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HAWAII ADMINISTRATIVE RULES

TITLE 17

DEPARTMENT OF HUMAN SERVICES

SUBTITLE 12 MED-QUEST DIVISION

CHAPTER 1721

MEDICAL ASSISTANCE TO

AGED, BLIND, OR DISABLED INDIVIDUALS

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SUBCHAPTER 1

GENERAL PROVISIONS

§17-1721-1 Purpose. The purpose of this chapter is to establish the categorical and financial eligibility requirements for the medical assistance programs for aged, blind, or disabled individuals. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §§435.120, 435.230, 435.300, 435.301)

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§17-1721-2 Definitions. For the purpose of this chapter:

"Categorically needy" means aged, blind, or disabled individuals:

- (1) Who are otherwise eligible for medical assistance and who meet the financial eligibility requirements for SSI or SSP or are considered under section 1619(b) of the Social Security Act to be SSI recipients; or
- (2) Whose categorical eligibility is protected by statute.

"Community" means the place of residence of an individual receiving long-term care services that is not a nursing facility or a medical facility.

"Community care foster family home" is a home that is certified by the department to provide a resident twenty-four hour living accommodations and home and community based services.

"Community spouse" is the spouse of an institutionalized individual who is not residing in a medical facility or nursing facility.

"Cost share" means the share of monthly medical expenses for long-term care services for an institutionalized individual who is subject to post-eligibility treatment of income.

"Cost-sharing related to Medicare Part D" means any premiums, deductibles, co-payments, co-insurance, and any cost incurred within the Part D coverage gap.

"Dependent family member" means the child, parent, or sibling of an institutionalized individual who is residing with the community spouse, or in the home of the institutionalized individual if there is no community spouse, who may be claimed as a tax dependent under the Internal Revenue Code by the institutionalized individual or the spouse of the institutionalized individual.

"Domiciliary care facility" means a licensed adult residential care facility which provides twenty-four hour living accommodation, personal care services, and appropriate medical care to adults by persons unrelated to the recipient. A treatment facility providing rehabilitative treatment services shall not be a domiciliary care facility.

"Family" means any persons requesting or receiving medical assistance, any legally responsible parents or

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spouses, and any other legally responsible persons residing in the same household.

"FPL" means the federal poverty levels that are issued by the United States Department of Health and Human Services used to determine eligibility for medical assistance programs.

"Home and community based services" or "HCBS" means long-term care services provided to an individual residing in a community setting who is certified by the department to be at nursing facility level of care and would be eligible for care provided to an individual in a nursing facility or a medical facility receiving nursing facility level of care.

"Income" means any monies received by an individual or family during a given month.

"Institutionalized individual" means an individual who is or is likely to be an inpatient at a medical facility receiving nursing facility level of care, or an inpatient at a nursing facility for a continuous period of institutionalization, or a recipient of home and community based services.

"Likely to remain" means that the attending or admitting physician, or the department or its designee, indicates that the individual is expected to reside in a nursing facility or a medical facility receiving nursing facility level of care for at least thirty consecutive days.

"Long-term care services" means services provided to an inpatient in a medical facility receiving a nursing facility level of care or to a resident of a nursing facility, or home and community based services provided for individuals residing in a community setting.

"Medical facility" means a facility which:

- (1) Is organized to provide medical care, including nursing and convalescent care;
- (2) Has the necessary professional personnel, equipment, and facilities to manage the medical, nursing, and other health needs of the patients on a continuing basis in accordance with accepted standards;
- (3) Is authorized under State law to provide medical care; and
- (4) Is staffed by professional personnel who have clear and definite responsibility to the

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institution in the provision of professional medical and nursing services including adequate and continual medical care and supervision by a physician; sufficient registered nurse or licensed practical nurse supervision and services and nurse aid services to meet nursing care needs; and appropriate guidance by a physician on the professional aspects of operating the facility.

"Medically needy" means aged, blind, or disabled individuals who are otherwise eligible for Medicaid, who are not categorically needy, and whose income and resources are within limits set under the Medicaid State Plan.

"Post-eligibility" is the process to determine an eligible individual's cost share of monthly medical expenses for an individual receiving long-term care services.

"RSDI" means Retirement, Survivors, and Disability Insurance benefits which are administered by the Social Security Administration under Title II of the Social Security Act.

"Spenddown" means the process by which a medically needy individual's monthly income in excess of the medically needy income standard is reduced by their incurred medical expenses.

"Spenddown amount" means the amount of an individual's income in excess of the medically needy income standard identified by the department as available to meet a portion of the individual's health care cost.

"Spouse" means a person who is lawfully married under Hawaii law.

"Standard of assistance" means a State need standard, expressed in a dollar amount, against which an individual's or family's income is compared, to determine eligibility for medical assistance.

[Eff 08/01/94; am 10/26/01; am 12/26/05;
am 01/31/09] (Auth: HRS §346-14; 42 C.F.R
§431.10) (Imp: HRS §§346-4;
346-29; 42 C.F.R. §§435.4; 435.1008; 42 U.S.C.
§1396r-5)

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§17-1721-3 (Reserved).

SUBCHAPTER 2

CATEGORICAL ELIGIBILITY REQUIREMENTS

§17-1721-4 Eligibility requirements for aged individuals. (a) The categorical eligibility requirement for an aged individual is that the individual be at least sixty-five years of age in the month of eligibility.

- (b) Verification of age shall be required.
- (1) Birth verification, including but not limited to legal documents and church records, may serve as verification.
- (2) Eligibility for or receipt of SSI or RSDI benefits on the basis of being aged may serve as verification of being an aged individual.
- (c) Unless there are reasons to doubt an individual's age, after initially being verified, recertification of an individual's aged status is not required.
[Eff 08/01/94; am 01/31/09] (Auth: HRS §346-14) (Imp: HRS §346-29; 42 C.F.R. §§233.39, 435.520, 435.522)

§17-1721-5 Eligibility requirements for blind individuals. (a) The categorical eligibility requirement for a blind individual is central visual acuity of 20/200 or worse in the better eye with correcting lens, or that the widest field of vision subtends an angle no greater than twenty degrees (tunnel vision).

- (b) Verification of blindness shall be required.
- (1) Eligibility for or receipt of SSI payments on the basis of blindness shall be verification of blindness.
- (2) Certification of blindness by the department's blind services division, Ho'opono, shall be verification of blindness, in the absence of eligibility for or payments of SSI benefits on the basis of blindness.

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(c) Recertification of blindness is not required if the department's blind services division, Ho'opono, certifies the blind individual's condition to be permanent with little chance of improvement, and therefore specifies that reevaluation is not necessary or warranted.

(d) Recertification of blindness is required if individual's condition is not permanent, there is a possibility of improvement, or reevaluation is recommended by the department's blind services division, Ho'opono.

- (1) Reevaluation shall be scheduled as recommended by Ho'opono.
- (2) If no reevaluation date is indicated, recertification will be scheduled on an annual basis. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: HRS §§346-29, 346-62; 42 C.F.R. §§435.530, 435.531)

§17-1721-6 Eligibility requirements for disabled individuals. (a) The categorical eligibility requirement for a disabled individual is that the individual be unable to engage in substantial gainful activity because of a medically determinable physical or mental impairment which may be expected to result in death or which has lasted or may be expected to last for a continuous period of not less than twelve months.

- (b) Verification of disability shall be required.
 - (1) Eligibility for or receipt of SSI or RSDI benefits on the basis of being disabled shall be verification of being a disabled individual.
 - (2) Certification of disability by the department's aid to the disabled review committee (ADRC) is required in the absence of eligibility for or receipt of SSI or RSDI disability benefits.

(c) Recertification of disability shall not be required if the department's ADRC certifies the individual's condition to be permanent with little chance of significant improvement and therefore specifies that reevaluation is not necessary or warranted.

- (d) Recertification of disability is required if

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the individual's condition is not permanent, there is a possibility of improvement, or reevaluation is recommended by the department's ADRC.

- (1) Reevaluation shall be scheduled as recommended by the ADRC.
 - (2) If no reevaluation date is indicated, recertification will be scheduled on an annual basis.
- (e) Disabled SSI recipients whose SSI benefits have been suspended or terminated as of March 1, 1995, shall continue to be considered SSI recipients if:
- (1) The basis of disability was primarily drug addiction or alcoholism as provided in section 1634(e) of the Social Security Act; and
 - (2) SSI benefits have been suspended due to non-compliance with treatment for drug addiction or alcoholism as provided in section 1634(e) of the Social Security Act or because of a mandatory suspension period while demonstrating compliance with treatment; or
 - (3) SSI benefits have been terminated because of the thirty-six month limit of SSI benefits for drug addiction or alcoholism as provided in section 1634(e) of the Social Security Act. [Eff 08/01/94; am 01/29/96]
(Auth: HRS §346-14) (Imp: HRS §346-29; 42 C.F.R. §§435.540, 435.541)

§17-1721-7 Essential persons. There are no provisions for coverage of an individual as an essential person to an aged, blind, or disabled individual, except in cases where an individual was eligible as an essential spouse in December 1973, and has continued to be eligible as an essential spouse until the present. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §435.131)

§17-1721-8 Medical assistance only for aged, blind, or disabled individuals. (a) Individuals who are certified as being aged, blind, or disabled shall be categorically eligible for medical assistance under

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one of the following coverage groups:

- (1) The mandatory categorically needy coverage for the aged, blind, or disabled, whose members are eligible for or receive SSI payments or SSP payments, or both;
 - (2) The medically needy coverage for the aged, blind, or disabled, whose members are financially ineligible for SSI benefits, but whose income is insufficient to meet medical expenses;
 - (3) The optional categorically needy coverage for the aged or disabled, whose members are allowed to qualify under a higher assistance standard, as allowed under the provisions of 42 C.F.R. §435.230(b)(2)(vi); or
 - (4) The optional categorically needy coverage for individuals residing in the community who meet the requirements of 42 C.F.R. §435.217 as follows:
 - (A) The individual would be eligible for Medicaid if institutionalized;
 - (B) The individual does not have income that exceeds income standards for the:
 - (i) Mandatory categorically needy,
 - (ii) Optional coverage of aged and disabled under the provisions of 42 C.F.R. §435.230(b)(2)(vi), or
 - (iii) Individuals in domiciliary care facilities;
 - (C) The individual has been determined to need home and community based services in order to remain in the community; or
 - (D) The individual may be covered under the terms of a home and community based waiver.
- (b) Individuals applying for or receiving medical assistance only shall not be required to apply for or receive SSI. [Eff 08/01/94; am 01/31/09] (Auth: HRS §346-14) (Imp: 42 C.F.R. §§435.121, 435.210, 435.217, 435.330; 42 U.S.C. §1396(a) (m))

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§§17-1721-9 to 17-1721-12 (Reserved).

SUBCHAPTER 3

PERSONAL RESERVE STANDARDS

§17-1721-13 Personal reserve standards. (a) The personal reserve standard is the maximum amount of countable assets that may be held by an individual, a family, or a household while establishing or maintaining eligibility for medical assistance.

(b) An individual, a family, or a household whose equity in non-exempt assets as determined in chapter 17-1725 exceeds the personal reserve standard for medical assistance shall be ineligible for medical assistance. [Eff 08/01/94; am 10/26/01; am 01/31/09] (Auth: HRS §346-14) (Imp: 42 C.F.R. §§435.3, 435.840, 435.843, 435.845)

§17-1721-14 Personal reserve standard for aged, blind, or disabled individuals. (a) For an individual or a couple applying for or receiving medical assistance, the personal reserve standards are equal to standards employed by the SSI program.

(b) For each additional family member, \$250 shall be added to the SSI personal reserve standard for a couple and the resultant amount is the personal reserve standard for the family. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: 42 C.F.R. §§435.1, 435.840, 435.841, 435.845)

§17-1721-15 to 17-1721-17 (Reserved).

SUBCHAPTER 4

STANDARDS OF ASSISTANCE

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§17-1721-18 Standards of assistance. (a) Individuals or families, who apply or receive medical assistance under the provisions of a specific coverage group, shall have their eligibility determined using the standard of assistance designated for that coverage group.

(b) When an individual meets the requirements of more than one coverage group, the department shall determine the individual's eligibility under that coverage group whose standard of assistance would best benefit the individual.

(c) Income, after allowable disregards and exemptions, shall be compared to the standards of assistance which are established for the different coverage groups under the State Plan. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: HRS §346-14; 42 C.F.R §§435.116, 435.121, 435.210, 435.230, 435.732, 435.831)

§17-1721-19 Standards of assistance for the optional categorically needy coverage of aged or disabled persons. (a) Individuals, who are age sixty-five or older or who are determined to be eligible for medical assistance on the basis of disability, shall be determined eligible for medical assistance on the basis of income, using a standard of assistance which is equal to the federal poverty guidelines for a family of applicable size.

(b) Cost incurred for medical care or any other type of remedial care shall not be deducted from income when determining financial eligibility for medical assistance under the provisions of this section. There are no spend-down provisions for these optional coverage groups.

(c) If income exceeds the applicable poverty guideline limit, the individual or family shall be evaluated for medical coverage under the medically needy coverage provisions. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §435.10) (Imp: 42 U.S.C. §1396a(m))

§17-1721-20 Standards of assistance for adults in domiciliary care facilities. (a) For adults in

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licensed domiciliary care facilities, both residential care facilities and community care foster family homes, the standards of assistance shall be equivalent to the rates of payment of the SSI program and SSP for:

- (1) Type I domiciliary care facility with not more than five residents; or
- (2) Type II domiciliary care facility with six or more residents.

(b) Costs incurred for medical care or any other type of remedial care not covered by the Medicaid program, shall not be deducted from income when determining financial eligibility for medical assistance under the provisions of this section. There are no spenddown provisions for these individuals in licensed domiciliary care facilities.

(c) If income exceeds the applicable standards of assistance under subsection (a), then the rules relating to persons with excess income at section 17-1721-36 shall apply. [Eff 08/01/94; am 11/25/96; am 01/31/09] (Auth: HRS §346-14; 42 C.F.R. §435.10) (Imp: 42 C.F.R. §§435.812, 435.814, 435.831)

§17-1721-21 Standards of assistance for mandatory categorically needy aged, blind, or disabled individuals. (a) For all individuals who meet the requirements in section 17-1721-8(a)(1), the medical assistance standard shall be equal to the SSI standard for an individual or a couple.

(b) Costs incurred for medical care or any other type of remedial care not covered by the Medicaid program shall not be deducted from income when determining financial eligibility for medical assistance under the provisions of this section. There are no spenddown provisions for these mandatory categorically needy individuals who are eligible for or receive SSI payments.

(c) If income exceeds the applicable standards of assistance under subsection (a), then the rules relating to persons with excess income at section 17-1721-36 shall apply. [Eff 08/01/94; am 01/31/09] (Auth: HRS §346-14; 42 C.F.R. §435.10) (Imp: 42 C.F.R. §§435.217; 435.812, 435.814, 435.831)

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§17-1721-22 Standards of assistance for medically needy aged, blind, or disabled individuals. For individuals who meet the requirements in section 17-1721-8(a)(2), the medical assistance standards shall be equal to the financial assistance payment standard for a family of the same size. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: HRS §346-53(e); 42 C.F.R. §§435.118, 435.812, 435.814, 435.831)

§17-1721-23 REPEALED [Eff 10/26/01; R 01/31/09] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: HRS §346-29; 42 C.F.R. §§435.116, 435.601, 435.814, 435.831)]

§§17-1721-24 to 17-1721-26 (Reserved).

SUBCHAPTER 5

DETERMINING MONTHLY NET INCOME

§17-1721-27 Rounding off income. There are no provisions for rounding off to whole dollar amounts when computing or determining income in the medical assistance only program. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: HRS §346-14)

§17-1721-28 Determining monthly countable income for aged or disabled persons. Monthly countable income shall be determined by the following process:

- (1) Determine unearned income according to chapter 17-1724;
- (2) Determine earned income according to chapter 17-1724;
- (3) Deduct \$20 from income, first from unearned income and any remainder from earned income;
- (4) If employed, the following deductions shall apply to the gross earned income:
 - (A) \$65;
 - (B) If disabled, all impairment-related work expenses shall be deducted from the

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- disabled individual's earned income if the individual's disability is sufficiently severe to result in a functional limitation requiring assistance in order to work as may be necessary to pay for the following:
- (i) Costs for attendant care services;
 - (ii) Medical devices;
 - (iii) Durable medical equipment;
 - (iv) Prosthetic and orthotic appliances; and
 - (v) Similar items and services.
- (C) Deduct one-half of the remainder of earned income;
- (5) Income of a disabled person may be excluded if needed to fulfill a plan to achieve self support. This exclusion applies to any income and in any amount of the disabled individual but shall not exceed in any month the amount of income remaining after application of all other income exclusions. The plan shall be approved by the department. After applying the exclusion based on a self-support plan to unearned income, if any portion of the exclusion is not applied, apply it to reduce the amount of the disabled individual's earned income; and
- (6) The net earned and unearned incomes are countable income. [Eff 08/01/94; am 01/31/09] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 C.F.R. §435.812)

§17-1721-29 Determining monthly net income for the blind. (a) Monthly countable income shall be determined by the following process:

- (1) Determine unearned income according to chapter 17-1724;
- (2) Determine earned income according to chapter 17-1724;
- (3) Deduct \$20 from income, first from unearned and any remainder from earned income;
- (4) If employed, \$65 shall be deducted plus one-half of the remainder of earned income; and

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(5) The remaining income, both earned and unearned is countable income.

(b) For blind individuals, any amount used to meet expenses attributable to employment shall be disregarded. The amount of expenses deductible shall not exceed the earnings of the blind recipient. Deductible expenses shall be those related to:

- (1) Transportation to and from work;
- (2) Job performance; and
- (3) Job improvement.

(c) Income of a blind person may be excluded if needed to fulfill a plan to achieve self support. This exclusion applies to any income and in any amount, but shall not exceed, in any month, the amount of income remaining after application of all other income exclusions. After applying the exclusion based on a self support plan approved by the department to unearned income, if any portion of the exclusion is not applied, apply it to reduce the amount of earned income. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 C.F.R. §435.812)

§§17-1721-30 to 17-1721-33 (Reserved).

SUBCHAPTER 6

FINANCIAL ELIGIBILITY DETERMINATION

§17-1721-34 Purpose. The purpose of this subchapter is to establish how financial eligibility for aged, blind or disabled individuals will be determined for the medical assistance programs. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: HRS §346-14)

§17-1721-35 General eligibility provisions. (a) Determination of financial eligibility for medical assistance only shall be based upon income and asset standards established by the department.

(b) Medical assistance shall be provided to an aged, blind or disabled individuals whose assets are

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within the prescribed retention limits, and whose income:

- (1) Is equal to or less than the medical assistance standards of the coverage group through which assistance is being sought or received; or
- (2) Exceeds the appropriate medically needy standards, but the excess is insufficient to pay for monthly medical expenses.
[Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: HRS §346-53(e); 42 C.F.R. §§435.118, 435.812, 435.814, 435.831)

§17-1721-36 Persons with excess income. (a) For an aged, blind or disabled person applying for or receiving medical assistance only as an optional categorically needy individual, a mandatory categorically needy individual, or an individual in a domiciliary care facility, income in excess of the appropriate standard of assistance shall deem the individual ineligible for medical assistance under that coverage group.

(b) When a person applies for or receives medical assistance with income that exceeds the appropriate standard of assistance for the groups in subsection (a), the person shall be entitled to receive medical assistance if the excess income can be spent down to the standard of assistance for the medically needy after deducting incurred medical expenses from months prior to the retroactive period:

- (1) The applicant's or recipient's monthly excess income is insufficient to meet the total monthly cost of medical care and services which are likely to be required on a continuing basis, whether at the level of ambulatory outpatient care, long-term institutional care or home and community based services; or
- (2) The total monthly excess income is insufficient to meet medical expenses of an acute medical service in that given month.

(d) The amount determined to be in excess of the appropriate standard of assistance shall be applied to the cost of medical care and services in the following order:

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- (1) Incurred medical expenses shall be deducted from excess income as provided in section 17-1721-37(a)(2); and
- (2) The balance, if any, be used to spenddown to the medically needy income limit as provided in section 17-1721-37(a)(3). [Eff 08/01/94; am 01/31/09] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 C.F.R. §§435.831, 435.832)

§17-1721-37 Incurred medical expenses. (a) The following shall be within the scope of incurred medical expenses:

- (1) Prior to the establishment of eligibility for medical assistance, the amount of health insurance premium an applicant or recipient is paying, whether for a private or government health plan, shall be deducted from excess income. If payment is made quarterly, or at longer intervals, the amount shall be prorated on a monthly basis;
- (2) Incurred medical expenses from months prior to the retroactive period, shall:
 - (A) Be deducted from the applicant's or recipient's excess income in the following order:
 - (i) Medicare monthly premium payments effective from the month of eligibility for medical assistance up to the buy-in month;
 - (ii) Other health insurance premiums, deductibles, or coinsurance charges;
 - (iii) Expenses incurred for necessary medical and remedial services that are recognized under State law but not included in the medical assistance program and said expenses from months prior to the retroactive period which were not previously considered and which remain a current liability to the applicant or recipient;
 - (iv) Expenses for necessary medical and

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remedial services included in the medical assistance program or that exceed the limitations on the amount, duration, or scope of services and said expenses from months prior to the retroactive period which were not previously considered and which remain a current liability to the applicant or recipient; and

- (v) QExA enrollment fees.
- (B) Exclude that portion of medical bills which are subject to payment by a third party, and past debts which have been forgiven by the provider.
- (3) Incurred medical expenses from current month and for months in the retroactive period, shall be deducted from the excess income except for:
 - (A) Those expenses that were previously deducted from income in any month in establishing eligibility for that month;
 - (B) That portion of medical bills which are subject to payment by a third party; and
 - (C) Past debts which have been forgiven by the provider.
- (b) The following health insurance premiums shall not be deducted from the excess income:
 - (1) Employer's contribution to the health plan;
 - (2) Premium paid in whole or in part by a non-eligible person; and
 - (3) Medicare premium payments for the newly approved applicant who is eligible for buy-in effective from the month of buy-in and for the on-going recipient who is already bought-in since these payments are not being made by the individual but will be made or are being made on the individual's behalf as provided in the buy-in agreement. [Eff 08/01/94; am 01/31/09] (Auth: HRS §346.14; 42 C.F.R. §431.10) (Imp: 42 C.F.R. §435.831

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§17-1721-38 Spenddown of excess income for a medically needy individual. (a) The monthly excess income of a person found eligible for medical assistance under section 17-1721-36(b) shall be applied to the person's medical expenses for the respective month.

(b) A person with excess income shall present evidence that incurred medical expenses not previously used to determine eligibility, are greater than the excess income for a given month before medical assistance coverage is provided.

(c) If a person over obligates the spenddown amount for a given month, the recipient's spenddown amount for the following month remains unchanged.

(d) A person who is currently eligible for Medicare benefits and medical assistance, the recipient's excess income shall be applied to Medicare's deductibles, and coinsurance, as well as Medicare's non-covered services. The balance of remaining cost, if any, shall be paid by the medical assistance program according to the department's reimbursement rates.

(e) A medically needy individual who is enrolled in a QExA health plan shall meet the spenddown obligation by paying the QExA enrollment fee. [Eff 08/01/94; am 12/26/05; am 01/31/09] (Auth: HRS §346.14; 42 C.F.R. §431.10) (Imp: 42 C.F.R. §§447.50, 435.800, 435.831)

§17-1721-39 Provision of coverage. (a) QExA health plans shall provide coverage for individuals eligible under this chapter, except for:

- (1) Medically needy individuals who are not expected to incur expenses sufficient to satisfy their spenddown obligation for a consecutive three-month period;
- (2) Individuals who are eligible for medical assistance for a period that is less than thirty days;
- (3) Children under age twenty-one who are residents of the State, receive child welfare services or subsidized adoption from the

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- department or court, and are placed in other states; and
- (4) Individuals who enter the State of Hawaii organ and transplant (SHOTT) program.
 - (b) Individuals in subsection (a) will be provided coverage on a fee-for-service basis for the services identified in chapter 17-1737.
 - (c) Individuals enrolled in the Medicaid waiver program for persons with developmental disabilities or mental retardation (DD/MR) shall have their primary and acute care services covered by a QExA health plan, but shall have their HCBS and intermediate care facility for the mentally retarded (ICF/MR) benefits covered under fee-for-service.
 - (d) Individuals who are enrolled in the Program for All-Inclusive Care for the Elderly (PACE) shall have all medical and long-term care services covered by the PACE program.
 - (e) Medically needy individuals who are disenrolled from a health plan for being two months in arrears of the payment of their enrollment fee are not eligible for coverage under this chapter unless the individual:
 - (1) Is no longer two full months in arrears in the payment of the enrollment fee; or
 - (2) Is a medically needy individual who is not expected to incur expenses sufficient to satisfy their spenddown obligation for a three-month period; or
 - (3) Qualifies as a mandatory categorically needy individual or an optional categorically needy individual under section 17-1721-8. [Eff 01/31/09]
(Auth: HRS §346-14) (Imp: HRS§346-14)

§§17-1721-40 to 17-1721-41 (Reserved).

SUBCHAPTER 7

FINANCIAL ELIGIBILITY AND LIABILITY OF INDIVIDUALS RECEIVING LONG-TERM CARE SERVICES

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§17-1721-42 Purpose. The purpose of this subchapter is to establish how financial eligibility and financial liability for the cost of long-term care services will be determined for an institutionalized individual requesting coverage of long-term care services. [Eff 08/01/94; am 01/31/09] (Auth: HRS §346-14) (Imp: HRS §346-14)

§17-1721-43 Determination of the community spouse resource allowance. (a) At the time of initial eligibility determination, the community spouse of an institutionalized individual who received long-term care services on or after September 30, 1989, shall be allowed to maintain countable assets to the maximum allowed by federal statutes or regulations with provisions for increase, as allowed by the Secretary of Health and Human Services by means of indexing, court order, or fair hearing.

(b) At the time of initial eligibility determination of an institutionalized individual, the total assets of both spouses, regardless of how the assets are held, shall be considered available to the institutionalized individual, except for the community spouse resource allowance, as defined by subsection (a).

(c) The assets retained by the community spouse, as allowed by subsection (a), shall not jeopardize the eligibility of the institutionalized individual. After the initial eligibility of the institutionalized individual is established, any assets of the community spouse, which do not include the institutionalized individual as a co-owner, shall not be considered during the continuous period of both medical assistance eligibility and institutionalization of the institutionalized individual.

(d) The post-eligibility interspousal transfer of assets shall be allowed for the legal transfer of assets from the institutionalized individual to the community spouse. After a protective period of ninety days, which may be extended if there are legal reasons or extenuating circumstances that delay such a transfer, any assets still legally available to the institutionalized individual shall be considered in the determination of continued eligibility of the

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institutionalized individual.

(e) The provisions of subsections (a) through (d) only apply to an institutionalized individual determined eligible for home and community based services who qualify for Medicaid as a medically needy individual or under the provisions of 42 C.F.R. §435.217. [Eff 08/01/94; am 01/31/09] (Auth: HRS §346-14; 42 C.F.R §431.10) (Imp: HRS §346-29; 42 U.S.C. §1396r-5, 42 U.S.C. §1315)

§17-1721-44 Post-eligibility treatment of income for an institutionalized individual. (a) After an institutionalized individual has been determined eligible for medical assistance coverage of long-term care services on the basis of income, the income of that individual must be applied toward the individual's cost share of long-term care and other medical care costs. A cost share is applicable to the following:

- (1) An individual residing in a nursing facility or a medical facility where the individual is provided nursing facility level of care services;
- (2) A medically needy individual residing in the community who is eligible to receive home and community based services; and
- (3) An optional categorically needy individual who needs to have eligibility established under the provisions of 42 C.F.R. §435.217.

(b) An individual's cost share is determined by deducting the following from the individual's income:

- (1) A personal needs allowance of:
 - (A) \$50 for an individual residing in a nursing facility or medical facility receiving a nursing facility level of care;
 - (B) One hundred percent of the FPL for a household of one for an individual residing in a private home in the community; or
 - (C) The standard of assistance for the medically needy for a household of one for an individual residing in a community care foster family home.
- (2) An amount for maintenance of the

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institutionalized individual's community spouse and dependent family member that shall be deducted first from the income of the institutionalized individual's income as follows:

- (A) The contribution from the institutionalized individual to the community spouse which shall be equal to the amount that the maximum community spouse maintenance needs allowance exceeds the countable income of the community spouse. The maximum community spouse maintenance needs allowance is defined by federal statutes or regulations and is subject to increases by means of indexing, court order, or fair hearing decree;
 - (B) The family allowance for each dependent family member, residing with the community spouse, which shall be equal to the amount that one third of the spousal allowance in subparagraph (A) exceeds the amount of the monthly income of that family member; or
 - (C) The family allowance for a dependent family member residing in the institutionalized individual's home, with no community spouse residing in the home, which shall be equal to the amount that the standard of assistance for the medically needy for a family of equal size, exceeds the amount of the monthly income of the family member.
- (3) Any incurred medical expenses as provided in section 17-1721-37, not covered by the medical assistance program excluding any unpaid portion of long-term care services that were not payable by Medicaid during a penalty period for the transfer of assets for less than fair market value established under the provisions of this chapter;
 - (4) Veterans Affairs benefits that have been reduced to \$90 for pensioners with no dependents; and
 - (5) Veterans Affairs benefits for unusual medical

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expenses (UME).

(c) Any income remaining, rounded down to the whole dollar, after following the procedures of subsection (b), represents the amount of the individual's cost share. [Eff 08/01/94; am 11/13/95; am 11/25/96; am 01/31/09] (Auth: HRS §346-14) (Imp: 42 C.F.R. §§435.726, 435.733, 435.735, 435.831, 435.832; 38 U.S.C. §3203; 42 U.S.C. §§1396a(r), 1396r-5; 42 U.S.C. §1315)

§17-1721-45 REPEALED [Eff 08/01/94; am 11/13/95; R 10/19/09] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §1396p(c))

§§17-1721-46 to 17-1721-49 (Reserved).

SUBCHAPTER 8

TREATMENT OF ASSETS FOR INDIVIDUALS REQUESTING COVERAGE OF LONG-TERM CARE SERVICES

§17-1721-50 Purpose. The purpose of this subchapter is to establish requirements for the treatment of assets for an individual who requests coverage of long-term care services. [Eff 10/19/09] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §1396p(c))

§17-1721-51 Definitions. For the purpose of this subchapter:

"Actuarially sound" means an annuity, promissory note, or similar financial contract where no payments will be made beyond the life expectancy of the owner of the contract as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration.

"Annuity" is a financial contract where the purchaser is assured a scheduled amount of payments for the duration of the contract.

"Blind child" means the child of an individual requesting coverage of long term care services who

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meets the categorical eligibility requirements of a blind individual in section 17-1721-5.

"Disabled child" means the child of an individual requesting coverage of long term care services who meets the categorical eligibility requirements of a disabled individual in section 17-1721-6.

"Encumbrance" means a financial claim or lien upon real or personal property.

"Fair market value" means the amount an asset is expected to sell without discount on the open market for such asset in the geographic area involved, and under the existing economic conditions. Fair market value includes valuable consideration.

"Home equity" means the fair market value of the individual's home property less financial encumbrances.

"IRA" means an individual retirement account.

"IRC" means the Internal Revenue Code of 1986.

"Irrevocable trust" means a trust whose term and conditions cannot be amended under any circumstances, including a court order.

"Life interest" means a type of real property ownership that gives the owner the use of the property or the right to income generated by a property during the lifetime of the owner, or both.

"Look-back period" means the period prior to and including the month of application for medical assistance for long-term care services during which assets that were transferred for less than fair market value shall be evaluated to determine if a penalty period is applicable.

"Penalty period" means a period in which Medicaid will not provide coverage of long-term care services for an individual, who is otherwise eligible for Medicaid, because the individual or the individual's spouse transferred assets for less than fair market value.

"Promissory note" means a written agreement signed by a person who promises to pay a specific sum of money at a specified time, or on demand, to the holder of the note.

"Remainder beneficiary" means the party that is designated to receive funds from an annuity, trust or similar legal contract, after the death of the owner.

"Revocable trust" means a trust whose terms and conditions can be amended.

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"Stream of income" means income that can be anticipated to be received more than once, e.g. rental or lease payments, royalties, annuity payments, pensions, court ordered settlements.

"Valuable consideration" means the value that an individual receives in exchange for his or her interest in an asset, some act, object, service, or other benefit which has a tangible or intrinsic value to the individual that is equivalent to or greater than the value of the transferred asset. [Eff 10/19/09]
(Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp:
42 U.S.C. §1396p(c))

§17-1721-52 Penalty period for the transfer of an asset for less than fair market value. (a) An individual who requests medical assistance for coverage of long-term care services shall be assessed a penalty period for coverage of these services if the individual or the individual's spouse, transferred an asset for less than fair market value within the applicable look-back period. The length of the look-back period shall be:

- (1) Thirty-six months for an asset transferred prior to February 8, 2006;
 - (2) Sixty months for an asset transferred to an irrevocable trust prior to February 8, 2006; and
 - (3) Sixty months for an asset transferred on or after February 8, 2006.
- (b) An asset that was transferred after the look-back period shall be considered as follows:
- (1) A penalty period shall be assessed if an individual transfers an asset after being determined eligible for coverage of long-term care services.
 - (2) A penalty period shall not be assessed for the transfer of an asset owned by the community spouse made after the individual has been determined eligible for coverage of long-term care services.
- (c) The transfer provision shall apply to an asset held by the individual and the individual's spouse when any action is taken that reduces or eliminates such individuals' ownership or control of such asset.

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(d) The transfer provision shall apply to countable assets in chapter 17-1725 owned by the individual and the individual's spouse, and to the following exempt assets in chapter 17-1725:

- (1) The home property;
- (2) The value of basic maintenance items of limited value essential for day-to-day living including but not limited to clothing, furniture, and appliances that exceeds \$5,000;
- (3) Motor vehicles except for one vehicle designated for use by the individual or their spouse; and
- (4) The equity value of a funeral plan that exceeds \$1,500.

(e) The transfer provision shall apply to the transfer of income of the individual and the individual's spouse, or their right to receive income, either as a single payment or a stream of income, that is countable in determining Medicaid eligibility under chapter 17-1724.

(f) The unpaid portion of long-term care expenses incurred during a penalty period shall not be deducted in post-eligibility as an incurred medical expense when a penalized individual becomes eligible for coverage of long-term care services. [Eff 10/19/09]
(Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §1396p(c))

§17-1721-53 Treatment of annuities. (a) An individual who requires coverage of long-term care services or the individual's spouse shall disclose any interest in annuities on each application or recertification of Medicaid eligibility.

- (1) An individual shall not be eligible for coverage of long-term care services if the individual or the individual's spouse fails to disclose any interest in an annuity.
- (2) The disclosure shall be required regardless of whether the annuity is irrevocable or treated as an asset in chapter 17-1725.

(b) The portion of the funds of an annuity purchased prior to February 8, 2006, that is not actuarially sound and is payable beyond the life

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expectancy of the annuitant shall be considered transferred.

(c) All funds used to purchase an annuity on or after February 8, 2006, by the individual or the individual's spouse shall be considered transferred if the department is not named as a remainder beneficiary in the first position, or in a position behind the spouse and dependent child of the individual for the amount of medical assistance paid on behalf of the annuitant.

- (1) The department shall notify the issuer of an annuity issued on or after February 8, 2006, of the right of the department to be a preferred remainder beneficiary.
- (2) The issuer may inform other remainder beneficiaries of the department's remainder interest.

(d) Funds used to purchase an annuity on or after February 8, 2006, by the individual or the individual's spouse, or on behalf of the individual or the individual's spouse, shall not be considered transferred if:

- (1) The annuity is considered:
 - (A) An individual retirement annuity that meets the requirements of section 408(b) of the IRC; or
 - (B) A deemed IRA under a qualified employer plan under section 408(q) of the IRC; or
- (2) The annuity purchased with proceeds from one of the following:
 - (A) A traditional IRA under section 408(a) of the IRC;
 - (B) An account or trust which is treated as a traditional IRA under section 408(c) of the IRC;
 - (C) A simplified retirement account under section 408(p) of the IRC;
 - (D) A simplified employee pension under section 408(k) of the IRC; or
 - (E) A Roth IRA under section 408A of the IRC; or
- (3) The annuity meets all of the following requirements:
 - (A) Is actuarially sound as determined in accordance with actuarial publications

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- of the Office of the Chief Actuary of the Social Security Administration;
- (B) Is irrevocable and non-assignable; and
 - (C) Makes equal payments throughout the term of the contract and does not defer payments or allow balloon payments.
- [Eff 10/19/09] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §1396p(c))

§17-1721-54 Treatment of promissory notes, loans and mortgages. (a) The assets used by an individual who requires coverage of long-term care services or the individual's spouse, to secure a promissory note, loan or mortgage on or after February 8, 2006, shall not be considered transferred if all of the following conditions apply to the promissory note, loan or mortgage:

- (1) The repayment term is actuarially sound;
- (2) Is irrevocable and cannot be sold;
- (3) Equal payments are made throughout the term of the contract; and
- (4) Cannot be cancelled upon the death of the individual or the individual's spouse.

(b) If the provisions of subsection (a) are not met, the transferred amount is equal to the outstanding balance owed as of the date of the individual's request for coverage of long-term care services.

(c) The portion of the funds used to secure a promissory note, loan or mortgage prior to February 8, 2006, that is not actuarially sound and is payable beyond the life expectancy of the owner of the funds shall be considered transferred.

[Eff 10/19/09] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §1396p(c))

§17-1721-55 Treatment of the purchase of a life interest in the home property of another. (a) The funds used by the individual who requires coverage of long-term care services or the individual's spouse to purchase a life interest in the home property of another, on or after February 8, 2006, shall be considered transferred if the purchaser did not reside

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on the property for a period of at least one year after the date of the purchase.

(b) For the purchase of a life interest in the property of another made on or after February 8, 2006 that meet the requirements of subsection (a), the portion of the funds that exceed the value of the life interest property based on the life estate tables published by the Social Security Administration, shall be treated as transferred assets.

(c) The portion of the funds used to purchase a life interest in the property of another by the individual or the individual's spouse prior to February 8, 2006, that exceed the value of the life interest in the property based on the life estate tables published by the Social Security Administration, shall be treated as a transferred asset.

[Eff 10/19/09] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §1396p(c))

§17-1721-56 Treatment of the transfer of income.

(a) A penalty period shall be assessed if the individual or the individual's spouse transferred income in the month it was received, or transferred a right to receive income.

(b) The penalty period for the transfer of income shall be calculated by dividing the amount of income by the statewide average monthly cost of nursing facility services assessed to a private patient at the time the individual requests coverage of long-term care services.

(c) The amount of income used to calculate a penalty period shall be:

- (1) The gross amount of the income transferred in the month it was received by the individual;
or
- (2) The total amount of income expected to be received when the right to receive a single source of income was transferred.
- (3) The total amount of income expected to be received during the individual's lifetime when the right to receive a stream of income was transferred. The total amount of income is calculated by multiplying the annual amount of income by the individual's life

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expectancy based on the life expectancy tables established by the Social Security Administration's Office of the Actuary. [Eff 10/19/09] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §1396p(c))

§17-1721-57 Transfer of assets that are not subject to the assessment of a penalty. A penalty period shall not be applied when:

- (1) The asset transferred was the individual's home and title to the individual's:
 - (A) Spouse;
 - (B) Child who is under age twenty-one, or a blind child or a disabled child;
 - (C) A sibling who has an equity interest in the home, and has resided in the home for at least one year immediately prior to the date the individual began receiving long-term care services; or
 - (D) An adult child, other than a child described in paragraph (B), who has resided in the home for at least two years immediately prior to the date the individual began receiving long-term care services and provided care which allowed the individual to reside at home.
- (2) The asset, other than a home, was transferred:
 - (A) To the individual's community spouse or another individual or entity for the sole benefit of the community spouse;
 - (B) From the community spouse to another individual or entity for the sole benefit of the community spouse;
 - (C) To the individual's child who is under twenty-one years of age, a blind child or a disabled child, or to a trust established after August 10, 1993, for the child; or
 - (D) To a trust established after August 10, 1993, solely for the benefit

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- of an individual under sixty-five years of age who is disabled as defined in section 17-1721-6.
- (3) The individual can substantiate that the individual intended to transfer the asset either at fair market value, or for other valuable consideration, or the asset was transferred exclusively for a purpose other than to qualify for medical assistance. Circumstances that meet the requirements of this subsection include, but are not limited to:
- (A) The individual was not receiving long-term care services at the time of the transfer;
 - (B) The individual was living independently at the time of the transfer;
 - (C) The individual did not have a pre-existing condition that could lead to the need for long-term care or assisted living at the time of the transfer;
 - (D) The transfer was not within the individual's control (e.g. court ordered); or
 - (E) A diagnosis of a previously undetected disabling condition leading to the need for long-term care eligibility occurred after the date of transfer.
- (4) The asset transferred for less than fair market value has been returned.
- (A) The returned asset must be evaluated for the impact on the individual's eligibility for Medicaid.
 - (B) Coverage of long-term care services shall be provided for any portion of a penalty period that was applied prior to the return of the asset.
 - (C) If only a portion of the transferred asset has been returned, and the individual is eligible for Medicaid, the penalty period shall be recalculated based on the balance of the unreturned asset.
 - (i) The end date of the recalculated

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- penalty period shall be applicable if it exceeds the amount of the penalty period already applied;
- (ii) Coverage of long-term services shall be provided for the portion of the penalty period that exceeds the end date of the recalculated penalty period.
- [Eff 10/19/09] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §1396p(c))

§17-1721-58 Determining a penalty period. (a) A penalty period shall be calculated by dividing the total uncompensated value of the asset transferred, by the statewide average monthly cost of nursing facility services assessed to a private patient at the time the individual requests coverage of long-term care services.

(b) A penalty period that results in less than a whole month shall not be rounded down or disregarded.

(c) A penalty period established for an asset that was transferred prior to February 8, 2006, shall be established for each month a non-exempted transfer occurred during the applicable look-back period specified in section 17-1721-52, and the following apply:

- (1) Multiple transfers made in the same month shall be combined to establish a penalty period for that month;
- (2) A penalty period shall commence on the first day of a month the asset was transferred; and
- (3) A penalty period that would commence within the term of another penalty period shall commence at the end of the prior penalty period.

(d) A penalty period established for an asset that was transferred on or after February 8, 2006, shall be applied as follows:

- (1) The value of any asset transferred during the applicable look-back period specified in subsection 17-1721-52(a) shall be combined and a single penalty period shall be determined.

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- (2) A separate penalty period shall be determined for each month a non-exempt transfer occurred after an individual was determined eligible for coverage of long-term care services.
- (3) The penalty period shall commence the later of:
 - (A) The first day of the month the asset was transferred;
 - (B) The date the individual would be eligible for coverage of long-term care services but for the imposition of a penalty under this subchapter; or
 - (C) The date a negative action can be taken in situations when timely notice of adverse action to the individual is required.
- (4) A penalty period that would commence within the term of another penalty period shall commence at the end of the prior penalty period.
 - (e) An established penalty period shall continue to run even in periods where the individual subject to the penalty period is not eligible for medical assistance, or is not receiving long-term care services.
 - (f) The department shall send a denial notice to an individual requesting coverage of long-term care services, or an adverse action notice to an individual who is receiving long-term care coverage, when imposing a penalty period. The notices shall meet the requirements of chapter 17-1713, and must inform the individual of:
 - (1) The type and amount of the asset used to determine the penalty period;
 - (2) The length of the penalty period;
 - (3) The start and end date of the penalty period;
 - (4) The authority under the Hawaii administrative rules to impose the negative action; and
 - (5) The individual's right to request a hardship waiver of the penalty period.
 - (g) If the spouse of a penalized individual becomes eligible for coverage of long-term care services, the penalty period may be allocated between the individual and the spouse. [Eff 10/19/09]
(Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp:
42 U.S.C. §1396p(c))

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§17-1721-59 Waiver of a penalty period due to undue hardship. (a) A penalty period may be waived if the department determines that the imposition of the penalty will cause undue hardship for the individual.

(b) Undue hardship exists if the application of a penalty period would deprive the individual of:

- (1) Medical care such that the individual's life or health would be endangered; or
- (2) Food, clothing, shelter, or other necessities of life.

(c) A waiver of a penalty period due to undue hardship may be granted if the individual provides satisfactory evidence to the department that the asset transferred:

- (1) Has been depleted below the resource standard specified in section 17-1721;
- (2) Has been converted to another asset that is not liquid or redeemable;
- (3) The return of the transferred assets would put the receiving party in serious deprivation such that the loss of income or the asset would qualify the receiving party for medical assistance;
- (4) The receiving party cannot be located by the individual or another, including but not limited to the individual's spouse, other family member, representative, or an agent of the nursing facility, after all attempts to locate the receiving party have been exhausted; or
- (5) The asset was transferred due to theft, fraud, or financial exploitation.

(d) The process for requesting and reviewing a waiver of a penalty period due to undue hardship is as follows:

- (1) The department shall send the individual a notice of denial or a notice of adverse action according to the requirements of chapter 17-1713 to inform the individual of the establishment of the penalty period and the individual's right to request a hardship waiver.
- (2) The individual shall have twenty calendar days from the mailing of the notice to request a hardship waiver and provide all

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- documentation to support the basis of the hardship waiver request.
- (3) The department shall make a determination of a waiver within ten business days after receiving the request for a waiver and the supporting documentation.
 - (4) An individual who is denied a hardship waiver request shall be informed of the enforcement date of the penalty period and the right to request a fair hearing under chapter 17-1703.
 - (e) Nursing facilities may request a hardship waiver on behalf of a resident upon authorization of the resident or the resident's personal representative. [Eff 10/19/09] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §1396p(c))

§17-1721-60 An individual with substantive equity in a home property. (a) An individual shall not be eligible for coverage of long-term care services if the individual's home equity interest exceeds \$750,000.

(b) The individual's home equity interest shall be determined by the fair market value less encumbrances.

(c) The provisions of this subsection do not apply if the individual's spouse, child under age twenty-one, a blind child, or a disabled child are residing in the individual's home.

(d) An individual affected by the provisions of this subsection is allowed to reduce their equity in the home property through the use of a reverse mortgage or a home equity loan without penalty.

(e) An individual affected by this subsection has the right to file for a waiver due to demonstrated hardship by which the individual is legally barred from taking action to access the equity in the property.

(f) Effective 2011, the amount of the equity interest shall be subject to increase each calendar year based on the percentage increase in the consumer price index for all urban consumers, rounded to the nearest \$1,000. [Eff 10/19/09] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §1396p(c))