## 2196 – FAMILY MEDICAID MEDICALLY NEEDY

**POLICY STATEMENT**

Family Medicaid Medically Needy (FM-MN) provides Medicaid coverage for children under 18 years of age and pregnant women whose BG income exceeds limits for all Family Medicaid COAs and PeachCare for Kids.

There are two types of FM-MN cases:

- De facto eligibility is determined when the BG's net countal income is equal to or less than the FM-MN Income Level (MNIL) for the BG size and resources are less than or equal to the FM-MN resource limit.
- Spenddown (SD) eligibility is determined when the BG's countable income is greater than the MNIL for the BG size and is offset by the incurred medical expenses of the BG. Resources must be less than or equal to the FM-MN resource limit.
-

**BASIC CONSIDERATIONS**

FM-MN is available to pregnant women who meet any of the following conditions:

- The budget group (BG) income exceeds the RSM PgW incor limit.
- The pregnant woman would be eligible for LIM upon the birth the child except the BG income and/or resources exceed the LIM limits.

FM-MN is available to children under 18 years of age who meet any of the following conditions:

- The child's BG income exceeds RSM and PeachCare income limit
- The child would be eligible for LIM except for excessive incor and/or resources.
- The child is in foster care with income exceeding LIM/CWFC, RS and PeachCare limits.

Eligibility for all Family Medicaid COAs (including RSM) and PeachCare must be ruled out prior to determining eligibility under FM-MN.

**BASIC CONSIDERATIONS (cont.)**

RSM income limits vary based on a child's age. Because of this, it is possible that a younger child may be RSM-Child eligible and a sibling may be FM-MN eligible because of RSM ineligibility.

All basic eligibility criteria must be met with the exception of living with a relative within the specified degree of relationship. Refer to Chapter 2200, Basic Eligibility Criteria.

**Resource Limit**

FM-MN resource limits are based on SSI resource limits.

If resources are less than or equal to the applicable resource limit at any time during a month, the BG is resource eligible for the entire month.

Use the chart below to determine the resource limit for a BG.

| Effective | Number in budget Group | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 7/1/98 through the present | $2000 | 4000 | 4100 | 4200 | 4300 | 4400 | 4500 | 4600 |
| Add $100.00 for each BG member above eight. | | | | | | | | |

**Review Period**

The FM-MN review period is 6 months. Each month of the 6 month FM-MN review period is a separate budget period and eligibility is determined for each month individually. The first budget period begins on the first day of the month in which the application is filed and ends with the last day of the application month. The second through sixth budget periods begin on the first day and end on the last day of each of the months 2 through 6. The review period begins on the first day of the month in which the application is filed and continues through the last day of the sixth consecutive month.

**Prior Months**

FM-MN is available for the three months prior to the application month. Each of the three prior months is budgeted separately using actual income and expenses for each of those months.

Income and expenses are anticipated for each one-month budget period in the six-month review period.

**BASIC CONSIDERATIONS (cont.)**

**De Facto FM-MN**

If the BG's net countable income for the budget period is equal to or less than the MNIL for the BG size for the budget period, the AU is de facto eligible for Medicaid.

De facto FM-MN eligibility begins on the first day of the month and expires on the last day of the month of the budget period, provided no changes occur during the month that affects eligibility.

**Spenddown FM-MN**

If the BG's net countable income for the budget period exceeds the MNIL for the BG size, the excess amount is the SD.

The SD must be met before the AU is approved for FM-MN.

The SD is met by subtracting allowable medical expenses of the BG members from the SD until the SD is zero.

When the SD is met, the case is considered FM-MN SD eligible and the AU members are approved for Medicaid effective the day the SD is met. Eligibility continues through the end of the month.

**Individuals Whose Medical Expenses Can Be Used**

The following individuals' medical expenses can be used to meet the SD:

- any BG member
- a deceased spouse or child of a BG member if s/he could ha been included in the BG at the time the medical expense was incurred

**NOTE:** Enumeration is not required for a deceased individual.

- the child of a BG member who has reached 18 years of age if tl child could have been included in the BG at the time the medical expense was incurred.

**NOTE:** The child does not have to be currently living in the home with the BG and does not have to be enumerated.

- the parent of a minor parent.

**BASIC CONSIDERATIONS (cont.)**

Medical expenses are used to meet the SD if they meet all of the following conditions.

- the bill is unpaid

  **EXCEPTION:** Medical bills paid during the budget period are allowed.

- a BG member is legally obligated to pay the expense

- there is no TPL coverage to pay the expense. Refer to Spec Considerations and Chart 2196.1, Allowable Medical Expenses in FM-MN in this section.

The SD may be met using medical expenses incurred prior to the budget period. If this situation occurs, the AU is eligible from the first day of the one-month budget period. Any remaining portion of the unpaid expense not used to meet SD in a month may be used to meet SD in subsequent months, provided the bill remains unpaid during those months.

If the SD is not met by previously incurred bills, the case is held in suspense status until bills are incurred that meet the SD for any month in the review period.

If the SD is met during a budget period, a first day liability (FDL) is calculated for the day the SD is met. The BG is responsible for paying the FDL. Form 400, MN First Day Liability is used to inform the A/R, the provider and DMA of the FDL amount for which the A/R is responsible.

**BASIC CONSIDERATIONS (cont.)**

If an A/R submits a medical expense after the expiration of the budget period, the bill can be used to meet or adjust the SD for the expired budget period only if it is submitted within three months of the expired period, unless Good Cause exists.

**NOTE:** If the bill is submitted in the fourth month after the expired FM-MN budget period and Good Cause does not exist, the bill can be used to meet a current or future SD if a BG member continues to be legally obligated to pay it and there is no TPR for that bill.

If an AU member becomes eligible for another Medicaid COA while the FM-MN case is in suspense status, terminate the review period and approve the AU member for the other COA.

A woman whose medical bills meet SD the day **after** the day the pregnancy terminates is **not** eligible for Medicaid as a pregnant woman.

**NOTE:** The newborn does not qualify for NB Medicaid.

A pregnant woman who applies for FM-MN prior to the termination of the pregnancy and whose medical bills meet SD on or before the day of the termination of pregnancy can be eligible for Medicaid through the month in which the 60th day from pregnancy termination occurs.

**Begin Authorization Date**

FM-MN Medicaid begins on the Begin Authorization Date (BAD), a specific day during the budget period.

**NOTE:** Medical expenses incurred prior to the BAD in a budget period are not paid by DMA.

The BAD is any of the following dates:

- the first day of the budget period if de facto eligibility established
- the first day of the budget period if SD is met using only unpa medical bills incurred prior to the budget period
- the day in the budget period in which the SD is met using bi incurred during the budget period or a combination of bills incurred during and prior to the budget period. This day can also be the first day of the budget period.

**PROCEDURES**

Screen for eligibility for all classes of Family Medicaid and for PeachCare for Kids.

If the AU is ineligible for all Family Medicaid COAs and PeachCare for Kids based on income or resources, proceed with FM-MN.

Follow the steps below to establish FM-MN eligibility.

**Step 1**

Conduct a face-to-face interview with the A/R.

**Step 2**

Determine the AU and BG. Refer to Chapter 2600, Family Medicaid Assistance Units and Budget Groups.

**Step 3**

Establish each budget month of the review period.

**Step 4**

Determine the countable resources of the BG for the budget period and compare to the FM-MN resource limit for the BG size to determine resource eligibility.

**Step 5**

Determine if a TPL resource exists that will pay for all or any portion of the medical expenses.

**Step 6**

Complete a FM-MN budget using the anticipated income and expenses of the BG. Refer to Section 2671, Family Medicaid Medically Needy Budgeting.

**Step 7**

If the BG net countable income is at or below the MNIL for the BG size, the AU is de facto eligible. Complete the following:

- Approve the members for FM-MN Medicaid effective the first d of the budget period.

- Notify the AU and DMA of the BAD and the ending date eligibility, the Medicaid number(s) for all AU members and issue Medicaid Certification for each month of de facto eligibility, including retroactive months.

If the AU is **not** de facto eligible, proceed to Step 8.

**PROCEDURES (cont.)**

**Step 8** If the net countable income of the BG exceeds the MNIL for the BG size, the amount of the excess is the SD. Explain to the A/R the SD process.

**Step 9** Determine whose expenses are allowed as deductions from the SD.

**Step 10**

Obtain itemized copies of bills for unpaid medical expenses and those paid during the budget period for the individuals determined in Step 9.

If a TPR exists, determine how much the TPR has paid or will pay toward these bills and subtract the TPR payment(s) from the bill(s). Use only the remaining amount toward meeting the SD.

Refer to Special Considerations and to Chart 2196.1, Allowable Medical Expenses for FM-MN in this section.

**Step 11**

Sort medical bills in ascending (oldest to most recent) chronological order.

Deduct from the SD the allowable prior medical bills (bills that were incurred prior to the budget period).

If the SD is met using prior medical expenses, approve FM-MN Medicaid for the AU members on the first day of the budget period. Complete the following actions:

- Approve FM-MN Medicaid for the AU members beginning t first day of the budget period.
- Notify the AU. Notification includes the BAD, the ending date eligibility and the Medicaid numbers for each AU member.
- Provide to the AU a Certification of Medicaid Eligibility any/all approved months.

If the SD is **not** met using prior medical expenses, proceed to Step 12.

**PROCEDURES (cont.)**

**Step 12** Deduct allowable medical expenses incurred during the budget period in ascending (oldest to most recent) chronological order.

Rank bills incurred the same day as follows:

1. incurred by BG members not included in the AU;

2. incurred by AU members but not covered by Medicaid (nc covered expenses such as over-the-counter medications or bills payable to non-Medicaid providers);

3. incurred by AU members payable to a Medicaid provider, t lowest dollar amounts first.

If the SD is met, proceed to Step 13.

If the SD is **not** met, skip to Step 14.

**Step 13** If the SD is met by bills ranking order 1 or 2 (as described in Step 12), **Form 400, First Day Liability** is not required, as the AU has no First Day Liability (FDL).

Complete the following actions:

- Approve the AU members for Medicaid to begin on the day which the bill that brought the SD to zero (the **break-even** bill) was incurred.

- Notify the AU. Notification includes the BAD and the ending da of eligibility and the Medicaid numbers for each AU member.

- Provide to the AU a Certification of Medicaid Eligibility any/all approved months.

**PROCEDURES (cont.)**

**Step 13 (cont.)** If the SD is met by bills in ranking order 3 (ad described in Step 12), **Form 400, First Day Liability** is necessary.

Complete the following actions:

- Issue a Form 400 for the break-even bill showing the dol amount of the FDL as the client liability.

- Issue Form 400 with a client liability of zero for all other bi incurred on the BAD that were not used to meet the SD.

  **NOTE:** Do not issue Form 400 for bills incurred on the BAD that were applied to the SD prior to the break-even bill as no portion of these bills is payable or reimbursable by DMA and are the total responsibility of the client.

- Report to the client and DMA the amount of the break-even b used to meet the SD as the FDL. If a manual Certification of Eligibility is used annotate the Certification, **FORM 400 REQUIRED.** The Certification must also include the month, day and year of the BAD and the ending date of eligibility.

  **NOTE:** For group medical practices, clinics, or other provider names that do not include the name of a specific physician or clinician who performed the medical service, include the name of the individual in addition to the group name.

- Notify the AU. Notification includes the BAD, FDL, the endi date of eligibility and the Medicaid numbers for each AU member.

- Provide to the AU a Certification of Medicaid Eligibility f any/all approved months.

**Step 14** If the SD is not met, place the case in suspense status until medical expenses adequate to meet the SD are incurred.

Subtract from the SD any medical expenses incurred during the budget period as they are provided by the AU, according to the date incurred.

**PROCEDURES (cont.)**

**Step 15** When medical expenses equal the SD for cases in suspense status, complete the following actions:

- Determine actual income already received during the budg period.
- Recalculate the SD using the actual income and any incor anticipated to be received in the remainder of the budget period.

**Step 16** If the recalculated SD is met, approve the AU for FM-MN, completing actions outlined in Step 13.

**Step 17** If the recalculated SD (see Step 15) is not met, place the case in suspense status and notify the AU of the amount of the SD for each budget period month remaining in the review period.

**Step 18** Subtract from the SD any medical expenses incurred during the budget period as they are provided by the AU, according to the date incurred.

**Step 19** If the SD is met, approve FM-MN according to procedures outlined in Step 13.

If the SD is not met during the one-month budget period, continue the case in suspense until enough bills are incurred to meet the SD in another budget period. Review the case every six months for continued eligibility.

| | |
|---|---|
| **SPECIAL CONSIDERATIONS** | The following types of medical expenses of a BG member who has the legal obligation to pay the expenses can be used to meet the FM-MN SD. |
| **Medical Expenses** | • Services provided by the following:<br>- hospital<br>- registered nurse<br>- medical clinic<br>- licensed practical nurse<br>- physician<br>- dentist<br>- hospice |

**Medical Expenses (cont.)**

- chiropractor
- psychiatrist
- osteopath
- mental health clinic
- oculist
- personal attendant (sitter)
- nursing assistant
- optician
- optometrist

- Medical care purchases, such as the following:
  - medical tests
  - eye glasses
  - hearing aids
  - contact lens
  - prescription drugs
  - medical supplies (bandages, tape, syringes, etc.)
  - dentures
  - over-the-counter drugs
  - prosthetic devices
  - immunizations
  - transportation costs to medical services (allow $.21 per m or actual cost, whichever is less).

- Elective surgery
- Health insurance premiums
- Medically necessary ambulance service

**NOTE:** These lists are not all inclusive.

Explore TPR coverage before applying any medical expenses as deductions from the SD.

**Verification of Medical Expenses**

Verify incurred medical expenses by any one of the following:

- itemized medical bill or statement
- receipts for payment of medical expenses
- medical Explanation of Benefits (EOB) listing covered/ nc covered and paid/unpaid medical expenses
- health insurance statement listing amount paid
- odometer reading for mileage expense
- other sources deemed appropriate.

Use the following chart to determine which medical expenses can be deducted to meet the spenddown in a MN case:

**CHART 2196.1 – allowable medical expenses for FM-MN**

| allowable | not allowable |
|---|---|
| • Medical bills belonging to individuals who are or could have been included in the BG when the expenses were incurred.<br>• Unpaid bills that a BG member remains liable for paying.<br>• Unpaid bills incurred **prior** to the budget period and not used in a prior month(s) determination of eligibility nor used to meet a prior spenddown.<br>• Bills that a BG member incurred during the budget period, whether paid or unpaid.<br>• Bills applied to an earlier spenddown that was never met can be deducted in a current spenddown if the bills are still owed and the individual who incurred them is still a BG member.<br>• Medical bills used in Aged, Blind, Disabled MN budgets in the spenddown process.<br>• Bills not presented to the worker during the budget period provided the BG member remains liable for payment as of the first day of the new budget period.<br>• For prior months MN budget period only: past medical debts, which have been written off subsequent to the budget period.<br><br>**NOTE:** If the bill was forgiven or written off prior to the end of the budget period, it is not allowed.<br><br>• the remainder of unpaid bills incurred prior to the budget period that has been turned over to a collection agency. If these medical bills are consolidated with other bills, only the portion that can be verified as unpaid medical expenses can be deducted.<br><br>**NOTE:** Monthly payments to a collection agency cannot be deducted.<br><br>• Medical expenses related to pregnancy:<br>- allow when BG becomes obligated for payment of the expense<br>- include prepayment of delivery fees or admission fees by the hospital.<br>- Bills from any time period can be used as long as a BG member still has a legal obligation to pay the bill. The incurred bills are not limited to the time of the emergency service. | • Medical bills past or present, which will paid by a liable third party.<br><br>**EXCEPTIONS:**<br><br>Deductibles and co-pays to be paid by the BG are allowed.<br><br>If a decision is pending as to who is liable, allow the deduction with the understanding that the eligibility is revoked if the decision is reversed.<br><br>If a bill is paid in full or in part to a provider or as a reimbursement to a BG member by a public program funded by the state or programs of political subdivisions of the state, allow this as a deduction as long as **no federal funds** are used and the bill was paid during the budget period.<br><br>Verify the source of the funding to ensure there are no federal funds used.<br><br>**NOTE:** Allow a reimbursement for this third party only **if** the bill was paid by the BG member and reimbursed in the same budget period. Do not allow the bill as a deduction if the BG member paid the incurred expenses prior to the budget period and was reimbursed in the budget period.<br><br>• For ongoing MN budget periods, pa medical debts which were forgiven or written off by the provider prior to the first day of a budget period or prior to the date the case is brought to final disposition.<br><br>• Medical expenses paid by Medicaid und three months-prior coverage.<br><br>• Medical bills applied in another budg period in which spenddown is met. |

Use the following chart to determine procedures for the use of Form 400, 964 and 246 in MN.

**CHART 2196.2 – MN instructions on forms 400, 964 and 246**

| IF | THEN ISSUE CERTIFICATION OF ELIGIBILITY | THEN ISSUE DMA FORM 400 | THEN ISSUE CLIENT NOTIFICATION |
|---|---|---|---|
| De facto eligible, i.e., there is no spenddown at the time of application | To A/R for providers.<br><br>Do not reference DMA Form 400. | Not required. | No first day liability is put on the form. |
| There was spenddown at the time of application but it was met with bills incurred prior to the budget period. | To A/R for providers.<br><br>Do not reference DMA 400. | Not required. | No first day liability is put on the form. |
| Spenddown is met by a BG member who is potentially Medicaid eligible and the bill is issued by a Medicaid provider for a Medicaid-covered expense. Also, spenddown is met with bills incurred during the budget period. | To A/R for providers.<br><br>Note in remark section **DMA F400 required.** Retain a copy for the case record. | To provider, whose bill meets spenddown (i.e., the break-even claim). Show the actual dollar amount to be paid by the recipient for that bill.<br><br>To every Medicaid provider with a subsequent bill on the BAD, show the amount to be paid by the recipient as zero.<br><br>In both of the above situations, keep a copy of each DMA 400 in the case record. | Enter the first day liability amount (column 5, Form 238 on the line immediately preceding the first line of the BAD). |
| Spenddown is met with bills incurred by a BG member who is not Medicaid eligible or with a bill from a non-Medicaid provider or with an expense that is not covered by Medicaid. | To A/R for providers.<br><br>**NOTE: DMA Form 400 not required.** | Not required. | No first day liability is put on the form. |