IBM Cúram Social Program Management
Version 6.0.5

*Cúram Income Support for Medical
Assistance Spend Down Guide*

IBM

Contents

Figures

Tables

Cúram Income Support for Medical Assistance Spend Down Guide

Spend Down is a medical assistance term that is used for persons whose income and assets are above the threshold for the state's designated medically needy criteria, but are below this threshold when medical expenses are factored in. Eligibility is determined for Spend Down by evaluating evidence that is recorded in the system against a predefined set of rules that are specific to Spend Down.

Introduction

Document Purpose

The purpose of the document is to provide a business level overview of the Spend Down Medical Assistance program and the implementation within Cúram Income Support for Medical Assistance.

It is important to note that this guide does not describe in detail how to use the Cúram application; it does, however, provide some application specifics where it is deemed helpful to the reader in understanding the Spend Down program.

Audience

This document is intended for business users who are interested in understanding the Cúram implementation of the Spend Down Medical Assistance coverage type. After reading this document, it is intended that the business user would have obtained a business level understanding of the program, of the specific evidence recorded in the system for the program, and of the processes for checking coverage type eligibility and the creation and management of the Spend Down product delivery.

Available Documentation

Supporting documentation relating to Medical Assistance and associated coverage types, including Spend Down can be found in the Business Analysts guide titled `Cúram Income Support for Medical Assistance Program Guide`.

Users may also find the business guides for other Medical Assistance programs useful. For Long Term Care, see the `Cúram Income Support for Medical Assistance Long Term Care Business Guide`. For Children's Health Insurance Program, see `Cúram Income Support for Medical Assistance Children's Health Insurance Program Guide`.

Spend Down Medical Assistance Program Overview

Spend Down Overview

Spend Down is a Medical Assistance term used for persons whose income and assets are above the threshold for the state's designated medically needy criteria, but are below this threshold when medical expenses are factored in. The difference between the individual's gross income less deductions and the actual income limit for the particular Medical Assistance program is called the Spend Down amount.

1

Spend Down is calculated on a period basis, and both eligibility and the Spend Down amount are re-determined each period.

An individual can meet the Spend Down amount by submitting allowed medical expenses to reduce/meet the Spend Down amount. Some states permit clients to pay cash to reduce/meet the Spend Down amount; this cash payment is called Pay-In. A combination of certain Expenses and Pay-In can be used to meet the Spend Down amount.

Spend Down is calculated on a period basis. Eligibility and the appropriate Spend Down amount must be re-determined each period. When the individual meets this Spend Down amount, they can receive Medical Assistance coverage from the date that Spend Down was met until the end of the specified Spend Down period. Spend Down does not apply to all Medical Assistance programs. Medical expenses which are allowed to be used to meet Spend Down vary across states.

People covered through a Spend Down approach are known as the Medically Needy. The Spend Down implementation covers the following groups of people that are Medically Needy if they meet income and resource eligibility guidelines or Spend Down to the eligibility guidelines:

- All pregnant women
- All individuals under 18 years of age
- Women who were medically needy during pregnancy must remain eligible for Medicaid services related to the pregnancy for 60-days beginning on the date of her child's birth.
- Individuals receiving long term care

Spend Down Period

Spend Down is calculated on a period basis. A Spend Down period is the defined length of time for which the individual can obtain coverage for Medical Assistance with Spend Down, provided that the individual meets the Spend Down amount calculated for the budget period, the length of which can vary, for example 1 or 6 months. Eligibility and the appropriate Spend Down amount must be re-determined each period. When the individual meets this Spend Down amount, they can receive Medical Assistance coverage from the date that Spend Down was met until the end of the specified Spend Down period.

Budget Period

The budget period is the time frame over which the medically needy individual's income is calculated. The state computes how much the individual's total income over the budget period exceeds the eligibility standard. This excess income is the amount the individual must Spend Down to become eligible for Medical Assistance. Once the individual shows that he or she has incurred medical expenses equal to or greater than the Spend Down amount, s/he will receive Medical Assistance to cover any additional medical expenses for the remainder of the budget period. At the end of the budget period, people must again show how much their income exceeds the state's threshold and again document that they have paid or incurred medical and remedial expenses to meet the Spend Down.

States may set budget periods of any length. The Medical Assistance Spend Down implementation defaults the budget period to one month, which is set by an environment variable within the system. It is important to note that multiple

budget periods within a single Spend Down period, where the caseworker would need to meet the Spend Down in each budget period of the Spend Down period, are not supported.

Retroactive Coverage

An individual may receive up to 3 months Retroactive coverage once determined eligible for a Medical Assistance with Spend Down and once they have met the Spend Down amount for the budget period.

Coverage

This chapter describes the processing involved in the management of a Spend Down product delivery case after it has been created and includes the following sections:

Spending Down

An individual can meet the Spend Down amount by submitting allowed medical expenses or pay-in to reduce/meet the Spend Down amount.

Spend Down Medical Expense Evidence

In the Cúram Spend Down eligibility process, business rules are applied to the medical evidence captured on an individual or household to determine if the medical expense can be used towards the Spend Down amount. The system will automatically validate, classify and define the sort order of the expenses available for use for a period. Not all medical expenses can be used towards Spend Down.

To enable the system to perform these functions, the case worker must enter the following additional information on the Spend Down Medical Expense:

- Who received the service to which the Medical Expense relates and indicate if the service recipient lives at home with the person responsible for payment of the expense
- Indicate if the service is medically necessary
- Indicate if the service is for a service covered under Medicaid
- Indicate if there is any third party liability related to the expense
- Indicate if service recipient has HMO
- Indicate if the service is of a type which is state covered

Classification of the expense can be entered by the caseworker at time of entry. If this field is populated, the system will not attempt to classify the expense. If the field is left blank, the system will automatically classify the expense. This can be subsequently overwritten by the caseworker.

Pay-In Evidence

Pay-In is the term given to payments made by households to State Authorities when the household's income level is slightly higher than the income limit for a Medically Needy Medical Assistance coverage type. Pay-In payments can be used on their own or in conjunction with certain types of expenses in order to meet the Spend Down amount.

When the caseworker captures a Pay-In, a new Pay-In record is recorded for the household member. The recording of payments received is controlled by an environment variable which can be turned off if not using Cúram Financials. If the environment variable to generate Cúram Financials is turned on, the system

automatically generates a Payment Received record within the Cúram Financial module. When the caseworker updates or deletes a Pay-In, these financial records are automatically updated.

Spend Down Eligibility

Introduction

This chapter outlines the process for determining eligibility for the Spend Down Medical Assistance coverage types and for creating the Spend Down product delivery.

Eligibility Determination

The Eligibility Determination process involves the determination of eligibility for the Spend Down Medical Assistance program. Eligibility is determined for Spend Down by evaluating evidence recorded in the system against a predefined set of rules which are specific to Spend Down. In order for an individual to be eligible for Spend Down, that individual must first be eligible on all categories except income for the Medically Needy coverage types specified for Spend Down. Once determined eligible for the Medical Assistance with Spend Down coverage type, the individual must then meet the Spend Down amount for the budget period.

Check Eligibility

The following is a high level summary of the check eligibility functionality.

Caseworkers are provided with the ability to:
- Check eligibility executes rules for medical assistance coverage types including medical assistance programs with Spend Down
- View the decisions (eligible & ineligible)
- View the automatically calculated Spend Down amount

Spend Down is calculated on a period basis. Eligibility and the appropriate Spend Down amount must be re-determined each period. When the individual meets this Spend Down amount, he or she can receive Medical Assistance coverage from the date that Spend Down was met until the end of the specified Spend Down period.

Rules

In the Cúram Spend Down eligibility process, business rules are applied to the evidence captured on an individual or household to determine potential eligibility for Medical Assistance with Spend Down. The business rules are based on the Medically Needy coverage type for which Spend Down is determined for.

Spend Down Details

Once eligibility has been determined for Medical Assistance with Spend Down the caseworker is presented with eligibility results from which the caseworker can select to authorize, decline or deny. If the caseworker selects to authorize an eligible result for a household member(s) eligible for Medical Assistance with Spend Down, the system will either create a new Spend Down product delivery or reuse an existing one. If the household member(s) has an existing Spend Down product delivery of the same type on the current integrated case, the system will update the existing Spend Down product delivery Spend Down details record with the new Spend Down period.

The household member must then furnish sufficient Medical Expense evidence or provide Pay-In, which the caseworker records as evidence in the system. Caseworkers are then required to enter additional Spend Down Medical Expense information to enable the system to classify the expense, automatically determine if it can be used, and present the available expenses to the caseworker in the appropriate order for use toward the particular Spend Down period.

Spend Down details are listed for all Spend Down periods determined for the household member(s) on the Spend Down product delivery. A caseworker may view Spend Down details for all Spend Down periods.

Retroactive Eligibility

An individual may receive up to 3 months Retroactive coverage once determined eligible for a Medical Assistance with Spend Down and once they have met the Spend Down amount for the budget period. The individual can receive a maximum of 3 months retroactive coverage. This covers the three-month period directly prior to the date of application for the Medical Assistance program.

Tip: For example, if a client applies for Spend Down on April 7th, then the three-month Retroactive period is January 7th - March 31st.

Individuals can also apply for retroactive coverage when there has been a break in program coverage of 30 days or more and they have not received coverage under any other coverage type (except Cost Sharing) during that period. Retroactive coverage will only be given on a month by month basis during this period up to a maximum of 3 months. Each month within the retroactive period is treated as a separate Spend Down period. Individuals must meet both the coverage type eligibility requirements and the Spend Down amounts in each individual month in order to receive retroactive coverage for that month.

The caseworker can trigger the system to check for retroactive eligibility on application or post application. If checking post application the caseworker must select the retroactive period they require eligibility to be determined for retroactively. The caseworker is presented with eligibility results from which the caseworker can select to authorize, decline or deny. If the case worker selects to authorize an eligible result for a household member(s) eligible or Medical Assistance with Spend Down, the system will either create a new Spend Down product delivery or reuse an existing one. If the household member(s) has an existing Spend Down product delivery of the same type on the current integrated case, the system will update the existing Spend Down product delivery with the retroactive Spend Down periods.

Spend Down Case Processing

Introduction

This chapter describes the additional case processing available to maintain and monitor a Spend Down product delivery case throughout its lifecycle. It begins with an overview of the information that can be viewed for a Spend Down product delivery case. The chapter then describes how a caseworker can apply a household member's expenses or pay-ins towards the Spend Down amount. The last two sections of the chapter describe reassessment processing and case closure for Spend Down product delivery cases.

Spend Down Details

From the Spend Down product delivery the caseworker can view the details of all Spend Down periods and Spend Down details records. The Spend Down Details page displays the start and end dates of the Spend Down period, the Spend Down amount for the period, the outstanding amount, the Spend Down status, whether or not Spend Down has been met, the reason if not met, and the Spend Down period status.

For each Spend Down Period, the caseworker can view the amounts and order in which Expenses/Pay-Ins have already been selected for use towards the Spend Down period.

Spend Down Coverage Start Date

The date of coverage is based on a number of factors including the date of the last evidence item used to reduce the outstanding Spend Down amount to zero, the date of application for the period and the start and end dates of the Spend Down period.

Generally the date of application is earlier than the Spend Down period end date. When the date of last evidence item used to meet Spend Down has a date prior to the date of application, the coverage start date is set to the date of application. When the date of the last evidence item used to meet Spend Down has a date post the date of application, the coverage start date is set to the date of the evidence item. If a Medical Expense is used, the incurred date of the expense is set, if Pay-In is used, the date paid is set.

If the date of application is later than the Spend Down period end date, the date of the last evidence item used to meet Spend Down has a date prior to the start date of Spend Down period, the coverage start date is set to the start date of Spend Down period. When the date of last evidence item used to meet Spend Down has a date post the start date of Spend Down period, the coverage start date is set to the date of the evidence item. If a Medical Expense is used, the incurred date of the expense is set, if Pay-In used, the date paid is set.

The coverage start date for Retroactive periods is set to the Retroactive Period start date for the first and second months this is from the first of the month, for the third month this is based on the date of application in the application month.

Applying towards Spend Down

The caseworker selects the evidence and the amounts to apply towards the Spend Down from either Expenses or Pay-Ins by selecting the required "Apply" link for the Spend Down period. Caseworkers can apply amounts directly from existing Expenses/Pay-Ins. Selecting an amount to apply from an Expense/ Pay-In will automatically recalculate the outstanding amount. Caseworkers repeat this process of allocating amounts until the outstanding amount is reduced to zero.

Order Expenses/Pay-In Applied

The system will initially define the order in which the expenses should be applied based on rules. This is presented to the caseworker in the list of expenses available for use. When the caseworker selects to use an Expense/Pay-In, the systems assigns an order number to the evidence item. The first evidence item selected for use is assigned an order number of 10, and each subsequent evidence item increases in increments of 10.

Caseworkers can modify the order of use and the amounts of evidence selected by selecting the edit option on the item they wish to modify in the list of Applied Expenses/Applied Pay-Ins. If the caseworker wishes to have one piece of evidence used before another piece of evidence they just set the order number on that evidence item to a number less than the order number of the previous evidence item, the lowest order number is 1.

Applying Expenses

The caseworker can view the current outstanding Spend Down amount, select an available expense and specify the amount to apply from that expense towards Spend Down. The caseworker can only select one expense from the list per transaction. The system will execute rules which will automatically validate, classify and order expenses for use based on the information recorded by the caseworker.

Applying Pay-In

The caseworker can view the current outstanding Spend Down amount, select an available Pay-In and specify the amount to apply from that Pay-In towards Spend Down. The caseworker can only select one Pay-In from the list per transaction. The list of available Pay-Ins returned are listed in the order of oldest first.

Spend Down Expense/Pay-In Rules

The Spend Down rules determine if the medical expenses are valid, the classification of the medical expense and the order the medical expense should be applied towards Spend Down. Pay-In order is also determined based on the sort order rules.

Valid Expense: Valid medical expenses are determined as follows:
- Is an allowable medical expense AND
- Medical Expense occurred within the medical expense expiry time limit AND
- Medical Expense is medically necessary AND
- Medical Expense is NOT on hold AND
- Medical Expense has an available amount AND
- Medical Expense is available for use towards Spend Down AND
- Medical Expense was incurred by a valid household member
- Allowable Medical Expenses are documented in the decision tables within the implemented rule set.

Available Amount: The amount available for use towards Spend Down for a Medical Expense:
- Use the medical expense obligated amount AND
- Determine the amount applied towards Spend Down in other Spend Down periods AND
- Subtract the total amount applied towards Spend Down in other Spend Down periods from the obligated amount AND
- The balance remaining is the available amount

Available for Use: A medical expense is only available for use towards Spend Down if it meets the following:
- Medical expense is unpaid OR
- Medical expense is part paid OR
- Medical expense is paid in full AND

- Date paid in full is the application month OR
- Date paid in full is a retroactive month

Valid Member: Valid members include the client and any family members who satisfy certain criteria:
- Is the client OR
- Is a family member AND
- Is in receipt of Medical Assistance OR
- The family member is disqualified from Medical Assistance OR
- The family member deems to the client
- Member lives at home with the person responsible for payment of the expense

Classification: Medical expenses are classified as either incurred or deductible:
- Medical expense is incurred OR
- Medical expense is deductible OR
- If the medical expense is unclassified determine classification AND
- Set the medical expense classification as incurred if determined to meet the criteria for an incurred medical expense OR
- Set the medical expense classification as deductible if determined to meet the criteria for a deductible medical expense OR

Incurred: A medical expense is considered incurred when:
- Medical expense was incurred for a service which would be covered by Medical Assistance OR
- Medical expense was incurred by a person who was covered under Medical Assistance at the time they incurred the expense

Deductible: A medical expense is considered deductible when:
- Medical expense is medically necessary and was incurred by a person on a date they were not eligible for Medical Assistance AND
- Medical expense was incurred for services which are not payable for Medical Assistance

Sort Order: Determines the order in which medical expense should be applied towards a Spend Down period for valid expenses which are available for the Spend Down period at the time of determination:
- Medical expenses paid in full, oldest paid first
- Unpaid medical expenses classified as deductible, oldest incurred first
- Unpaid medical expenses classified as deductible, oldest incurred first

Expenses which are not available for use are stored by the system but are not presented to the caseworker.

Modify Applied Expense/Pay-In

The caseworker can modify the amount of an Expense/Pay-In which has been previously specified by the caseworker to be applied to the Spend Down period, or modify the order number of the Expense/Pay-In.

Validations exist to prevent entering an amount that is greater than the outstanding amount or greater than the amount available on the Expense/Pay-In.

The current Spend Down Details record is either updated or superseded. If the Modify Applied Expense/Pay-In is performed in a Spend Down period where the Spend Down status is " Not Approved", the current Spend Down Details record is updated rather than superseded. The amount used and the amount available for use for each Expense/Pay-In is updated and listed on the Spend Down Details page. If the Spend Down status is "Approved" then the record is superseded and a new record is created with the updated details. If, as a result of the modification, the outstanding amount is greater than 0, then the Spend Down details must be modified accordingly.

Undo Applied Expense/Pay-In

The caseworker can undo the application of the amount of an Expense/Pay-In which has been previously specified by the caseworker to be applied towards the Spend Down period.

If the Undo Applied Expense/Pay-In is performed in a Spend Down Period where the Spend Down status is " Not Approved", the current Spend Down details record is not superseded and the Expense/Pay-In is updated with the amount used and the amount available for use. The current Spend Down details record is updated, and the Expense/Pay-In is removed from the list of Applied Expenses/Pay-Ins. If the Spend Down status is "Approved", then the record is superseded and a new record is created with the updated details. If, as a result of the undo, the outstanding amount is greater than 0, then the Spend Down details must be modified accordingly.

Unassign All

Functionality exists to undo the application of all evidence (both Expenses and Pay-Ins), which had been previously specified by the caseworker to be applied towards the current Spend Down period (regardless of whether the evidence has been applied towards Spend Down or not) in a single request. The outstanding Spend Down amount is automatically updated.

The system then automatically updates the evidence, and the evidence items will be available to the caseworker for selection in the appropriate Spend Down periods. The old Spend Down Details record for the period is either superseded or updated depending on the current Spend Down status.

The updated/superseded record shows the standard Spend Down details including the Spend Down amount and the new outstanding amount, but the Applied Expense and Applied Pay-In sections are not populated in the record. Caseworkers must then manually apply evidence again to each of the periods affected.

Approve Spend Down Period

Once the Spend Down amount has been reduced to zero the caseworker can approve the Spend Down period. By selecting Approve Spend Down Period the system will proceed with the application of the selected evidence towards the Spend Down period.

Validations check the combination of evidence entered, and providing there are no errors, the system will automatically check the outstanding Spend Down amount for the period. The system automatically updates the following:

• The Spend Down status for the current period is set to "Approved" and the outstanding amount set to zero.
• The product delivery is set to Active when the Spend Down period is the current period.

- The Spend Down reason for the period is set to "Spend Down Met" and the Spend Down coverage date is populated.
- The Expense/Pay-In is updated with amount used and amount available for use.
- A "Spend Down Program Coverage Active" communication is issued to the household member. This communication outlines the Spend Down details for the period, the coverage period, and the evidence used to meet the Spend Down.

Deny Spend Down Period

If a client fails to provide enough Expenses/Pay-In to reduce the Spend Down amount to zero or they choose not to proceed, the caseworker may deny the Spend Down period. The caseworker must enter a reason to indicate why Spend Down cannot be met for the period. Once the reason is entered and the caseworker selects to save, the system will automatically set the status of the product delivery to "Closed" when the Spend Down period is the current period. The product delivery status will not be reset if the Spend Down period is a past period.

The Spend Down status for the period is set to "Denied", and the Spend Down reason is set to the reason the caseworker selects, for example "Insufficient Expenses". As Spend Down was not met for this period, the system reverses the application of the amounts specified from the Expenses/Pay-Ins and updates the amounts available.

Reassessment

A Spend Down case can be reassessed at various stages over a given period of time when a change of circumstance has occurred. Reassessment detects whether an individual is potentially eligible for other Medical Assistance coverage types. If ineligible, the system recalculates the Spend Down amount for the period(s) affected by the change in evidence. The reassessed amount may be greater or less than the previously calculated amount and thus different processing is required to handle this. The household member may decide it is not beneficial to retain coverage after reassessment. This section details the possible change in circumstances and their impact.

Change in Circumstance

Changes made to income, expense or household evidence for Integrated Cases which have a Spend Down product delivery case will have their Spend Down product delivery cases reassessed. A household member may have been eligible for different Medical Assistance coverage types in different Spend Down periods, and it is therefore possible that he or she may have a few different Spend Down product delivery cases on the same Integrated Case. The household member can only have one current (open, approved, active, rejected, suspended) Spend Down product delivery case in any Spend Down period.

Changes to Income and/or Expenses evidence, for example Child Support, Dependent Care, Employment evidence, may reduce or increase the income and may also trigger reassessment.

The addition or removal of a household member may also increase or decrease the income of the household, thus requiring reassessment.

An income change tolerance amount is defined as an environment variable which when set, will prevent any system action on existing Spend Down periods provided the income evidence changes are within the agreed tolerance amount of the original total net income of the income unit. The tolerance is defined as a

percentage of the total net income and is defaulted to 1% within the system. The income change tolerance only applies to changes in income; it does not apply to changes in income limits.

If the evidence change occurs in the current period, only the current period is affected. If the evidence change effects a past period, all periods from that point onwards will be reassessed.

It is understood that household members must provide details of change in circumstances/evidence within a timely manner, normally within 10 days of the occurrence of the change and thus most evidence changes only effect the current period. However it is necessary to support reassessment across past periods to cater for acceptable late arriving evidence or inaccurate evidence details entered in error by the caseworker.

Recalculate the Spend Down Amount: When the household is not eligible for another coverage type as a result of the change of evidence, reassessment triggers the recalculation of the Spend Down amount for the period(s) affected by the change in evidence. The new recalculated amount may be greater or less than the previously calculated amount and thus different processing is required to handle this.

New Spend Down Amount greater than old Spend Down Amount: If the newly recalculated Spend Down amount is greater than the previous amount for that Spend Down period, and the previous Spend Down amount was met for the period, the system automatically updates several records. The current Spend Down Details record for that period is superseded, the outstanding amount and Spend Down details are updated with the indicator reset to not met. If the change occurs in the latest Spend Down period, or if in past period when product delivery case status is closed, then the product delivery case status is reset to "Approved". If it is a past period and the product delivery case status is other than closed, the status of the product delivery case is not reset.

The caseworker may then either choose to retain coverage for the affected period or not, and there are different processes required to cater for either possibility which are detailed below. This process is repeated for each period affected.

Retain Coverage after recalculation of Spend Down amount: If the caseworker chooses to retain coverage for the affected period, he or she must meet the new Spend Down amount by using existing or submitting new Expense/Pay-In evidence to reduce the new Outstanding Spend Down amount to zero. If it is a past period that is affected, the caseworker must undo the application of all Expense/Pay-In evidence from the beginning of the following Spend Down period onwards, so as Expense/Pay-In evidence is applied correctly from the affected period onwards. The caseworker can view the information in the current Spend Down Details record for the period and apply the evidence for use towards the Spend Down.

Once the outstanding Spend Down amount has been reduced to zero and the caseworker has approved the Spend Down period, the system sets the current Spend Down status for each period to "Approved", sets the Spend Down reason to "Spend Down Met" and adjusts the coverage start date, if necessary. The expenses are updated with the amount used and amount available for use, and when the Spend Down period is the current period, the product delivery case status is set to "Active"; if Spend Down period is a past period, the product delivery case status is not reset.

A communication is issued to the household member, "Spend Down Program Coverage Active", which outlines the Spend Down details for the period, and shows the date Spend Down was met, the coverage period, and the evidence used to meet the Spend Down.

Not Retain Coverage after recalculation of Spend Down amount: The caseworker may choose not to retain coverage for the affected period, as he or she decides it is not beneficial to do so, or there are insufficient expenses to meet the new higher, re-calculated Spend Down amount. The caseworker denies the Spend Down period which sets the status to "Denied", they must also select a reason for the denial.

The system automatically undoes the application of the Expenses/Pay-Ins used in the period so they are available for use in a future period. As coverage is not retained, the Spend Down period status is set to "Not Approved", the used amount and available for use amounts on the expenses are updated.

If the period affected is a current period and no applications have been received for a future period, the caseworker must trigger the standard close case function from the product delivery home page.

New Spend Down Amount less than old Spend Down Amount: If the newly recalculated Spend Down amount is less than the previous amount for that Spend Down period, it can bring about two possibilities:

- Where the Spend Down was met for that period as a result of the recalculation, the household member has overpaid for the period and the overpayment must be addressed.
- Where the Spend Down was not met for that period, but with the new recalculated lower Spend Down amount, the household member could have been able to meet it with the expenses available at that point in time and the potential eligibility must be addressed.

Over Payment due to Recalculation of Spend Down: When the system detects that there has been an overpayment by the household member towards a Spend Down period due to recalculation of Spend Down, the system automatically supersedes the current Spend Down Details record for that period. The new negative outstanding amount is updated on the current Spend Down Details record, which indicates the amount by which the household member has overpaid.

Potential Eligibility for Medical Assistance Program with Spend Down due to Recalculation of Spend Down: The system automatically recalculates the Spend Down amount as a result of reassessment. In the instance where the Spend Down amount is reduced and the household member did not meet the previously higher Spend Down amount, the member may have possibly been able to meet the lower Spend Down with the expenses available at the time. The system cannot determine if the household member could have met it, and it is therefore necessary for the household member to be given the option to reapply for the past period. The system automatically supersedes the current Spend Down Details record for that period and updates with the new lower Spend Down amount.

Ineligible after Reassessment: When reassessment returns an ineligible result for a previously eligible Spend Down period, the system must close the product delivery case and update the end date of the Spend Down period depending on the length of the Spend Down period.

Eligibility Renewal

The current implementation of the Spend Down program does not cater for eligibility renewal. If a household member wants coverage for an ensuing period, the caseworker follows a manual process whereby the claimant must reapply for Spend Down.

Closing Product Delivery Case

A Spend Down product delivery case may be closed at any point in the lifecycle of the product delivery. The caseworker can close a product delivery by choosing the close link on the product delivery home page. When the caseworker submits the close request, the system automatically:

- Sets the status of the product delivery case to closed
- Issues the appropriate communication to the household member (defined by templates)
- Closes all tasks associated with the case

In the event that the manual closure is requested before the end of a Spend Down period, the system automatically sets the end date for the Spend Down period to the last day of the month in which the product delivery was manually closed.

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