Virginia Regulatory Town Hall

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# Final Regulation
# Agency Background Document

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| **Agency name** | DEPT. OF MEDICAL ASSISTANCE SERVICES |
| **Virginia Administrative Code (VAC) citation** | 12VAC30-40 |
| **Regulation title** | Eligibility Conditions and Requirements |
| **Action title** | ADAPT |
| **Document preparation date** | August 27, 2003; NEED GOV APPROVAL BY OCT 3 rd |

This information is required for executive review (www.townhall.state.va.us/dpbpages/apaintro.htm#execreview) and the Virginia Registrar of Regulations (legis.state.va.us/codecomm/register/regindex.htm), pursuant to the Virginia Administrative Process Act (www.townhall.state.va.us/dpbpages/dpb_apa.htm), Executive Orders 21 (2002) and 58 (1999) (www.governor.state.va.us/Press_Policy/Executive_Orders/EOHome.html), and the *Virginia Register Form, Style, and Procedure Manual* (http://legis.state.va.us/codecomm/register/download/styl8_95.rtf).

## Brief summary

*In a short paragraph, please summarize all substantive changes that are being proposed in this regulatory action.*

This suggested final action simplifies 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. This regulatory change eliminates 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.

In addition, this action removes the disparity in the methods for counting specific types of real and personal property depending on the covered group for which the aged, blind, or disabled individual qualifies. In addition, the amendments clarify exemptions for the former home of an institutionalized recipient, household goods and personal effects, and cemetery plots as well as

clarifying that financial eligibility can be met anytime during a month if resources are within the applicable limits on any day in such month.

## Statement of final agency action

*Please provide a statement of the final action taken by the agency including (1) the date the action was taken, (2) the name of the agency taking the action, and (3) the title of the regulation.*

I hereby approve the foregoing Regulatory Review Summary with the attached amended State Plan pages Eligibility Conditions and Requirements ADAPT (12 VAC 30-40-100, 240, 280 and 290) and adopt the action stated therein. I certify that this final regulatory action has completed all the requirements of the Code of Virginia § 2.2-4012, of the Administrative Process Act.

8/27/2003
Date

/s/ P. W. Finnerty
Patrick W. Finnerty, Director

Dept. of Medical Assistance Services

## Legal basis

*Please identify the state and/or federal source of legal authority to promulgate this proposed regulation, including (1) the most relevant law and/or regulation, including Code of Virginia citation and General Assembly bill and chapter numbers, if applicable, and (2) promulgating entity, i.e., the agency, board, or person. Describe the legal authority and the extent to which the authority is mandatory or discretionary.*

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.

## Purpose

*Please explain the need for the new or amended regulation by (1) detailing the specific reasons why this regulatory action is essential to protect the health, safety, or welfare of citizens, and (2) discussing the goals of the proposal and the problems the proposal is intended to solve.*

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.

## Substance

*Please identify and explain the new substantive provisions, the substantive changes to existing sections, or both where appropriate. A more detailed discussion is required under the "All changes made in this regulatory action" section.*

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 21 (02), 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. This regulatory 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 more liberal methods of evaluating resources for QMBs, SLMBs, and QIs. This regulation intends to count the resources for QMBs, SLMBs and QIs the same as other Medicaid groups of similarly situated individuals.

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 of the State Plan. The existing regulation currently requires a finding that the parent's disability meet the Social Security definition of disability. However as a result of this regulatory action, the regulation is being amended to also 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.

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.

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.

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 of the State Plan.

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.

## Issues

*Please identify the issues associated with the proposed regulatory action, including:*
*1) the primary advantages and disadvantages to the public, such as individual private citizens or businesses, of implementing the new or amended provisions;*
*2) the primary advantages and disadvantages to the agency or the Commonwealth; and*
*3) other pertinent matters of interest to the regulated community, government officials, and the public.*

*If the regulatory action poses no disadvantages to the public or the Commonwealth, please so indicate.*

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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.

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.

## Changes made since the proposed stage

*Please describe all changes made to the text of the proposed regulation since the publication of the proposed stage. For the Registrar's office, please put an asterisk next to any substantive changes.*

There are no changes in these final, adopted regulations over those which were proposed for public comment period.

## Public comment

*Please summarize all comment received during the public comment period following the publication of the proposed stage, and provide the agency response. If no public comment was received, please so indicate.*

DMAS' proposed regulations were published in the June 2, 2003, *Virginia Register* (VR 19:19) for their public comment period from June 2nd through August 1, 2003. Comments were received from the Virginia Poverty Law Center. A summary of the comments received and the agency's responses follows.

This commenter generally supported the changes that are contained in this action: (i) simplifying Medicaid eligibility requirements for counting income and resources for aged, blind and disabled individuals, QMBS, SLMBs and QIs; (ii) continuing exemptions for in-kind support and maintenance, cemetery plots, and household goods and personal effects; (iii) making the resources rules for QMBs, SLMBs and QIs the same as those for the categorically needy; (iv) accepting a disability determination made by civil service entities as well as Social Security, for purposes of the former home rule; and, (v) incorporating into the state plan current policy regarding eligibility for a full month when the individual is eligible at any time in the month. The commenter had further specific comments as set out below:

| VAC section | Comment | Agency response |
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| 12 VAC 30-40-140(b) and (d) | The regulatory language in both sections could be simplified by eliminating the reference to 1902(a)(10)(A)(ii)(X). This section of the Act does nothing but refer to | The language contained in the regulatory package is the language that is contained on the federal preprint page as issued by CMS. DMAS cannot change the language on the preprint. |

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| | 1396m(1). If the reference is kept, the phrasing in 140(d) is more accurate. | |
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| 12 VAC 30-40-140(h) | Suggest using the same phrasing as in the income section. "...the agency uses the methods of the SSI program and/or any more liberal methods in 12 VAC 30-40-290." | The language contained in the regulatory package is the language that is contained on the federal preprint page as issued by CMS. DMAS cannot change the language on the preprint |
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| 12 VAC 30-40-240 - | Because of federal requirements and Virginia's adoption of the 80% FPL category, these restrictive resource rules only apply to the Medically Needy and to institutionalized persons with income between 80% FPL and 300% SSI. Maintaining all of the restrictions unnecessarily complicates the program for recipients, case workers, and policy makers. For example, the contiguous property rule only applies now to institutionalized people who generally have to dispose of home property after 6 months anyway, and to medically needy non-institutionalized aged/ disabled who have to spend-down to ridiculously low, income eligibility levels (around and below 30% FPL). It really doesn't make sense to continue application of this rule (and all its tedious requirements) on these two populations. Any cost-savings from the rule are probably minimal. When it does apply, the contiguous property typically affects the poor living in rural areas of the state. This has always been unfair and discriminatory. It's time to eliminate the rule. The other resource restrictions should also be examined to determine whether they should continue to be applied on this small subset of the ABD population; and whether the resulting complexities (and dozens of manual pages) are justified for policy or financial reasons. | These comments relate to the 209(b) issue. This regulatory package only conforms the State Plan to existing procedures and does not address the 209(b) issue. Reviewing and revising DMAS' more restrictive rules is a major undertaking and requires extensive fiscal analysis. |

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| 12 VAC 30-40-280 (B) - | There should also be a sufficient income disregard to insure that any parent receiving TANF cash assistance is also income eligible for Medicaid. | The regulatory package did not address this section; the regulations only conform the State Plan to existing operational procedures. |
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| 12 VAC 30-40-280 (D) - | The commenter opposed the consideration of in-kind support and maintenance for the special income level group of institutionalized individuals. The commenter stated that this appears to be a restrictive change in current policy that will render some individuals ineligible for institutional and/or community based care. In the relevant [manual] policy sections (M1460.600(D); 1460.610 and 1460.611), there is no mention of counting in-kind support and maintenance; in fact it is specifically noted that third party payments are NOT income. This proposal is not consistent with DMAS' effort to simplify program requirements. | This comment is directed to 12 VAC 30-40-280 (C) *not (D)*. The statute that deals with the 300% income group provides that the person's income is determined under section 1612 of the Act but without regard to the exclusions and disregards listed in subsection 1612(b) of the Act. Because the statute specifies how income is to be counted in determining whether a person's income exceeds the 300% FFP (Federal Financial Participation) limit, the statute precludes CMS from being able to approve the use of less restrictive income methodologies for this group. Therefore, the exception of the special income level group must remain in DMAS regulations and related State Plan section in order to secure federal approval and related federal funding. |
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| 12 VAC 30-40-290 (G) - | In order to simplify the program, categorically and medically needy families and children should not be subject to resource rules. This would be consistent with Medicaid program rules for children and pregnant women up to 133% FPL and FAMIS rules for children up to 200% FPL. | This regulatory package is intended only to conform the State Plan to existing operational procedures. DMAS intends to eliminate the resource rules for the categorically needy families and children groups and will be filing in the near future a separate regulatory package to address the issue. |
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## All changes made in this regulatory action

*Please detail all changes that are being proposed and the consequences of the proposed changes. Detail new provisions and/or all changes to existing sections.*

1. More liberal methods of counting income: 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 (12 VAC 30-40-280). Having to determine the fair market value of in-kind support and maintenance provided to aged, blind, and disabled individuals is administratively difficult and imposes additional and unnecessary financial hurdles for applicants and recipients. Therefore, this action proposes to continue exempting in-kind support and maintenance costs from eligibility calculations and specifies such exemption in the State Plan.

2. More liberal methods of treating resources for QMBs, SLMBs, and QIs: The State Plan does not currently reflect the use of 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 because fluctuations in income cause many individuals to move between Categorically or Medically Needy and QMB status. 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 be 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 additional 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 the necessity of accumulating documentation whenever an individual moves from being eligible as a Medically Needy individual to eligible as a QMB.

Making the methods of counting resources identical between these groups whenever 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: The current regulation exempts the former home of an institutionalized individual if the home is occupied by a dependent disabled parent whose disability meets the Social Security Administration's definition of disability. Many individuals have been determined to be disabled by the Civil Service Commission; however, that disability determination is not currently recognized under the current regulation. The proposed regulation will recognize Civil Service disability determinations as well as Social Security disability determinations and thus eliminate burdensome and unnecessary referrals to the Disability Determination Service when an individual has already received a Civil Service disability determination.

4. Exemption of cemetery plots: This regulatory action will correct an oversight in the State Plan by clearly designating that individually owned cemetery plots are exempt from liberal than

the SSI limitation of one cemetery plot for each immediate family member. Oftentimes, 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. Cemetery plots do not have substantial resale value, especially when the unused plots are located among the plots of family members already deceased. Requiring documentation regarding which family member each plot will be used for is unnecessary and burdensome for the applicant and eligibility worker.

5. Exemption of household goods and personal effects: This regulatory action will incorporate into the State Plan the long-standing policy of exempting the value of an applicant's household goods and personal effects from being counted when determining Medicaid eligibility. Medicaid eligibility workers are not experts in appraising the value of household goods and personal effects, and having to obtain appraisals by independent experts would greatly and unnecessarily increase the time and expense of determining Medicaid eligibility. Further, to disrupt the household of an elderly or disabled individual and deny them access to Medicaid because of the value of a personal property item that is used for everyday living is unduly invasive for the applicant.

6. Determining eligibility based on resources: This regulatory action clarifies existing policy and a long-standing rule by adding to the State Plan that Medicaid coverage is available for the full month if an individual is eligible at any time during the month. This policy differs from the SSI program that counts resources that are owned on the first day of each month. Under the SSI rules, if an applicant's resources exceed eligibility limits on the first day of a month, the individual is not eligible at any time during that month, even if resources are reduced during the month. If Virginia were to follow this SSI policy, it would work an extreme hardship on many aged and disabled individuals, especially those individuals who are 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 costs. 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 individuals.

Under the proposed more liberal resource rule, if the applicant reduces his excess resources by $50, he would become Medicaid eligible during that month. This proposed rule 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.

## Family impact

*Please assess the impact of the proposed regulatory action on the institution of the family and family stability.*

This regulatory action will not have any negative effects on the institution of the family or family stability. It will not increase or decrease disposable family income or erode the marital commitment. It will not discourage economic self-sufficiency, self-pride, or the assumption of family responsibilities.