HAWAII ADMINISTRATIVE RULES

TITLE 17

DEPARTMENT OF HUMAN SERVICES

SUBTITLE 12 MED-QUEST DIVISION

CHAPTER 1721

MEDICAL ASSISTANCE TO

AGED, BLIND, OR DISABLED INDIVIDUALS

Subchapter 1 General Provisions



Subchapter 2 Categorical Eligibility Requirements



Subchapter 3 Personal Reserve Standards



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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)

§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 an optional state supplement or are considered under section 1619(b) of the Social Security Act (42 U.S.C. 1382h(b)) to be SSI recipients; or

(2) Whose categorical eligibility is protected by statute.

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

"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.

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

"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 institution 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 waiver services.

"Institutionalized spouse" means the spouse of the community spouse who is an institutionalized individual.

"Likely to remain" means that the attending or admitting physician or a medical consultant from the Department indicates that the individual is expected to reside in a medical institution or nursing facility for at least thirty consecutive days. This decision is generally made at the beginning of the continuous period of institutionalization.

"Medical institution" means an institution 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 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.

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

"SSI" means Supplemental Security Income, a financial assistance program for aged, blind, or disabled individuals administered by the Social Security Administration under Title XVI of the Social Security Act.

"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] (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. §1396 r-5, Pub. L. 108-173)

§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 65 years of age within the initial 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 ] (Auth: HRS §346-14) (Imp: HRS §346-29; 42 C.F.R. §435.520)

§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 that 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.

(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 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 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;

(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; or

(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 the Omnibus Reconciliation Budget Act (OBRA) of 1986 (42 U.S.C. §1396a(m)).

(b) Individuals applying for or receiving medical assistance only shall not be required to apply for or receive SSI. [Eff 08/01/94 ] (Auth: HRS §346-14) (Imp: 42 C.F.R. §§435.121, 435.210, 435.330; 42 U.S.C. §1396a(m))

§§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.

(c) Assets shall not be considered in determining the eligibility of a blind or disabled pregnant woman or child born after 09/30/83, who meets the requirement in sections 17-1721-5 or 17-1721-6. [Eff 08/01/94; am 10/26/01 ] (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

§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. For adults in licensed domiciliary care facilities, both residential care facilities and adult foster homes, the standards of assistance shall be:

(1) Equivalent to the rates of payment of the federal Supplemental Security Income program for the respective levels of care under the department's point system; or

(2) For persons whose levels of care have not been certified by the department's social services staff, the department of health's staff, or any other agency designated by the department, the privately arranged board rates with a ceiling of the highest level of care rate established by the department. [Eff 08/01/94; am 11/25/96 ] (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. For all individuals who meet the requirements in section 17-1721-8(a)(1), the medical assistance standards shall be equal to the SSI standard for an individual or a couple. [Eff 08/01/94 ] (Auth: HRS §346-14; 42 C.F.R. §435.10) (Imp: 42 C.F.R. §§435.812, 435.814, 435.831)

§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 Standards of assistance for medically needy blind or disabled pregnant women and children born after September 30, 1983. For individuals who meet the requirements of sections 17-1721-5 or 17-1721-6, the medical assistance standards shall be:

(1) One hundred eighty-five percent of the federal poverty level for a blind or disabled pregnant woman which includes the number of unborn children for her family size;

(2) One hundred eighty-five percent of the federal poverty level for a blind or disabled infant under age one for a family of applicable size;

(3) One hundred thirty-three percent of the federal poverty limit for a blind or disabled child age one but less than age six for a family of applicable size; and

(4) One hundred percent of the federal poverty limit for a blind or disabled child age six born after September 30, 1983, for a family of applicable size. [Eff 10/26/01 ] (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 net income for aged or disabled persons. (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
(5) The remaining income, both earned and unearned is countable income.

(b) 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, 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 earned income.

(c) After eligibility for medical assistance is determined, disabled beneficiaries may qualify for impairment related work expenses. These expenses shall be available 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 the costs of attendant care services, medical devices, equipment, prosthesis, and similar items and services. [Eff 08/01/94 ] (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
(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 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 a person applying for or receiving medical assistance only as a optional categorically needy aged or disabled individual, income in excess of the appropriate assistance standard for the coverage group shall deem the individual ineligible for medical assistance under that coverage group.

(b) For persons applying for or receiving medical assistance as a mandatory categorically needy aged, blind, or disabled individual, income in excess of the SSI standards shall deem the individual ineligible for medical assistance under that coverage group.

(c) When a person applies for medical assistance under the the coverage groups not addressed in subsections (a) and (b), and the person's income exceeds the appropriate medical assistance standard, the person shall be entitled to receive medical assistance if, after first 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 ambulating outpatient care or long-term institutional care; 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 medical assistance standard shall be applied to the cost of medical care and services in the following order:

(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, to cost sharing as provided in section 17-1721-37(a)(3).

[Eff 08/01/94 ] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 C.F.R. §§435.831, 435.840, 435.841, 435.845)

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

(1) Prior to 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, except for that portion of medical bills which are subject to payment by a third party and past debts which have been forgiven by the provider, shall be deducted from the applicant's or recipient's excess income in the following order:

(A) Medicare monthly premium payments effective from the month of eligibility for medical assistance up to the buy-in month;

(B) Other health insurance premiums, deductibles, or coinsurance charges;

(C) 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; and

(D) Expenses for necessary medical and remedial services 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; and

(3) Incurred medical expenses from current month and for months in the retroactive period, except for that portion of medical bills which are subject to payment by a third party, shall be applied to the cost sharing.

(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 ] (Auth: HRS §346.14; 42 C.F.R. §431.10) (Imp: 42 C.F.R. §435.831)

§17-1721-38 Cost sharing of medical care cost. (a) The monthly excess income of a person found eligible for medical assistance under section 17-1721-36(c) shall be applied to the person's medical expenses for the respective month.

(b) For a person with excess income, evidence that incurred medical expenses were greater than the excess income for a given month shall be presented before medical assistance coverage is provided.

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

(d) For 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 to Medicare's non-covered services. The balance of remaining cost, if any, with the exception of any drugs that are covered under Part D and any cost-sharing related to Medicare Part D shall be paid by the medical assistance program according to the department's reimbursement rates. [Eff 08/01/94; am 12/26/05] (Auth: HRS §346.14; 42 C.F.R. §431.10) (Imp: 42 C.F.R. §§447.50, 435.800, 435.831; Pub. L. 108-173)

§§17-1721-39 to 17-1721-41 (Reserved).

SUBCHAPTER 7

MEDICALLY INSTITUTIONALIZED INDIVIDUALS

§17-1721-42 Purpose. The purpose of this subchapter is to establish how financial eligibility and financial liability of recipient for cost of long term care will be determined for medically institutionalized individuals, as well as the penalties for the disposal of assets. [Eff 08/01/94 ] (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 a person institutionalized 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 spouse, the total assets of both spouses, regardless of how the assets are held, shall be considered available to the institutionalized spouse, 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 spouse. After the initial eligibility of the institutionalized spouse is established, any assets of the community spouse, which do not include the institutionalized spouse as a co-owner, shall not be considered during the continuous period of both medical assistance eligibility and institutionalization of the institutionalized spouse.

(d) The post-eligibility interspousal transfer of assets shall be allowed for the legal transfer of assets from the institutionalized spouse 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 spouse shall be considered in the determination of continued eligibility of the institutionalized spouse.

(e) As an individual admitted to a home and community-based services waiver program is considered to be institutionalized, the provisions of subsections (a) through (d) apply to such a person and the person's spouse. [Eff 08/01/94 ] (Auth: HRS §346-14;

42 C.F.R §431.10) (Imp: HRS §346-29; 42 U.S.C. §1396 r-5)

§17-1721-44 Post-eligibility treatment of income for individuals in medical institutions. (a) After an individual has been determined eligible for medical assistance on the basis of income and that individual has been in or is likely to remain in a medical institution for more than thirty days, the income of that individual must be applied toward the individual's institutional and other medical care costs.

(b) To determine the amount of the individual's income to be applied to medical expenses, the following shall be deducted from the individual's income:

(1) A personal needs allowance of $30 monthly.

(2) An amount for maintenance of the individual's dependent spouse and family as follows:

(A) The contribution from the institutionalized spouse to the community spouse shall be the amount by which the maximum community spouse maintenance needs allowance exceeds the income otherwise available to 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; and

(B) The family allowance for each family member, aside from the community spouse, shall be equal to the amount by which one third of the spousal allowance in section 17-1721-44(b)(2)(A) exceeds the amount of the monthly income of that family member. For the purposes of this subparagraph, "family member" only includes minor or dependent children, dependent parents, or dependent siblings of the institutionalized or community spouse who are residing with the community spouse;

(3) Any incurred medical expenses as provided in section 17-1721-37, not covered by the medical assistance program;

(4) VA benefits that have been reduced to $90 for pensioners with no dependents; and

(5) VA benefits for unusual medical 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 income to be applied toward the cost of institutionalization. [Eff 08/01/94; am 11/13/95; am 11/25/96 ] (Auth: HRS §346-14) (Imp: 42 C.F.R. §§435.831, 435.832; 38 U.S.C. §3203)

§17-1721-45 Disposal of assets for less than fair market value. (a) Any institutionalized applicant who is an inpatient at a medical institution receiving a nursing facility level of care, or is an inpatient at a nursing facility, or is a recipient of home and community based waiver services, shall be assessed a period of ineligibility for coverage of nursing facility level of care or home or community based waivered services if they, or their spouse, disposed of any assets for less than fair market value within:

(1) Thirty six months prior to the month of application for medical assistance; or

(2) Sixty months prior to the month of application for medical assistance, if the assets were transferred to an irrevocable trust.

(b) Any recipient who becomes an inpatient at a medical institution receiving a nursing facility level of care, or is an inpatient at a nursing facility, or is a recipient of home and community based waiver services, shall be assessed a period of ineligibility for coverage of nursing facility level of care or home or community based waivered services if they, or their spouse, disposed of any assets for less than fair market value within:

(1) Thirty six months prior to the month the recipient became an institutionalized individual or received home and community based waiver services; or

(2) Sixty months prior to the month the recipient became an institutionalized individual or received home and community based waiver services if the assets were transferred to an irrevocable trust.

(c) The period of ineligibility shall begin with the month of transfer and be equal to the total uncompensated value of the transferred assets counted towards the personal retention level according to

section 17-1721-14, divided by the latest statewide average monthly cost of nursing home care assessed to a private patient at the time of application of the institutionalized applicant or at the time the recipient becomes institutionalized.

(d) The transfer provision will apply to assets held by individuals described in subsections (a) and (b) in joint tenancy, tenancy in common or similar arrangement when any action is taken, either by such individuals or any other person that reduces or eliminates such individual's ownership or control of such asset.

(e) The transfer provision shall not be applicable when:

(1) The asset transferred by the individual was the individual's home and title to the home was transferred to:
    (A) The spouse;
    (B) A child who is under age twenty-one, or a disabled or blind adult child;
    (C) A sibling who has an equity interest in the home and who has resided in the home for at least one year prior to the date the individual became an institutionalized individual; or
    (D) An adult child, other than a child described in subparagraph (B), who has resided in the home for at least two years prior to the date the individual became an institutionalized individual, and who provided care which allowed the individual to reside at home rather than becoming an institutionalized individual;

(2) The assets, other than a home, were transferred:
    (A) To the community spouse or another for the sole benefit of the community spouse;
    (B) From the community spouse to another for the sole benefit of the community spouse;
    (C) To the individual's child or a trust established after August 10, 1993 for the individual's child who is under twenty-one years of age, blind or disabled as defined in sections 17-1721-5 and 17-1721-6; or

(D) To a trust established after August 10, 1993 that was established solely for the benefit of an individual under sixty five years of age who is disabled as defined in section 17-1721-6;

(3) A satisfactory showing is made to the State that the individual intended to dispose of the assets either at fair market value, or for other valuable consideration, or the assets were transferred exclusively for a purpose other than to qualify for medical assistance;

(4) All the assets transferred for less than fair market value have been returned; or

(5) The State determines that denial of coverage of nursing level of care would result in undue hardship which exists but is not limited to:

(A) When the individual is unable to pay for the medical care costs at a medical institution where the level of care provided is equivalent to nursing facility care, or at a nursing facility, or at home receiving home and community based waiver services; and

(B) When denial of coverage would seriously threaten the continuing care or well-being of the individual.

(f) If the community spouse of a penalized individual becomes eligible for medicaid, the period of ineligibility for nursing facility level of care can be allocated between the spouses.

(g) The transfer provision, prohibits the State from imposing a period of Medicaid ineligibility due to transfer of assets except as provided in this section which specifically applies to the institutionalized applicant or recipient who becomes institutionalized and becomes an inpatient at a medical institution receiving a nursing facility level of care, or is an inpatient at a nursing facility, or is a recipient of home and community based waiver services.

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