DEPARTMENT OF HEALTH CARE FINANCE

NOTICE OF PROPOSED RULEMAKING

The Director of the Department of Health Care Finance (DHCF or the Department), pursuant to the authority set forth in An Act to enable the District of Columbia (District) to receive federal financial assistance under Title XIX of the Social Security Act for a medical assistance program, and for other purposes, approved December 27, 1967 (81 Stat. 744; D.C. Official Code § 1-307.02 (2016 Repl. & 2019 Supp.)), and Section 6(6) of the Department of Health Care Finance Establishment Act of 2007, effective February 27, 2008 (D.C. Law 17-109; D.C. Official Code § 7-771.05(6) (2018 Repl.), hereby gives notice of the intent to adopt amendments to Chapter 95 (Medicaid Eligibility), Chapter 98 (Financial Eligibility for Long Term Care Services), and Chapter 101 (Services My Way Program) of Title 29 (Public Welfare) of the District of Columbia Municipal Regulations (DCMR).

The rulemaking adds new Sections 9515 (Medically Needy) and 9516 (Spend Down for Medically Needy Coverage); amends Sections 9804 and 9899; and amends Section 10107 of Title 29 DCMR.

DHCF is the single state agency responsible for the administration of the State Medicaid program under Title XIX of the Social Security Act (the Act) and Children's Health Insurance Program (CHIP) under Title XXI of the Act in the District. This proposed rulemaking amends Chapter 95 of Title 29 DCMR by incorporating new sections that detail the medically needy eligibility group and the spend down process and requirements pursuant to Section 1902(e)(14)(D)(i) of the Act (42 USC § 1396a(e)(14)(D)(i); 42 CFR §§ 435.300–435.350, 435.831).

This rulemaking provides clarity and consistency in the District's methods and procedures for determining Medicaid eligibility for medically needy applicants and beneficiaries that wish to obtain medically needy Medicaid eligibility through spend down. Medically needy is a federally established category that extends Medicaid coverage to certain individuals with high medical expenses whose income exceeds the maximum income for their eligibility category, but who would be otherwise eligible for Medicaid. These individuals therefore must spend down their income in order to meet medically needy Medicaid eligibility. Although the District has medically needy spend down requirements in place, the medically needy spend down policies are not formally included in a single rule.

This rulemaking provides the first comprehensive set of standards for eligibility and the spend-down process. This rulemaking sets forth the budget periods and the calculation the Department uses to determine an individual's spend down obligation, and the process the Department uses to determine the start date of an individual's Medicaid eligibility. This rulemaking also defines the types of expenses that an individual may use to meet his or her spend down obligation, and the requirements for beneficiaries to maintain medically needy Medicaid coverage through spend down. The following eligibility categories shall be eligible for medically needy spend down if they are over the applicable income limit and have met other financial, non-financial, and medical and functional (if applicable) eligibility requirements: (1) medically needy parents and

caretaker relatives; (2) medically needy individuals under age nineteen (19); (3) medically needy individuals aged nineteen (19) or twenty (20); (4) medically needy pregnant women; and (5) individuals that are aged sixty-five (65) or older, blind or disabled.

An applicant or beneficiary shall first meet all financial, non-financial, and medical (if applicable) eligibility factors before an applicant or beneficiary may be eligible for medically needy spend down. Applicants may use incurred medical and remedial care expenses and incurred institutional expenses in order to meet their spend down obligation. Once an applicant has met the spend down obligation for his or her respective budget period, DHCF shall determine that the individual is eligible for Medicaid for the remainder of their spend down budget period. DHCF considered developing an amendment to the District's State Plan for Medical Assistance (SPA) to obtain authority to accept expenses incurred earlier than the third month before the individual's month of application, pursuant to the requirements set forth under 42 CFR § 435.831(g)(2). However, DHCF plans to codify its current policies on medically needy spend down without a State Plan Amendment (SPA) in the interim to study how beneficiaries experience the process, and to potentially develop a SPA in the future.

The Director gives notice of the intent to take final rulemaking action to adopt this proposed rulemaking not less than thirty (30) days from the date of publication of this notice in the *D.C. Register*.

Chapter 95, MEDICAID ELIGIBILITY, of Title 29 DCMR, PUBLIC WELFARE, is amended by adding new Sections 9515 and 9516 as follows:

9515 MEDICALLY NEEDY

9515.1 This section establishes the conditions of medically needy eligibility for individuals, identified in Subsection 9515.3, who have income in excess of District Medicaid or Medicaid Waiver standards at the time of application, renewal, or redetermination.

9515.2 The medically needy eligibility category shall be subject to the spend down provisions of Section 9516 and all other requirements applicable to District of Columbia Medicaid or Medicaid Waiver programs, including but not limited to, application requirements set forth under Section 9501, and Chapters 19 and 42 (as applicable) of Title 29 DCMR, and DHCF policy.

9515.3 The following Modified Adjusted Gross Income (MAGI) eligibility coverage groups may be eligible for District Medicaid under this Section:

(a) Parents and caretaker relatives with household income above the amount determined in accordance with Subsection 9506.2;

(b) Individuals under age nineteen (19) with household income above the amount determined in accordance with Subsection 9506.6;

(c) Individuals aged nineteen (19) or twenty (20) with household income above the amount determined in accordance with Subsection 9506.7; and

(d) Pregnant women with household income above the amount determined in accordance with Subsection 9506.3.

9515.4 Individuals that are sixty-five (65) or older, blind or disabled with household income above the amounts determined in accordance with Section 9511 of this chapter and have resources at or below the Supplemental Security Income (SSI) resource levels of four thousand dollars ($4,000) for an individual and six thousand dollars ($6,000) for a couple may be eligible for District Medicaid under this section. This eligibility coverage group includes individuals applying for or receiving long-term services and supports.

9515.5 MAGI and non-MAGI eligibility coverage groups identified at Subsections 9515.3 and 9515.4 shall meet the following non-financial eligibility criteria, where applicable, as a condition of medically needy Medicaid or Medicaid Waiver eligibility:

(a) Non-financial categorial requirements as identified at Subsection 9506.9, which are as follows:

(1) District residency pursuant to 42 CFR § 435.403;

(2) Provision of a Social Security Number (SSN) or proof of exemption pursuant to 42 CFR § 435.910 and Subsection 9504.7; and

(3) U.S. citizenship or nationality, or satisfactory immigration status;

(b) Non-financial technical requirements for long-term care services, waiver services, or to establish medical or functional level of need as follows:

(1) Federal requirements set forth under 42 USC § 1382c for individuals that are aged sixty-five (65) or older, blind, or disabled;

(2) Non-financial requirements set forth under Chapter 19 for individuals applying for services under the Home and Community Based Services (HCBS) Waiver for Individuals with Intellectual and Developmental Disabilities (ID/DD);

(3) Non-financial requirements set forth under Section 989 for individuals applying for services in nursing facilities;

(4) Non-financial requirements set forth under Chapter 41 for individuals applying for services in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID); and

(5) Non-financial requirements set forth under Chapter 42 for individuals applying for services under the HCBS Waiver for Persons Who Are Elderly and Individuals with Physical Disabilities (EPD).

9515.6 When applying for Medicaid, applicants shall comply with the application requirements set forth under Section 9501 of this chapter, and individuals applying for or enrolled in the HCBS Waiver programs under Subsection 9515.4(a) shall also comply with the application requirements set forth under Chapters 19 and 42 (as applicable for the HCBS Waivers for ID/DD and EPD, respectively) of Title 29 DCMR, and DHCF policy.

9515.7 After the Department determines that an individual meets all non-financial and medical or functional (if applicable) eligibility factors as described in this section but is over the applicable income limit, the individual may become eligible for medically needy Medicaid through the spend down process, pursuant to the requirements set forth under Section 9516.

9516 SPEND DOWN FOR MEDICALLY NEEDY COVERAGE

9516.1 This section establishes the calculation of spend down and eligibility determination process for medically needy individuals who have income above the income limit for their respective eligibility coverage group, pursuant to the requirements set forth under 42 CFR § 435.831.

9516.2 The spend down process shall not apply to individuals that have resources above the resource limit for their respective eligibility coverage group.

9516.3 Individuals in eligibility groups described in Subsections 9515.3 through 9515.4 with household incomes that exceed the income limit but otherwise meet the eligibility requirements for their coverage group shall submit qualifying incurred medical and remedial expenses in order to qualify for medically needy coverage through spend down. The individual shall submit expenses that may be used as follows:

(a) To fulfill the individual's spend down obligation during a retroactive budget period or prospective budget period, as described in Subsections 9516.8 and 9516.13; or

(b) To be carried forward to fulfill a spend down obligation in a future budget period if any unpaid amount submitted for a previous budget period was unused, subject to the requirements set forth under Subsections 9516.15.

9516.4 The Department shall use budget periods in accordance with Subsection 9516.6 to compute the spend down obligation that an individual must meet in order to be eligible for medically needy Medicaid through spend down. Except for computing the spend down obligation(s) for retroactive medically needy Medicaid coverage as described in Subsections 9516.5 and 9516.8, the initial budget period begins on the first day of the first month an individual applies for Medicaid.

9516.5 An individual may request a separate budget period for retroactive medically needy coverage through spend down for up to three (3) calendar months immediately before the month of application, subject to the requirements set forth under Subsection 9516.8.

9516.6 The Department shall use the following budget periods for individuals who have been determined eligible for medically needy coverage through spend down:

(a) For eligibility groups described in Subsections 9515.3 and 9515.4(a) who are not applying for or receiving long term care services and supports, the Department shall use a one (1) month period to budget the individual's spend down obligation; and

(b) For the eligibility groups described in Subsection 9515.4(a) who are applying for or receiving long term care services and supports, the Department shall use a six (6) month period to budget the individual's spend down obligation.

9516.7 The Department shall use the following process to calculate the spend down obligation for medically needy coverage for an individual who meets one of the eligibility groups under Subsections 9515.3 and 9515.4:

(a) Subtract allowable deductions from the applicant's or beneficiary's gross income, as appropriate, in accordance with the requirements set forth in Section 9511 of this chapter, 42 CFR § 435.831(b)(1)(i), and 42 CFR § 435.831(b)(2), to determine countable income;

(b) Determine the dollar amount of the medically needy income limit (MNIL), as described in Supplement 8a to Attachment 2.6-A, page 2 of the Medicaid State Plan (also found at: https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/DHCFStatePlanAttach2-6aSup8a.pdf), that applies to the applicant's or beneficiary's household size for each month of the budget period as follows:

(1) The MNIL for a household of two (2) or more individuals shall be fifty percent (50%) of the annual Federal Poverty Level (FPL); and

(2) The MNIL for a household of one shall be ninety five percent (95%) of the MNIL for a household of two (2).

(c) Verify that the applicant's or beneficiary's countable income, as determined under Section 9511, exceeds the Medically Needy Income Level (MNIL) in accordance with the methodology described in 42 C.F.R. §§ 435.831(b)(1)(i) or (b)(2);

(d) Calculate the applicant's or beneficiary's spend down obligation as follows:

(1) For individuals using a one (1) month budget period:

Countable income – MNIL = Individual's spend down obligation for the one (1) month budget period; and

(2) For individuals using a six (6) month budget period:

(Countable income – MNIL) × 6 = Individual's spend down obligation for the six (6) month budget period; and

(e) Use documentation of qualifying medical or remedial expenses to determine whether the documented expenses meet the conditions of a qualifying medical or remedial expense pursuant to the requirements set forth in Subsections 9516.10 and 9516.12.

9516.8 If an individual requests retroactive Medicaid coverage pursuant to Subsection 9516.5, the Department shall calculate the retroactive budget period, which shall be considered separately from the prospective budget period, as follows:

(a) Determine the individual's countable income, consistent with the process described in Subsection 9516.7(a). The Department shall only consider the income available to the individual in the month(s) that the individual requests retroactive coverage;

(b) Determine the individual's MNIL using the process described in Subsection 9516.7(b). The Department shall base the MNIL on the month(s) requested for retroactive coverage;

(c) Verify that the applicant's or beneficiary's countable income exceeds the MNIL in accordance with the methodology described in 42 CFR §§ 435.831(b)(1)(i) or (b)(2);

(d) If the requested months of retroactive coverage are consecutive, the individual shall have a choice to either:

(1) Consider each month of retroactive coverage separately to determine a spend down amount for each month using the calculation described in Subsection 9516.7(d)(1); or

(2) Combine the excess income for each month to obtain one spend down amount for the retroactive period using the calculation described in Subsection 9516.7(d)(1). For example, if an individual requests retroactive coverage for two (2) consecutive months and chooses to combine the excess income for each month, the calculation shall be as follows:

(Countable income for month one (1) – MNIL) + (countable income for month two (2) – MNIL) = Individual's spend down obligation for the two (2) month retroactive period;

(e) If the requested months of retroactive coverage are not consecutive, consider each month separately and determine a spend down amount for each month using the calculation described in Subsection 9516.7(d)(1); and

(f) The individual shall have a choice to apply a specific qualifying incurred medical or remedial expense towards a spend down amount for a retroactive budget period, prospective budget period, or both, as long as the expense meets the requirement in Subsection 9516.10(d).

9516.9 The Department shall deduct the following types of qualifying incurred medical or remedial expenses that meet the requirements of Subsections 9516.10 and 9516.12, once the spend down amount is determined:

(a) Medicare and other health insurance deductibles, coinsurance charges, enrollment fees, copayments and premiums;

(b) Medical or remedial expenses for necessary medical or remedial services not included in the Medicaid State Plan or HCBS Waivers;

(c) Medical or remedial expenses for necessary medical or remedial services included in the Medicaid State Plan or HCBS Waivers, which exceed the Department's limitations on amount, duration, or scope of services, as described in Section 3 of the District's Medicaid State Plan, Appendix C of the HCBS Waivers, and corresponding rules; and

(d) Medical or remedial expenses for necessary medical or remedial services included in the Medicaid State Plan or HCBS Waivers which are within the Department's limitations on amount, duration, or scope of services, as described in Section 3 of the District's Medicaid State Plan, Appendix C of the HCBS Waivers, and corresponding rules.

9516.10 To be determined a qualifying incurred medical expense, an expense shall meet the following requirements:

(a) Be a necessary cost incurred by an individual for medical goods or services that meets one of the types of expenses outlined in Subsections 9516.9(a)-(d), and may include, but is not limited to the following types of medical goods and services:

(1) Inpatient hospital services;

(2) Outpatient hospital services;

(3) Laboratory and x-ray services;

(4) Nursing facility services;

(5) Physician services;

(6) Clinic services;

(7) Dental services;

(8) Rehabilitation services;

(9) Durable Medical Equipment (DME); and

(10) Home health services;

(b) Be an incurred expense for which the individual, the individual's family, or the individual's financially responsible relatives, as described in 42 CFR § 436.602, is financially liable;

(c) Not be subject to payment by a third party unless the third party is a State or territory's public program financed by the State or territory, other than the Medicaid program;

(d) Not already be used to meet a spend down obligation for a previous budget period, unless an unused and unpaid portion of an expense is being carried forward consistent with Subsection 9516.3(b); and

(e) Be verified by a prescription, referral, bill, receipt, or written statement regarding the goods or services provided, or through other means of documentation required in DHCF policy.

9516.11 Only applicants and beneficiaries of institutional services described in Subsection 9515.4(a) may use medical institutional expenses (other than expenses in acute care facilities) projected to the end of the budget period at the Medicaid reimbursement rate to meet their spend down obligation, subject to the following conditions:

(a) Only medical expenses that are not subject to payment by a third party may be counted;

(b) Medical expenses shall include expenses that the individual or family or financially responsible relatives, as described in 42 CFR § 436.602, are projected to incur within the six (6) month budget period;

(c) Only medical expenses related to institutional care may be projected; and

(d) Projected medical institutional expenses applied towards an individual's spend down obligation shall be subject to the six (6) month periodic reconciliation of expenses to determine whether spend down was met in accordance with 42 CFR § 435.831(i)(2).

9516.12 To be determined a qualifying incurred remedial expense, an expense shall meet the following requirements:

(a) Be a nonmedical support service cost, that does not pertain, relate, or belong to the study and practice of medicine, or the science and art of the investigation, prevention, cure, and alleviation of disease;

(b) Be a cost that is made necessary by the individual's medical or functional condition and that is directly related to the individual's medical or functional care;

(c) Be a necessary cost for a good or service, consistent with the descriptions in subparagraphs (a)-(b) of this subsection, that meets one of the types of expenses outlined in Subsections 9516.9(a)-(d), and may include, but not be limited to:

(1) Travel costs incurred in order to obtain medical services or supplies; and

(2) Home or vehicle modifications that provide a direct medical or functional benefit and is necessary due to the individual's medical or functional condition;

(d) Be an incurred expense for which the individual, the individual's family, or the individual's financially responsible relatives, as described in 42 CFR § 436.602, is financially liable;

(e) Not be subject to payment by a third party unless the third party is a State or territory's public program financed by the State or territory, other than the Medicaid program;

(f) Not have been used to meet a spend down obligation for a previous budget period, unless Subsection 9516.3(b) applies; and

(g) Be verified by a prescription, referral, bill, receipt, or written statement regarding the goods or services provided, or through other means documented in DHCF policy.

9516.13 Pursuant to 42 CFR § 435.831(f), the Department shall deduct incurred medical and remedial expenses that have not been previously applied in establishing eligibility, based on age of bills as follows:

(a) For the retroactive budget period, paid or unpaid expenses incurred during such period;

(b) For the first prospective budget period that also includes any of the three (3) preceding months, paid or unpaid expenses incurred during such period;

(c) For the first prospective budget period that includes none of the months preceding the month of application, paid or unpaid expenses incurred during such budget period and any of the three (3) preceding months;

(d) For any of the three (3) months preceding the month of application that are not includable under Subparagraph (b) of this subsection, expenses incurred in the three (3) month period that were a current liability of the individual in any such month for which a spend down calculation is made;

(e) Current payments made in the current budget period on other expenses incurred before the beginning of the budget period; and

(f) If the individual's eligibility for medical assistance was established in each such preceding period, expenses incurred before the current budget period, to the extent that such expenses are unpaid and are:

(1) Described in Subsection 9516.9; and

(2) Carried over from the preceding budget period or periods because the individual had a spend down obligation in each such preceding period that was met without deducting all such incurred, unpaid expenses.

9516.14 Pursuant to 42 CFR § 435.831(h)(2), the Department shall deduct incurred medical and remedial expenses in chronological order by the date each service is furnished, or in the case of insurance premiums, coinsurance or deductible charges, the date such amounts are due. Expenses for services furnished on the same day shall be deducted in the following order:

(a) Medical or remedial care expenses for necessary medical or remedial care not included in the Medicaid State Plan;

(b) Medical or remedial care expenses for necessary medical or remedial care included in the Medicaid State Plan, but which exceed the Department's limitations on amount, duration, or scope of services; and

(c) Medical or remedial care expenses for necessary medical or remedial care included in the Medicaid State Plan and which are within the Department's limitations on amount, duration, or scope of services.

9516.15 The Department shall not apply medical and remedial expenses towards an individual's initial spend down obligation if the expenses were incurred more than three months before the month of application, subject to Subsection 9516.13(e).

9516.16 Once the applicant has submitted medical and remedial expenses to the Department to meet the spend down obligation and has met all other Medicaid eligibility factors, as appropriate, the Department shall make an eligibility determination and provide notice in accordance with Subsection 9516.24.

9516.17 For individuals described in Subsections 9515.3 and 9515.4, the Department shall determine the start of the eligibility period as follows:

(a) If the individual's spend down obligation is met on a date within the budget period, eligibility shall begin on the date the spend down obligation is met (which shall be the latest date of service of an expense submitted and approved to meet the spend down obligation for that budget period) and end on the last day of the individual's budget period, unless Subsection 9516.18 applies; and

(b) If the individual's spend down obligation is met using only expenses for services received on a date prior to the budget period, eligibility shall begin on the first day of the first month of the budget period and end on the last day of the individual's budget period.

9516.18 For individuals who are required to contribute a portion of income towards the costs of institutional care or HCBS Waiver services pursuant to the requirements set forth under Section 9804 of Title 29 of the District of Columbia Municipal Regulations (DCMR), the eligibility start date shall be the first day of the budget period if:

(a) The individual's spend down obligation is met after the first day of the budget period; and

(b) Beginning eligibility after the first day of the budget period makes the individual's share of health care expenses under the post eligibility treatment of income rules, as determined under Section 9804 of Title 29 DCMR, greater than the individual has in contributable income.

9516.19 Pursuant to 42 CFR § 435.831(i)(5), expenses used to meet a spend down obligation shall not be reimbursed under Medicaid.

9516.20 In order to obtain Medicaid reimbursement for any remaining portion of an expense that was not used to meet a previous spend down, the expense shall meet the applicable requirements set forth under the District's Medicaid State Plan and applicable laws and regulations.

9516.21 For beneficiaries using a six (6) month budget period, if the individual meets his or her spend down obligation for the first budget period and becomes eligible for medically needy Medicaid, the following shall occur:

(a) The Department shall automatically determine that beneficiary is eligible to qualify for medically needy Medicaid by meeting spend down in accordance with Subsection 9516.7 for a second six (6) month budget period;

(b) The Department shall send a notice that otherwise complies with Section 9508 to the beneficiary sixty (60) days in advance of the end of the first budget period to inform the beneficiary that the beneficiary's medically needy Medicaid eligibility will expire at the end of the current budget period, and the individual must inform the Department of any changes in circumstances that would affect his or her Medicaid eligibility. The Department may also include additional information in the notice as follows:

(1) The beginning and ending dates of his or her next budget period;

(2) The amount of his or her spend down obligation for the next budget period; and

(3) Notice that the individual must submit sufficient qualifying incurred medical and remedial expenses to meet spend down for the next budget period before he or she will regain medically needy Medicaid eligibility.

9516.22 Upon renewal, the Department shall calculate an individual's six (6) month spend down obligation in accordance with the methodology described in Subsection 9516.7, and shall take into account any submitted but unused expenses that can be carried over from a previous budget period, if applicable.

9516.23 For continued medically needy Medicaid coverage through spend down, the following shall occur:

(a) For beneficiaries with a six (6) month budget period:

(1) The Department shall send the beneficiary a notice consistent with Subsection 9516.21(b); and

(2) The Department shall send the beneficiary a renewal form for the beneficiary's completion no later than ninety (90) days prior to the end of the beneficiary's twelfth (12th) month of Medicaid eligibility, as long as the beneficiary has met his or her spend down obligation for both six (6) month budget periods; and

(b) For beneficiaries with a one (1) month budget period, the beneficiary shall continue to meet his or her spend down obligation for each budget period. After the beneficiary's twelfth (12th) month of medically needy Medicaid eligibility, the beneficiary shall submit a new application to the Department, consistent with Subsection 9515.7, in order for the Department to re-determine the beneficiary's Medicaid eligibility.

9516.24 The Department shall provide timely and adequate notice of eligibility and enrollment determinations and the right to appeal to applicants and beneficiaries consistent with the requirements set forth in Section 9508, 42 CFR § 435.917 and other applicable rules.

9516.25 The Department may include additional information in the notice described in Subsection 9516.24 that is not required under federal or District law, which may include but is not limited to the following:

(a) The beginning and end dates of the individual's budget period, as described in Subsection 9516.6;

(b) The beginning and end dates of the individual's eligibility period, which shall be the time period during which spend down has been met (consistent with the requirements set forth under Subsection 9516.17) and the individual is fully eligible for Medicaid;

(c) The individual's spend down obligation, as determined in accordance with Subsection 9516.7, for the individual's corresponding budget period;

(d) Instructions for submitting documentation of expenses consistent with the requirements set forth under Subsections 9516.10(e) and 9516.12(g);

(e) Instructions that the individual may submit documentation for a twelve (12) month period;

(f) The total amount of the acceptable qualifying incurred medical and remedial expenses that the individual has already submitted, if any;

(g) Description of expenses that were submitted but are not acceptable towards the individual's spend down obligation;

(h) An explanation of why any documentation was not acceptable pursuant to the requirements of Subsections 9516.10 and 9516.12, if applicable;

(i) The remaining amount of incurred medical and remedial expenses that is required to meet the individual's spend down obligation; and

(j) The amount of unpaid expenses that may be carried over towards the next budget period.

Section 9599, DEFINITIONS, Subsection 9599.1, is amended to add the following definitions:

Budget Period – The timeframe over which the individual's income is calculated to determine medically needy Medicaid eligibility.

Carry Over Expense – An unpaid, incurred medical and remedial care expense that may be applied towards a spend down obligation in a future budget period(s) if it was incurred within a previous budget period in which spenddown eligibility was established, remains the liability of the individual, and was not fully counted in any previous budget period in which eligibility was met.

Home and Community-Based Services Waiver (HCBS Waiver) Programs – Shall be consistent with the definition set forth under 42 CFR § 440.180.

Incurred expense – An expense for which the individual, the individual's family, or the individual's financially responsible relative is currently financially liable.

Medically Needy Income Level (MNIL) – Fifty percent (50%) of the Federal Poverty Level (FPL) for a household of two (2) or larger; the MNIL for a household of one is ninety-five percent (95%) of that for a household of two, as described in Supplement 8a to Attachment 2.6-A, page 2 of the Medicaid State Plan (also found at:

https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/DHCFStatePlanAttach2-6aSup8a.pdf).

Prospective budget period – The timeframe over which an individual's income is calculated that does not include the retroactive months for which an individual requests retroactive Medicaid coverage.

Retroactive budget period – The timeframe of up to three (3) months preceding the month of application for which an individual's income is calculated.

Spend Down – Spend down is the process by which an individual may use medical or remedial expenses to reduce countable income to the MNIL to meet financial eligibility requirements for Medicaid coverage.

Spend Down Obligation – The monthly amount of the individual's gross countable income which is over the MNIL multiplied by the number of months in the budget period.

Section 9804, POST ELIGIBLITY TREATMENT OF INCOME, of Chapter 98, FINANCIAL ELIGIBILITY FOR LONG TERM CARE SERVICES, is amended as follows:

Subparagraph (f) of Subsection 9804.4 is amended to read as follows:

(f) Incurred remedial expenses, if the expenses are not subject to payment by a third party, including incurred remedial expenses used to meet a spend down obligation;

Section 9899, DEFINITIONS, is amended as follows:

The term "Remedial Care Expenses" in Subsection 9899.1 is amended as follows:

Remedial Care Expenses: Shall have the same meaning as set forth under Chapter 95 of Title 29 DCMR.

Section 10107, PARTICIPANT-DIRECTED SERVICES BUDGET FORMULATION, of Chapter 101, SERVICES MY WAY PROGRAM, is amended as follows:

Subsection 10107.3 is amended as follows:

10107.3 The amount resulting from the calculation described in Subsection 10107.2 shall represent the *Services My Way* participant's monthly PDS allocation amount, which shall be used to compute the participant's PDS budget. If the participant is a medically needy applicant or beneficiary that must spend down income in accordance with Section 9516 of Chapter 95 of Title 29 DCMR to be eligible for Medicaid, the participant's PDS budget shall only be approved for a six (6) month

period, consistent with the participant's spend down budget period, as defined in Section 9516 of Title 29 DCMR.

Comments on these rules should be submitted in writing to Melisa Byrd, Senior Deputy Director/Medicaid Director, Department of Health Care Finance, Government of the District of Columbia, 441 4th Street, N.W., Suite 900, Washington D.C. 20001, via telephone on (202) 442-8742 or via email at DHCFPubliccomments@dc.gov, within thirty (30) days of the date of publication of this notice in the *D.C. Register*. Additional copies of these rules are available from the above address.