds the individual's income can be applied against his or her patient liability in following months.

i. Criteria for Deduction of Health Insurance Premiums

Premiums are deducted for health insurance policies that meet the following criteria:

1. The policy is reported to TennCare as third party liability (TPL);

2. Benefits are assignable and the individual has agreed to assign them to the State of Tennessee (TennCare); and

3. Premiums are paid by the individual, and not by a third party.

Life insurance premiums are not allowed as a deduction.

ii. Medicare Premiums

Medicare Parts A, B, C or D premiums are deductible as health insurance premiums, unless:

1. The individual is SSI eligible;

2. The individual is enrolled as an SSI Pickle Pass Along or Disabled Adult Child (DAC); or

3. The individual is enrolled in any of the following Medicare Savings Programs: Qualified Medicare Beneficiary (QMB), Specified Low Income Medicare Beneficiary (SLMB), Qualifying Individual (QI) or Qualified Disabled Working Individual (QDWI).

g. Incurred Medical Expenses for Institutionalized Individuals

The law allows for the deduction of expenses incurred by the eligible individual for medical or remedial care that are recognized by state law as medical or remedial care items but are not included in the State Plan. Tennessee calls these non-covered expenses Incurred Medical Expenses (IMEs).

IMEs also include expenses incurred during the three (3) months immediately prior to application for coverage of institutional care.

Institutional charges incurred during an institutional coverage ineligibility period due to an uncompensated transfer of assets may not be used as IME deductions.

Cost items are those medical or remedial services and goods that must be provided by the nursing care providers. Cost items cannot be charged to the patient or allowed as an IME deduction.

i. Criteria for Deduction of an Expense

1. The expense(s) must not be subject to payment by a third party not expecting reimbursement, e.g., medical or health insurance, medical trust fund, Medicare, etc.

2. The expense may be unpaid or paid by the client during the month(s) of eligibility determination or paid by a member of the client's family and reimbursement is expected by the family member.

3. The expense must not have been allowed previously as a necessary item.

4. The expense must be outstanding and considered collectible by the party who provided the medical service and one for which the client is legally liable. Debt sent to a collection agency is still considered collectible by the original party for purposes of this IME policy.

5. Medical expenses incurred up to three months prior to the month of application during TennCare Medicaid ineligibility do not impact whether the bill is an allowable medical expense, e.g. while an applicant is spending down resources to become eligible.

Example: Mrs. Carter applied for TennCare Medicaid for the month of January. She did not meet TennCare Medicaid eligibility for that month due to exceeding the resource limit. She reapplied on April 1, 2016. She incurred charges for the facility stay from January, February, and March. The facility charges may be used as an allowable expense as they occurred during the three months prior to eligibility.

ii. Incurred Medical Expenses in the Budget

Verified IME deductions are allowed from patient liability for qualifying paid medical expenses. IMEs are allowed until the full unpaid balance has been deducted, or until the expenses are paid in full, whichever comes first.

iii. Qualifying Expenses

Payments for the following types of medical or remedial care recognized under state law, but not encompassed within the State Plan, are subject to the following criteria:

1. Eyeglasses and necessary related services

Deductions can only be made for the following services and must be the least of the provider's usual and customary charges, billed charges or the Medicaid fee schedule:

a. Examination and refraction;
b. Frame;
c. Lenses (bifocal); and
d. Lenses (single).

No deductions should be made for the first pair of eyeglass or contact lenses after cataract surgery, since those are allowed by TennCare.

2. Hearing aids and necessary related services

Deductions can only be made for the following services and must be the least of the provider's usual and customary charges, billed charges or the Medicaid fee schedule:

a. Audiogram;
b. Ear mold;
c. Hearing aid;
d. Batteries; and
e. Hearing aid orientation.

3. Dental services

Effective January 1, 2023, dental services are a covered benefit for all adults enrolled in TennCare Medicaid. Dental services covered by the adult dental benefit are not allowed as an IME for TennCare enrollees. A list of covered procedures is posted on the TennCare website. Deductions can be made for dental services that are not covered by the adult dental benefit, in accordance with TennCare's dental fee listing, whether such services are provided at a dental office, on-site at the Long-Term Care Facility (LTCF), or through a mobile dental services provider. Denied dental services may be eligible as an IME and will be reviewed on a case-by-case basis but only after denial of coverage by TennCare dental insurance.

4. Other medical service recognized under state law but not covered by TennCare Medicaid

Deductions for any other medical service recognized under state law but not covered by TennCare Medicaid will be made at the least of the provider's usual and customary charges, billed charges or 80% of the Medicare fee schedule. Deductions will be allowed only for services that are determined by the State to be medically necessary for the particular individual on whose behalf the services are being requested.

5. Charges for nursing home days incurred as the result of bed-holds or therapeutic leave days

Charges for nursing home days incurred as the result of bed-holds or therapeutic leave days that are in excess of the number of days covered under the State Plan for the type of facility in question are not allowable deductions.

6. Prescription Drugs

There are four criteria that a prescription drug must meet to be an allowable IME:

a. It must not be subject to a payment by a third party (e.g., Medicare or private insurance);
b. It must be recognized under State law;
c. It must not be covered by Medicaid; and
d. It must be determined by the state to be medically necessary.

Here are the IME coverage policies for four frequently requested drugs:

Drug	Covered by Medicare?	Covered by Medicaid/ TennCare?	Status as an allowable IME deduction?	Reasoning
Medically necessary benzodiazepines	Yes	Yes	Not allowed	Drug is covered by both Medicare and TennCare
Medically necessary cough and cold products	Yes, EXCEPT products used for symptomatic relief of cough and colds	Yes, EXCEPT products used for symptomatic relief of cough and colds	*Only if* the products are used for the symptomatic relief of cough and colds	IME deduction can only be applied to drugs not covered by TennCare and Medicare
Medically necessary prescription vitamin and mineral products	Yes, but ONLY IF the items are prenatal vitamins and fluoride preparations	Yes, but ONLY IF the items are prenatal vitamins and fluoride preparations	*Only if* the items are NOT prenatal vitamins and fluoride preparations	IME deduction can only be applied to drugs not covered by TennCare and Medicare
Medically necessary smoking cessation products	Prescription-only smoking cessation products are COVERED; non-prescription drugs are NOT COVERED	Yes	Not allowed	Prescription-only smoking cessation products are covered by Medicare and TennCare; non-prescription drugs are covered by TennCare

TennCare does not cover prescription drugs for individuals who are dually eligible for both Medicare and TennCare. These individuals are considered to have access to Medicare Part D for their prescription drug coverage, regardless of whether they choose to enroll in Medicare Part D or not.

iv. Dental Services Provided in a LTCF

There are certain requirements that must be met by the mobile dental service providers in order to have their services covered as an incurred medical expense.

1. These are the requirements of the mobile dental service:

a. To obtain a signed consent form from the responsible party prior to performing any dental services. If the responsible party fails or refuses to sign the consent form and has not made any arrangements for alternative dental care, the LTCF is authorized to sign the form on behalf of the resident. The consent will remain valid for the length of the resident's stay (only one form per patient, not one per procedure), unless otherwise revoked by the responsible party.

b. To deliver the consent form, along with the verification of services form, via hand delivery, mail or facsimile to TennCare Connect.

c. To contract with a dentist licensed in the State of Tennessee who is a Medicare/Medicaid provider. A licensed dentist must perform all services. The dentist's name and provider number must be entered on the IME request form prior to submitting the bill to TennCare.

d. To create and supply all new forms that are submitted from the mobile dental service provider and the LTCF. The facility should ensure that a copy of these forms is kept on file in the patient records at the facility, along with proof that the services were provided by a licensed dentist.

2. These are the requirements for TennCare Member Services:

a. Prior to authorizing a deduction for any IME received from a mobile dental services provider, the Eligibility Specialist must view and document in the data base that the consent form, the IME request form, and the verifications of service form have been provided.

b. Any services related to the provision of dentures deemed medically necessary must be thoroughly documented in the electronic case record. Process the IME request within thirty (30) days after receipt.

c. Once the bills have been processed, Tenncare must notify the responsible party and the LTCF of any action taken to approve or deny the expense as an IME deduction. These expenses will be deducted from the patient's total income. This will reduce the patient liability.

Note: Payment can only be made from the patient liability amount, not from the patient's trust account or the PNA. If the patient liability is already zero, then payment cannot be allowed.

v. Information Needed with Incurred Medical Expense (IME) Submission

The Incurred Medical Expense (IME) submission must include the following information:

1. A verification of service/item received,
2. Consent for receipt of service/item,
3. Information relating to medical necessity, and
4. Other identifiers relating to the IME, including the provider number and a description of the service/item received.

h. Incurred Medical Expenses Carry Forward Amount

When the total of incurred medical expenses (and health insurance premiums) is greater than the individual's total income less PNA, mandatory expenses, CSIMA and DIMA deductions for the month, deduct only the amount equal to the available income. Incurred medical expenses in excess of the individual's total available income are carried over into the next month as an IME Carry Forward Amount from the previous month. Expenses will be carried over until the full amount of the expense is deducted or the expense is paid in full, whichever occurs first.

Document Title	Post-Eligibility Treatment of Income
First Published	04.17.2015

Revision History

Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
07.01.2016	4.b.i-iii.; 5.a.i.; 11	Terms and Standards; CSIMA Calculation; CSIMA Example; Calculate DIMA; Information Needed with Item D Submission	2-6; 11	Non-Substantive Change	LW
07.01.2016	8.	Item D Deductions for Institutionalized Individuals	7	Policy Clarification	LW
08.01.2017	4.b.i.; 5.a.	Terms and Standards; General Rules	2-3; 5	Policy Clarification	AJ
08.01.2017	4.b.iii.; 5.a.i.	CSIMA Example; Calculate DIMA	4-6	Non-Substantive Change	AJ
08.01.2017	5.b.	Dependent Relatives Living in the Home Without a Community Spouse	6-7	Policy Change	AJ
01.03.2018	4.b.i.; 4.b.iii	Terms and Standards; CSIMA Example	2-5	Non-Substantive Change	AJ
07.03.2018	4.b.i-iii.; 5.b.ii.	Terms and Standards; CSIMA Calculation; CSIMA Example; Calculate DIMA	2-6	Non-Substantive Change	TN
10.08.2018	4.b.i.; 4.b.iii.	Terms and Standards; CSIMA Example	3; 5	Non-Substantive Change	TN
03.18.2019	1.; 2.-2.a.; 3.; 3.c.; 3.f.; 3.h.	Legal Authority; Policy Statement; Determination of Total Income; Income Not Included in Total Income; PETI Deductions from Total Income; Mandatory Expenses; Health Insurance Premiums; Incurred Medical Expenses Carry Forward Amount	1-5; 10; 15-16	Policy Clarification	AJ
03.18.2019	2.b.; 3.b.i.; 3.d.ii.1.	VA Pensions Limited to $90 Per Month; Nursing Facility; Terms and Standards	1-2; 6	Policy Change	AJ
03.18.2019	3.b.iii.; 3.g.	Statewide ID and Comprehensive Aggregate Cap Waivers; Incurred Medical Expenses for Institutionalized Individuals	3; 11-15	Non-Substantive Change	AJ
07.01.2019	3.d.ii.1-3.; 3.e.ii.2.	Legal Authority; Terms and Standards; CSIMA Calculation; CSIMA Example; Calculate DIMA	1; 6-9	Policy Clarification	TB
07.01.2020	1.; 3.d.ii.1-	Policy Statement; Terms and Standards; CSIMA	1; 6-9; 11; 15	Non-Substantive Change	TN

	3.; 3.e.ii.2.; 3.f.ii.3; 3.g.iv.1.b.; 3.g.3iv.2.b-c	Calculation; CSIMA Example; Calculate DIMA; Medicare Premiums; Dental Services Provided in a LTCF			
07.01.2021	3.d.ii.1-3; 3.e.ii.2	Terms and Standards; CSIMA Calculation; CSIMA Example; Calculate DIMA	3-9	Non-Substantive Change	TN
01.04.2022	3.d.ii.1.c.i; 3.d.ii.3.a-c	Terms and Standards; CSIMA Example	6; 8	Non-Substantive Change	TN
07.01.2022	3.d.ii.1-3; 3.e.ii.2.	Terms and Standards; CSIMA Calculation; CSIMA Example; Calculate DIMA	6-9	Non-Substantive Change	TN
11.01.2022	3.d.ii.1.c; 3.d.ii.3.	Terms and Standards; CSIMA Example	6; 8	Non-Substantive Change	TN
07.03.2023	3.d.ii.1-3.; 3.e.ii.2.	Terms and Standards; CSIMA Calculation; CSIMA Example; Calculate DIMA	6-9	Non-Substantive Change	TC
10.02.2023	3.d.ii.1.c;3.d.ii.3.a	Terms and Standards; CSIMA Example	6;8	Non-Substantive Change	CE
1.02.2024	3.g.iii.3.	Dental services	13	Policy Change	LW