MANUAL MATERIAL TRANSMITTED					
MANUAL: INCOME MAINTENANCE			**CHANGE NUMBER:** 80		
DELETE			**INSERT OR CHANGE**		
PAGES	**CHAPTER**	**DATED**	**PAGES**	**CHAPTER**	**DATED**
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33 - 34	16	8/95	4	16	8/95
			33	16	7/97
			34	16	8/95
DATE: May, 1997			**TO:** All Income Maintenance Manual Holders		

This change is being made to extend SSI Medicaid eligibility through the SSA appeal process when an individual is determined no longer disabled for SSI and files an appeal with SSA in a timely manner.

In some, but not all instances, the individual will continue to receive an SSI benefit payment. Medicaid eligibility continues regardless of whether or not the individual continues to receive such payment.

Changes related to this policy were made in Chapters 2, 4 and 16.

Questions should be directed to the IM Policy Unit in the Office of Family Support.

- TM coverage expires

- Medically Needy non-spenddown cases that are not redetermined in the sixth month of the POC, and

- Medically Needy spenddown cases are closed at the end of the POC, regardless of whether spenddown was met or not.

In no instance is Medicaid Coverage under one coverage group stopped without consideration of Medicaid eligibility under other coverage groups. This is done before the client is notified that his Medicaid eligibility will end. Eligibility is determined based on case record information. The client may be required to visit the office only for completion of a Social Summary for a MRT referral.

See Section 2.11,D for special procedures for SSI Medicaid when an individual is determined no longer disabled by SSA.

E. CORRECTIVE PROCEDURES

1. Reimbursement For Out-of-Pocket Expenses

When determining if the client is eligible to receive direct reimbursement for out-of-pocket medical expenses which would have otherwise been paid by Medicaid, but for the error or delay of the Department, it is the responsibility of the Department to act on each application or case action correctly within a reasonable period of time, unless the delay is due to factors beyond the control of the Department. A reasonable period of time must be interpreted on a case-by-case basis.

In addition, if an application has been erroneously denied, the client is eligible to receive direct reimbursement for out-of-pocket medical expenses paid by the client which would otherwise been paid by Medicaid, but for the error of the Agency.

Reimbursement for out-of-pocket medical expenses is limited to reimbursement for those services covered by Medicaid. The client is reimbursed for the entire sum of his out-of-pocket expenses for those covered services even if that expenditure exceeds the Medicaid fee schedule in effect at the time the expenditure was incurred.

Direct reimbursement may be made for purchases of drugs during the time before submission of the request, if the purchases were made following:

- The failure of the Department to act on the application within a reasonable period of time and the delay is not due to factors beyond the control of the Department; or

- The erroneous denial of the application for Medicaid.

The CSM is responsible for determining if the client is eligible to receive reimbursement for out-of-pocket medical expenses. If it is determined that the client is eligible to receive reimbursement, the CSM must submit a memorandum to the IM Policy Unit in OFS requesting reimbursement, along with the original invoices for the medical expenses for which reimbursement is requested. The memorandum must contain the amount of the reimbursement that is due the client and the accompanying bills must be marked or highlighted to indicate if they are used for reimbursement.

2. Holding the Medicaid Card

Medicaid cards of TANF recipients may be held only when the case is eligible for School Clothing Allowance only, and is approved after the August deadline. Other Medicaid cards may not be held under any circumstances.

3. Procedures Relating to Incorrect Or Returned Medicaid Cards

Upon receipt of these cards, the State Office mails them to the appropriate county office. Medicaid cards for TANF recipients on the monthly payroll are part of the mailing package which includes the TANF check and are returned to Accounts Receivable. When a client reports that information on his Medicaid card is incorrect, he may take it to the county office for correction.

When the address is incorrect, the Worker remails the card or gives it to the client when he learns the correct address. Medical cards for TANF clients on the monthly payroll are released with the check using the ES-14. The transmission to correct the address must be done before deadline.

When duplicate Medicaid cards are authorized or case information is incorrect, the card is not sent to the client. The county office receives a printout titled Invalid Medical Cards Not Printed. The Worker must take action to correct the case and send a corrected card. See Chapter 21.

4. Incorrect Eligibility Dates

When an incorrect periods of eligibility is reflected in Blocks 81, 82 or 83, the Worker must send a memorandum to the IM Policy Unit, giving the case name, and certificate number, to request that Blocks 81, 82 and 83 be manually entered to reflect the correct eligibility dates for the client.

When a client who has a spenddown, submits bills and meets the spenddown, later sends in additional bills which would have met the spenddown at an earlier date, special procedures apply as follows:

- When the case is active, the Worker must close the case, reopen it for the same POC and re-enter the spenddown. Since the case is still in a current POC, a corrected card is mailed form the State Office at the time the spenddown is reentered.

- When the POC has ended, the Worker must reopen the case, have the Medicaid card mailed to the county office, rewrite the card to reflect the correct eligibility dates and mail the card to the client.

The Worker must send a corrected ES-MS-1 to OMS and send a memorandum to the IM Policy Unit requesting that Block 81, 82 or 83 be manually entered to reflect the correct eligibility dates for the client. A form ES-NL-A must be sent to the client to inform him of his correct date of eligibility.

2.5 MEDICAID FOR TANF RECIPIENTS

See Section 2.3.

- The Worker has information that the client has moved to another state.

- The Worker has information that the client died.

When an individual no longer receives SSI because SSA determines he is no longer disabled, SSI Medicaid must be continued for 60 days from the date of the SSA notification that SSI will be stopped. It is continued after the 60-day period when:

- The individual is not eligible under any other Medicaid coverage group; and

  NOTE: Medicaid for this purpose must be under a full-coverage group with no spenddown requirement for the individual.

- The individual has requested an appeal of the decision in a timely manner, as determined by SSA.

The SSI Medicaid continues until a decision is made after the SSA hearing regardless of whether or not the individual continues to receive an SSI payment. A decision after the hearing occurs when the SSI Medicaid recipient has no right to further administrative appeal. See Chapter 4 for verification of appeal status. See Appendix A of this chapter for SDX information.

EXAMPLE: When a recipient fails to appeal an adverse SSA Administrative Law Judge (ALJ) decision to the Appeals Council and the Appeals Council decides not to review the case on its own motion, the ALJ decision is the decision after the hearing for purposes of continued Medicaid, if the 60-day deadline for requesting or initiating an Appeals Council review has expired. If, however, a timely request is made for an Appeals Council review, the decision after the hearing is the Appeals Council's decision to either deny a review or a final decision on the appeal.

When an SSI Medicaid case, also certified for Food Stamps, is closed and there is sufficient information to continue Food Stamps, an F number is opened, with no interruption in benefits.

No interruption in benefits means that the client must receive his first issuance of Food Stamps under the F case number anytime in the calendar month immediately following the effective month of the closure of the SSI Medicaid case.

2.12 QUALIFIED MEDICARE BENEFICIARIES (QMB)

When a client is dually eligible for QMB coverage and another full Medicaid coverage group, both benefits are issued under the full Medicaid coverage group case number. Continuing eligibility for both benefits must be determined separately based on the changed case circumstances. If the client remains eligible for both benefits at the same level the full Medicaid coverage group case is updated in the data system to reflect the current case information. If the change results in a spenddown in the full Medicaid case and the client remains eligible for QMB, the QMB benefit must be removed form the full Medicaid case and issued in a Q case number. If the client is ineligible for QMB, the benefit is discontinued after proper notification.

- Elig-dte: Beginning date of POE; also Block 9 in M-219 system.

  Also includes the birthdate, benefit code and name of the child who attains age 6.

  When this printout is received, the Worker must take the indicated action.

D. LIST OF ALL ACTIVE ABD CASES WITH DUPLICATE SSNS

This is a quarterly printout of duplicate SSNs in two or more A, B or D active cases. This is a statewide listing; two copies are sent to each county. The cases are listed statewide, by SSN in ascending order.

The printout includes:

- SSN
- Data Block in which the SSN is located
- Case number, including county number
- Case name
- Address

When a case appears on this printout, the Worker must determine if:

- An individual has two (or more) active SSI Medicaid cases
- The SSN is in error

The Worker must take corrective action. When two counties are involved, the county of the case listed first is responsible.

E. NEED TO EVALUATE PRINTOUT

This printout contains the following information:

- Case No: The C-219 system case number. This and the C-219 case name is the only C-219 information on the printout.
- SDX Name

- Res. Address: If the SSI recipient has a representative payee, the recipient's address is here.

- C-219 Name

- Pay Address: This is the address of the representative payee, if any. Otherwise, it is the address of the recipient.

- SDX/SSN: Social Security Account Number

- Off CD: This is the code which identifies the District SSA office responsible for the SSI case.

- M/E CD: Medicaid Eligibility Code

- Pay CD: Payment Status Code

- T/S CD: Transaction Code

When a case appears on this printout, the Worker must determine if the client is eligible as a Deemed SSI Recipient or any other Medicaid coverage group. See Section 2.11,D for special procedures for SSI Medicaid when an individual is determined no longer disabled by SSA. These individuals may appear on the printout with Pay CD = N07.

F. SDX LISTING OF T30, S09, AND M01 CASES

This is a printout of individuals who are on a weekly SDX tape and whose payment status code is T30, S09 or M01 and indicates the following:

- Name and address

- Cert. No: If the individual has an active A, B or D Medicaid case and the SDX SSN matches the C-219 SSN.

- SSN from the SDX

- SSI Amount

- Payment Status: Indicates T30, S09 or M01.

- DOB: Date of Birth.

- SEX: This will be M, F or U.

A county only receives this printout when it has cases with a code T30, S09 or M01.

Explanation of the payment status codes and action are listed below:

Payment Status Code - S09

This is a suspense code.

When a client's name appears on this printout, the Worker must send an HS-3 to SSA to determine the client's SSI eligibility status. When the HS-3 is returned, the Worker takes appropriate action.

Payment Status Code - M01

This code indicates the individual is in a forced payment situation.

Worker action is as follows:

If the individual is currently receiving SSI Medicaid, no action is needed.

If the individual is not currently a recipient of SSI Medicaid, an HS-3 is used to obtain information from SSA to open the case.

Payment Code - T30

This code indicates that one record in SSA's data system is being terminated for the individual and that a replacement record may be established for him.

When an individual with a T30 status code appears on the printout, the Worker must contact SSA using form HS-3 to determine if his eligibility for SSI is continuing. When the response to the HS-3 is received, appropriate action is taken.

G. CATEGORICAL RELATEDNESS

ITEM	PROGRAMS	WHEN TO VERIFY	POSSIBLE SOURCES OF VERIFICATION
1. Disability, Blindness	SSI-Related Medicaid, CDCS	Prior to approval; when MRT or BMS requires revaluation.	Receipt of RSDI, MRT decision, BMS decision
2. Pregnancy	Poverty-Level Pregnant Women, Deemed Poverty-Level Pregnant Women	Prior to approval	Statement from attending physician or other person medically qualified to diagnose pregnancy
3. Appeal of Termination of SSI - No Longer Disabled	SSI Medicaid	Prior to case closure and evaluation for other Medicaid coverage groups	Letters to client from SSA, written statement from SSA

H. GENERAL FACTORS

ITEM	PROGRAMS	WHEN TO VERIFY	POSSIBLE SOURCES OF VERIFICATION
1. Identity	All Programs and coverage groups	Prior to approval **NOTE:** Is not waived for FS Expedited Service cases	Driver's license, school records, marriage records, library card, credit cards, Employment Services registration card, Social Security card, written statements from neighbors, police records, employment records
2. Residence	FS	Prior to approval	Rent or mortgage receipts, landlord's statement, written statements from neighbors, employment records

16.3 MEDICAID ELIGIBILITY BETWEEN COVERAGE GROUPS

The Worker must consider all of the following information in determining eligibility and in establishing eligible cases.

A. CONSIDERATION OF ALL MEDICAID COVERAGE GROUPS

The client cannot be expected to know which Medicaid coverage group to apply for. When the client expresses an interest in applying for Medicaid, the Worker MUST EXPLORE ELIGIBILITY FOR ALL MEDICAID COVERAGE GROUPS. This does not mean that applications for all coverage groups must be taken and processed. It means that Medicaid eligibility cannot be denied until the client has been considered for each coverage group and that, if the client is eligible under more than one coverage group, he is approved for the one that will provide him with the most benefits in the fastest time frame.

Even if the client does not request an eligibility determination for Medicaid, the Worker must explain its availability if he believes the family could benefit from it.

IN NO INSTANCE IS MEDICAID COVERAGE UNDER ONE COVERAGE GROUP TO BE STOPPED WITHOUT CONSIDERATION OF MEDICAID ELIGIBILITY UNDER ALL OTHER COVERAGE GROUPS. This is done before the client is notified that his Medicaid eligibility will end. Eligibility is determined based on case record information. The client may be required to visit the office only for completion of a Social Summary for MRT.

See Section 2.11,D for special procedures for SSI Medicaid when an individual is determined no longer disabled by SSA.

B. WHO RECEIVES LIMITED COVERAGE

All Medicaid coverage groups receive the full services the State offers to its Medicaid recipients except the following coverage groups: QMB, SLIMB, Illegal Aliens, AIDS Programs, QDWI. The limitations are described in Sections 16.5 - 16.11. In addition, any coverage group's services can be limited when a penalty for an uncompensated transfer of resources is applied. Refer to Chapter 17 to determine when to apply such a penalty and to Chapter 23 for coding instructions to accomplish the limitation.

C. BACKDATING MEDICAID COVERAGE

Unless specifically stated under the appropriate coverage group, Medicaid coverage may be backdated for up to three months prior to the month of application, provided all eligibility requirements were met at that time and provided the client has unpaid medical expenses.

D. CASE TRANSFERS FROM ONE COVERAGE GROUP TO ANOTHER

Due to limitations of the Department's data systems, the following coverage group transfer rules must be applied. They apply when a TRANS transaction is used and/or when the case coding changes so that the case changes from one coverage group to another.

- A case which receives full Medicaid coverage must not be transferred to a case which receives limited coverage and vice versa.

- A case which receives limited Medicaid coverage must not be transferred to a case which receives more limited coverage and vice versa.

- A case for Poverty-Level, Qualified and Newborn children must not be transferred to an AFDC/U-Related or SSI-Related case and vice versa.

The Medicaid limitations placed on a case because of an uncompensated transfer of resources follows the individuals involved, regardless of their coverage group. Such individuals are not considered to receive limited Medicaid services for purposes of this section. This section only deals with data system transfers from one coverage group to another.

16.6 CATEGORICALLY NEEDY, MANDATORY - FOR AGED, BLIND OR DISABLED

NOTE: No Categorically Needy coverage group is subject to a spenddown provision.

A. SSI RECIPIENTS (C-219 SYSTEM)

Income: SSI Payment Level **Assets: $2,000 Individual**
$3,000 Couple

SSI is a public assistance program administered by the Social Security Administration (SSA), which provides cash benefits to eligible aged, disabled or blind individuals.

The Program began in January, 1974. As of the first day of that month, all individuals who were receiving state-administered Old Age Assistance (OAA), Aid to the Disabled (AD) and Aid to the Blind (AB) were converted to SSI. At the same time, SSA Offices began processing applications made directly to them.

The amendment to the Social Security Act which established SSI and subsequent rules and regulations gave the states some options regarding Medicaid coverage for SSI recipients.

West Virginia elected to cover all SSI recipients and to accept SSA's determination of eligibility for SSI as the sole eligibility determination for Medicaid. West Virginia is, then, referred to as a "1634 state" based on the section of the Social Security Act which allows this.

Consequently, there is no application or eligibility determination process for SSI Medicaid. Instead the Department depends upon SSA for the information needed to open and evaluate continuing eligibility for SSI Medicaid cases.

A tape exchange between DHHR and SSA results in the production of several SDX printouts which the Worker uses to approve or evaluate an SSI case for continuing eligibility in the C-219 system. These printouts are described in Chapters 1 and 2.

NOTE: For SSI recipients who are children in foster care or whose adoptive families receive adoption assistance, refer to 16.5,B,3 and 4.

B. DEEMED SSI RECIPIENTS (C-219 SYSTEM)

The following coverage groups are required by law to be treated as SSI recipients for Medicaid purposes. Therefore,

the information in item A, above, is also applicable to these cases.

1. Disabled Adult Children (DAC)

Income: N/A **Assets: N/A**

An individual is eligible for Medicaid as a Disabled Adult Child when all of the following conditions are met:

- He is at least 18 years old.
- He became disabled or blind before reaching the age of 22.
- He was eligible for SSI based on disability or blindness.
- He lost SSI eligibility as a result of becoming entitled to or receiving an increase in child's insurance benefits on or after 7-01-87.

Eligibility is determined by SSA and communicated to the Department through SDX printouts. The client must not be required to apply for this coverage group.

2. Blind, Disabled - Substantial Gainful Activity (SGA)

Income: N/A **Assets: N/A**

Persons who received SSI due to a disabling impairment, but who also engage in substantial, gainful activity, are eligible for Medicaid even though their SSI payments may stop. Eligibility for this coverage group is determined by SSA. Such persons continue to appear on SDX printouts as eligible SSI recipients.

There are no special procedures for this coverage group and the client is not required to apply for Medicaid.

3. Essential Spouses of SSI Recipients

Income: N/A **Assets: N/A**

Under West Virginia's former OAA, AD, and AB Programs, spouses of the aged, disabled or blind person, who were not themselves aged, disabled or blind, were included in the benefit group as Essential Spouses.

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Changes related to this policy were made in Chapters 2, 4 and 16.

Questions should be directed to the IM Policy Unit in the Office of Family Support.

- TM coverage expires

- Medically Needy non-spenddown cases that are not redetermined in the sixth month of the POC, and

- Medically Needy spenddown cases are closed at the end of the POC, regardless of whether spenddown was met or not.

In no instance is Medicaid Coverage under one coverage group stopped without consideration of Medicaid eligibility under other coverage groups. This is done before the client is notified that his Medicaid eligibility will end. Eligibility is determined based on case record information. The client may be required to visit the office only for completion of a Social Summary for a MRT referral.

See Section 2.11,D for special procedures for SSI Medicaid when an individual is determined no longer disabled by SSA.

E. CORRECTIVE PROCEDURES

1. Reimbursement For Out-of-Pocket Expenses

When determining if the client is eligible to receive direct reimbursement for out-of-pocket medical expenses which would have otherwise been paid by Medicaid, but for the error or delay of the Department, it is the responsibility of the Department to act on each application or case action correctly within a reasonable period of time, unless the delay is due to factors beyond the control of the Department. A reasonable period of time must be interpreted on a case-by-case basis.

In addition, if an application has been erroneously denied, the client is eligible to receive direct reimbursement for out-of-pocket medical expenses paid by the client which would otherwise been paid by Medicaid, but for the error of the Agency.

Reimbursement for out-of-pocket medical expenses is limited to reimbursement for those services covered by Medicaid. The client is reimbursed for the entire sum of his out-of-pocket expenses for those covered services even if that expenditure exceeds the Medicaid fee schedule in effect at the time the expenditure was incurred.

When duplicate Medicaid cards are authorized or case information is incorrect, the card is not sent to the client. The county office receives a printout titled Invalid Medical Cards Not Printed. The Worker must take action to correct the case and send a corrected card. See Chapter 21.

4. Incorrect Eligibility Dates

When an incorrect periods of eligibility is reflected in Blocks 81, 82 or 83, the Worker must send a memorandum to the IM Policy Unit, giving the case name, and certificate number, to request that Blocks 81, 82 and 83 be manually entered to reflect the correct eligibility dates for the client.

When a client who has a spenddown, submits bills and meets the spenddown, later sends in additional bills which would have met the spenddown at an earlier date, special procedures apply as follows:

- When the case is active, the Worker must close the case, reopen it for the same POC and re-enter the spenddown. Since the case is still in a current POC, a corrected card is mailed form the State Office at the time the spenddown is reentered.

- When the POC has ended, the Worker must reopen the case, have the Medicaid card mailed to the county office, rewrite the card to reflect the correct eligibility dates and mail the card to the client.

The Worker must send a corrected ES-MS-1 to OMS and send a memorandum to the IM Policy Unit requesting that Block 81, 82 or 83 be manually entered to reflect the correct eligibility dates for the client. A form ES-NL-A must be sent to the client to inform him of his correct date of eligibility.

- The Worker has information that the client has moved to another state.

- The Worker has information that the client died.

When an individual no longer receives SSI because SSA determines he is no longer disabled, SSI Medicaid must be continued for 60 days from the date of the SSA notification that SSI will be stopped. It is continued after the 60-day period when:

- The individual is not eligible under any other Medicaid coverage group; and

  NOTE: Medicaid for this purpose must be under a full-coverage group with no spenddown requirement for the individual.

- The individual has requested an appeal of the decision in a timely manner, as determined by SSA.

The SSI Medicaid continues until a decision is made after the SSA hearing regardless of whether or not the individual continues to receive an SSI payment. A decision after the hearing occurs when the SSI Medicaid recipient has no right to further administrative appeal. See Chapter 4 for verification of appeal status. See Appendix A of this chapter for SDX information.

EXAMPLE: When a recipient fails to appeal an adverse SSA Administrative Law Judge (ALJ) decision to the Appeals Council and the Appeals Council decides not to review the case on its own motion, the ALJ decision is the decision after the hearing for purposes of continued Medicaid, if the 60-day deadline for requesting or initiating an Appeals Council review has expired. If, however, a timely request is made for an Appeals Council review, the decision after the hearing is the Appeals Council's decision to either deny a review or a final decision on the appeal.

When an SSI Medicaid case, also certified for Food Stamps, is closed and there is sufficient information to continue Food Stamps, an F number is opened, with no interruption in benefits.

No interruption in benefits means that the client must receive his first issuance of Food Stamps under the F case number anytime in the calendar month immediately following the effective month of the closure of the SSI Medicaid case.

- Elig-dte: Beginning date of POE; also Block 9 in M-219 system.

  Also includes the birthdate, benefit code and name of the child who attains age 6.

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- SSN
- Data Block in which the SSN is located
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When a case appears on this printout, the Worker must determine if:

- An individual has two (or more) active SSI Medicaid cases
- The SSN is in error

The Worker must take corrective action. When two counties are involved, the county of the case listed first is responsible.

E. NEED TO EVALUATE PRINTOUT

This printout contains the following information:

- Case No: The C-219 system case number. This and the C-219 case name is the only C-219 information on the printout.
- SDX Name

Explanation of the payment status codes and action are listed below:

Payment Status Code - S09

This is a suspense code.

When a client's name appears on this printout, the Worker must send an HS-3 to SSA to determine the client's SSI eligibility status. When the HS-3 is returned, the Worker takes appropriate action.

Payment Status Code - M01

This code indicates the individual is in a forced payment situation.

Worker action is as follows:

If the individual is currently receiving SSI Medicaid, no action is needed.

If the individual is not currently a recipient of SSI Medicaid, an HS-3 is used to obtain information from SSA to open the case.

Payment Code - T30

This code indicates that one record in SSA's data system is being terminated for the individual and that a replacement record may be established for him.

When an individual with a T30 status code appears on the printout, the Worker must contact SSA using form HS-3 to determine if his eligibility for SSI is continuing. When the response to the HS-3 is received, appropriate action is taken.

G. CATEGORICAL RELATEDNESS

ITEM	PROGRAMS	WHEN TO VERIFY	POSSIBLE SOURCES OF VERIFICATION
1. Disability, Blindness	SSI-Related Medicaid, CDCS	Prior to approval; when MRT or BMS requires revaluation.	Receipt of RSDI, MRT decision, BMS decision
2. Pregnancy	Poverty-Level Pregnant Women, Deemed Poverty-Level Pregnant Women	Prior to approval	Statement from attending physician or other person medically qualified to diagnose pregnancy
3. Appeal of Termination of SSI - No Longer Disabled	SSI Medicaid	Prior to case closure and evaluation for other Medicaid coverage groups	Letters to client from SSA, written statement from SSA

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West Virginia elected to cover all SSI recipients and to accept SSA's determination of eligibility for SSI as the sole eligibility determination for Medicaid. West Virginia is, then, referred to as a "1634 state" based on the section of the Social Security Act which allows this.

Consequently, there is no application or eligibility determination process for SSI Medicaid. Instead the Department depends upon SSA for the information needed to open and evaluate continuing eligibility for SSI Medicaid cases.

A tape exchange between DHHR and SSA results in the production of several SDX printouts which the Worker uses to approve or evaluate an SSI case for continuing eligibility in the C-219 system. These printouts are described in Chapters 1 and 2.

NOTE: For SSI recipients who are children in foster care or whose adoptive families receive adoption assistance, refer to 16.5,B,3 and 4.

B. DEEMED SSI RECIPIENTS (C-219 SYSTEM)

The following coverage groups are required by law to be treated as SSI recipients for Medicaid purposes. Therefore,