

The Income Spenddown Process in Connecticut's Medicaid Program

By: Jennifer Proto, Principal Analyst
October 4, 2022 | 2022-R-0136

Issue

This report summarizes the income spenddown process under Connecticut's Medicaid program.

The Office of Legislative Research is not authorized to provide legal opinions and this report should not be considered one.

Summary

To qualify for Medicaid in Connecticut (also known as HUSKY), participants must meet program requirements including income and asset limits. However, people with incomes exceeding these limits who otherwise meet eligibility requirements may still qualify if they have significant medical expenses. Similar to how a deductible works, the spenddown process allows a "medically needy" person's excess income to be reduced by their medical bills (e.g., prescriptions, medical equipment, and doctor visits). People with incomes reduced below the annual medically needy income limit (MNIL) become eligible for Medicaid and any further medical expenses are covered for the remainder of their spenddown period. This report does not cover qualifying for Medicaid by spending down extra assets that may be covered by the program's look back rule.

Medically Needy Coverage

Federal law gives states the option of providing Medicaid to groups of individuals who do not qualify for coverage because they do not fit into a particular eligible category (e.g., cash assistance recipient). In Connecticut, one such group is the "medically needy," which comprises people who are not eligible as categorically needy (for purposes of cash assistance) but meet eligibility of Aged,

Blind, or Disabled (MAABD, also known as HUSKY C) coverage, except for being over income or asset limits.

The Department of Social Services (DSS) uses the MAABD MNIL and asset criteria to determine eligibility under this coverage group, including to calculate the person's specific spenddown amount. People whose income exceeds the MNIL can qualify for Medicaid coverage after spending down their excess income on certain medical or remedial services for which they, a family member, or certain third parties pay or incur ([42 C.F.R. § 435.301, et. seq.](#), and [42 C.F.R. § 435.1007](#)).

Once a state decides to have a medically needy category, the spenddown policies are mainly prescribed by federal regulations. At the state level, these are found in the DSS Uniform Policy Manual rather than in statute.

Budget Periods

Under federal regulations, states must set the budget period for participants in spenddown at no longer than six months and may use more than one period ([42 C.F.R. § 435.831\(a\)](#)). If the participant is eligible for retroactive eligibility for Medicaid (up to three months before application), their income is counted separately for each month of the retroactive period spenddown and must take into account expenses incurred during that time (see [42 C.F.R. § 436.831\(a\)\(2\)](#) and this [brochure](#)).

Like many states, Connecticut uses a 6-month budget period. The MNIL is set by DSS each year and varies according to the size of the assistance unit (i.e., household) and the region of the state (for [2022](#), this is \$643/month in [Region A](#) and \$532/month in [Regions B and C](#)) in which they reside. DSS applies a standard income disregard to each case. These factors are taken into consideration when determining the amount of a person's income that is over the HUSKY income limit during the 6-month budget period (i.e., spenddown amount). Similar to an insurance deductible, HUSKY will not pay medical expenses up to this amount but may pay for any medical expenses subsequently incurred through the end of the budget period.

Example: Mr. Smith applies for HUSKY in January but is over income by \$100 a month. For his 6-month spenddown budget period from January through June, Mr. Smith's income is over the HUSKY C income limit by \$600 (\$100 a month x 6 months). HUSKY will not pay the first \$600 of medical expenses, up to this spenddown amount. On February 15, Mr. Smith goes to the emergency room and incurs a \$750 expense, which he submits to DSS. As Mr. Smith has met his spenddown "deductible," he now qualifies for HUSKY. HUSKY will pay the \$150 remainder of this bill and for

any eligible medical expenses Mr. Smith incurs from this date through the end of his budget period (June).

DSS notes that spenddowns are only activated after bills are submitted and verified by the department. Thus, if sufficient bills were not submitted until November 21, 2021, for a spenddown cycle running July through December then the person would only be eligible for about 40 days of coverage – not six months of coverage. A new spenddown cycle will start January 1, 2022, and coverage again moves to inactive until additional bills are submitted to meet the next spenddown budget period (January through June). A bill used to become eligible previously cannot be used again, except that an unused portion of a bill may be applied.

Notice and Processing

There is no grace period once a change in a HUSKY participant's eligibility (e.g., receipt of a cost of living increase or Medicare) moves them into a spenddown. However, DSS provides notice of the intended adverse action. According to DSS, the department sends or mails the following notices at least 10 days prior to the date by which a participant enters into a spenddown:

1. Notice of Action (NOA) that outlines the participant's eligibility change to spenddown and provides some related information, and
2. Spenddown Welcome Packet which goes into greater detail about the spenddown process.

These notices include information on the kind of medical bills that can or cannot be applied towards spenddown amounts. DSS notes that as the majority of participants have additional insurance coverage (Medicare and Medicare Savings Program) there may not always be sufficient medical bills to meet their spenddown requirement.

Implications of entering spenddown are particularly important for participants receiving routine, if not daily, medical care like self-directed HUSKY C participants who rely on a home health aide. In such cases, DSS notes that these participants do not always connect personal care assistants as being part of their Medicaid benefit and may not realize that entering a spenddown means that they are ultimately responsible for paying the professional when Medicaid coverage becomes inactive.

Until 2012, DSS staff in the 12 DSS regional offices collected and reviewed medical expenses for spenddown cases. DSS [changed](#) this procedure with the intent to make the process more efficient. Participants in spenddown now directly submit medical bills by mail or fax to a HUSKY Spenddown Processing Center for review. Center staff send correspondence outlining the details about the bills submitted (if bills were accepted) and the remaining spenddown amount, if any. The staff provide

technical assistance to members who call and can answer questions from participants about their HUSKY eligibility.

Policy Changes

With a few exceptions, most of the procedures for the medically needy and spenddown policies have not changed since at least 1988 (UPM §§ [5520.20](#), [5520.20P](#), [5520.30](#)). In 1993, DSS changed the policy manual to conform to a federal change that allows third party payments made by the state or a town on the applicant's behalf to be used towards their spenddown (UPM § [5520.25](#)(B)(1)(b); Transmittal UP No. 93-16).

Most recently, in December 2021, the federal Centers for Medicare and Medicaid Services (CMS) changed [guidance](#) relative to how states can provide coverage to individuals in the medically needy coverage group who receive home and community-based services, such as Community First Choice. Under the new “construction rule,” states may adopt higher effective income and asset eligibility limits for people who need home and community-based services. According to CMS, this option provides states with another tool “to ‘rebalance’ their Medicaid coverage of long-term services and supports from institutional to community-based care.”

JP:rr