

H-1000 MEDICALLY NEEDED PROGRAM (MNP)**H-1010 GENERAL INFORMATION**

The Medically Needy Program (MNP) provides Medicaid coverage to individuals or families who have income that is at or below the Medically Needy Income Eligibility Standard (MNIES) or have income which exceeds the MNIES but have enough medical expenses to reduce (spend-down) their excess income.

Note:

Resources are not considered for Modified Adjusted Gross Income (MAGI)-related eligibility groups.

Resources are considered for Non-MAGI-related eligibility groups. Refer to [Z-900 Resource Limits by Program](#). Resource eligibility should be explored using the Spousal Impoverishment Resource Provisions for individuals who are legally married and who have been, or are expected to be institutionalized for thirty (30) consecutive days. Refer to [I-1660 Spousal Impoverishment Resource Provisions \(LTC/HCBS\)](#).

Spend-Down MNP eligibility must be considered if the applicant/enrollee is income ineligible for all programs.

H-1010.1 Categorical Relatedness

MNP eligibility cannot be considered prior to establishing income ineligibility in a MAGI-related or Non-MAGI related eligibility group.

Spend-down MNP has no upper income limit. Income eligibility is based on allowable medical expenses exceeding countable income.

H-1010.2 MNIES

The income standard used in MNP is the MNIES. Refer to [Z-300 Medically Needy Income Eligibility Standards \(MNIES\)](#).

H-1011 MNP GROUPS

There are three (3) MNP groups.

1) MAGI-related Regular Medically Needy

Individuals or families who have income which is at or below the MNIES. Regular Medically Needy is only applicable to MAGI-related eligibility groups.

2) Spend-down Medically Needy

Spend-Down MNP is considered after establishing income ineligibility in Regular MNP or a Non-MAGI related eligibility group and excess income remains.

The following individuals may be considered for Spend-down MNP:

- Individuals or families who meet the requirements in a MAGI-related eligibility group. Refer to H-1020;
- Non-institutionalized individuals or couples who meet the requirements in a Non-MAGI related eligibility group. Refer to H-1030;
- Institutionalized individuals who have been, or are expected to be in a medical institution for a continuous period of thirty (30) days, and have income which exceeds the individual Federal Benefit Rate (FBR). Refer to H-1030; or
- Institutionalized individuals residing in a long-term care facility with Medicare coinsurance who have income which exceeds the special income level (SIL). The SIL is three (3) times the current FBR. Refer to H-1030.

3) LTC/HCBS Spend-down Medically Needy

Individuals residing in a Medicaid long term care (LTC) facility who are not on Medicare coinsurance or individuals offered a waiver opportunity for home and community-based services (HCBS) who have income which exceeds the SIL.

Refer to H-1040 and H-1050 for instructions.

Note:

HCBS Spend-down Medically Needy is limited to the Adult Day Health Care (ADHC), Community Choices (CC), New Opportunities (NOW), and Residential Options (ROW) waivers.

H-1011.1 Regular MNP

Individuals or families who meet the MAGI-related categorical requirements and have income at or below the monthly MNIES are certified for Regular MNP. Refer to H-1020, C-related MNP.

Note:

The Parents/Caretaker Relative Program has a higher income limit than Regular MNP.

H-1011.2 Spend-down MNP

After completing the MAGI-related MNP or Non-MAGI related budget and excess income remains, deduct the allowable medical bills (refer to H-1011.5) incurred by the income unit to spend-down (reduce) the excess income to zero. Medical bills are deducted in chronological order (date order) based on the date of service).

Verify the applicant/enrollee is liable for payment of the allowable bills used in the spend-down. If the allowable medical bills reduce the excess income to zero in the eligibility/budget period and all other eligibility factors are met, income eligibility is established. Eligibility for Medicaid begins on the date the excess income is spent down. If there is no Medicaid liability in the month the excess income is spent down, eligibility will begin on the first day of the month following the spend-down date in which there is a Medicaid liability or the first day of the month of the requested period of coverage whichever is earlier.

Note:

The applicant cannot choose to exclude a month of eligibility coverage in which there is a Medicaid payable expense.

H-1011.3 Eligibility/Budget Period**Non-institutionalized**

The eligibility/budget period for non-institutionalized individuals is

based on quarters (three (3) consecutive calendar months equal one (1) quarter) and is based upon the month of application.

Institutionalized

The eligibility/budget period for institutionalized individuals is based on a one (1) month budget period.

The month of application must be one of the eligibility/budget months, unless the applicant requests retroactive eligibility to cover medical bills incurred three (3) months prior to the month of application.

An application form may be used for up to twelve (12) months unless there is a break in coverage.

Note:

A break in coverage for MNP is defined as the enrollee not being eligible for an entire month. One day of eligibility in the month is considered as being eligible for the entire month with no break in coverage.

The months of coverage shall not include previous Medicaid covered months, excluding Take Charge Plus, ** pure Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB) or Qualified Individual (QI) certifications.

Example:**Spend-Down Eligibility Period**

The date of application is April. The applicant incurred medical expenses for services received in January, February, March and April. The medical expenses from January, February and March were used in the eligibility/budget. The excess income was reduced to zero with a March expense with a remaining liability on the expense. The eligibility period would be March, April and May.

Consecutive eligibility/budget periods

If an individual requests further coverage and has bills for medical services which are not covered by Medicaid and the bills were not used in a previous eligibility determination, the medical bills may be carried forward and used in the subsequent eligibility/budget period.

H-1011.4 Limited Certifications for Non-Institutionalized Individuals

It is necessary in some instances to consider less than a full quarter of

coverage. When considering less than a full quarter, multiply the monthly MNIES times the number of eligible months.

Income above the MNIES is not a reason for limiting the certification.

Any of the following conditions are reasons to limit the eligibility period to less than three months:

- Death of an applicant;
- The applicant/enrollee does not meet a non-financial eligibility or categorical requirement in one or two months of the quarter;
- Full Medicaid coverage under another program for part of the quarter;
- Excess resources (Non-MAGI-related group); or
- In an Emergency Medical Services (EMS) certification.

H-1011.5 Medical Expenses Allowed in the Spend-down Process

- Allow all bills for medical services for which the applicant is legally liable and are recognized as medically necessary under state law (e.g., psychiatric, dental, physical therapy services, medical equipment, and medical supplies).

Note:

Medical services not covered or limited by Medicaid are allowed in the spend-down calculation. For example, dental care for individuals age 21 or older.

For purposes of the Medicaid Program, "medically necessary under state law" refers to any medical service required by an applicant as prescribed by a physician. The physician must have the service included in the applicant/enrollee's treatment plan. If a copy of the treatment plan is not available, a letter from the physician indicating the need for the service may be used. An example of this service would be an attendant in the home who is not legally responsible for the care of the individual and who is providing personal care needs to an applicant/enrollee.

- Allow bills for Medicaid covered medical services which are provided without charge (free care) to the applicant when services are delivered by a Medicaid-qualified provider and no third party will be charged for the medical services. (Federal financial participation (FFP) is available for Medicaid payments for care provided to individuals without charge.)
- Allow only the portion of the medical expense that is not covered or paid by a third party such as copays, coinsurance, or deductibles.
- Allow unpaid bills for medical services received not more than three (3) months prior to the month of application in chronological order from the oldest to the most recent.

If an applicant has been determined eligible for a budget period, any allowable bills that are not Medicaid payable (dental bills hearing aids, eyeglasses for a person 21 and over) and were not used in the spend-down for that budget period may be carried forward and used in the spend-down for the next budget period. As long as the applicant continues to be eligible in each subsequent budget period, allowable bills not previously used can be carried forward for use in the next budget period.

If the applicant becomes ineligible for a budget period and a break in coverage of at least one (1) month occurs, previous bills cannot be carried forward. The applicant will need to reapply and submit new bills.

- Allow current payments made on medical bills that were incurred prior to the spend-down period if the bills have not been used in a previous spend-down. A current payment is a payment made within the spend-down period.

Note:

Treat unpaid loans and credit card charges which were used to pay the medical provider as unpaid medical bills if they were not used previously. Verify the applicant's current liability. Verify that the loans and credit card charges were actually used to pay medical bills.

- Allow bills for all persons included in the MNIES.
- Allow bills incurred by a deceased person who would have been

included in the MNIES if another person included in the MNIES is legally responsible for the bills.

- Allow Medicare or other private health insurance premiums when payment is due. For example, if the individual's policy is based on an annual premium, the premium deduction cannot be used again until the premium payment is due for an additional twelve (12) month policy period. If individuals are included in the policy but are not included in the MNIES, allow only the pro-rata share for the individuals included in the MNIES.
- Allow current state mileage reimbursement for medical transportation.
- Allow incurred Medicare coinsurance charges that are not payable by a third party while on skilled nursing care. Medicare coinsurance charges cannot be projected for individuals in a long term care facility.

Bills used to spend-down excess income are the responsibility of the applicant/enrollee. Bills used in a spend-down budget that establishes eligibility can only be used once. All bills must be applied in chronological order. If bills occur on the same date, use the following designated order:

- 1) Bills for services not payable or covered by Medicaid, such as a dental bill for someone who is 21 and over;
- 2) Hospital bills;
- 3) All remaining bills.

To determine the chronological order of hospital bills (state and private) that cannot be itemized, use the per diem for the daily charges. The per diem is determined by dividing the total number of days, excluding the discharge date, into the total bill.

Applicants receiving services in hospitals operated by the LSU Healthcare system have separate physician bills for each hospital day.

1011.6 Medical Expenses Not Allowed in the Spend-down Process

- Do not allow unpaid bills for services incurred more than three (3) months prior to the month of application.

- Do not allow bills marked "free care" incurred more than three (3) months prior to the month of application.
- Do not allow bills for individuals not included in the MNIES.
- Do not allow bills, portions of bills, or current payments on bills that have previously been allowed in a spend-down.
- Do not allow bills for services incurred during a prior period of Medicaid coverage except for:
 - Bills for services not covered by Medicaid;
 - Bills not paid because the provider did not accept Medicaid assignment; and
 - Bills for services provided after the applicant/enrollee has exhausted his annual limitation of services, such as an adult exceeding twelve (12) visits per year.
- Do not allow paid bills for services incurred more than three (3) months prior to the month of application.
- Do not allow paid or unpaid bills for services incurred after the eligibility/budget period being considered.
- Do not allow bills for which the applicant is no longer liable.
- Do not allow bills for anticipated services such as a package of services which are paid prior to the date the services are rendered.

Exception:

If a pre-paid package is itemized, services incurred and paid in the spend-down period can be allowed according to the schedule of the itemized bill.

- Bills or the portion of bills which have been paid or will be paid by insurance, legal settlement, family member who is not in the income unit or assistance unit or any other third party resource.

Take reasonable measures to determine the legal liability of third parties to pay for incurred expenses.

Do not forestall an eligibility determination simply because third party liability cannot be ascertained or payment by the third party has not been received.

Medicare Eligibles

If after exhausting every reasonable effort to determine the exact liability determine the liability as:

- the deductible for Medicare Part A (inpatient); and
- the deductible plus 20 percent of the balance of the actual charges for Medicare Part B (outpatient).

Note:

For hospital inpatient stays, Medicare eligibles are allowed only the deductible for Part A. Do not allow the additional 20 percent for actual hospital charges.

Non-Medicare Eligibles

If every reasonable effort to determine the exact amount of the liability has been exhausted, obtain an estimated amount from the insurance company to be used in the spend-down process.

H-1012 MAGI-RELATED MNP CARETAKER RELATIVE

To be considered for Parents and Caretaker Relatives MNP, the individual must:

- Be a parent, grandparent, sibling or step-sibling, brother or sister-in-law, step-parent, aunt, uncle, first cousin, niece or nephew, the legal spouse of parents or caretaker relatives;
- Assume primary responsibility of a dependent child under age 18, or is age 18 and a full-time student in high school or vocational/technical training;
- Be included in the MAGI household with the dependent child,

Note:

Non-legal parents (non-qualified aliens) of a dependent child may only be eligible for EMS or Louisiana Children's Health

Insurance Program (LaCHIP) Phase IV.

Individuals who are not considered to be a caretaker relative should be reviewed under the Non-MAGI related groups.