4. Deeming

NOTE: When determining income to be deemed to an eligible client, public assistance maintenance income, as defined by SSA, not by **DFA**, of the spouse or parent from whom income is deemed is excluded in the deeming process, i.e., it is not deemed. In addition, any income which was considered (counted or excluded) in computing the amount of such income maintenance payments is also excluded.

These income maintenance payments are:

- WV WORKS
- SSI
- Needs-based payments resulting from the Refugee Act of 1980
- Payments from the Disaster Relief and Emergency Assistance Act
- Payments from general assistance programs of the Bureau of Indian Affairs
- State or local government assistance programs based on need. EITC payments and tax refunds are not considered to be based on need.
- Payments from the U.S. Department of Veterans Affairs programs, when such payments are based on need. VA pensions are based on need, but not payment made for service-connected disabilities.

a. Financial Responsibility

In order to deem income correctly, it is necessary to determine who in the home is financially responsible for whom.

The Social Security Act limits financial responsibility for Medicaid purposes to legal spouses and legal parents. Persons related to or associated with a dependent child as a stepparent, grandparent, alien sponsor, legal guardian, or in any way other than as a parent, are not financially responsible for the child. When income is deemed to a parent from a stepparent, no portion of the amount deemed to the parent is deemed to the children. Only if there is financial responsibility from one person to another or others, can that person's income be deemed.

Legal spouses are defined the same way for AFDC-Related Medicaid as for AFDC Medicaid. See Chapter 15.

Legal parents are natural or adoptive parents.

b. General Deeming Instructions

Deeming is most often accomplished by including the income of financially responsible persons in the total income of the Income Group and applying the AFDC Medicaid disregards and deductions to that income. However, some case situations require a different method of deeming, as described in item d. below.

c. Deeming When There Is No Stepparent, Caretaker Relative Other Than a Parent or Major Parent

(1) When No Dependent Child Has Income

The non-excluded income of the parent(s) is the only income counted. This income is then subject to the AFDC Medicaid disregards and deductions, unless the parent, or one of the parents, is an SSI-Related Medicaid recipient. In this case, the SSI-Related Medicaid disregards and deductions are applied to his income and the remainder is added to the income of the other parent, after the AFDC Medicaid disregards and deductions have been applied to the other parent's income.

(2) When At Least One Dependent Child Has Income

For those children in the home with no income, the procedure in item (1) above is followed.

For children in the home with income, add together the non-excluded income of the child and the parent(s), unless one of the parents is an SSI-Related Medicaid recipient. In this case, the SSI-Related Medicaid disregards and deductions are applied to his income and the remainder is added to the income of the other parent and the child, after the AFDC Medicaid disregards and deductions have been applied to the income of the other parent and child.

d. Deeming When There Is A Stepparent, Caretaker Relative Other Than A Parent Or A Major Parent

NOTE: Although eligibility begins on the date of service of the medical bills which bring the spenddown amount to $0, expenses incurred on that date which are used to meet the spenddown, as indicated on Screen AGTM, are not paid by Medicaid.

NOTE: An AG which meets a spenddown remains eligible until the end of the POC in the following situations, regardless of whether or not the individuals is an AG member.

- A member(s) of the Income Group experiences an increase in income; or

- An individual(s) with income is added to the Income Group; or

- An individual(s) is removed from the Needs Group

The following procedures are required to accomplish the spenddown process.

- The Worker prepares the verification checklist or ES-6, attaches an ES-6A and gives them to the client during the intake interview or mails them after the interview.

  If the client indicates he needs help to understand the procedure for meeting his spenddown, the Worker provides all help needed. In no instance is the client to be denied Medicaid because he is physically, mentally or emotionally unable to verify his medical expenses.

- The client is requested to provide proof of his medical expenses, date incurred, type of expense and amount and to submit them to the Worker by the application processing deadline.

- When the bills or verification are received, the Worker reviews them to determine:

  - The expenses were incurred, they are not payable by a third party, and the client will not be reimbursed by a third party.

- The individual(s) who received the medical service is one of the people described in item b. below.

- The expenses are for medical services and are appropriate to use to meet a spenddown. See item c. below.

- The Worker must enter the pertinent information about expenses received from the client on Screen AGTM.

  - The date of service

  - The provider of the service

  - The total amount of the bill

  - The third-party liability amount

- Medical Processing in BMS accesses RAPIDS Screen AGTM to determine the date on which spenddown is met. Additional notification is required only when a change is necessary to add additional medical expenses after the spenddown is met and will result in an earlier POE. In this instance the Worker must use form IM-MS-1 and highlight or circle in red the bill which meets the client's spenddown. A copy is sent to Medical Processing in BMS and a copy is filed in the case record. The client's eligibility begins the day the amount of incurred medical expenses at least equals his spenddown amount.

  NOTE: Although eligibility begins on the date of service of the medical bills which bring the spenddown amount to $0, expenses incurred on that date which are used to meet the spenddown, as indicated on Screen AGTM, are not paid by Medicaid.

- If the client does not submit sufficient medical bills by the application processing deadline, the application is denied.

  The application is automatically denied by RAPIDS when the applicant indicates there are no medical bills or anticipated medical expenses in the 30-day application period which may be used to meet the spenddown for the Medicaid AG member(s). This is indicated by the Worker on RAPIDS Screen AGMS.

which the client became eligible. No payment or part of a bill which is used to make a client eligible may be used again. Old unpaid bills, which are being collected by an agency other than the medical provider, may be used when the expense is still owed to the provider. If the expense has been written off by the provider, it is no longer considered the client's obligation, and is, therefore, not an allowable spenddown expense.

Medical bills that were previously submitted, but were not sufficient to meet the spenddown, are used again in a new POC. However, when any old or new bill is used and the spenddown is met, those same bills must not be used again in a new POC. When only a portion of the old bill, incurred outside the current POC, is used to meet spenddown, any remaining portion of the bill for which the client is still liable may be used to meet spenddown in a new POC.

In addition, when the client submits an old bill and then withdraws his application, the old bill may be used again if he reapplies.

- Health insurance premiums, including Medicare or the enrollment fee for a Medicare-approved drug discount card

- Medicare co-insurance, deductibles and enrollment fees

- Necessary medical or remedial care expenses. This includes, but is not limited to:

  - Office visits to a physician
  - Hospital services, inpatient and outpatient
  - Emergency room services
  - Prescriptions
  - Over-the-counter drugs prescribed by a physician
  - Eye examinations
  - Eye glasses
  - Dental services
  - Therapy prescribed by a physician
  - Chiropractic services
  - Prosthetic devices
  - Durable medical equipment prescribed by a physician
  - Rental of sickroom supplies
  - Cost of in-home care
  - Services of other licensed practitioners of the healing arts, such as podiatry.

Do not deduct any expenses which are included in a package of services, prior to the date services are rendered, such as, charges for prenatal care and delivery services or orthodontia.

- Necessary medical and remedial services which are covered services under Medicaid.

- Expenses for personal care services defined as: services provided in a client's home which are prescribed by a physician, delivered in accordance with a plan of treatment and provided by a qualified person who is not a member of the client's family, under the supervision of a registered nurse. For these purposes, home is defined as the client's full time residence, but does not include a hospital, nursing facility, intermediate care facility or any other setting in which nursing services are, or could be, made available.

  Family member for these purposes is defined as:

  - A spouse
  - A parent or stepparent of a minor child
  - A parent of an adult child
  - An adopted child or adoptive parent of a recipient
  - An adult sibling or step-sibling of a minor child
  - An adult sibling residing with an adult sibling recipient
  - An adult child of an adult recipient.

  The services must fall into any of the following general groups. Each general group shown below is further defined by examples, but is not limited to only the examples shown.

  - Personal Hygiene/Grooming: care of hair, nails, teeth, mouth; shaving; bathing; toilet assistance; dressing; laundry, when related to incontinence.

  - Non-Technical Physical Assistance: routine bodily functions; routine skin care, including application of non-prescription skin care products; change of simple dressings; repositioning or transferring into and out of bed, on and off seats; walking, with or without equipment; assist in administration of medication; following directions of a professional for use of medical supplies.

- Nutritional Support: meal preparation; feeding; assisting with special nutritional needs, including preparation of special formulas, prescribed feedings or special diets.

- Environmental: housecleaning, dusting and vacuuming; laundry; ironing and mending; making and changing beds; dishwashing; food shopping; payment of bills; essential errands; activities and transportation necessary to move the client from place to place; other similar activities of daily living.

Expenses billed to the client for the personal care services shown above must, at a minimum, specify the amount billed for each general group of services.

Ongoing or one-time-only medical expenses **are not** projected. They must be used no earlier than actually incurred. Those persons who are billed for their care at intervals longer than monthly are to have the expenses used to meet spenddown on the date services are performed, not on the date billed. Such expenses are not incurred prior to receipt of services.

12. Unavailable Income

Income intended for the client, but received by another person with whom he does not live, when the individual receiving this income refuses to make it available, is excluded.

13. Income Received For A Non-Income Group Member

Income received by a member of the Income Group, which is intended and used for the care and maintenance of an individual, whose income is not used in determining the eligibility of the payee's AG, is excluded as income.

14. Income Received From Military Personnel Deployed to a Designated Combat Zone

There is no provision for excluding income received as a result of service in a designated combat zone.