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Those Medically Needy individuals who have no spenddown meet the requirement of Medicaid eligibility. Those who meet their spenddowns prior to the need for nursing facility care, have met the requirement of being eligible, through the current POE. After the POE during which nursing facility services begin, the client's situation is treated according to item 3 or 4 below. Those who do not meet their spenddowns prior to the need for nursing facility care are treated according to item 3 or 4 below.

When an applicant is not a recipient of full Medicaid coverage, the following test is made to determine eligibility.

3. Gross Income Test

If the client is not eligible under items 1 or 2 above, Medicaid eligibility may be established as follows:

- Determine the client's gross non-excluded monthly income.

- Compare the income to 300% of the current maximum SSI payment for one person.

To be Medicaid eligible, his income must be equal to or less than 300% of the SSI payment.

Once Medicaid eligibility is established in this manner, the client's contribution toward his cost of care is determined in the post-eligibility process. There is no spenddown amount for persons determined eligible in this way.

EXAMPLE: When the current maximum SSI payment is **$623**, the client's gross, non-excluded monthly income is compared to **$1,869**.

NOTE: SSI-Related Medicaid disability and asset guidelines must be met.

4. SSI-Related Medicaid Test

If the client is not eligible under items 1, 2 or 3 above, his eligibility as an SSI-Related Medicaid client must be explored as another way to receive financial assistance for the cost of nursing facility services.

All policies and procedures in effect for other SSI-Related cases apply to these cases, including the determination of a spenddown amount, if applicable.

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EXCEPTIONS:

- Income is not deemed.

- The MNIL for one person is always used. See Chapter 10, Appendix A.

- The spenddown amount is determined on a monthly basis.

When the client's monthly cost of care exceeds his monthly spenddown amount, the spenddown is assumed to be met and Medicaid eligibility is established. In addition, if his monthly spenddown amount exceeds his monthly cost of care, he may become eligible for Medicaid based on a 6-month POC, but not for payment of nursing facility services.

Case examples of the entire process of determining eligibility and the amount of the client's contribution are found below in item D.

NOTE: Only for cases with a community spouse -- the amount of the spenddown is used only for comparison with the cost of care. It is not used as a part of the client's contribution toward his cost of care as it is for all other nursing facility cases which must meet a spenddown.

D. POST-ELIGIBILITY PROCESS

In determining the client's contribution toward his cost of nursing facility care, the Worker must apply only the income deductions listed below. This is the post-eligibility process. The remainder, after all allowable deductions, is the resource amount, which is at least part of the amount the client must contribute toward his cost of care. The client's spenddown amount, if any, as determined in item C,4 above, is added to this amount to determine the client's total contribution toward his nursing care, except when there is a community spouse. In cases with a community spouse, the spenddown is not added to the computed resource amount. The spenddown is used only to compare to the cost of care to determine eligibility. See item 2 below.

1. Income Disregards And Deductions

Only the following may be deducted from the client's gross, non-excluded income in the post-eligibility process:

a. Personal Needs Allowance

This amount is subtracted from income to cover the cost of clothing and other personal needs of the nursing facility resident. The

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The amount of the deduction is determined as follows for each family member:

Step 1: Subtract the family member's total gross non-excluded income from the minimum SMS. See Chapter 10, Appendix A. If the income is greater than the minimum SMS, no deduction is allowed for that member.

Step 2: Divide the remaining amount by 3, and round the resulting amount up.

EXAMPLE: $201.07 = $202

Step 3: Add together the individual deductions for all family members to determine the total FMA which is deducted from the income of the institutionalized individual.

NOTE: The FMA for each family member must not exceed one-third of the minimum SMS. See Chapter 10, Appendix A.

d. Outside Living Expenses (OLE)

Single individuals and couples, when both spouses are institutionalized, receive a $175 deduction from income for maintenance of a home when a physician has certified in writing that the individual, or in the case of a couple, either individual, is likely to return to the home within 6 months. The amount may be deducted for up to 6 months.

When both spouses are institutionalized, only one spouse may receive the OLE. They may choose which spouse receives the deduction.

e. Non-Reimbursable Medical Expenses

When the client is Medicaid eligible, only as determined in items C,2, 3 or 4 above, certain medical expenses which are not reimbursable may be deducted in the post-eligibility process. Incurred medical expenses, including nursing facility costs (except for nursing facility costs for clients with a community spouse), for which the client will not be reimbursed, are subtracted from his remaining income. When the client becomes eligible for nursing

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facility services after expiration of a penalty period for transferring resources, nursing facility expenses incurred during the penalty period which are non-reimbursable from another source may be used as a deduction. Non-reimbursable means the expense will not be or has not been paid to the provider or reimbursed to the client by any third-party payer, such as, but not limited to, Medicare, Medicaid, private insurance or another individual. The incurred expense must be the responsibility of the client.

The total of all non-reimbursable medical expenses **is entered in RAPIDS. The total amount is not rounded.**

NOTE: For all AG's except those with a community spouse, the amount of the client's spenddown, if any, which was calculated during the eligibility determination process, is treated as a non-reimbursable medical expense and subtracted from the client's income along with any other medical expenses the client may have

(1) Time Limits and Verification Requirements for Expenses

A non-reimbursable medical expense may be permitted only for services provided in the month of application and the 3 months prior to the month of application. This includes nursing facility expenses incurred during a penalty period for transferring resources.

EXCEPTION: A deduction may be given if there is evidence of a payment in the 3 months prior to application, even when the expense was incurred prior to that time.

EXAMPLE: Mrs. C applies for Medicaid for payment of nursing home expenses in October. She obtained a wheelchair in June and made payments in July, August and September. She still owes 10 more payments. The payment may be used as a deduction, even though she purchased it prior to the 3-month period, since there is evidence of a payment in the 3 months prior to application.

EXAMPLE: Same situation as above, except that Mrs. C did not make any payments during July, August or September. Since she did not incur the expense in the 3 months prior to the month of application or the month of application and made no payments during the 3-month period, no deduction is given.

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2. Determining The Client's Total Contribution

Because the amount of medical expenses used to meet the client's spenddown cannot be paid by Medicaid, the spenddown amount becomes part of the client's contribution toward his cost of care.

NOTE: When the client has a community spouse, the spenddown amount is not part of his contribution to his cost of care.

This amount is added to the resource amount determined in item 1 above to determine the client's total monthly contribution toward the cost of his nursing care.

If the client is Medicaid eligible without a spenddown according to items C,2 and C,3 above, the resource amount from item 1 is his total cost contribution.

When the client resides in more than one nursing care facility during the same calendar month, the Worker must determine the portion of the client's cost contribution which must be paid to each facility. The Worker follows the steps below to determine how much of the client's total contribution must be paid to the first facility he entered. If the client's total contribution must be paid to Facility #1, no further calculation is necessary. If not, the amount(s) paid to the other(s) is determined in the same way. The ES-NH-3 is used for notification of the amount due each facility.

Step 1: Determine the client's monthly contribution toward his cost of care.

Step 2: Multiply the number of days the client was in Facility #1 by the per diem rate for the facility. The result is the clients cost of care for this facility for the month.

Step 3: Compare Step 1 to Step 2.

If Step 1 is less than or equal to Step 2, the client's entire contribution toward his cost of care is paid to Facility #1.

If Step 1 is greater than Step 2, the Step 2 amount is paid to Facility #1 and the difference between Step 1 and Step 2 is paid to Facility #2.

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E. EXAMPLES

EXAMPLE: Single Individual with OLE, Categorically Needy

A Pass-Through Medicaid recipient enters a nursing home and wants Medicaid to pay toward his cost of care. He has $1,900/month unearned income. He is a single individual with OLE.

Medicaid eligibility is already established. Even though his income exceeds 300% of the SSI payment level, he is eligible without a spenddown as a Categorically Needy Medicaid recipient. Therefore, only post-eligibility calculations must be performed. The Worker records that the client was a Deemed SSI Recipient prior to nursing care eligibility so that eligibility may be restored if he no longer requires nursing care. Post-eligibility calculations are as follows:

$1,900.00	Client's gross monthly non-excluded income
- 50.00	Personal Needs Allowance
$1,850.00	Remainder
- 175.00	OLE
$1,675.00	Client's resource amount which is also his total contribution toward his cost of care.

EXAMPLE: Single Individual With OLE, Medically Needy

Same situation as above except that the client is not a Deemed SSI Recipient. His Medicaid eligibility must be established as an SSI-Related individual.

	Eligibility
$1,900.00	Income
- 20.00	SSI Income Disregard
$1,880.00	Remainder
- 200.00	MNIL for 1
$1,680.00	Monthly Spenddown

The monthly cost of care in the facility is $2,500. Therefore, his spenddown is met for the month and post-eligibility calculations are performed for any additional contribution he must make.

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Post-Eligibility

$1,900.00	Income
- 50.00	Personal Needs Allowance
$1,850.00	Remainder
- 175.00	OLE
$1,675.00	Remainder
- 93.50	Medicare **Part B** premium (non-reimbursable medical expense)
$1,581.50	Remainder
- 1,680.00	Spenddown (non-reimbursable medical expense)
0.00	Resource Amount

The client has no resource amount, so his total contribution is $1,680, his spenddown amount. The Department will not pay any part of the $1,680 because it is the client's spenddown and he is, by definition, liable for it.

EXAMPLE: Single Individual Without OLE, Medically Needy

Same as above except the client has no OLE. The client's spenddown amount is the same as determined above.

Post-Eligibility

$1,900.00	Income
- 50.00	Personal Needs Allowance
$1,850.00	Remainder
- 93.50	Medicare **Part B** premium (non-reimbursable medical expense)
$1,756.50	Remainder
- 1,680.00	Spenddown (non-reimbursable medical expense)
$ 76.50	Resource Amount

The client's total contribution toward his cost of care is:

$1,680.00	Spenddown
+ 76.50	Resource Amount
$1,756.50	Total Contribution

EXAMPLE: Married Individual Without Community Spouse, Medically Needy

Mr. Smith is married, but has been separated from his wife for 10 years. He has 1 dependent child still living in his home. His monthly income is $1,900. He has non-reimbursable medical expenses of **$93.50** (Medicare **Part B** premium).

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Eligibility

$1,900.00	Income
- 20.00	SSI Disregard
$1,880.00	Remainder
- 200.00	MNIL
$1,680.00	Monthly Spenddown

Post-Eligibility

$1,900.00	Income
- 50.00	Personal Needs
$1,850.00	Remainder
- 93.50	Medicare **Part B** premium (non-reimbursable medical)
$1,756.50	Remainder
- 1,680.00	Spenddown (non-reimbursable medical)
$ 76.50	Resource
+1,680.00	Spenddown
$1,756.50	Total Contribution

NOTE: Mr. Smith is not eligible for the FMA, because there is no community spouse.

EXAMPLE: Married Individual With Community Spouse, Medically Needy

Mr. Holley has the following income:

$1,250.00	RSDI
+ 800.00	Retirement
$2,050.00	Total Income

He has a community spouse who has $585/month RSDI income and $365/month earned income, for a total of $950. His child receives $585/month RSDI.

Eligibility

$2,050.00	Income
- 20.00	SSI Disregard
$2,030.00	Remainder
- 200.00	MNIL
$1,830.00	Monthly Spenddown

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Post-Eligibility

Community Spouse Deduction:	$ 600.00	Shelter
	+ **287.00**	SUA
	$ **887.00**	Total Shelter/Utilities
	- 495.00	30% Min. SMS
	$ **392.00**	Excess Shelter/Utilities
	+ 1,650.00	Min. SMS
	$ **2,042.00**	
	- 950.00	Total gross monthly non-excluded income of Community Spouse
	$1,092.00	CSMA
Family Maintenance Deduction:	$1,650.00	Min. SMS
	- 585.00	Income
	$1,065.00	Remainder ÷ 3 = $355 FMA

$2,050.00	Income
- 50.00	Personal Needs
$2,000.00	Remainder
- **1,092.00**	CSMA
$ **908.00**	Remainder
- 355.00	FMA
$ **553.00**	Remainder
- **158.50**	Medicare premium and doctor bill
$ 394.50	Resource and total contribution toward his care

The client has a **$394.50** resource to contribute to his care. Because there is a community spouse, the spenddown amount determined in the eligibility process is not subtracted as a non-reimbursable medical expense and is not added to the resource to determine his total contribution.