

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

The Medically Needy Program (MNP) is designed to provide Medicaid coverage when an individual's or family's income and/or resources are sufficient to meet basic needs in a categorical assistance program but not sufficient to meet medical needs according to MNP standards.

H-1010.1 Categorical Relatedness

These individuals must have been denied categorical assistance because of income or resources:

- Regular and Spend-down MNP allow a higher income standard than **LIFC**.
- Spend-down MNP has no income limit (an advantage for those who are income ineligible for CHAMP).

Exception:

The categorical requirement applies to applicants/**recipients** applying for MNP under the Refugee Resettlement Program or the Cuban/Haitian Entrant Program. MNP for the E category is Refugee Medical Assistance, not Medicaid.

Reminder:

An MNP application cannot be initiated prior to establishing ineligibility in a categorically related assistance group.

H-1010.2 MNIES

The income standard used in MNP is the Medically Needy Income Eligibility Standard (MNIES). Refer to Z-300.

H-1011 GROUPS

Individuals shall not be certified in Medically Needy unless ineligible for an entry level program due to Income (LIFC, SSI) **.

- Regular Medically Needy recipients are those individuals or families who meet all LIFC related categorical requirements and whose income is within the Medically Needy Income Eligibility Standard (MNIES) **.
- Spend-down Medically Needy recipients are those non-institutionalized individuals or families ** whose income has been spent down to the MNIES. Spend-down applicants may qualify for the Medically Needy Program on the basis that countable income has been spent or is obligated to pay unpaid medical expenses. ***Resources for SSI related individuals or couples must fall within MNP resource limit.***
- LTC Spend-down Medically Needy recipients are those individuals or couples who are residents of Medicaid LTC facilities and whose resources fall within SSI limits but whose income is above the special income limits (CAP).

H-1011.1 Regular MNP

Individuals and families whose income ** are within allowed MNP limits and who meet C-related factors are certified for regular MNP. Refer to H-1020, C-related MNP.

H-1011.2 Spend-down MNP

If there is excess income remaining after the regular MNP budget, certain medical bills incurred by the income unit are used in chronological order (the order in which services are furnished) to reduce the income (spend-down). If the benefit unit has enough medical bills to reduce countable income below the MNIES (or reduce excess income to zero) in a three-month period and other eligibility factors are met, they are eligible for Medicaid coverage for the remainder of the spend-down quarter.

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H-1011.3 Eligibility Period

The eligibility period for non-institutionalized individuals is considered in three month units (quarter) and is based upon the application date. The month of application is considered as one of the three months of eligibility, unless a completely retroactive certification is requested. Retroactive certification is limited to the three months prior to the month of application.

Example:

An MNP application is filed in March. The months that may be considered for eligibility are:

- December, January, and February for a completely retroactive period,
- January, February, and March,
- February, March, and April, or
- March, April, and May.

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The Spend-Down Quarter Screening Guide (BHSF Form MNP/SG) is used to explore and document the months of coverage needed/requested by the applicant. Contact the applicant if the quarter of coverage originally requested is no longer to his advantage.

The months of coverage shall not include previous Medicaid-covered months, excluding pure QMB, SLMB or QI certifications.

H-1011.4 Limited Certifications

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 would be a reason for considering a limited certification:

- death of an applicant,
- the applicant/recipient does not meet a non-financial eligibility or categorical requirement in one or two months of the quarter,
- **income below the FBR—(SSI referral mode),**
- Medicaid coverage or SSI or **LIFC** eligibility for part of the quarter, or
- excess resources (**for SSI related category**).

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"ITALICS" Text Revised

H-1011.5 Bills Allowed in the Spend-down Process

***** The applicant must be legally liable for payment of bills used in the spend-down process. Unpaid medical bills for services furnished more than 3 months before the month of application may not be used in the spend-down process. Bills used to reduce income below the MNIES are the applicant's responsibility for payment. These bills cannot be used in any subsequent spend-down calculation.***

Allow **medical** bills for all persons included in the MNIES.

Allow bills incurred by a deceased family member who would have been in the MNIES if a person included in the MNIES is legally responsible for the bills.

Allow all bills for medical services for which the applicant/recipient is **legally** liable and which are recognized as medically necessary under state law (e.g., psychiatric, dental, physical therapy services, medical equipment, and medical supplies). ***** Medical services not covered or limited by Medicaid are allowed in the spend-down calculation.***

******** For example, Medicaid limits the recipient to a certain number of physician visits per year. In a spend-down ***** calculation***, there is no limit on the number of bills for physician visits if the other criteria as outlined below are met.

Note:

For purposes of the Medicaid Program, "medically necessary under state law" refers to any medical service required by an applicant/recipient as prescribed by a physician. The physician must have the service included in the applicant/recipient'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/recipient.

To determine 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.

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H-1011.5 Continued

Applicants in state acute care hospitals have separate physician's bills for each hospital day.

Use the following criteria in the designated order to determine which medical bills may be allowed in the spend-down process:

- Allow unpaid bills for services received prior to the spend-down quarter in chronological order, oldest to most recent. ***Unpaid bills must be for services furnished not more than 3 months prior to application date.***
- ***Allow current payments made on medical bills. A current payment is a payment made within the spend-down quarter.***

Note:

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

- Allow insurance premiums when payment is due. For example, if the individual's policy is based on an annual premium, this premium deduction cannot be used again until the premium payment is due for an additional twelve 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.

H-1011.5 Continued

- Allow paid and unpaid bills, health insurance premiums, co-payments and deductibles incurred for services received within the spend-down quarter, in chronological order, oldest to most recent. If multiple services are received on the same date, services verified as not covered by Medicaid or non-payable by Medicaid (because the provider does not accept Medicaid) may be used before hospital bills. Otherwise, hospital bills shall be used first in the spend-down calculation.
- Allow **** *current state mileage reimbursement for*** medical transportation.

H-1011.6 Bills Not Allowed in the Spend-down Process

Use the following criteria to determine which medical bills cannot be allowed in the spend-down process:

- ***Unpaid medical bills for services furnished more than 3 months prior to the month of application.***
- Provider bills marked "free care" cannot be used in the spend-down process because the applicant/recipient has no liability to pay for the service.

Bills from providers shall be evaluated in terms of the bill presented either by the applicant/recipient or the provider and the determination of which bills can be used in the spend-down shall be according to the amount billed to the applicant/recipient. Stamps, notes and amendments to the bill that specify an amount for which the applicant/recipient is liable contrary to the billed amount shall be disregarded. To be used in the spend-down process, the bill which is part of the provider's computer records must document the liability for charges.

- Do not allow bills or portions of bills which have been paid or will be paid by insurance, ***legal settlement, family member*** or any other third party resource unless the third party is a public program other than Medicaid.
- Take all 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. G-400 prescribes a time period for reaching decisions on Medicaid eligibility i.e., 90 days for applicants who apply on the basis of disability and 45 days for all others. It establishes a time limit for receipt of third party payment or verification of third party intent to pay in order to determine deductible expenses under spend-down. Efforts to determine the liability of a third party must continue through the last day of this period.

H-1011.6 Continued**- Medicare Eligibles**

If after exhausting every reasonable effort to determine exact liability and the last day of the time limit prescribed by G-400 has passed, determine the liability as:

- the deductible for Part A, and
- the deductible plus 20% of the balance of the actual charges for Part B.

Note:

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

- Non-Medicare Eligibles

If after exhausting every reasonable effort to determine exact liability and the last day of the time limit prescribed by G-400 has passed, obtain an estimated amount from the insurance company to be used in the spend-down process.

- Do not allow bills for individuals not included in the MNIES.
- Do not allow bills or portions of bills used in previous spend-down certifications ***or current payments made on bills used in previous spend-down certifications.***

H-1011.6 Continued

- 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 or failed to file for reimbursement and the time limit for filing has expired, and
 - bills for services provided after the recipient has exhausted his annual limitation of services.

Note:

In the above-mentioned instances, verify that the applicant remains liable for payment. Document and file Medicaid denials of payment obtained from the provider or from the Program Specialist. Denials based on provider billing problems cannot be used if the timely filing period has not expired (two years from the date of service).

- Do not allow paid bills for services incurred prior to the quarter for which assistance is requested.
- Do not allow paid or unpaid bills for services incurred after the quarter for which assistance is requested.
- Do not allow bills for which the applicant/recipient is no longer liable. Applicant/recipient liability for all bills must be verified. **

H-1011.6 Continued

- 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 quarter can be allowed according to the schedule of the itemized bill.

H-1012 C-RELATED MNP CARETAKER RELATIVE

A caretaker relative for MNP purposes is an adult who:

- is in the LIFC income ** unit with a deprived minor child,
- is a qualified relative of a child who is deprived and eligible for SSI, PAP, or CHAMP, and
- is not eligible for inclusion in the LIFC or PAP because of income **.

To certify a qualified relative as a caretaker relative, there must be at least one minor child who is deprived and receiving/applying for Medicaid.

An essential person may be included with a qualified relative in an MNP caretaker relative certification, but there can be no essential person if there is no qualified relative certified in C-MNP. Refer to H-210.2, LIFC Assistance/Benefit Unit.

Stepparents or payees only who do not meet the above requirements must qualify as individuals under category A, B, or D, if they do not meet the LIFC essential person criteria.

Example #1:

Mrs. Green applies for LIFC for herself and her two deprived children, Mary and Thomas. The family unit is not eligible for LIFC based on Mrs. Green's income. Both children were born after September 30, 1983 and are determined eligible for CHAMP. Because the children are deprived and receiving Medicaid, Mrs. Green is potentially eligible as a C-related MNP caretaker relative.

H-1012 Continued**Example #2:**

Mrs. Anderson receives Social Security. She is also payee only for her niece and nephew. Because she has chosen not to be in the income ** unit for LIFC, she cannot be certified for C-related MNP caretaker relative.

REGULAR AND SPEND-DOWN MEDICALLY NEEDY - C-RELATED**H-1020****H-1021 ELIGIBILITY DETERMINATION PROCESS**

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

H-1021.1 Determine Assistance/Benefit Unit

Include anyone who was not eligible in a categorical group because of income **. This may be the entire LIFC assistance unit, if their income ** made them ineligible for LIFC and no member is eligible for categorical Medicaid.

Reminder:

Do not include sanctioned individuals even though they are included in the income ** unit. Do not add ***anyone*** to the original assistance unit.

H-1021.2 Establish Categorical Requirements

Categorical requirements must have been established in the LIFC, PAP, or CHAMP program.

H-1021.3 Establish Non-Financial Eligibility

Non-financial eligibility requirements must have been established in the LIFC, PAP, or CHAMP program with regard to the following factors:

- Age I-100
- Assignment of Rights I-200
- Citizenship/Alien Status I-300
- Deprivation I-500
- Enumeration I-600
- Residence I-1900

H-1021.4 Establish Need**A. Determine Composition of the Income ** Unit**

The C-MNP income ** unit (MNIES):

- may include all those included in the original LIFC, PAP income ** unit if it is to the MNP applicant's advantage unless the applicant chooses to exclude persons as stated in H-100.3, Assistance/Benefit Unit-Optional Exclusions.
- may include persons already Medicaid-certified (CHAMP, PAP), if it is to the family's advantage. Example: Mr., Mrs., and their children, X and Y, are applying for MNP. Y is certified for CHAMP, but is also included in the MNIES (4 persons) so that the rest of the family will be regular MNP instead of spend-down MNP.
- shall include the unborn in determining eligibility for Pregnant Women or a MUM.

H-1021.4 Continued

- may include restricted persons with income ** who are excluded from PAP if these restricted persons were in the original LIFC income ** unit and their inclusion does not cause a child to lose any Medicaid overage/benefits.

Example:

Child A was excluded from the PAP certification of his mother and sibling Child B. Child A can be considered for MNP because his exclusion was mandatory. Certification of child A for MNP does not cause his sibling to lose PAP coverage.

- shall not include anyone **not** in the original LIFC income ** unit.
- shall include sanctioned parents even though they are not included in the assistance/benefit unit.
- shall include the stepparent in a caretaker relative certification. In working the stepparent budget, refer to I-1528. Use the LIFC 100% Need Standard for needs of the stepparent and his dependents.

Note:

The stepparent is in the MNIES and his needs are also allowed by the 100% Need Standard.

- shall include the parent(s) of a MUM in a caretaker relative certification for the MUM. In working the MUM's parent(s) budget, refer to I-1528. Use the LIFC 100% Need Standard for the needs of the MUM's parent(s) and their dependents.

Note:

The MUM's parent(s) are in the MNIES and their needs are also allowed by the 100% Need Standard.

H-1021.4 Continued**B. Determine Need/Countable Income****Regular Medically Needy**

- Step 1. Add monthly gross earned income for all individuals in the income unit.
- Step 2. Subtract the LIFC standard earned income deduction for each employed person.
- Step 3. Subtract dependent care cost for members of the assistance unit.
- Step 4. Add the total unearned income for all individuals in the income unit.
- Step 5. Convert to a quarterly amount.
- Step 6. Compare the total countable income to the MNIES for the number of people in the income unit.

Note:

Refer to H-1011.4 for limited 1 or 2 month certifications.

If income is equal to or less than the MNIES, the assistance unit is income eligible for Regular MNP.

If income is greater than the MNIES, the assistance unit is ineligible for Regular MNP. Consider for Spend-down MNP.

H-1021.4 Continued**Spend-down Medically Needy**

If the applicant/recipient has been determined income ineligible for Regular MNP, subtract medical bills from the excess income (determined in the Regular MNP budget) in the following order:

- Step 1. Subtract allowable bills for individuals other than the applicant who are included in the MNIES.
- Step 2. Subtract unpaid bills for services received prior to the spend-down quarter in chronological order.
- Step 3. Subtract allowable health insurance premiums. Refer to H-1011.5, Bills Allowed in the Spend-down process.

Note:

Liability for health insurance premiums arises in the month payment is due, rather than in the month (or months) for which coverage is purchased.

- Step 4. Subtract paid and unpaid bills including insurance co-payments and deductibles incurred for services received within the spend-down quarter in chronological order (per diem if necessary), oldest to most recent. Hospital bills shall be used before physicians' bills in the spend-down process.

On the date excess income is absorbed, the applicant is eligible for Spend-down MNP. This date is referred to as the spend-down date. If the spend-down date occurs before the requested period of coverage, the first day of the first month of coverage shall be the spend-down date.

H-1021.5 Eligibility Decision

Evaluate all eligibility requirements and verification received to make the eligibility decision to either reject, close, certify, or continue eligibility.

H-1021.6 Certification Period**Regular MNP**

The certification period shall not exceed a total of six months, including any retroactive coverage (up to three months).

Spend-down MNP

Certification shall not exceed three months. This certification will be automatically closed. Refer to H-1011.2, Spend-down.

H-1021.7 Notice of Decision

Send the appropriate notice of decision to the applicant/recipient.

Reminder:

BHSF Flyer WIC ** must be given to the applicant/recipient **.

H-1021.8 Form 110-MNP

BHSF Form 110-MNP shall be completed when necessary. Once the spend-down date is determined, ask the applicant about all medical services received on the spend-down date. Complete the form listing each provider who rendered medical services on the spend-down date.

If, after certification, a provider or the recipient states that treatment was provided on the spend-down date, send a Form 110-MNP to that provider even if the bill was not provided to use in the spend-down budget. Do not require proof that the service was provided.

To correct the spend-down date to an earlier date after **** MEDS** certification:

- ******
- ***open an eligibility determination, work corrected budget, and back up start date, and***
- retrieve and void all previously issued Forms 110-MNP ***and issue corrected forms.***

SPEND-DOWN MEDICALLY NEEDY—NON-LTC - SSI-RELATED**H-1030****H-1031 ELIGIBILITY DETERMINATION PROCESS**

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

H-1031.1 Determine Assistance/Benefit Unit

The assistance/benefit unit consists of the applicant/recipient.

H-1031.2 Establish Categorical Requirement

Verify that the applicant/recipient is:

- aged,
- blind, or
- disabled.

Refer to E-0000, Category.

H-1031.3 Establish Non-Financial Eligibility

Verify eligibility for each member of the assistance/benefit unit with regard to the following factors:

- Assignment of Third Party Rights I-100
- Citizenship/Alien I-300
- Enumeration I-600
- Residence I-1900

H-1031.4 Establish Need**A. Determine Composition of the Income/Resource Unit**

The SSI-MNP income/resource unit (MNIES) includes:

- applicant/recipient,
- applicant/recipient and ineligible spouse living in the home,
- applicants/recipients who are a couple, or
- applicant/recipient who is a minor and his parent(s) living in the home.

Note:

Alien sponsors are not included in the MNIES because their needs are considered in the deeming process.

B. Determine Need/Countable Resources

Determine total countable resources of the members of the income/resource unit. Income received in any month of the three-month budget period does not become a resource until a new three-month budget period begins. Refer to I-1630, Need - SSI-Related Resources.

Compare countable resources to the MNP resource limit for the number in the income/resource unit. Refer to Z-900, Charts.

If resources are greater than the limit, the applicant/recipient is ineligible for MNP.

If resources are equal to or less than the limit, the applicant/recipient is resource eligible for MNP. Continue the eligibility determination process.

H-1031.4 Continued**C. Determine Need/Countable Income - Spend-down MNP****Individual**

If the applicant/recipient is an individual with no spouse or with an ineligible spouse with no income, go to Step 1.

Ineligible Spouse Deeming

If there is an ineligible spouse with income, ** apply deeming policy, I-1420. **** *Add the ineligible spouse's remaining unearned income to all of the eligible individual's unearned income. Add the ineligible spouse's remaining earned income to all the eligible individual's earned income. Calculate all budget steps and compare countable income to the couple MNIES.***

Parent(s) to Child Deeming

If the applicant/recipient is a minor child apply deeming policy, I-1420. Any income deemed from the parent(s) is considered unearned income of the applicant/recipient. Go to Step 1.

Couple

If both members of a couple are potentially eligible, go to Step 1.

Budget Steps

- Step 1. Determine unearned income, including income deemed from the ** parent(s) ***or alien sponsor(s)***. For a couple combine all unearned income. ***(See MEM I-1424.2 when spouse to spouse deeming is applicable)***.
- Step 2. Subtract one \$20 SSI disregard per income unit, if applicable.
- Step 3. Subtract any remainder of the \$20 SSI disregard from gross earnings. ***(See MEM I-1424.2 when spouse to spouse deeming is applicable)***.

H-1031.4 Continued

- Step 4. Subtract one earned income deduction from the remaining gross earnings of the income unit. The earned income deduction is \$65 and one half of the remainder of the earnings.
- Step 5. Combine the remainders in Step 2 and Step 4.
**
- Step 6. Convert the monthly income amount to a quarterly amount.
- Step 7. Compare the remainder to the MNIES for the number in the income/resource unit to determine the excess income to spend down.
- Step 8. Subtract allowable bills for individuals other than the applicant who are included in the MNIES.
- Step 9. Subtract unpaid bills for services received prior to the spend-down quarter, in chronological order, ***oldest to most recent***.
- Step 10. Subtract allowable health insurance premiums. Refer to H-1011.5, Bills Allowed in the Spend-down process.

Note:

Liability for health insurance premiums arises in the month payment is due, rather than in the month (or months) for which coverage is purchased.

- Step 11. Subtract paid and unpaid bills ***including insurance co-payments and deductibles*** incurred for services received within the spend-down quarter, in chronological order (per diem if necessary), oldest to most recent. **

H-1031.4 Continued**Note:**

If multiple services are received on the same date, services verified as not covered by Medicaid or non-payable by Medicaid (because the provider does not accept Medicaid) may be used before hospital bills. Otherwise, hospital bills shall be used first in the spend-down calculation.

On the date excess income is absorbed, the applicant is eligible for Spend-down MNP. This date is referred to as the spend-down date. If the spend-down date occurs before the requested period of coverage, the first day of the first month of coverage shall be the spend-down date.

H-1031.5 Eligibility Decision

Evaluate all eligibility requirements and verification received to make the eligibility decision to either reject, close, certify, or continue eligibility.

H-1031.6 Certification Period

A spend-down MNP certification shall not exceed three months. This certification will be automatically closed. Refer to H-1011.2, Spend-down MNP.

H-1031.7 Notice of Decision

Send the appropriate notice of decision to the applicant/recipient.

Reminder:

Send BHSF Flyer WIC, if appropriate, to the applicant/recipient. **

H-1031.8 Form 110-MNP

BHSF Form 110-MNP shall be completed on every Spend-down MNP certification. When the spend-down date is determined, ask the applicant about all medical services received on the spend-down date. Complete Form 110-MNP listing each provider who rendered medical services on the spend-down date.

If after certification a provider or the applicant states that treatment was rendered on the spend-down date, send a Form 110-MNP to that provider even if the bill was not available to be used in the spend-down budget. Do not require proof that the service was provided.

To correct the spend-down date to an earlier date after WIS certification:

- send a memorandum to **** BHSF Claims Resolution Section** advising of the correction,
- retrieve and void all previously issued Forms 110-MNP, and
- issue a new medical card for the corrected spend-down period when **** BHSF Claims Resolution Section** provides notification that the corrected spend-down date has processed on the MMIS files.

SPEND-DOWN MEDICALLY NEEDED--LONG TERM CARE - SSI-RELATED**H-1040****H-1041 ELIGIBILITY DETERMINATION PROCESS**

A person who resides in an LTC facility whose income is over the CAP ** may be eligible for MNP *LTC* Spend-down. ***There are 2 MNP LTC spend-down type cases. These type cases are used when all other factors of LTC eligibility have been explored and found to be within eligibility standards as listed in section H-830 and H-831.***

A Type 25 is used for an individual whose income is over the CAP and the excess income is spent down using allowable incurred medical expenses, insurance premiums and the projected Medicaid Facility Rate. If the individual's income is spent down using the projected Medicaid Facility Rate, Medicaid eligibility begins the first day of the month. The projected Medicaid Facility Rate may be prorated if the individual was not in the facility for the entire month.

A Type 22 is used for an individual whose income is over the CAP and the excess income cannot be spent down using allowable incurred medical expenses, insurance premiums and the projected Medicaid Facility Rate. The excess income may be spent down using a combination of the actually incurred daily private facility fee and a proration of the projected Medicaid Facility Rate.

*****Individuals certified under the Spend down MNP LTC type cases may be eligible for vendor payment to the LTC Facility. (No vendor payment is authorized to the LTC facility if the post PLI eligibility determination results in Liability that exceeds the facility 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-1041.1 Determine Assistance/Benefit Unit

The assistance/benefit unit consists of the **** applicant/recipient.**

H-1041.2 Establish Categorical Requirement

Verify that the applicant/recipient is:

- aged,
- blind, or
- disabled.

Refer to E-0000, Category.

H-1041.3 Establish Non-Financial Eligibility

Verify eligibility for each member of the assistance/benefit unit with regard to the following factors:

- Assignment of Third Party Rights I-100
- Citizenship/Alien Status I-300
- ***Continuity of Stay*** ***I-400***
- Enumeration I-600
- ***Medical Certification*** ***I-1000***
- Residence I-1900
- ***SES Referral*** ***I-2000***

H-1041.4 Establish Need**A. Determine Composition of the Income/Resource Unit**

For the month of admission only, the income/resource unit consists of the:

- institutionalized applicant/recipient,
- applicant/recipient and ineligible spouse living in the home,
- institutionalized applicants/****recipients** who are a couple, or
- applicant/recipient who is a minor and his parent(s) living in the home.

After the month of admission, the income/resource unit consists of the institutionalized individual.

Consider eligibility for Spend-down MNP-**LTC** based on **** monthly** figures.

B. Determine Need/Countable Resources

Determine countable resources of the income/**resource** unit. Refer to **H-831.4C and I-1630**, Need - SSI-Related Resources.

Compare countable resources to the **** SSI** resource limit for the number in the income/resource unit. Refer to Z-900, Charts. The resource standard in MNP-LTC is the SSI resource standard.

If resources were disposed of within 36 months (60 months if trust established) prior to application, refer to 1-1670, Need-SSI-Related Resources, Transfer of Resources for Less than FMV. If the applicant/recipient is ineligible for vendor payment because of a transfer of resources for less than the FMV, consider eligibility for Medicaid benefits without vendor payment (Type Case 51).

If countable resources are greater **for an individual** than the **** SSI** resource limit, the applicant/recipient is ineligible for MNP-**LTC**. ***If countable resources for an individual with a legal spouse in the community are greater than that the SSI resource standard refer to I-1660, Spousal Resource Section.*** ******

H-1041.4 Continued

If resources are equal to or less than the limit, continue the determination of need.

C. ** *Eligibility Determination of Need/Countable Income*

**** *The MNP-LTC applicant's countable income, after certain deductions, must be equal to or less than the MNIES for the number of persons in the income unit.***

Budget Steps

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

Step 2. Subtract \$20 SSI disregard per income unit, if applicable.

Step 3. Determine gross earned income for the individual. Subtract any remainder of the \$20 SSI disregard from gross earnings.

Step 4. Subtract earned income deduction from the remaining gross earnings of the income unit if the earnings meets the criteria as set forth in section I-1536-- SSI Related Income Deductions. The earned income deduction is \$65 and one half of the remainder of the earnings.

Step 5. Combine the remainders in Step 2 and Step 4.

Step 6. Subtract the MNIES from the remaining income

H-1041.4 Continued

Step 7 Determine allowable medical bills, as listed in H-1011.5 and H-1011.6

Note:

MNP regulations allow the state to project the LTC Medicaid Facility Rate for MNP-LTC spend down purposes. Regulations do not allow the state to project medical and remedial care expenses that are not for institutional care. SNF co-insurance is not considered an institutional expense for MNP purposes and may not be projected to reduce excess income in LTC spend down determinations.

Step 8 Subtract allowable unpaid bills for services received prior to the month of application, in chronological order, oldest to most recent.

Note: Only unpaid medical bills for services incurred within 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 9. Subtract allowable health insurance premiums. Refer to page 3 of I-1536. Refer to H-1011.5, Bills Allowed in the Spend-down process.

Note:

Liability for health insurance premiums arises in the month payment is due, rather than in the month (or months) for which coverage is purchased. Premiums must be paid by the applicant/recipient.

Example: Wife enters a nursing facility and her supplemental medical insurance premium is taken out of her husband's retirement check. This would not be an allowable deduction.

H-1041.4 Continued

Step 10. Subtract the monthly Medicaid Facility Rate. The daily Medicaid Facility Rate is located on Info Lab. To determine the monthly Medicaid Facility Rate multiply the daily rate for the facility times 365 and divide by 12. This amount is used for a full month.

Note:

For month of admission the Facility Rate must be prorated using the number of days an individual is in the facility in the month of entry, if the applicant is not admitted on the first day of the month.

Example:

Individual admitted on the 16th of the month. The expense for the partial month is determined by multiplying the daily Medicaid Facility Rate times the number of days remaining in month including the date of admission. Daily Medicaid Facility Rate is located on Info Lab on the intranet.

If the remaining income is 0, the individual has spent down to the MNIES for 1 and is eligible for MNP LTC Type 25 spend-down (Over the CAP and under the Medicaid Facility Rate). Proceed with the PLI determination (H-1041.5).

If there is remaining income the individual should be considered for Type 22 MNP LTC (Over the CAP and Over the Medicaid Facility Rate). Continue with section D. below.

H-1041.4 Continued**D. Eligibility Determination of Need/Countable Income for Individuals over the CAP and over the Medicaid Facility Rate (Type 22).**

Follow steps 1 through 9 above (Section C. Eligibility Determination of ** Need/Countable Income Over the CAP and below the Medicaid Facility Rate).

Step 10. Subtract the daily private Facility Rate and any other medical expenses incurred on a daily basis in chronological order. The daily private rate is used until the excess income is less than the prorated balance of the Medicaid Facility Rate.

Example #1:

The individual is in the facility as of the 1st day of the month. The gross monthly income was \$2870.70. The \$20.00 standard deduction, MNIES (\$92.00 rural parish) and Medicare insurance premium of 58.70 are subtracted from the gross monthly income. The monthly spend-down liability is calculated to be \$2700.00. The projected Medicaid facility Rate for the month is \$2574.16 (\$84.63 per day). The private rate is \$3650.00 per month (\$120.00 per day). Since incurred medical expenses and the projected monthly Medicaid Facility Rate are not sufficient to meet the spend-down liability, the individual is not eligible. However after remaining in the institution for 3 days the individual has actually incurred expenses of \$360.00 at the private rate (\$120 X 3). The projected Medicaid facility fee at the Medicaid rate for the remaining days in the month is \$2369.64 (\$84.63 X 28 days). Thus as of the 4th day of the month the combination of actually incurred bills (\$360.00) plus the projected expenses at the Medicaid rate (\$2369.64) equal the spend down liability (\$2700.00) and the individual is eligible effective the 4th day of the month.

H-1041.4 Continued

	\$2870.70	Gross monthly income
	<u>- 20.00</u>	Standard Deduction
	2850.70	
	<u>- 92.00</u>	MNIES for 1 person
	2758.70	
	<u>- 58.70</u>	Medical Insurance (Medicare)
	2700.00	
	\$2700.00	Monthly spend down liability
	<u>-2574.16</u>	Projected Medicaid Facility Fee
	125.84	Spend down liability not met
	\$2700.00	Monthly spend down liability
<u>- 120.00</u>		Daily private rate for Day 1
	2580.00	Remaining spend down liability
	<u>- 120.00</u>	Daily private rate for Day 2
	2460.00	Remaining spend down liability
	<u>- 120.00</u>	Daily private rate for Day 3
	2340.00	Remaining spend down liability
	<u>-2369.64</u>	Prorated Projected Medicaid Facility Fee
	.00	Spend down met on the 4th day of the month.

H-1041.4 Continued**Example #2:**

The individual entered the facility on the 17th day of January. The gross monthly income was \$2870.70. The \$20.00 standard deduction, MNIES (\$92.00 rural parish), and Medicare insurance premium of \$58.70 are subtracted from the gross monthly income. The monthly spend-down liability is calculated to be \$2700.00. The projected Medicaid Facility Rate for the month is \$2574.16 (\$84.63 per day). The private rate is \$3650.00 per month (\$120.00 per day). The incurred medical expenses and the prorated projected monthly Medicaid Facility Rate (\$84.63 X 15 = \$1269.45) are not sufficient to meet the spend-down liability. The incurred medical expenses and the prorated private rate of \$1800.00 (\$120.00 X 15), are calculated and are not sufficient to meet the spend-down liability, the individual is not eligible for the month of entry.

\$2870.70	Gross monthly income
- 20.00	Standard Deduction
2850.70	
- 92.00	MNIES for 1 person
2758.70	
- 58.70	Medical Insurance (Medicare)
2700.00	

\$2700.00	Monthly spend down liability
1269.45	Prorated Projected Medicaid Facility Fee
1430.55	Spend down liability not met

\$2700.00	Monthly spend-down Liability
-1800.00	Prorated Private Rate
900.00	Spend-down Liability <u>not</u> met and the individual is not eligible for the month of entry.

H-1041.4 Continued

If the remaining income is 0, the individual has spent down to the MNIES for 1 person and is eligible for MNP LTC Type 22 spend-down (Over the CAP and Over the Facility Fee). Proceed with the PLI determination.

The spend-down date is the date the excess income can be spent down using the remaining prorated Medicaid Facility Fee. A Form 110- MNP is required for this type case. Refer to H-1041.8.

If there is remaining income after allowable incurred medical expenses have been considered in the budget process the client is not eligible for Medicaid. Send notice of ineligibility.

H-1041.5 Determine the PLI for MNP LTC over the CAP

Determine the PLI for the month of admission and following months.

Step 1 Determine total countable monthly income.

Step 2 Total the unearned income. Include VA Aid and Attendance.

***Step 3 Total the gross earned income.
Subtract 65 plus ½ the remainder***

Step 4 Add the total countable unearned income and countable earned income.

Step 5 Deduct the personal care needs allowance. Refer to Charts, Z-700.

Note: The reduction of the VA Improved Pension to a maximum of \$90.00 is protected as the personal care needs allowance. Allow \$90 PCN when VA actually reduces the pension to \$90.

H-1041.5 Continued

Step 6 Deduct Medical insurance premiums - Refer to Page 3 of I-1536, Need-SSI Related Income deductions.

Step 7 Deduct any allowance for the community spouse and for dependents living in the home prior to admission. Refer to pages 4 and 5 of I-1536, Need-SSI Related Income deductions. The remainder is the patient liability for the **enrollee**.

If patient liability is:

- Equal to or greater than the facility fee, certify the **enrollee** for Medicaid without vendor payment to the facility or
- less than the facility fee, certify the **enrollee** for Medicaid with vendor payment to the facility. **For LTC Spend-down MNP (type 22)** certifications the start date will be the date as determined in Section D (Eligibility Determination of Need/Countable Income for Individuals over the SIL and Over the Medicaid Facility Rate). The start date, the segment start date and the spend-down date on the form 110-MNP should all be the same date.

H-1041.6 Certification Period

Certification for Spend-down MNP LTC Type 25 may not exceed *twelve (12) months*.

Note:

Although the instructions allow a twelve (12) month certification period, a review of the budget must be completed at six (6) month intervals to determine if the client remains eligible. ECR entries will document case review.

Six (6) month review: Actual projected Medicaid facility fee expenses must be verified prior to establishing a new spend-down period. The projected estimate of facility fees must be reconciled with actual incurred expenses. The facility fee can be reconciled using rates on the Medicaid Eligibility Portal or using MMIS files reflecting amount billed by the provider.

A renewal must be completed on this type case.

Certification for Spend-down MNP LTC Type 22 is limited to 1 month. There is no renewal as this is an open/closed certification.

H-1041.7 Notice of Decision

Send the appropriate notice of decision to the applicant/enrollee.

H-1041.8 Form 110-MNP

A Form 110 MNP will be required for all type 22 certifications.
Refer to H-1031.8 Spend-down MNP - SSI-Related, Form 110-MNP.