P-2424 Spenddown for ACCS (M421.24)

Medicaid eligibility is based on individual or household income and resources. The net income is compared to the Protected Income Level (PIL). If the individual has income greater than the PIL they may spend excess income on medical expenses to reduce their income to the PIL and become Medicaid eligible under the coverage group known as Medically Needy (M200.3). These expenses can be paid or unpaid medical bills incurred in the current accounting period or past bills that they still due and will not previously used to meet a prior spendown. (M421).

Eligible medical expenses must be deducted from the individual's countable income in the following order.

- Health Insurance (M421.1) (including Medicaid premium if paid by individual)
- Noncovered Medical Expenses – over-the-counter meds (M421.2).
- Covered medical expenses that exceed limitation on the amount, duration or scope of services covered, i.e., physical therapy (M423).
- Covered medical expenses that do not exceed limitations mentioned above which have been incurred in a spenddown period minus third party liability, such as a doctor's visit (M422).
- Covered medical expense means medical items or services that Medicaid would pay for if the person were eligible as a Medicaid recipient.
- assistive community care services (M421.24)

Spenddowns are calculated on a six-month basis. The individual becomes eligible for Medicaid on the 1st day that the allowed medical expenses equal or exceed the spenddown amount.

The exception to this rule is the ACCS applicant who becomes eligible for Medicaid the 1st day of the month of application, providing eligibility shows that the individual will meet his/her spenddown within the six month spenddown period using ACCS expenses. The applicant will become ACCS eligible when the spenddown has been met. See P-2424.

The completed PATH 225A (Verification of Eligibility) will be sent to the individual, a copy will be sent to the level III Residential Care home provider, and a copy for the case file. The PATH 225A VOE will indicate the Medicaid eligibility date, the ACCS eligibility date, and next review date.

Not everyone will have a spenddown, for instance SSI recipients and individuals whose net income is below the PIL, therefore the eligibility start date for Medicaid and ACCS will be the same.

P-2424 Spend-Down (M400's)

Spend-Down is defined at M400. A spend-down period may start with the month of application, any of the three previous months (M113) for which the recipient has unpaid medical bills and meets all other eligibility requirements, or the month of closure. A "spend-down" (or "accounting") period is generally six months (M421) but may be less when a new member joins the household. It always begins on the first of a month regardless of the closure date. (Ex. An ongoing case closes 8/18 due to increased income. The spend-down period begins 8/1.)

In ANFC-related Medicaid, the spend-down is calculated for each individual. See P-2422 E for detailed procedures.

In SSI-related Medicaid, the spend-down is calculated for the assistance group. (M240)

A. Computation of Spend-Down Amount (M422)

1. Determination at Application or Review/Reapplication at end of spend-down period.

   a. Determine the net countable income for each of the six months. Use verified actual income for the months in the past. Estimate future months. See M352.1 and P-2422 D for ANFC-related Medicaid and P-2421 B for SSI/AABD-related Medicaid income determinations.

   b. Determine if any members of the group are subject to one of the federal poverty income guideline tests (see M200, M300, P-2420 B and P-2422 E). If yes, determine if they are eligible under that test. If not, or if no one is subject to one of these tests, proceed to c.

   c. Determine the protected income level for each month in the accounting period. Each month's PIL may vary depending upon the household's size and periodic changes in the PIL amount. (See P-2420 A-B.)

   d. Subtract the total PIL for the accounting period from the same period's income. The balance is the spend-down amount.

   e. Determine if the client meets the spend-down using anticipated medical expenses, bills and/or the Residential Care Home - personal care deduction if appropriate (P-2421 D).

   f. If the spend-down is met, see P-2423 A to grant.

g. If the spend-down is not met, deny or close the case.

Fill in any allowable anticipated medical expenses (see P-2424 B1) on the DSW 214A (Medicaid Spend-Down Record). Give the DSW 214A to the client with the Medicaid Covered Services and Medically Needy Program pamphlets.

P-2424 Spend-Down

1. Computation of Spend-Down Amount (Continued)

If the client has already submitted bills or has anticipated medical expenses, add the following blurb to the notice:

Your household has submitted $_____ in medical expenses which may be used to meet the spend-down.

2. Changes

See P-2422 F#3 for instruction and examples in ANFC-related Medicaid. The following instructions and examples are for SSI-related Medicaid only.

a. When a client reports decreased income or a change in household size, redetermine the spend-down for the same six-month accounting period. (If income increases, do not recalculate the spend-down until the client brings you bills to meet it.) Verify and use actual income for all months in the past. Total the income in the accounting period and compare it to the total PIL for the accounting period. Adjust the spend-down amount or start a spend-down period as appropriate. Send a notice.

If eligibility begins earlier than originally stated on a
DSW 220MP [Notice of Decision (Medicaid Provider)], send a "corrected" DSW 220MP to each provider. If the initial date of eligibility changes, also send a DSW 220MP to those who provided service on that day.

When a client reports a change resulting in a recalculation of the spend-down and the PILs changed during the spend-down period, remember to use the appropriate PILs for the months involved. Do not recalculate using new PILs if a change is not reported by the client.

b. If the client becomes eligible for SSI or ANFC for any of the original six months, redetermine the spend-down by comparing the income and PIL for the months in the original spend-down period during which the recipient was not eligible for ANFC or SSI.

Example #1: SSI-Related Applicant, Retroactive Coverage Requested

Mrs. Spry, 69, applied for Medicaid on April 1. She has hospital bills after Medicare payments, from last January to the present and wants retroactive coverage. Her income is from a private pension fund plus Social Security. She lives outside Chittenden County.

P-2424 Spend-Down (Continued)

A. Computation of Spend-Down Amount (Continued)

2. Changes (Continued)

		Countable Income	PIL for 1
3.	January	780.37 (actual)	683
2.	February	780.37 (actual)	683
1.	March	822.51 (actual)	683
Applied	April	822.51 (estimated)	683
	May	822.51 (estimated)	683
	June	822.51 (estimated)	683
	TOTAL	$4,850.78	$4,098 = $752.78 spend-down

Example #2: SSI-Related Case with a Spend-Down Has Income Change

Mr. and Mrs. Energetic, both over 65, apply for Medicaid on January 27. Their actual countable income in January was $711.44. They are denied due to excess income. Mr. Energetic receives $511.80 Social Security and estimated future additional averaged countable earned income of $225/month. On April 15th Mrs. Energetic reports her husband's job has ended and that she'll receive $50 income in April only.

	1/27		4/15	
	Countable Income	PIL for 2	Countable Income	PIL for 2
January	$ 711.44 actual	683	$711.44 actual	683
February	716.80 est.	683	710.07 actual	683
March	716.80 est.	683	705.03 actual	683
April	716.80 est.	683	541.80 actual	683
May	716.80 est.	683	491.80 est.	683
June	716.80 est.	683	491.80 est.	683
	$4295.44	$4098	$3651.94	$4098

1/27 - $4295.44 B $4098 PIL = $197.44 spend-down
4/15 - $3651.94 B $4098 PIL = $ 0 so eligibility begins January 1 for both Mr. & Mrs. Energetic.

Example #3: SSI-Related Case with Spend-Down Becomes SSI Recipient/PIL Changes

Mr. and Mrs. Granger are both 70 years old and apply for Medicaid on May 3. They live in Chittenden County. Mr. Granger gets $450 a month in Social Security and a pension of $400 a month. With the $20 disregard, their countable income is $830 a month. The PIL for 2 at the time is $733, so they have a spend-down of $582 ($830 B 733 = $97, $97 x 6).

P-2424 Spend-Down (Continued)

A. Computation of Spend-Down Amount (Continued)

2. Changes (Continued)

On August 3 they tell you that Mr. Granger's pension plan has dried up. His last payment was received in June and he began receiving SSI on August 1.

Recalculate his spend-down for May 1 - July 31st and Mrs. Granger's eligibility for May 1 - October 31st. The PIL for 1 or 2 changed to $741 effective July 1.

	May	June	July	Aug.	Sept.	Oct.
Income:	$830.00	$830.00	$430.00	SSI	SSI	SSI
PIL:	$733.00	$733.00	$741.00	$741.00	$741.00	$741.00

Total Income: $2090 (May - July)
Total PIL: $2207 (May - July)
Spend-Down: $ 0

Mr. Granger is eligible May 1.

From May through July Mrs. Granger's household income was $2090. From August to October, her income is 0 because her husband's SSI is not counted. Therefore, her income over the six month period is $2090. Since the PIL for 1 for the same period is $4430 ($733 x 2 plus $741 x 4), she is eligible for the entire period of May 1 - October 31st. Mrs. Granger may also be eligible for SSI, so suggest that she apply.

P-2424 Spend-Down (Continued)

B. Meeting the Spend-Down (M423 and M414)

Medical expenses are deducted from the spend-down amount.

1. Determine what anticipated medical expenses can be used to meet the spend-down.

   a. Health insurance may be allowed if it can be reasonably assumed that the coverage will continue during the accounting period.

   b. Over-the-counter drugs may be allowed if the usage is reasonable (see PP&D facing M430-M439 dated 11/30/88). If the reported usage seems excessive, get a written statement of medical necessity before allowing the deduction.

      These are the only anticipated medical expenses that can be deducted before they are actually incurred.

2. When you receive a DSW 214A Medicaid Spend-Down Record from the client, or when processing bills the client brings, follow these steps:

   a. Verify (where applicable) each expense by matching it with a provider's bill or statement.

   b. If an expense has been billed to insurance, look on the provider's statement or an Explanation of Benefits to see how much insurance paid.

      If Medicare is the insurance and the provider accepts assignment, the client's cost is the balance remaining on the fee schedule cost after Medicare pays its portion. For example, the providers' charge is $70 and the fee schedule says $50. Medicare pays $40 and the client is responsible for $10. Count only the $10 towards the spend-down.

      If the provider does not accept assignment or the insurance is private, the client's cost is the balance remaining after the insurance company pays its portion. For example, if the provider charges $70 and insurance pays $40, the client is responsible for $30.

   c. If the expense is recent and no statement concerning insurance is available yet, see #3 below for estimating

third party liability.

P-2424 Spend-Down (Continued)

B. Meeting the Spend-Down (M423 and M414)

2. You may use SPEC/C/BILLS in ACCESS to record and code medical expenses as stated and numbered in M414 P.2. You may also use a DSW 203B(LTC) (Medicaid Eligibility Worksheet-LTC) or DSW 203B1 (Medicaid Worksheet SSI/AABD Related) or a DSW 203S (Medicaid Spend-Down Worksheet). In ANFC-related Medicaid, use a separate worksheet for each individual spend-down.

3. In ANFC-related Medicaid, the Medicaid group chooses how to apply each expense (including health insurance premiums) to a spend-down. Any group member's expense (or a part of an expense) may be used to meet the spend-down of any group member. Each expense can only be counted once. A final decision on how to allocate bills is not made until the group has enough bills to meet a spend-down for at least one member. Bills actually used to meet a spend-down and make someone eligible cannot be used again.

   Ex. Mom and son each have a spend-down of $300. Mom has a $200 bill from her doctor. Her options are:

   a) All $200 toward her spend-down, or
   b) All $200 toward her son's spend-down, or c) Part of the $200 (for instance, $125) toward her spend-down and the balance ($75) to her son's spend-down.

   She'll make a final decision when she has at least $300 in bills and wants one of them to be eligible. Mom may not apply $200 to her spend-down and the same $200 to her son's spend-down.

4. The date medical expenses, after insurance and third party payments have been subtracted, equal or exceed the spend-down is the first day of the client's eligibility in the spend-down period. Third party liability may be estimated if payments have not been made yet and a history exists of similar payments or you have documentation for your estimate (for example, a call to the provider asking for the usual insurance payment for this procedure or using the Medicaid reimbursement rate).

   a) If the medical expense exceeds the spend-down remaining

on the first day of eligibility, the client can choose which provider to pay or decide to make payments to each provider proportionately.

b) See P-2423 Section A to grant.

5. If the medical expense does not meet the spend-down, see P-2423 Section B for notice.
6. If the spend-down is met at any point within the six-month accounting period:
   a) If the application was a DSW 201 and DSW 202 and the resource test has been met, see P-2423 Section A to grant.
   b) If the application was a DSW/VDH 010B (WIC/Medicaid/Dr. Dynasaur Program Application), and the person who meets the spend-down is subject to but still cannot pass a federal poverty income guideline test, determine resource eligibility. Send a DSW 202 and a DSW 202V with this text:

P-2424 Spend-Down (Continued)

B. Meeting the Spend-Down (M423 and M414)

_____has met a spend-down. In order to determine Medicaid eligibility, I now need information on your family's resources. Answer questions 15-20 on the enclosed DSW 202 (Statement of Need) and sign the last page.

If the person is resource eligible, see P-2423 Section A to grant. If the resource test is failed, send a notice explaining the resource spend-down. If the person does not return the DSW 202, send a DSW 202V2 (see P-2401).

Example #1 Spend-Down Met at Application: Mr. and Mrs. Jones, both 65, applied for Medicaid on January 23rd and do not ask for retroactive assistance. You determine that they have a spend-down of $89. They each pay a Medicare premium of $42.50 per month, which exceeds their spend-down ($85 x 6 = $510). Their date of eligibility is January 1st if they meet all other eligibility tests. [They may choose to meet their spend-down with other expenses and have Vermont pay their Medicare premiums through QMB (Qualified Medicare Beneficiary) if eligible. See P-2441 B.]

Example #2 Spend-Down Met with Health Insurance and Non-Covered Expense: Mr. and Mrs. J.J. Goyea apply for Medicaid on February 1st and have a spend-down of $325. Mr. Goyea is 67 years old and Mrs. Goyea is 55. Mrs. Goyea has a dental bill of $275 for dentures on February 3. Mr. Goyea has Medicare Part B, costing him $42.50 per month or $255.00 for the spend-down period.

$325.00	- spend-down
-255.00	- health insurance
$ 70.00	
-275.00	- non-covered expense
$ 0.00	

The remainder of Mrs. Goyea's denture bill ($205) may be used to meet a future spend-down if it is still unpaid.

Mr. Goyea is eligible for Medicaid from February 1st through July 31st. Because Mrs. Goyea is not aged, blind or disabled, she is not eligible.

Example #3 Spend-Down Met/Potential Prescription Reimbursement: Mr. and Mrs. King, both 75, have a spend-down of $522.00. Their Medicare Part B premiums cost $42.50 per month each, or $510 for the accounting period. On December 1, the first day of their spend-down period, Mrs. King purchased a prescription for $45.00.

$522.00	- spend-down
-510.00	- health insurance
$ 12.00	
- 45.00	- covered expense

$ 0.00

The Kings are eligible for Medicaid effective December 1. Mrs. King does not get reimbursed by Medicaid for the difference between the cost of the prescription and the spend-down amount. She may ask her pharmacist to reimburse her $33.00, and the pharmacist can bill Medicaid for the difference between the amount she is responsible for and the Medicaid fee schedule, but the pharmacist is not required to reimburse her.

P-2424 Spend-Down (Continued)

B. Meeting the Spend-Down (M423 and M414)

Example #4:

Mrs. Longworth and children apply for Medicaid on April 1st. Mr. Longworth provides health insurance for the children, but does not pay any of their medical bills or child support. The spend-down is $153.50 for each person. One of the children was hospitalized from April 15th to April 30th. Income has not changed. You determine that all of her expenses are for covered services and do not exceed limitations.

Since she has no other bills, her total on April 8th toward the spend-down is $164, so the spend-down is met for one person. Mrs. Longworth decides that the child who was hospitalized will be eligible. Her remaining $10.50 in expenses on April 18th will be paid by Medicaid. The other family members still have a spend-down.

Example #5: Applying Expense Sequence in M423 P.2

Medicaid Group:
John and Mary - parents not categorically eligible
Joanne - age 19
Spend-down period - 7/1 to 12/31
Spend-down amount - $697.50

		Expenses
A) Health insurance expenses for all 3 of them (quarterly):	7/31	$144.02
	10/31	$144.02

Total:$288.04

B) Non-covered medical expenses: None
C) Covered medical expenses that exceed limitations: None

P-2424 Spend-Down (Continued)

B. Meeting the Spend-Down (M423 and M414)

Example #5: Applying Expense Sequence in M423 (Continued)

D) Covered medical expenses that do not exceed limitations:

	Expenses
June doctor bills after insurance payment	$ 65.00
June hospital bills after insurance payment	$150.00
June pharmacy bill still outstanding	$ 4.29
7/1 Joanne's hospital bill after insurance	$ 35.00
7/1 Joanne's doctor bill after insurance	$ 15.00
7/2 Joanne's hospital bill after insurance	$ 35.00
7/2 Joanne's doctor bill after insurance	$ 15.00
7/2 John's pharmacy bill after insurance	$ 5.95
7/2 John's doctor bill after insurance	$ 25.00
7/3 Mary's pharmacy bill after insurance	$ 3.05
7/3 Joanne's hospital bill after insurance	$ 35.00
7/3 Joanne's doctor bill after insurance	$ 15.00
7/4 Joanne's hospital bill after insurance	$ 35.00
Total:	$438.29
Total of A, B, C, and D:	$726.33

Since Joanne's spend-down is $697.50 and the bills on July 4 total $726.33, she is eligible on July 4. Medicaid will pay $28.83 of the hospital bill ($726.33 - $697.50) and she is responsible for $6.17 ($35.00 - $28.83).

Example #6: Covered and Non-Covered Expenses Used to Meet Spend-Down

Alice is pregnant, fails the 200% income test, and has a spend-down of $4692.00 for December through May. In March, she sends you several bills which you sort as follows:

	Expenses
A) Health insurance premiums (for six months)	$ 480.00
B) Non-covered medical expenses	
12/7 hearing examination (no insurance coverage)	$ 65.00
3/10 periodontal surgery (no insurance coverage)	$ 595.00
Total:	$ 660.00
Total of A and B:	$1140.00
C) Covered medical expenses that exceed limitations	None

P-2424 Spend-Down (Continued)

B. Meeting the Spend-Down (M423 and M414)

Example #6: Covered and Non-Covered Expenses Used to Meet Spend-Down (Continued)

D) Covered medical expenses that do not exceed limitations

1/1 - 1/10	hospital after insurance payment	$2000.00
1/1 - 1/10	physician bills after insurance payments	$ 900.00
1/1 - 1/10	prescription drugs (no insurance coverage)	$ 400.00
2/5	chiropractic services (no insurance coverage)	$ 150.00
2/17	chiropractic services (no insurance coverage)	$ 75.00
3/1	physician bill after insurance payment	$ 40.00
	Total:	$3565.00
	Total of A, B, C, and D:	$4705.00

Alice meets her spend-down on 3/1. Medicaid will pay $13 ($4705 - $4692) of her physician's bill on 3/1 and she is responsible for $27.