5160:1-3-04.1 **Medicaid: Eligibility through the Spenddown Process.**

(A) The purpose of this rule is to set forth the spenddown process used in medicaid eligibility determinations for aged, blind, or disabled (ABD) individuals. The spenddown process provides a means through which an individual who meets all eligibility criteria other than the income test can qualify for coverage for one or more months as an aged, blind, or disabled individual as described in rule 5160:1-3-02.

(B) Definitions.

(1) "Aged, blind or disabled (ABD) medicaid program" means the program set forth in Chapter 5160:1-3 of the Administrative Code. The only three medicaid categories for which the spenddown process applies are: medicaid for the aged, medicaid for the blind, and medicaid for the disabled.

(2) "Countable income" has the same meaning as in rule 5160:1-3-03.11 of the Administrative Code.

(3) "Current incurred medical expense" means a medical bill or a portion of a medical bill that:

(a) Must be:

(i) For a medically necessary medical item or service provided to the individual or to the individual's family member during the month for which the individual is seeking to obtain medicaid eligibility through the spenddown process; and

(ii) An expense the individual or family member is liable to pay, regardless of whether the individual or family member has already paid it.

(b) Includes a transportation expense, as defined in paragraph (B)(13) of this rule, incurred by the individual or family member during the month for which the individual is seeking to obtain medicaid eligibility through the spenddown process.

(c) Does not include:

(i) An expense that has already been used in the spenddown process as a basis for approving medicaid eligibility for any individual; or

(ii) Any expense excluded from earned income as an "impairment-related work expense (IRWE)" as described in 20 C.F.R. 404.1576 (as in effect on March 1, 2014); or

(iii) Any expense excluded from earned income as a "blind work

expense" as defined in rule 5160:1-3-03.11 of the Administrative Code; or

(iv) An expense the individual or family member has not yet incurred for a medical item or service because it has not yet been provided.

(4) "Family member," for the purpose of this rule:

(a) For an individual of any age, means:

(i) The individual's spouse or deceased spouse, unless a court has eliminated the individual's duty of medical support to such spouse; or

(ii) The individual's natural or adopted child under the age of eighteen, including a deceased child, unless a court has eliminated the individual's duty of medical support to such child; or

(iii) The individual's former spouse, including a deceased former spouse, provided the individual has a duty of medical support to the former spouse.

(b) For an individual under age eighteen, means:

(i) The individual's natural or adoptive parent, unless a court has eliminated such parent's duty of medical support to the individual; or

(ii) The individual's sibling (including half-siblings) under the age of eighteen, who lives with the individual; or

(iii) The individual's deceased parent, provided that the surviving parent, who lives with the individual, had a duty of medical support of the deceased parent at the time of his or her death; or

(iv) The individual's deceased sibling (including half-siblings), provided the deceased sibling lived with the individual at the time of his or her death, and a parent who lives with the individual had a duty of medical support to the deceased sibling at the time of his or her death.

(c) Does not include a step-parent, a step-child or a step-sibling.

(5) "Incurred" means that the individual or family member has become liable to pay a medical bill as defined in paragraph (B)(8) of this rule. An expense is incurred on the date liability for the expense arises.

(6) "Individual," for the purpose of this rule, means a person or married couple applying for or receiving medical assistance and subject to the spenddown process in this rule.

(7) "Medicaid need standard" means the income limit set forth in rule 5160:1-3-03.5 of the Administrative Code that is applicable to the individual.

(8) "Medical bill" means an invoice for a medically necessary medical item or service provided to the individual or family member.

(9) "Medical insurance premiums" means the amount paid for insurance coverage for medical items or services such as health, dental, vision, long term care, hospital, prescriptions, etc.

(10) "Medically necessary" has the same meaning as in rule 5160-1-01 of the Administrative Code.

(a) Medical insurance premiums as defined in paragraph (B)(9) of this rule, and nursing facility (NF) and intermediate care facility for individuals with intellectual disabilities (ICF-IID) costs of care as described in paragraph (E)(3) of this rule, are always considered medically necessary.

(b) The administrative agency may generally accept that medical expenses and bills submitted in the spenddown process are for items or services that were medically necessary. In an unusual situation, the administrative agency may question whether an item or service was medically necessary. In such a situation, the administrative agency will need to determine whether the item or service was medically necessary by following these steps:

(i) Contact the individual and assist the individual with gathering relevant information from the medical provider and other appropriate persons about the medical necessity of the item or service.

(ii) If the medical provider of the item or service indicates that item or service was not medically necessary, the administrative agency shall not use the expense for that item or service in the spenddown process.

(iii) If the medical provider of the item or service indicates that the item or service was medically necessary, the administrative agency may use the expense for that item or service in the spenddown process in accordance with the other provisions of this rule. If the administrative agency questions the provider's statement

regarding medical necessity, the administrative agency must ask the prior authorization unit (PAU) of the Ohio department of medicaid (ODM) to determine whether the item or service was medically necessary.

(iv) If the PAU decides that the item or service was medically necessary, the administrative agency must use the expense for that item or service in the spenddown process in accordance with the other provisions of this rule. The PAU decision is for the sole purpose of determining whether the item or service was medically necessary. The PAU decision is not for the purpose of determining whether to prior authorize the item or service under rule 5160-1-31 of the Administrative Code, nor for the purpose of determining whether the item or service is payable by the medicaid program.

(v) If the PAU decides that the item or service was not medically necessary, the administrative agency shall not use the expense for that item or service in the spenddown process.

(11) "Spenddown amount" means the dollar amount by which the individual's countable income exceeds the applicable medicaid need standard. The individual must satisfy the spenddown amount in accordance with paragraph (D) of this rule in order to become eligible for medicaid for all or part of a given month.

(12) "Subject to the spenddown process" means that the individual:

(a) Meets the criteria for age, blindness, or disability as defined in rule 5160:1-3-02 of the Administrative Code; and

(b) Has countable monthly income that exceeds the medicaid need standard applicable to the individual; and

(c) Is otherwise eligible for the ABD medicaid program.

(13) "Transportation expense" means a reasonable expense incurred by the individual or family member for transportation that is needed to obtain a medically necessary item or service.

(a) Transportation expenses include but are not limited to the following:

(i) Charges for public transportation;

(ii) Expenses related to the transportation such as parking fees and tolls;

(iii) The state mileage reimbursement rate as set by the Ohio office of

budget and management for the use of a private motor vehicle owned by the individual or family member, in effect on the date of travel;

(iv) The actual expense incurred by the individual or family member for transportation by a private motor vehicle not owned by the individual or family member;

(v) Overnight lodging expenses if overnight travel is needed to obtain the medical item or service;

(vi) Actual expenses for meals, up to thirty dollars per person per day, subject to the restrictions in paragraph (B)(13)(a)(vii) of this rule, when overnight travel is required;

(vii) Attendant care costs and/or the costs of a companion if a medical provider verifies that an attendant and/or companion is required due to the age, physical, and/or mental condition of the individual or family member; and

(viii) Expenses related to delivering a medical service or item to the individual or family member.

(b) Transportation expenses do not include the following:

(i) The cost of transportation provided to the individual or family member through county-administered transportation assistance; or

(ii) Any transportation expenses excluded from income as an "impairment-related work expense" (IRWE) as described in 20 C.F.R. 404.1576 (as in effect on September 1, 2014); or

(iii) Any transportation expense excluded from earned income as a "blind work expense" as defined in rule 5160:1-3-03.11 of the Administrative Code.

(c) The administrative agency may generally accept that transportation expenses submitted in the spenddown process are for transportation that was needed to obtain a medically necessary item or service and that the cost is reasonable. If the administrative agency questions whether a transportation expense was needed and/or reasonable, the administrative agency will need to determine whether the expense was needed and/or reasonable by following these steps:

(i) Contact the individual and assist the individual with gathering relevant information from the medical provider and other appropriate persons concerning all of the relevant circumstances

including the following:

(A) The age, physical and mental condition and transportation needs of the individual; and

(B) The medical item or service for which the individual needed the transportation; and

(C) The suitability of the transportation alternatives reasonably available to the individual; and

(D) The reasonableness of the expense based on the circumstances; and

(E) Any other relevant factors.

(ii) After considering all of the above factors, if the administrative agency determines that the expense or a portion of the expense was not needed and/or not reasonable, the administrative agency shall not use the expense in the spenddown process.

(14) "Unpaid past medical expense" (UPME) means a medical bill or a portion of a medical bill, as defined in paragraph (B)(8) of this rule, that:

(a) Is still owed, and is not subject to payment by a third party who is legally obligated to pay the bill; and

(b) Is not a NF or ICF-IID bill that is owed for services provided to a family member; and

(c) Has not been used in a previous month to meet a spenddown amount.

(C) Calculation of spenddown amount. If the individual's countable monthly income, as determined in accordance with rule 5160:1-3-03.11 of the Administrative Code, exceeds the applicable medicaid need standard, the administrative agency must calculate the amount, if any, of the monthly spenddown as follows.

(1) Medical insurance premiums.

(a) Determine the total amount of all monthly medical insurance premiums of the individual and family members. Do not round down. Subtract that amount from the individual's countable monthly income and round down to the nearest whole dollar.

(i) If the result is less than or equal to the applicable medicaid need standard, the individual is eligible for medicaid for the entire month without any monthly spenddown amount.

(ii) If the result is greater than the applicable medicaid need standard, continue to paragraph (C)(2) of this rule.

(b) An individual who is eligible for a medicare premium assistance program (MPAP) in accordance with rule 5160:1-3-02.1 of the Administrative Code has the option to decline such eligibility.

(i) If the individual accepts MPAP eligibility and the administrative agency has obtained verification that the medicaid program has begun paying the individual's medicare premiums, then the individual's medicare premiums are not deducted in the spenddown process.

(ii) If the individual declines MPAP eligibility, then the individual's medicare premiums, if paid, are deducted at the step set forth in paragraph (C)(1)(a) of this rule.

(2) Determine the total NF or ICF-IID cost of care for the individual as calculated in accordance with paragraph (E)(3) of this rule. Do not round down. Subtract that amount from the result calculated in paragraph (C)(1)(a) of this rule and round down to the nearest whole dollar.

(a) If the result is less than or equal to the applicable medicaid need standard, the individual is eligible for medicaid for the entire month without any monthly spenddown amount.

(b) If the result is greater than the applicable medicaid need standard, continue to paragraph (C)(3) of this rule.

(3) Determine the total amount of the individual's and family members' UPMEs as determined in accordance with paragraph (E)(2) of this rule. Do not round down. Subtract that amount from the result calculated in paragraph (C)(2) of this rule and round down to the nearest whole dollar.

(a) If the result is less than or equal to the applicable medicaid need standard, the individual is eligible for medicaid for the entire month without any monthly spenddown amount.

(b) If the result is greater than the applicable medicaid need standard, the amount that is over the need standard is the individual's monthly spenddown amount. In order to become eligible for medicaid for all or part of the month, the individual must satisfy the monthly spenddown amount through one of the methods set forth in paragraph (D) of this rule.

(D) Ways of meeting spenddown. If the individual has a monthly spenddown amount

calculated in accordance with paragraph (C) of this rule, the individual may satisfy, or meet, the spenddown through one or more of the following methods, and must do so each month in order to be eligible for medicaid:

(1) Recurring.

(a) The individual meets the spenddown requirement for one or more months if the individual is found eligible for Medicaid pursuant to paragraphs (C)(1), (C)(2), or (C)(3) of this rule.

(b) If the individual's and/or family members' expenses described in paragraph (C) of this rule are not equal to or greater than the spenddown amount for a given month, the individual may satisfy the spenddown amount by using one or more of the methods set forth in paragraphs (D)(2) to (D)(4) of this rule.

(2) Incurred. This method is frequently called "delayed spenddown".

(a) At the individual's option, the individual may satisfy spenddown for a month by incurring a dollar amount of current medical expenses, as defined in paragraph (B)(3) of this rule, equal to or greater than the spenddown amount for the month.

(b) If the individual does so, the individual is eligible for medicaid for the month starting on the date the individual and/or family member(s) incurred the current medical expenses that, combined with all other current incurred medical expenses for the month, equal or exceed the individual's spenddown amount for the month.

(3) Pay-in.

(a) At the individual's option, the individual may satisfy spenddown for a month by paying to the administrative agency the dollar amount of the spenddown amount for the month.

(b) If the individual does so, the individual is eligible for medicaid for the entire month.

(c) A third party may pay in on behalf of the individual or a group of individuals subject to spenddown by making payments directly to the administrative agency from the third party's funds or other funds. Such payments are not considered income, are not included in the individual's countable monthly income, and do not negatively affect the individual's medicaid eligibility.

(4) Combination of methods.

(a) At the individual's option, the individual may meet the spenddown by using the incurred method described in paragraph (D)(2) of this rule for one or more months, and the pay-in method described in paragraph (D)(3) of this rule for one or more other months.

(b) At the administrative agency's option, the administrative agency may permit the individual to combine the two methods in a single month as follows:

(i) After the individual and/or family member has incurred an amount of current medical expenses for the month that is less than the individual's spenddown amount for the month, the administrative agency may permit the individual to pay in the difference between the current incurred medical expenses and the spenddown amount.

(ii) If the individual does so, the individual is eligible for medicaid for the month starting on the date the individual or family member incurred the last current medical expense for the month.

(5) Failure to satisfy spenddown for a month. If the individual does not satisfy spenddown for a month, the individual is not eligible for medicaid for the month but may be eligible for any future month in which the individual satisfies spenddown.

(E) Treatment of expenses.

(1) Treatment of current incurred medical expenses subject to payment by a third party:

(a) If covered by medicare:

(i) If the medicare expense is one for which the individual does not have supplemental medicare coverage, the amount of the current incurred medical expense shall be:

(A) Until the individual's medicare deductible is met: one hundred per cent of each such medicare expense; and

(B) After the individual's medicare deductible is met:

(i) If the medicare approved rate is known, twenty per cent of the medicare approved rate; or

(ii) If the medicare approved rate is not known, twenty percent of the charge for each such expense.

(ii) If the medicare expense is one for which the individual has supplemental medicare insurance, the expense shall not be considered a current incurred medical expense.

(b) If written off by the provider: the expense is treated as a current incurred medical expense for the month in which the item or service was provided.

(c) If paid, or subject to payment, by a third party that is not legally obligated to pay the expense for the individual or family member: the expense is treated as a current incurred medical expense for the month in which the item or service was provided, even if it is paid by the third party later in the same or a subsequent month.

(d) If paid or subject to payment by a third party that is legally obligated to pay the expense or a portion of the expense for the individual or family member: the expense is not treated as a current incurred medical expense.

(e) If an agency or program provides a direct medical service based on a "sliding" or "ability-to-pay" fee scale, only the amount the individual or family member is liable to pay for the service is treated as a current incurred medical expense.

(2) Treatment of UPMEs. For the purposes of calculating the spenddown amount, the amount of UPME to be subtracted is determined in accordance with this paragraph.

(a) A UPME is considered to have been incurred in the month during which the provider supplied the item or service to the individual or family member.

(b) The individual is not required to pay or provide evidence of paying the UPME for medicaid purposes.

(c) UPMEs that may be applied in the spenddown process are:

(i) Incurred during a month in which the individual or family member receiving the item or service was not eligible for medicaid.

(ii) Incurred during a month in which the individual did not satisfy the monthly spenddown amount even with the application of the bill.

(iii) For a medical item or service that was not paid, or payable, by medicaid regardless of whether the individual receiving the item or service was eligible for medicaid during the month in which

the UPME was incurred because the UPME is for an item or service:

(A) That was not covered by medicaid; or

(B) That was supplied by a provider who was not participating in medicaid; or

(C) That was supplied by a medicaid provider who did not accept medicaid for the UPME.

(d) For an individual residing in a NF or ICF-IID:

(i) Any unpaid NF or ICF-IID costs incurred while the individual was in a period of restricted coverage as the result of an improper transfer of assets, as provided in rule 5160:1-3-07.2 of the Administrative Code, cannot be used as a UPME until the period of restricted coverage has expired.

(ii) Any NF or ICF-IID costs that were used to satisfy spenddown liability during a period of restricted coverage, and that remain unpaid after the period of restricted coverage has expired, shall not be used as a UPME.

(e) The administrative agency shall assist the individual with choosing the amount of the UPME to apply, and the month(s) for which to apply it. To assist the individual with making an informed decision, the administrative agency shall determine the minimum number of months for which the UPME might be applied. To make this determination, the administrative agency shall:

(i) Determine the combined total of all the UPMEs of the individual and family members;

(ii) Divide the total UPME by the result calculated in paragraph (C)(2) of this rule;

(iii) The quotient is the minimum number of months the UPME would allow the individual to meet the spenddown amount, assuming no changes in any factor that would affect the calculation of the spenddown amount.

(f) The amount of the UPME the administrative agency must subtract in the calculation of the spenddown amount in paragraph (C)(3) of this rule is either:

(i) The amount of the UPME the individual chooses to use; or

(ii) If the individual does not choose an amount to use, the difference between the result calculated in paragraph (C)(2) of this rule and the medicaid need standard applicable to the individual.

(g) A UPME or portion of a UPME that the administrative agency applies toward the spenddown for a given month cannot be used again in the spenddown process for a future month.

(h) A UPME or portion of a UPME that the administrative agency does not apply toward the spenddown can be used to meet the spenddown for a future month.

(3) Treatment of NF or ICF-IID cost of care. For the purposes of calculating the spenddown amount for an individual who resides in a licensed NF or ICF-IID, the cost of care is determined as follows.

(a) If the facility is certified for the medicaid program, the cost of care is the medicaid per diem rate.

(b) If the facility is not certified for the medicaid program, the cost of care is the amount the facility requires the individual to pay (private pay rate) for the care received, but both of the following conditions must be met:

(i) The facility has a current license from the Ohio department of health; and

(ii) The individual's attending physician has provided a written statement that care in the facility is medically necessary.

(c) The NF or ICF-IID cost of care of the individual's family member cannot be used in the spenddown process.

(4) Treatment of medical expenses used in the spenddown process. Any medical expenses of the individual or family member that are used in the spenddown process to approve the individual's medicaid for a given month remain the obligation of the individual or family member and are not payable by the medicaid program.

(F) Spenddown during retroactive months in which the individual incurred a medically necessary medical expense:

(1) The administrative agency must determine whether the individual is retroactively eligible, including eligibility through the spenddown process, in accordance with rule 5160:1-1-51 of the Administrative Code.

(2) If the individual is not retroactively eligible (even through the spenddown

process), the individual may apply the medical expense as a UPME in the spenddown process for a month in which the individual is otherwise eligible.

(3) If the individual is retroactively eligible (whether through the spenddown process or not):

(a) The individual may apply the UPME in the spenddown process for the retro month only if the UPME is not payable by medicaid, as described in paragraph (E)(2)(c)(iii) of this rule; and

(b) The individual must apply the UPME to meet the spenddown for the retro month(s) first, before using it to meet the spenddown for any subsequent month.

(G) Treatment of individuals eligible for medicaid under Section 1619 of the Social Security Act.

(1) An SSI recipient who is eligible for medicaid under Section 1619 of the Social Security Act is not subject to the spenddown process. The 1619-eligible person shall not have a spenddown amount regardless of the amount of his or her countable monthly income.

(2) When a 1619-eligible person lives with a spouse, neither the 1619-eligible person nor his or her spouse is subject to the spenddown process. The 1619-eligible person and his or her spouse shall not have a spenddown amount regardless of the amount of their countable monthly income.

(H) Application of proper need standard. The correct medicaid need standard applicable to the individual, as set forth in rule 5160:1-3-03.5 of the Administrative Code, is determined as follows.

(1) If a household contains a husband and wife, both of whom are subject to the spenddown process, the husband and wife are budgeted together, meaning that their countable income is compared to the couple need standard.

(2) If a household contains a husband and wife, only one of whom is subject to the spenddown process, the income of the spouse who is subject to the spenddown process may be compared to either the individual or couple need standard, in accordance with the deeming of income provisions set forth in rule 5160:1-3-03.9 of the Administrative Code.

(3) Except for married couples, each individual in a household who is subject to the spenddown process is budgeted as an individual, meaning that the individual's countable income is compared to the individual need standard.

(4) There may be more than one individual subject to the spenddown process in a household.

(I) Administrative agency responsibilities. The administrative agency shall:

(1) Determine whether the individual is eligible for medicaid under any other medicaid category, and allow the individual the choice of which category of medicaid to accept.

(2) In order to assist the individual with making informed decisions about the spenddown process, explain to and/or discuss with the individual the following:

(a) The individual's choice to decline MPAP eligibility, as described in paragraph (C)(1)(b) of this rule;

(b) The individual's choice of which category of medicaid to accept, as described in paragraph (I)(1) of this rule;

(c) The various recurring and incurred spenddown medical expenses the individual may use in the spenddown process; and

(d) The methods for satisfying spenddown.

(3) Issue the medicaid card for the month within two business days after the individual submits verification showing that current incurred medical expenses for the month satisfy the spenddown amount for the month.

(4) Implement and make available in writing reasonable policies and procedures for administering the pay-in spenddown method. The policies and procedures must:

(a) Permit and provide reasonable methods of accepting payments by third parties on behalf of individuals and groups of individuals subject to spenddown.

(b) Ensure that, at the individual's option, the individual will receive a medicaid card for a month on or about the first day of the month by making his or her pay-in payment by a date chosen by the administrative agency near the end of the preceding month.

(i) If the administrative agency receives the individual's pay-in payment before the preceding month's cutoff date for benefit issuance, the administrative agency will authorize the issuance of the medicaid card in the electronic eligibility system within two business days after the cutoff date; or

(ii) If the administrative agency receives the individual's pay-in payment on or after the preceding month's cutoff date for benefit

issuance, the administrative agency will issue the card within two business days after the administrative agency receives the individual's pay-in payment.

(c) Ensure that, at the individual's option, the individual may pay-in for a given month at any time during the month and that the administrative agency will issue the card for the month within two business days after the administrative agency receives the individual's pay-in payment.

(d) Establish reasonable methods for accepting and accounting for pay-in payments, including but not limited to:

(i) Accepting cash payments;

(ii) Defining conditions for accepting checks or money orders; and

(iii) Establishing provisions for refunding or crediting unused pay-in amounts.

(e) Establish provisions for refunding the individual's pay-in payment for a month in the event the individual:

(i) Becomes eligible for medicaid for the month through means other than the spenddown process;

(ii) Becomes ineligible for medicaid for the month despite meeting the spenddown; or

(iii) Paid in more than the spenddown amount, whether due to the individual's error or to the administrative agency's error in calculating the spenddown amount.

(5) Document all pay-in spenddown payments in the electronic eligibility system and in the individual's case record, and issue a receipt to all individuals and third parties who make pay-in spenddown payments. The documentation and receipts must state:

(a) The date payment was received; and

(b) The name of the person or entity from whom the payment was received; and

(c) The name and identifying case information of the individual for whom the payment was made; and

(d) The month of medicaid eligibility for which the pay-in payment will be used and the effective date of medicaid for that month; and

(e) The amount of the payment and the form in which it was paid.

(6) Document in the electronic eligibility system and in the individual's case record:

(a) For each month's current incurred medical expenses submitted by or on behalf of the individual:

(i) The name of the provider of the medical item or service;

(ii) The item or service provided;

(iii) The date the item or service was provided;

(iv) The name of the individual or family member to whom the item or service was provided;

(v) The amount the individual or family member paid or is liable to pay for the item or service; and

(vi) The date the administrative agency authorized the medicaid card for the month, or the specific reason(s) the administrative agency did not authorize a medicaid card for the month.

(b) For current incurred medical expenses that require a decision by the PAU, as described in paragraph (B)(10) of this rule:

(i) The provider's statement;

(ii) The PAU decision; and

(iii) All other information related to the administrative agency's decision to use or not use a current incurred medical expense in the spenddown process.

(c) For transportation expenses that the administrative agency has determined cannot be used in the spenddown process:

(i) A description of which specific transportation expense(s) were not used; and

(ii) A clear explanation of the administrative agency's determination.

(d) For UPMEs:

(i) The name of the provider;

(ii) The item or service provided;

(iii) The date item or service was provided;

(iv) The name of the individual or family member to whom the item or service was provided;

(v) The amount still owed for the item or service; and

(vi) The month(s) for which the UPME or a portion of the UPME was used in the calculation of the spenddown amount.

(7) Issue proper notice and hearing rights as set forth in division 5101:6 of the Administrative Code.

(8) Not deny ABD medicaid for an individual who is applying for medicaid and does not anticipate satisfying spenddown in the month of application or in one or more future months. Instead, the administrative agency shall cause the electronic eligibility system to give the individual the type of eligibility that will only issue a medicaid card to the individual for those months for which the individual satisfies the spenddown amount.

(9) Not propose to terminate ABD medicaid for an individual who does not satisfy spenddown for one or more months. Instead, the administrative agency shall cause the electronic eligibility system to give the individual the type of eligibility that will only issue a medicaid card to the individual for those months for which the individual satisfies the spenddown amount.

(J) Individual responsibilities.

(1) The individual must submit monthly to the administrative agency, by mail, facsimile, or in person, verification of the current incurred medical expenses the individual wishes to apply against the individual's spenddown amount for the month. Verifications may include unpaid bills, statements, invoices, paid receipts, etc.

(2) For each expense, the individual must provide the name of the provider, the item or service provided, the date the item or service was provided, the name of the individual or family member to whom the item or service was provided, and the amount the individual or family member paid or is liable to pay for the item or service.

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