

Department of Public Health and Human Services	Section: HOME & COMMUNITY BASED SERVICES/WAIVER
MEDICAL ASSISTANCE	Subject: Income Budgeting Process for Waiver Individuals

Supersedes: MA 1002-1 (07/01/06); Bulletins MA 82 (11/28/06) and MA 87 (10/29/07)

References: ARM 37.40.1401, .1406-.1408, and 37.82.101

► GENERAL RULE--Home & Community Based Services (HCBS) Waiver applicants and recipients may be either categorically needy or medically needy. The following budgeting policies are to be applied to individuals in the Physically Disabled waiver (WD), Aged waiver (WA), or either of the Developmental Disabilities waivers (WO) without spouses, and with spouses when the spouses are either also enrolled in the HCBS/Waiver program or are institutionalized.

► **NOTE:** HCBS waiver applicants and recipients enrolled in either the Severely Disabling Mental Illness (SDMI) or Psychiatric Residential Treatment Facility (PRTF) waivers (WM) must qualify for Medicaid through non-waiver policies in order to qualify for those waivers. Budgeting methods in the 600 section of this manual apply to SDMI and PRTF waiver recipients.

CATEGORICALLY NEEDY ELIGIBILITY DETERMINATION Use the following calculation to determine whether a waiver applicant or recipient is eligible for categorically needy coverage:

	Unearned income
-	<u>General income disregard</u>
=	Countable unearned income
	Earned income
-	Balance of general income disregard
-	<u>\$65 work expense disregard</u>
=	Remainder
-	<u>One-half remainder</u>
=	Countable earned income
	Countable unearned income
+	<u>Countable earned income</u>
=	Total countable income
-	<u>Categorically needy income standard for one</u>
=	Balance

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If balance is:

1. \$0 or less, client is eligible for categorically needy coverage; or
2. More than \$0, client must be reviewed for medically needy eligibility.

If the applicant/recipient is determined to be categorically needy and has dependent family members, no income allowance will be calculated, because there is no remainder (incurment) from which to deduct the allowance.

MEDICALLY NEEDY ELIGIBILITY DETERMINATION

Use the following calculation to determine whether a waiver applicant/recipient is eligible for medically needy coverage:

$$\begin{array}{r}
 \text{Unearned income} \\
 - \text{General income disregard} \\
 \hline
 = \text{Countable unearned income} \\
 \\
 \text{Earned income} \\
 - \text{Balance of general income disregard} \\
 - \text{Work expense disregard(s)} \\
 \hline
 = \text{Remainder} \\
 \hline
 \text{One-half remainder} \\
 \hline
 = \text{Countable earned income} \\
 \\
 \text{Countable unearned income} \\
 + \text{Countable earned income} \\
 \hline
 = \text{Total countable income} \\
 - \text{Medically needy income limit for one} \\
 - \text{Medically needy income deduction (MA 002)} \\
 \hline
 = \text{Incurment}
 \end{array}$$

TEAMS

Categorically needy or medically needy determination and incurment will be calculated by TEAMS in a manner similar to other Medicaid programs, using the WABD (Waiver Benefit Determination) screen. If the case is medically needy with an incurment, the INCU (Incurment) screen will also be used.



EXCEPTION: Because there is no “WM” subtype available on APMA, and because PRTF and SDMI waiver recipients must qualify for Medicaid through non-waiver avenues, PRTF and SDMI waiver recipients will be registered for non-waiver program types on APMA, and waiver eligibility will be entered on the WACI screen using the “WM” code.

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► **FAMILY
CONTRIBUTION**

If a Medicaid applicant/recipient's family (or anyone else) pays an additional amount directly to the facility to upgrade the person from

**TO ASSISTED
LIVING FACILITY
OR GROUP HOME**

a semi-private to a private room, for a "nicer" room, or for additional food (as examples), the additional charge is considered in-kind income for shelter or food. Assisted living facilities and group homes are not residential medical facilities. (Room and board charges paid to residential medical facilities, such as nursing homes, are considered to be medical expenses.)

PROCEDURE

Responsibility:

ACTION

DSD Field Service
Specialists/HCBS Case
Management Team

1. Notify the County Office of Public Assistance, using form DD/MA-55, "Entrance/Discharge into Medicaid Home and Community Based Services", that the applicant:

- a. is eligible for WA (Aged Waiver) or WD (Disabled Waiver) services and an opening is available;
- b. has been selected to receive WO (Developmentally Disabled Waiver) services;
- c. has been selected for enrollment in the SDMI or PRTF waiver (WM).

► Mountain Pacific
Quality Health
Foundation

2. For WA, WD, and SDMI waiver individuals only:
 - a. Complete Form MA-61, "Screening Determination"; and
 - b. Provide the OPA and the HCBS Case Management Team with a copy of Form MA-61 indicating whether the client's placement is authorized.

The pre-screening criteria are the same for WA, WD, SDMI and nursing home services. If a client has a pre-screening indicating waiver services are appropriate and subsequently enters a nursing home from the waiver program, the same pre-screening form may be used for the nursing home stay. A client with a valid pre-screening who resides in a nursing home may leave the nursing home and directly enter the waiver program without a new pre-screening as well.

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| Applicant/
Representative | 3. Complete Medicaid application form HCS-245 or HCS-250. Appear for an interview if scheduled; and provide all required verification. |
| Eligibility Case
Manager | 4. If the client meets all non-financial eligibility criteria, complete the Medicaid eligibility determination. |
| Applicant/
Representative | 5. If medically needy with an incurment, complete, sign and return HCS-410 "Declaration of Choice". |
| Eligibility Case
Manager | 6. Enter HCBS/Waiver start date on the TEAMS <u>Waiver Client Information (WACI)</u> screen. |
- ▶ **NOTE:** HCBS/Waiver eligible SSI cash recipients must continue to be coded on APMA with the subtype SA, SD or SB on TEAMS; other WA, WD, or WO waiver participants are to be coded with APMA subtypes of WA, WD or WO, as appropriate. SDMI and PRTF waiver recipients must be coded on APMA under a non-waiver Medicaid subtype, and if eligible, waiver of "WM" is entered on WACI. Coverage dates must be entered on the WACI screens for **all** waiver participants.
7. Notify the following of the eligibility determination including the amount of the incurment obligation, if any:
- a. Aged (**WA**) or Disabled (**WD**) Waiver:
- ▶ (i) applicant; and
(ii) community spouse (if applicable).
- b. Developmentally Disabled (**WO**) Waiver:
- (i) applicant;
(ii) DD case manager; and
(iii) DSD Regional Manager (the billing authority).
8. Notify HCBS/Case Management Team (for WA and WD waiver types only) of the approval of Medicaid and the incurment amount only.
9. Complete the "To Be Completed by County Office" section of DPHHS-DD/MA-055:
- a. return the white copy to the originator; and

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b. retain the yellow copy in the case file.

10. Schedule a financial redetermination for twelve (12) months, if applicable.

NOTE: HCBS/Waiver clients need not be re-evaluated for level of care needs at the time of financial redetermination.

HCBS Case
Management Team/
DSD Case Manager

11. When a client no longer meets the level of care requirement or leaves the waiver program for other reasons:

- a. discharge the client; and
- b. notify the OPA case manager via DD/MA-055 and MA-061.

Eligibility Case
Manager

12. When a client is discharged from HCBS/Waiver coverage or is determined ineligible for Medicaid:

- a. enter HCBS/Waiver end date on the TEAMS WACI (Waiver Client Information) screen;
- b. close the case, if appropriate, after completion of an ex parte review. Timely notice of closure of Medicaid is required.

NOTE: HCBS/Case Management Team or DSD are responsible for notifying the client of termination of waiver services. OPA is only responsible for notification of closure of Medicaid benefits or changes to incurment amounts.

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