10A NCAC 23E .0210 PATIENT LIABILITY

(a) Patient liability shall apply to clients who live in facilities for skilled nursing, intermediate nursing, intermediate care facility for individuals with an intellectual disability, or other medical institutions.

(b) The client's patient liability for cost of care shall be computed as a monthly amount after deducting the following from his or her total income:

(1) An amount for his or her personal needs as established under the Medicaid State Plan;

(2) Income given to the community spouse to provide him or her a total monthly income from all sources, equal to the "minimum monthly maintenance needs allowance" as defined in 42 U.S.C. 1396r-5(d)(3)(A);

(3) Income given to family members described in 42 U.S.C. 1396r-5(d)(1), to provide each, from all sources of income, a total monthly income equal to:

(A) One-third of the amount established under 42 U.S.C. 1396r-5(d)(3)(A)(i); or

(B) Where there is no community spouse, an amount for the number of dependents, based on the income level for the corresponding budget unit number, as approved by the NC General Assembly and stated in the Appropriations Act for categorically and medically needy classifications;

(4) The income maintenance level provided by 42 U.S.C. 1396r-5(d)(3)(A)(i) or State statute for a single individual in a private living arrangement with no spouse or dependents at home, for whom the physician of record has provided a written statement that the required treatment is such that the patient is expected to return home within six months, shall be allowed by the county department of social services; and

(5) An amount for unmet medical needs as determined under Paragraph (f) of this Rule.

(c) Patient liability shall apply to institutional charges incurred from the date of admission or the first day of the month and shall not be prorated by days if the client lives in more than one institution during the month.

(d) The county department of social services shall notify the client, the institution, and the State of the amount of the monthly liability and any changes or adjustments.

(e) When the patient liability as calculated in Paragraph (b) of this Rule exceeds the Medicaid reimbursement rate for the institution for a 31-day month:

(1) The patient liability shall be the institution's Medicaid reimbursement rate for a 31-day month; and

(2) The client shall be placed on a deductible determined in accordance with regulations, Rules .0208 and .0209 of this Section, and the Medicaid State Plan.

(f) The amount deducted from income for unmet medical needs shall be determined as follows:

(1) Unmet medical needs shall be the costs of:

(A) Medical care covered by the program that exceeds limits on coverage of that care and is not subject to payment by a third party;

(B) Medical care recognized under State and federal tax law that is not covered by the program and that is not subject to payment by a third party; and

(C) Medicare and other health insurance premiums, deductibles, or coinsurance charges that are not subject to payment by a third party.

(2) The amount of unmet medical needs deducted from the patient's monthly income shall be limited to monthly charges for Medicare and other health insurance premiums.

(3) The actual amount of incurred costs that are the patient's responsibility shall be deducted when reported from the patient's liability for one or more months.

(4) Incurred costs shall be reported by the end of the six-month Medicaid certification period following the certification period in which they were incurred.

History Note: *Authority G.S. 108A-54; 108A-54.1B; 42 C.F.R. 435.733; 42 C.F.R. 435.831; 42 C.F.R. 435.832; 42 U.S.C. 1396r-5;*
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