CHAPTER 23-001 – AABD/MA BUDGETING AND SPOUSAL IMPOVERISHMENT BUDGETING

23-001.01 Alternate Living Arrangements: The standard of need for alternate living arrangements is a consolidated allowance for items necessary for basic subsistence. Included in this standard are:

1. Board;
2. Room;
3. Clothing;
4. Personal needs;
5. Laundry;
6. Transportation; and
7. Medical and remedial services (Note: The consolidated standard of need for board and room [see 477 NAC 23-001.03] includes items 1 through 6 but does not include remedial services)

23-001.02 Licensing of Facilities: In determining the appropriate standard to be allowed, the current licensure/certification of the facility shall be verified. If the facility is covered under more than one licensure/ certification, it shall be verified in which section the client is residing and which licensure/certification applies.

Nebraska law directs DHHS and other public and private agencies that arrange and supervise living arrangements to report any facility which is not currently licensed and serves more than three individuals. Central Office, Aged and Disabled Services, must be contacted if an unlicensed facility is identified.

23-001.03 Board and Room: Board and room does not include care or supervision and may be with a relative.

In addition to the actual amount of board and room paid, the client is allowed a personal needs allowance. The total allowance must not exceed the standard for Board and Room, see 477-000-044.

23-001.04 Standards and Allowances for Clients in Various Facilities

23-001.04A Licensed Assisted Living Facility: An Assisted Living facility provides accommodation and board and care (e.g., personal assistance in feeding, dressing, and other essential daily living activities) for four or more individuals not related to the owner, occupant, manager, or administrator. These individuals are unable to sufficiently or properly care for themselves or manage their own affairs because of illness, disease, injury, deformity, disability, or physical or mental infirmity.

Individuals residing in Assisted Living facilities do not require the daily services of licensed, registered, or practical nurses. However, staff in an assisted living facility may assist the individuals residing there in taking routine oral or external medication and also provide for storage and handling of the medication.

The monthly standard for an Assisted Living Facility includes an allowance for personal needs of the client. See 477-000-044 for the payment standard.

23-001.04B Certified Adult Family Home: An Adult Family Home is a residential living unit which provides full-time residence with minimal supervision and guidance to not more than three individuals age 19 or older. Service includes board and room with meals, standard furnishings, equipment, household supplies, and facilities to ensure client comfort. These individuals are essentially capable of managing their own affairs but are in need of supervision. This may include supervision of nutrition by the facility on a regular, continuing basis, but not necessarily on a consecutive 24-hour basis.

The monthly standard for an Adult Family Home includes an allowance for personal needs of the client. See 477-000-044 for the payment standard.

23-001.04C Licensed Group Home for Children and/or Child Caring Agency (Formerly Group Homes for the Mentally Retarded): This group care facility provides 24-hour accommodation for minors including care and supervision. The home provides services to two or more individuals who are developmentally disabled.

The monthly standard for a Licensed Group Home for Children or a Child Caring Agency includes an allowance for personal needs of the client. See 477-000-044 for the payment standard.

23-001.04D Licensed Center for the Developmentally Disabled: A center for the developmentally disabled is any facility, place, or building not licensed as a hospital which provides accommodation, board, training, and other services when appropriate, primarily or exclusively, for four or more persons who are developmentally disabled.

Staff in a center for the developmentally disabled may assist individuals residing there in taking routine oral or external medication and also provide for storage and handling of the medication.

The term "center" includes:

1. Group Residence - Any group of rooms located within a dwelling and forming a single habitable unit with living, sleeping, cooking, and eating facilities for 4 through 15 developmentally disabled persons.
2. Institution for the Developmentally Disabled - Any facility other than a skilled nursing facility or an intermediate care facility I or II where 16 or more developmentally disabled persons reside.
3. The monthly standard for a Licensed Center for the Developmentally Disabled includes an allowance for personal needs of the client. See 477-000-044 for the payment standard.

23-001.04E Long Term Care Facility: The payment to a long term care facility includes an allowance for personal needs of the client which is determined by the licensure or certification of the facility where the client resides, see 477 NAC 23-001.01.

This facility may be considered for all alternate care standards. The maximum amount allowed is the Assisted Living standard, see 477-000-044. For a client living in a care facility, see 477 NAC 23-001.15E.

23-001.04F Assisted Living Waiver: See 477-000-028 and 477-000-012 for the standard for an individual receiving Assisted Living Waiver services. The monthly standard includes an allowance for personal needs of the client.

23-001.04G Licensed Mental Health Center: Mental health center means a facility where shelter, food, counseling, diagnosis, treatment, care, or related services are provided for a period of more than 24 consecutive hours to persons residing at the facility who have a mental disease, disorder, or disability.

23-001.05 AABD/MA continuation for SSI clients: The standard of need is used for independent living and shelter costs or the consolidated standard for alternate living when SSI notifies the agency that the client will continue to receive full SSI payment for up to three months because the individual is likely to return to his/her previous living arrangement. The procedures in 477 NAC 23-001.15E are followed for allowing shelter and/or utilities when:

1. SSI reduces or terminates the payment at the end of the three-month extension;
2. SSI determines that the client does not qualify for the full benefit for the three-month period; or
3. The client was not receiving SSI before admission to the medical facility.

If the client is in a hospital (or receiving acute hospital care) or licensed alcohol/drug treatment center, standard of need must be used which most accurately reflects the client's living arrangement.

23-001.06 Buy-In of Part B: A client is eligible for state payment of Medicare Part B premium (buy-in) if his/her income is equal to or less than 100% of the federal poverty level.

For Medicare beneficiaries, see 477 NAC 24-002.

Note: If a client in an alternate care facility goes to a care facility, the alternate care standard must continue to be budgeted until it is apparent that the client will not return to the alternate care facility (not to exceed two months). If the client remains in the care facility beyond two months, Central Office approval is required in order to continue using the alternate care standard.

23-001.07 Medical Budgeting for AABD/MA

23-001.07A Medical Budget: A medical budget or system must be used to determine eligibility for Medicaid and Medicaid share of cost cases. If at any time factors change that affect the budget, the budget must be re-computed.

If the parent(s)' income has been deemed to the child, the medical expenses (including insurance premiums) of the parent(s) and any siblings for whom the parent(s) is responsible for paying medical expenses may be applied to the child's share of cost.

23-001.07B Spousal Impoverishment Medical (SIMP) Budget: A SIMP budget is required for an eligible spouse in a specified living arrangement and an ineligible spouse in the community:

1. SIMP budget is used to calculate the amount of income (if any) to be allocated from the eligible spouse to the ineligible spouse and/or family members.
2. SIMP budget is used to calculate eligibility for Medicaid only or Medicaid with share of cost for the eligible spouse

23-001.07C Standard Levels: When computing a medical budget, the following individuals are considered in determining the unit or family size:

1. Client; and
2. Spouse.
3. The applicant/spouses minor child(ren) residing in the household.

When computing a budget, only the client is considered in determining the medically needy or Federal Poverty income level.

If the client is in a hospital (or receiving acute hospital care) or licensed alcohol/drug treatment center, the standard of need shall be used which most accurately reflects the client's living arrangement.

When computing a medical budget, the following steps are used to determine if the client is eligible for MA only or MA with excess:

1. Compare the client's net income to the percent of the Federal Poverty Level (FPL) (see appendix 477-000-012). If the client's income is equal to or less than the FPL, the client is eligible for MA only. If the client's income is more than the FPL, go to step 2 to determine the amount of Share of Cost. For clients in long term care, go directly to step 2.
2. Subtract the medically needy income level from the client's net income to determine the amount of Share of Cost (see 477-000-045).

When a client enters long term care, the standard is not reduced to the long term care level or Assisted Living Waiver level until the first full month that the client resides in long term care.

23-001.08 Disregards for Medical budgets: In addition to disregards outlined in 477 NAC 20-001, the following disregards are allowed:

23-001.08A Medical Insurance Disregards: The cost of medical insurance premiums is deducted if the client or responsible relative is responsible for payment. The Medicare Part B premium which the client or responsible relative is responsible for paying is included in this disregard. Exception: The cost of premiums for income-producing policies is not allowed as a medical deduction.

23-001.08B Guardianship/Conservator Fee: The expense of a guardian or conservator fee is allowed as paid, up to a maximum of $10 per month. If the guardian/conservator is required by the court to purchase a bond and file an annual report with the court, the amount allowed by the court for expenses (in excess of $120) may also be disregarded.

23-001.08C Clients in LTC Facility or Receiving Assisted Living Aged and Disabled Waiver Services: In addition to the maintenance allowance for long term care or the standard for Assisted Living, the following expenses are deducted:

1. Cost of homeownership or rent expense, including utilities up to six months. The allowances must not exceed the maximum shelter amount for one (see 477-000-044) if the client does not have a spouse.
2. Guardian or conservator fee as paid, up to a maximum of $10 per month. If the guardian/ conservator is required by the court to purchase a bond and file an annual report with the court.

23-001.08D Budgeting Individuals in Long Term Care for Three Continuous Months: Use non-SSI budgeting procedures for individuals in long term care when SSI does not make a change in living arrangement at the end of three full continuous months and income exceeds the FBR for a single individual in an institution (see 477-000-037).

23-001.08E Client Living in a Care Facility: The budget of a client living in a care facility shows:

1. The standard of need; and
2. An amount up to $10 when the client has a guardian or conservator who requests a fee (see 477 NAC 23-001.15B).

The expense of home ownership and/or utilities may be allowed only until it is apparent that the client cannot live there again (not to exceed six months).

The budget may allow for the expense of rent and/or utilities for up to six months. The total time for either allowance shall not exceed six months. The allowances must not exceed the maximum shelter amount for on (see 477-000-044) if the client does not have a spouse.

Exception: See 477 NAC 23-001.12 for budgeting a client who continues to receive full SSI benefits for up to three months.

Note: If a client in an alternate care facility goes to a care facility, the budget must continue to allow the alternate care standard until it is apparent that the client will not return to the alternate care facility (not to exceed two months). If the client remains in the care facility beyond two months, Central approval is required to continue using the alternate care standard.

23-001.09 Income When the Eligible Spouse Is in a Specified Living Arrangement and the Ineligible Spouse and/or Family Member(s) Is in the Community:

23-001.09A Definitions

23-001.09A1 Community Spouse: A spouse who is:

1. Not applying for or receiving assistance;
2. Not residing with the alternate care spouse unless the alternate care spouse is in the home and eligible for Home and Community-Based Waiver Services; and
3. Not in a hospital, skilled nursing facility, intermediate care facility, or intermediate care facility for persons with a developmental disability.

23-001.09A2 Family Members: Minor children residing with a community spouse, or dependent parents or siblings of the community spouse or alternate care spouse who reside with the community spouse and could be claimed as dependents for tax purposes.

23-001.09A3 Maintenance Allowance: The amount deducted from an alternate care spouse's income to meet the maintenance needs of the community spouse and family members.

23-001.09A4 Maintenance Need Standard: The income standard to which the community spouse's and other family members' income is compared for the purpose of determining the amount of allowance which may be made from the alternate care spouse's income.

23-001.09B Allocation of Income: When computing the Medicaid budget for an alternate care spouse in a specified living arrangement, only his/her income (SIMP budget) is considered. Income of a community spouse is not considered available to the alternate care spouse. Some of the income of the alternate care spouse may be allocated to the community spouse and/or family members to bring their income up to a minimum monthly amount. The amount which may be allocated is computed on the SIMP budget. If the community spouse does not provide verification of his/her income, SIMP budget is not used. A Medical budget would be used for the client and no allocation of the client's income would be made to the community spouse.

When allocated allowances are not made available to the community spouse, these allowances shall not be deducted from the client's income on side one of the SIMP budget. The allowances for other family members shall be deducted, even if the institutionalized spouse does not make these allowances available to the family members.

The alternate care spouse must be residing in one of the following living arrangements for these special budgeting procedures to apply:

1. A long term care facility;
2. An Adult Family Home;
3. A Licensed Assisted Living Facility;
4. A Center for the Developmentally Disabled; or
5. Receiving services in a Home and Community Based Service Waiver or PACE.

If the spouse no longer meets the definition of a community spouse spousal impoverishment budgeting stops the first month possible.

Budgeting procedures apply beginning with the month an eligible spouse enters a specified living arrangement (even if it is a partial month) and cease with the first full mnoth the alternate care spouse is no longer in a specified living arrangement. An assessment and designation of resources shall be completed.

The community spouse or other family member shall not be on assistance if s/he is included in this budgeting procedure. They may be eligible in their own right, but may choose not to apply if this is to their benefit.

23-001.09C Determining Ownership of Income: All income must be verified to determine the amount of the income and the individual in whose name the income is received.

1. If payment is made in the name of both spouses, half is considered available to each spouse.
2. The income shall be divided by the number of payees if payment is made in the name of one or both spouses and a third party.
3. Only the spouse's proportionate share is considered available to him/her.
4. If income is paid to one spouse and a third party but the verification reveals that the income is intended for both spouses, both spouses shall be included in the division to determine the proportionate share.

If income does not specify either spouse, one-half of the amount is considered available to each spouse.

The client may appeal the assumption of ownership of income.

23-001.09D Determining the Family Member's Maintenance Need Standard:

1. Takes the percent of the Federal Poverty Level (477-000-012);
2. Subtracts the family member's gross income; and
   Note: SSI is included as income.
3. Divides the result by 3.

A separate calculation is completed for each family member. This is calculated on the SIMP budget.

23-001.09E Determining the Spousal Maintenance Need Standard:

1. Takes the percent of the Federal Poverty Level (477-000-012); and
2. Adds excess shelter costs, if any.

Excess shelter cost is the amount by which the rent or cost of home ownership (e.g. mortgage, taxes, insurance and cooperative/condominium maintenance fees) plus a utility standard exceed the prescribed shelter limit.

The utility standard shall be allowed even if utilities are included in the rent.

Shelter costs shall not be prorated even if someone lives with the community spouse.

If the community spouse is paying board and room, the food stamp allotment for one is subtracted from the actual board and room paid to determine shelter. See 477-000-044 for the utility standard and the shelter limit. This is calculated on the SIMP budget.

23-001.09F Income Provisions: All income is included in the calculation, including SSI and income of minors.

If the primary income, RSDI, SSI, earnings, etc., is equal to or exceeds the maintenance need standard, other income does not need to be verified.

If income is $10 or less for anyone, it does not need to be verified.

23-001.09G Budgeting the Alternate Care Spouse: The following is deducting amounts from the alternate care spouse's net earned and unearned income in computing the alternate care spouse's budget:

1. MNIL or FPL level (477-000-012);
2. Guardian/Conservator fee;
3. Amount allocated to the community spouse and/or family member(s);
4. Medicare premium and/or health insurance premium. If the couple has a combined health insurance premium, one-half of the amount is allowed on the client's budget.

This is calculated on the SIMP budget.

23-001.10 Computation of Net Income for AABD/MA:

23-001.10A Income Disregarded: Income disregarded for the AABD/MA client is not considered in determining the eligibility of or the amount of assistance for the client or any other individual.

Savings from disregarded income are considered the same as assets accumulated from any other source.

23-001.10B Income Taxes Paid: Income taxes that must be paid on unearned income are not deducted from the income for budgeting purposes.

23-001.10C Garnishments and Overpayments: See definition at 477 NAC 20-001.25

Exception: The amount after deduction of the overpayment is used if the client received both AABD/MA and the other benefit at any time during which the overpayment occurred and the overpaid amount was included in the AABD/MA budget.

23-001.10D Offset of Earnings: If a client has a combination of farm, self-employment, and regular earned income, a loss from one source of income may be used to offset a gain from another source.

23-001.10E Prospective Budgeting: The most recent three months' actual income must be averaged to arrive at the gross income amount for the income period. Income is converted for weekly and bi-weekly income.

This figure is used to project medical eligibility for the next 12 months unless:

1. There was a significant change in the income of the previous three months; or
2. A significant change is anticipated during the projected 12-month period. When income fluctuates, an average of income must be used for the three most recent consecutive months.

When income is stable, one month's income must be used.

When income fluctuates, the three most recent consecutive months must be used.

23-001.10F Medical Budget Periods: The medical budget is normally computed on a monthly basis. See 477-000-009 for procedures.

23-001.10G Procedures for Change: It must be determined if the change(s) affects Medicaid eligibility.
If it does:

1. Compare resources to the resource limit;
2. Compare the income to the medically needy income level;
3. Determine eligibility based on the household composition;
4. Recompute the budget; and
5. Send an adequate and/or timely notice of change.