H-1050 SPEND-DOWN MEDICALLY NEEDY - HOME AND COMMUNITY-BASED SERVICES (HCBS) - SSI-RELATED

H-1051 ELIGIBILITY DETERMINATION PROCESS

Eligibility in SD MNP HCBS cannot be considered prior to establishing income ineligibility for the HCBS program. Refer to H-900 Home and Community-Based Services (HCBS).

Individuals who meet the eligibility requirements for the Community Choices, Adult Day Health Care, Residential Options Waiver, Supports, or New Opportunities Waiver Programs, but have countable monthly income that is over the special income limit (SIL), may be eligible for Medicaid healthcare coverage and payment of waiver services under the Spend-down Medically Needy HCBS Program. The applicant/beneficiary must incur monthly medical expenses in an amount greater than or equal to their excess income to be eligible for Medicaid.

The Medicaid Program considers the anticipated or projected cost for home and community-based waiver services as an incurred medical expense deduction. The projected waiver rate is based on the average monthly waiver costs associated with the waiver and is used to reduce the excess monthly income. Refer to Z-2400 Average Projected Rates for MNP By Program.

Other allowable incurred medical expenses include Medicare and private health insurance premiums, deductibles, coinsurance or copayment charges, and medical/remedial care expenses incurred by an individual that are not subject to payment by a third party. Verification of the applicant/beneficiary's responsibility for payment of the incurred expense is required.

The projected waiver rate must be prorated when the applicant/beneficiary was not medically certified for the entire month. (Refer to the effective date recorded on the BHSF 142, Notice of Medical Certification.) When the projected waiver rate and the incurred medical expenses are equal to or greater than the applicant/beneficiary's excess income, income eligibility is established for the budget period. Medicaid eligibility begins the first day of the budget period. Vendor payment eligibility will begin the later of the effective date recorded on the BHSF 142 or the date financial eligibility is established.

When the projected waiver rate and incurred medical expenses are not sufficient to spend-down the applicant/beneficiary's excess income to zero, eligibility is not established for the budget period. Continue the income eligibility process to determine if the applicant/beneficiary meets spend-down in the following budget period.

Example:
The applicant is medically approved for the Community Choices Waiver Program on July 15th. The applicant's gross monthly income is $3,062.00. After deducting the $20 SSI disregard and the $92 monthly MNIES, the applicant's excess income is $2,950.00. The individual's monthly Medicare premium is $109.00. The prorated projected waiver rate for July 15th to the end of the month is $2,794.46 ($5,000.00 average projected monthly rate x 12 months ÷ 365 days = $164.38 projected daily rate x 17 days = $2,794.46). The applicant has no other incurred medical expense deductions. After deducting the allowable incurred expenses, the applicant's excess income does not spend-down to zero and is income ineligible for the budget period. **

$3,062.00	Gross monthly income
- 20.00	SSI standard deduction
$3,042.00	
- 92.00	Rural monthly MNIES for 1
$2,950.00	Excess Income to spend-down
$2,950.00	
- 109.00	Medicare premium
$2,841.00	
- 2,794.46	Prorated waiver rate
46.54	Remaining Income

The application should be held for the next month to determine if the applicant will spend-down using for a full month of incurred expenses.

Individuals certified under the Spend-down MNP HCBS Program may be eligible for payment of HCBS waiver services (vendor payment). No payment is authorized to the waiver provider if the post eligibility determination results in a patient liability that exceeds the projected waiver rate.

Determine eligibility by applying the following criteria. The elements have been listed in the most logical order, but work on all steps

simultaneously.

H-1051.1 Determine Assistance Unit

The assistance unit consists of the applicant/beneficiary.

H-1051.2 Establish Categorical Requirements

Verify that the applicant/beneficiary is:

- Aged;
- Blind; or
- Disabled.

Refer to E-0000 Category.

H-1051.3 Establish Non-Financial Eligibility

Verify eligibility for the applicant/beneficiary with regard to the following factors:

- Assignment of Third Party Rights I-200
- Citizenship/Identity/Qualified Non-Citizen Status I-300
- Continuity of Stay I-400
- Enumeration I-600
- Medical Certification I-1000
- Residence I-1900

H-1051.4 Establish Need

Verify the applicant has been offered an opportunity (slot) for HCBS.

A. Determine Composition of the Income Unit

The income unit consists of:

- The applicant/beneficiary; or
- The applicant/beneficiary who is a minor child and the parent(s) with whom the child lived for the month of admission (the month of eligibility listed on the BHSF

Form 142) only. Refer to I-1420 Need - Deeming. After the first month of eligibility, the income unit consists of the HCBS participant.

Note:
Never consider the income of the community spouse/legal dependent(s) at home in determining eligibility for an institutionalized/HCBS individual. Refer to I-1537, Spousal Income Provisions.

B. Determine Countable Income

Determine the total countable monthly income of the applicant/beneficiary including any parental deemed income.

The applicant's countable income, after allowable deductions, must be equal to or less than the MNIES or equal to or less than the excess income.

Budget Steps

Step 1. Determine gross unearned income for the individual excluding VA Aid and attendance.

Step 2. Subtract $20 SSI standard deduction

Step 3. Remainder is countable unearned income.

Step 4. Determine gross earned income for the individual. Subtract any remainder of the $20 SSI standard deduction from gross earnings.

Step 5. Subtract $65 and one half of the remainder of the earnings.

Step 6. Remainder is countable earned income.

Step 7. Add the remaining countable unearned and earned income from in Step 3 and Step 6.

Step 8. Subtract the monthly MNIES for one (1)

Step 9. If the income remaining is greater than $0.00, deduct allowable incurred medical expenses. Determine allowable incurred medical expenses.

Refer to H-1011.5 Medical Expenses Allowed in the Spend-down Process and H-1011.6 Medical Expenses Not Allowed in the Spend-down Process.

Step 10. Subtract allowable incurred medical expenses.

Note:
Only unpaid medical bills for services incurred within three (3) months prior to the application month may be used in the spend-down process. Refer to H-1011.5, Bills Allowed in the Spend-down Process.

Step 11. Subtract the projected waiver rate. Refer to Z-2400.

Note:
The projected waiver rate must be prorated when the applicant/beneficiary was not medically certified for the entire month.

Example:
The applicant is medically certified for the Community Choices Waiver Program on April 15th. The applicant's gross monthly income is $2,830.00. After subtracting the $20 standard deduction and $92 monthly MNIES from the gross monthly income, the applicant's excess income is $2,718.00. The applicant's Medicare premium is $109.00. The prorated projected waiver rate from April 15th to the end of the month is $2,630.08 ($5,000 average projected monthly rate x 12 months ÷ 365 days = $164.38 projected daily rate x 16 days). The applicant has no other incurred medical expenses deductions. The allowable incurred medical expenses are sufficient to meet spend-down.

$ 2,830.00	Gross monthly income
- 20.00	SSI standard deduction
$ 2,810.00	
- 92.00	Rural monthly MNIES for 1
$ 2,718.00	Excess Income to spend-down
$ 2,718.00	

- 109.00	Medicare premium
$ 2,609.00	
- 2,630.08	Prorated waiver rate
0.00	

Step 12. If the remaining income is greater than $0.00, spend-down is not met and the applicant is income ineligible.

If the projected waiver rate is prorated for the budget month, review eligibility for the following month using the monthly projected waiver rate. If the remaining income is greater than $0.00, spend-down is not met and the applicant is income ineligible. Review the applicant for all other Medicaid programs.

C. Determine Composition of the Resource Unit

The resource unit consists of:

- The applicant/beneficiary;
- The applicant/beneficiary and the community spouse; or
- For the month of admission only (the month of eligibility listed on the BHSF Form 142), the applicant/beneficiary who is a minor child and the parent(s) with whom they lived during the month. Refer to I-1420 Need - Deeming. After the first month of eligibility, the resource unit consists of the applicant/beneficiary.

  Exception:
  Do not deem resources from parent(s) to a child who has been discharged from a facility to his home to receive HCBS.

D. Determine Countable Resources

Determine eligibility with regard to resources:

- Determine total countable resources of the applicant/beneficiary. Refer to I-1630 SSI-Related Resources.

If the applicant/beneficiary has a community spouse, refer to I-1660 Spousal Impoverishment Resource Provisions.

Resources transferred for less than FMV within the 60 month look back-period make the applicant/beneficiary ineligible for the waiver program for the duration of the penalty period. Refer to I-1670 Transfer for Less than FMV.

Equity interest in home property that exceeds the allowable home equity limit makes the applicant/beneficiary resource ineligible for the waiver program.

Eligibility should be considered in other non-waiver programs.

- Compare total countable resources to the LTC resource limit for an individual. Refer to Z-900 Resource Limits by Program.

  If resources are equal to or less than the individual resource limit, the applicant/beneficiary is resource eligible for HCBS. Continue the determination of need.

  If resources are greater than the individual resource limit, the applicant/beneficiary is resource ineligible for HCBS.

H-1051.5 Determine the Patient Liability

Post-eligibility treatment of income (PETI) rules are used to calculate an applicant/beneficiary's contribution to their cost of care for nursing home, Home and Community Based Waiver or ICF/IID services. Also called patient liability (PLI). PLI is the amount the applicant/beneficiary must pay towards their monthly cost of care. It is based on the amount of monthly income remaining after allowable deductions.

Refer to I-1538 Patient Liability-Post Eligibility Treatment of Income (PETI) for the Patient Liability calculation process.

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The monthly patient liability will be paid directly to the waiver services

provider by the applicant/beneficiary or responsible party and shall be used to reduce the Medicaid payment to the provider. The waiver services provider will be responsible for collecting the patient liability.

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The agency is responsible for informing the applicant/beneficiary of the monthly patient liability requirement for participation in the waiver before Medicaid is approved. The applicant/beneficiary must agree to pay the required PLI amount prior to certification.

If the applicant/beneficiary agrees to pay the required PLI amount, the certification is completed.

If the applicant/beneficiary does not agree to pay the patient liability amount, the application for HCBS will be rejected. Eligibility must be considered in all other non-waiver Medicaid programs.

H-1051.6 Certification Period

Certification for Spend-down MNP HCBS may not exceed 12 months.

Note:
Although the instructions allow a 12-month certification period, a review of the budget must be completed at six (6) month intervals to determine if the client remains eligible. Enterprise Document Management System (EDMS) case record entries will document the case review.

Six (6) month review: Actual projected waiver expenses must be verified prior to establishing a new spend-down period. The projected waiver expenses must be reconciled with actual incurred expenses. The waiver expenses can be reconciled using the Medicaid Enterprise System (MES) files reflecting the amount billed by the provider(s).

H-1051.7 Notice of Decision

Send the appropriate Notice of Decision to the applicant/beneficiary, the provider and OAAS/OCDD.