Virginia Regulatory Town Hall

# Notice of Intended Regulatory Action
# Agency Background Document

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| **Agency Name:** | Dept. of Medical Assistance Services 12 VAC 30 |
| **VAC Chapter Number:** | 12 VAC 30-40-140, 12 VAC 30-40-240, 12 VAC 30-40-290 |
| **Regulation Title:** | Medicaid Eligibility:Methods for Counting Income & Resources |
| **Action Title:** | ADAPT |
| **Date:** | May 16, 2002 |

This information is required prior to the submission to the Registrar of Regulations of a Notice of Intended Regulatory Action (NOIRA) pursuant to the Administrative Process Act § 9-6.14:7.1 (B). Please refer to Executive Order Twenty-Five (98) and Executive Order Fifty-Eight (99) for more information.

## Purpose

*Please describe the subject matter and intent of the planned regulation. This description should include a brief explanation of the need for and the goals of the new or amended regulation.*

The purpose of this proposal is to simplify Medicaid eligibility requirements for counting income for aged, blind, and disabled individuals and by conforming methods for counting certain resources of Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiaries (SLMBs) and Qualified Individuals (QIs) with the methods for counting the resources of other Medicaid aged, blind, and disabled recipients.

Current Medicaid policy requires that the value of in-kind support and maintenance be counted as income in determining the financial eligibility of individuals under the Aged, Blind, or Disabled Categorically Needy and Medically Needy groups. In-kind support and maintenance means food, clothing or shelter or any combination of these provided to an individual. The fair market value of in-kind support and maintenance is counted as income when evaluating the financial eligibility of the above-referenced groups. This regulatory change would eliminate the difficulty in and subjective nature of determining the fair market value of in-kind support and maintenance for all Aged, Blind, and Disabled covered groups with the exception of the special income level group for institutionalized individuals. Thus, simplifying and more accurately assessing the financial eligibility criteria for such groups.

In addition, the methods for counting specific types of real and personal property differ depending on the covered group for which the aged, blind, or disabled individual qualifies. This regulatory action proposes to remove this disparity. In addition, the regulatory amendments will clarify exemptions for the former home of an institutionalized recipient, household goods and personal effects, and cemetery plots. Also, the regulations will clarify that financial eligibility can be met anytime during a month if resources are within the applicable limits on any day in such month. Medicaid enables eligible Virginians to access necessary health and medical care. Consistent and clear eligibility requirements are essential to ensure the effective administration of the Medicaid program.

## Basis

*Please identify the state and/or federal source of legal authority to promulgate the contemplated regulation. The discussion of this authority should include a description of its scope and the extent to which the authority is mandatory or discretionary. The correlation between the proposed regulatory action and the legal authority identified above should be explained. Full citations of legal authority and, if available, web site addresses for locating the text of the cited authority must be provided.*

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The *Code of Virginia* (1950) as amended, §32.1-325, grants to the Board of Medical Assistance Services (BMAS) the authority to administer and amend the Plan for Medical Assistance. The Code also provides, in the Administrative Process Act (APA) §§2.2-4007 and 2.2-4013, for this agency's promulgation of proposed regulations subject to the Governor's review.

Sections 1902(a)(10)(A)(i), (ii), and 1902 (a)(10)(C) of the *Social Security Act* (the *Act*) describe the mandatory, optional, and Medically Needy groups of Aged, Blind, and Disabled individuals who are eligible for Medicaid. Section 1902(a)(10)(E) Clauses (i), (iii), and (iv) of the *Act* describe mandatory groups of qualified Medicare beneficiaries (QMBs), specified low-income Medicare beneficiaries (SLMBs), and qualified individuals (QIs) respectively, who are eligible for Medicaid. Section 1902(r)(2) of the *Act* grants States the authority to use eligibility requirements for Medicaid that are more liberal than the requirements of the most closely related public cash assistance program. Section 1902(f) of the *Act* grants States the authority to impose more restrictive eligibility requirements for the aged, blind, and disabled recipients than those imposed by the Social Security Administration for the Supplemental Income (SSI) program.

## Substance

*Please detail any changes that would be implemented: this discussion should include a summary of the proposed regulatory action where a new regulation is being promulgated; where existing provisions of a regulation are being amended, the statement should explain how the existing regulation will be changed. The statement should set forth the specific reasons the agency has determined that the proposed regulatory action would be essential to protect the health, safety or welfare of citizens. In addition, a statement delineating any potential issues that may need to be addressed as the regulation is developed shall be supplied.*

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The sections of the State Plan and the corresponding regulations affected by this action are Attachment 2.6-A (12VAC30-40-100), Supplement 5 to Attachment 2.6-A (12VAC30-40-240), Supplements 8a (12 VAC 30-40-280) and 8b (12VAC30-40-290) to Attachment 2.6-A.

In accordance with Executive Order 25 (98), the Department continuously reviews its regulations. A review of the regulations revealed six regulations that can be improved.

1. More liberal methods of counting income: The State Plan provides that the income methods of the SSI program are used in determining the income eligibility of the Aged, Blind, and Disabled groups covered under the State Plan. Federal law at § 1902(a)(10)(C) links the income and resource methods for Aged, Blind, and Disabled individuals to the SSI program; however, § 1902(r)(2) of the *Act* permits states to use more liberal methods of counting income and resources. The State Plan does not currently reflect more liberal methods of evaluating income; however, the Virginia Medicaid program has excluded the value of in-kind support and maintenance as income for Aged, Blind, and Disabled individuals covered under the State Plan. This exemption has long been in practice but has not heretofore been expressly set forth in the State Plan in Supplement 8a. Having to determine the fair market value of in-kind support and maintenance provided to aged, blind, and disabled individuals is administratively difficult and would impose additional and unnecessary financial hurdles on applicants and recipients. Therefore, this action proposes to continue exempting in-kind support and maintenance costs from eligibility calculations and specify such in the State Plan.

2. More liberal methods of treating resources for QMBs, SLMBs and QIs: The current regulations contain a discrepancy in the manner in which real and personal property is evaluated in determining eligibility for different covered groups of aged, blind, and disabled individuals. Federal law identifies and defines groups of individuals who must be covered by Medicaid programs operated in the States. Among these are several groups of aged, blind, and disabled individuals. Individuals who are aged, blind, and disabled and who have income below stipulated income limits are eligible for full Medicaid benefits as Categorically Needy or Medically Needy individuals. However, aged, blind, and disabled individuals who qualify for Medicare and whose income is higher than the Categorically or Medically Needy income limits may be eligible for Medicaid payment of the Medicare cost sharing portion as:

- a Qualified Medicare Beneficiary (QMB) if income is below 100% of the federal poverty limits (FPL);

- a Specified Low-Income Medicare Beneficiary (SLMB) if an individual meets all the requirements to be a QMB except income, and income is less than 120% of FPL; or

- a Qualified Individual if he meets all the requirements to be a QMB except income and income is at or below 175% of FPL.

Federal law permits states some latitude in setting the financial eligibility requirements for these groups. Federal law at 1902(a)(10)(C) links the income and resource methods for aged, blind, and disabled individuals to the methods of the SSI program. However, Section 1902(r)(2) of the

*Act* permits States to use more liberal methods of counting income and resources. The State Plan lists a number of more liberal methods of counting resources for the Categorically Needy or the Medically Needy individuals than those methods employed by the SSI program. These more liberal methods permit the exemption of:

- cemetery plots owned by the individual;
- up to $3500 in cash assets designated for burial;
- real property that cannot be sold after a reasonable effort to sell has been made;
- life rights to real property;
- one automobile; and
- life, retirement, and other related types of insurance policies with face values totaling $1,500, or less on any person 21 years old and over. Policies on individuals under age 21 are exempt regardless of the face value.

The State Plan does not currently reflect the use of the more liberal methods of evaluating resources for QMBs, SLMBs, and QIs. According to the State Plan, the resource methods of the SSI program are used in determining their eligibility. This discrepancy makes the determination of eligibility more complex for local eligibility workers and presents an unnecessary burden for these applicants. For example, individuals with very low income may qualify for eligibility both as a Categorically Needy or Medically Needy individual and as a QMB. In some instances, the same individual may be eligible as medically needy part of the year and eligible only as a QMB for the rest of the year.

A Medically Needy individual may own an automobile regardless of value. However, the QMB rules only exempt an automobile if valued at $1500 or less unless burdensome documentation is presented verifying that the automobile is used to obtain medical care. Requiring special documentation of visits to the doctor represents unnecessary and bureaucratic requirements that burden the recipient and create unnecessary administrative costs for the state. However, once the documentation is submitted, the person becomes eligible. Therefore, this regulation proposes to exempt one automobile, regardless of its value, without having to accumulate the burdensome documentation whenever he moves from eligibility as a Medically Needy individual to a QMB.

Because of fluctuations in income, many individuals move between Categorically or Medically Needy and QMB status. Making the methods of counting resources identical between the groups wherever possible treats groups of similarly situated individuals equitably and reduces eligibility determination errors and administrative costs.

3. Exemption of the former home of an institutionalized individual: Medicaid exempts the former home of an institutionalized individual for six months after institutionalization. After that date, the value of the former home is counted in determining continuing Medicaid financial eligibility unless dependent relatives occupy the home, in which case the home may continue to be exempt. A disabled parent is one of the dependent relatives listed in 12VAC30-40-240 and in Supplement 5 to Attachment 2.6-A. The regulation currently requires a finding that the parent's disability met the Social Security definition of disability. In order to avoid unnecessary referrals

to the Disability Determination Service for disability determination, the regulation is being amended also to recognize determinations of civil service disability.

4. Exemption of cemetery plots: This exemption has long been in Medicaid regulations but is not listed in the State Plan in Supplement 8b to Attachment 2.6-A. The exemption is found in State regulations at 12VAC30-40-240. Although 12 VAC 30-40-240 refers to 12 VAC 30-40-290, the reference to cemetery plots was inadvertently left out of the latter regulation.

This regulatory change corrects this oversight and illustrates that this exemption is more liberal than the SSI limitation of one cemetery plot for each immediate family member. In many instances, one individual in a family may hold title to more than one cemetery plot intending the plots to be used for family members yet to be designated. Requiring burdensome documentation regarding which family member each plot will be used for is unnecessary. Cemetery plots do not have substantial resale value, especially when the unused plots are located among the plots of family members already deceased.

5. Exemption of household goods and personal effects: This exemption has long been in practice but is not listed in the State Plan in Supplement 8b. When determining eligibility for SSI, the Social Security Administration has a complex policy for evaluating which household goods and personal effects of applicants should be counted when determining financial eligibility. What possessions may be exempted because they are used in the operation of the home or kept as personal effects is quite detailed. For example, only one wedding and one engagement ring are exempt. Furthermore, furniture items have to be evaluated to determine whether the item has unusual value.

Additionally there are elaborate justifications for exemption if an item has unusual value but is used in everyday living. For example, if the dining room table is an antique but is the only table the family has to eat on, it can be exempted. Otherwise, the value of the item has to be counted in determining the individual's eligibility for SSI. To disrupt the household of an elderly or disabled individual and deny them access to Medicaid because of a personal property item used for everyday living is unduly invasive for applicants and practically difficult for eligibility workers to administer. Eligibility workers are not experts in appraising the value of such property. Having to obtain appraisals by independent experts greatly and unnecessarily increases the time and expense of determining Medicaid eligibility.

Medicaid has never counted the value of household goods and personal effects in determining Medicaid eligibility. In 1984, due to changes in federal law in the Deficit Reduction Act, the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services) required States to file more liberal resource methods in the State Plan. At that time, Governor Charles Robb directed DMAS to continue the more liberal resource methods previously used, including disregarding the value of household goods and personal effects. Certain more liberal resource methods were filed in the State Plan, but through an inadvertent error, the requirements for evaluating household goods and personal effects were not filed in the State Plan. Thus, the policy has never been formally incorporated into the State Plan. In order to ensure that the policy is duly promulgated, the State Plan is being amended to reflect this long-standing policy.

6. Determining Eligibility Based on Resources: When determining Medicaid eligibility, an individual shall be eligible in a month if his or her countable resources were at or below the resource standard on any day of such month. This policy differs from the SSI program, which only counts resources owned on the first day of each month. If an applicant's resources exceed eligibility limits on the first day of month, such individual would not be eligible at any time during that month, even if their resources are reduced for the remainder of the month. If Virginia were to follow this policy, it would work an extreme hardship on many aged and disabled individuals, especially those entering nursing homes. The Medicaid resource level for an individual is $2,000 in countable resources. If an individual owns even one dollar over the resource limit, that individual is ineligible. If an individual needs to enter a nursing home, he is often not admitted unless he can demonstrate eligibility for Medicaid or unless he has enough resources to privately pay for the full month's cost. For example, under SSI rules, an individual with $2,050 in resources on the first day of the month would be ineligible for the entire month. If he needed to go to a nursing home, he presumably would not have enough money to pay privately for the nursing home nor could he be Medicaid eligible. Such a result would mean that admission would have to be delayed until the following month. This could result in a backup of patients in hospitals awaiting Medicaid eligibility or denial of access to proper care for such individual. Under Medicaid's more liberal resource rule, if the applicant reduced his excess resources by $50, he would become Medicaid eligible during that month. This ensures that the individual can actually maintain the full resource allowance and access needed medical care at any time during a month in which his resources meet the Medicaid limits.

This rule has been in operation in Virginia for many years. Attachment 2.6-A of the State Plan for Medical Assistance provides that coverage is available for the full month if the individual is eligible at any time during the month. This has always been interpreted to mean that if an individual's resources meet the financial eligibility criteria on any day during the month, the individual is eligible to receive Medicaid services during that entire month. However, the State Plan has never clearly stated this rule. Therefore in order to ensure that the regulatory language clearly sets forth this more liberal method of counting resources, the language is being added to Supplement 8b to Attachment 2.6-A.

This regulatory action is also making a technical correction by removing federally permitted preprinted language from 12 VAC 30-40-100, item h, which is the reference to coverage of COBRA Beneficiaries. This does not belong in the Virginia Administrative Code. Its inclusion was inadvertent when the federally issued Title XIX State Plan for Medical Assistance Services was incorporated into the VAC.

These regulations are essential to the efficient and equitable application of Medicaid eligibility criteria. By making Medicaid eligibility determination more efficient and objective, eligible Virginians can better access needed health and medical care. Reducing the administrative burden for local eligibility workers reduces cost to the taxpayers for Medicaid administration.

## Alternatives

*Please describe, to the extent known, the specific alternatives to the proposal that have been considered or will be considered to meet the essential purpose of the action.*

The regulatory changes in this proposed action are designed to improve the efficiency and economy of administering Virginia's Medicaid program. By streamlining and simplifying the complex Medicaid eligibility requirements, applicants and recipients will be relieved of unnecessary red tape and barriers and local eligibility workers can apply more consistent and uniform requirements in performing their duties. The Department projects no negative issues involved in implementing this proposed change. All these policies have been in effect for years. The regulations are designed to ensure that the regulations fully support the administrative procedures already utilized by local agencies.

## Family Impact Statement

*Please provide a preliminary analysis of the potential impact of the proposed regulatory action on the institution of the family and family stability including to what extent the regulatory action will: 1) strengthen or erode the authority and rights of parents in the education, nurturing, and supervision of their children; 2) encourage or discourage economic self-sufficiency, self-pride, and the assumption of responsibility for oneself, one's spouse, and one's children and/or elderly parents; 3) strengthen or erode the marital commitment; and 4) increase or decrease disposable family income.*

This regulatory change will have a positive impact on families by reducing the confusion and red tape they must face when dealing with a government agency. Aged and disabled individuals and their family members will be able to better understand and comply with Medicaid eligibility rules when unnecessary or complicated requirements are eliminated and when eligibility processes are streamlined.