	GEORGIA DIVISION OF FAMILY AND CHILDREN SERVICES MEDICAID POLICY MANUAL			
	Chapter:	**2100**	**Effective Date:**	**February 2020**
	Policy Title:	**Family Medicaid Medically Needy**		
	Policy Number:	**2196**	**Previous Policy Update:**	**MT 47**

REQUIREMENTS

Family Medicaid Medically Needy (FM-MN) provides Medicaid coverage for children under 19 years of age and for pregnant women whose BG income exceeds limits for all Family Medicaid COAs and PeachCare for Kids®.

BASIC CONSIDERATIONS

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

- The budget group (BG) income exceeds the Pregnant Woman Medicaid net taxable income limit.
- The pregnant woman would be eligible for Parent/Caretaker with Child(ren) Medicaid upon the birth of the child except the BG net taxable income exceeds the Parent/Caretaker with Child(ren) Medicaid limits.

FM-MN is available to children under 19 years of age who meet any of the following conditions:

- The child's BG income exceeds Children Under19 Years of Age Medicaid and PeachCare for Kids® net taxable income limits.
- The child would be eligible for Parent/Caretaker with Child(ren) Medicaid except for excessive net taxable income.
- The child is in foster care with income exceeding Parent/Caretaker with Child(ren) Medicaid, CWFC, Children Under 19 Years of Age Medicaid, and PeachCare for Kids® net taxable income limits.

Eligibility for all Family Medicaid COAs (including Children Under 19 Years of Age Medicaid) and PeachCare for Kids® must be ruled out prior to determining eligibility under FM-MN.

BASIC CONSIDERATIONS (cont.)

Children Under 19 Years of Age Medicaid net taxable income limits vary based on a child's age. Because of this, it is possible that a younger child may be Children Under 19 Years of Age Medicaid eligible and a sibling may be FM-MN eligible because of Children Under 19 Years of Age Medicaid ineligibility.

All basic eligibility criteria must be met with the exception of living with a relative within the specified degree of relationship and cooperating with DCSS for child only cases. 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.								

Renewal Period

The FM-MN renewal period is 6 months. Each month of the 6-month FM-MN renewal 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 renewal 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 budgeted prospectively for each one-month budget period in the six-month renewal period. Refer to Section 2653, Prospective Budgeting.

BASIC CONSIDERATIONS (cont.)

Spenddown FM-MN

Spenddown (SD) eligibility is determined when the BG's net 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.

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 Expense May Be Used

The following individuals' medical expenses may be used to meet an AU's SD:

- any BG member
- a deceased spouse or child of a BG member if s/he could have 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 19 years of age if that 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.

Allowable Medical Expenses

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.

BASIC CONSIDERATIONS (cont.)

Allowable Medical Expenses (cont.)

- a BG member is legally obligated to pay the expense
- there is no TPL coverage to pay the expense. Refer to Special 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 renewal period.

NOTE: SD that remains in suspense status should be closed with the correct closure codes to refer to the Federally Facilitated Marketplace (FFM).

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 member or the provider of the FDL amount for which the member is responsible.

If a member 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 an 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 FM-MN case 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 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. Refer to Section 2720, Continuous Coverage for Pregnant Women.

BASIC CONSIDERATIONS (cont.)

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 DCH.

Begin Authorization Date

The BAD is any of the following dates:

- the first day of the budget period if SD is met using only unpaid medical bills incurred prior to the budget period
- the day in the budget period in which the SD is met using bills 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 Accept the Medicaid application from the A/R and establish the six-month renewal period. Obtain a written statement of choice when a bill that could potentially be paid by Medicaid is used to meet SD for an ongoing month. Medically Needy Option Statement.

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 renewal 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 prospectively budgeted income and expenses of the BG. Refer to Section 2671, Family Medicaid Medically Needy Budgeting.

PROCEDURES (cont.)

Step 7 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 applicant/member the SD process.

Step 8 Determine whose expenses are allowed as deductions from the SD.

Step 9 Obtain itemized copies of bills for unpaid medical expenses and those paid during the budget period for the individuals determined in Step 8.

Step 10 Determine which medical bills may be applied to the SD.

Step 11 If a TPL exists, determine how much the TPL has paid or will pay toward these bills and subtract the TPL payment(s) from the bill(s). Use only the remaining amount toward meeting the SD.

Step 12 Sort medical bills in ascending (oldest to most recent) chronological order.

Step 13 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 the first day of the budget period.
- Notify the AU. Notification includes the BAD, the ending date of eligibility and the Medicaid numbers for each AU member.
- Provide to the AU a Form 962 for any/all approved months that can not be entered in the system. Fax form 962 to DXC to be manually updated.

If the SD is **not** met using prior medical expenses, proceed to Step 14.

Step 14 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 (noncovered expenses such as over-the-counter medications or bills payable to non-Medicaid providers);

PROCEDURES (cont.)

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

If the SD is met, proceed to Step 15.

If the SD is **not** met, skip to Step 16.

Step 15 If the SD is met by bills ranking order 1 or 2 (as described in Step 14), **Form 400, First Day Liability** is not required, as the AU has no FDL.

Complete the following actions:

- Approve the AU members for Medicaid to begin on the day in which the bill that brought the SD to zero (the **break-even** bill) was incurred.
- Notify the AU of the BAD and the ending date of eligibility and the Medicaid numbers for each AU member.
- Provide to the AU a Form 962 for any/all approved months that can not be entered into the system. Fax form 962 to DXC to be manually updated.

If the SD is met by bills in ranking order 3 (as 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 dollar amount of the FDL as the client liability
- Issue Form 400 with a client liability of zero for all other bills 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 DCH and are the total responsibility of the client.

- Report to the client and DCH the amount of the break-even bill used to meet the SD as the FDL. If a manual Form 962 is used, indicate the BAD as the “Eff Date” and the last day of the budget period as the “End Date”. Complete the “First Day Liability” field, indicate Form 400 is required (Y) and whether the breakeven bill was for a pharmacy (Y or N).

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.

PROCEDURES (cont.)

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

- Provide the AU a Form 962 for any/all approved months that cannot be entered into the system. Fax form 962 to DXC to be manually updated.

Step 16 If the SD is not met, place the case in suspense status until medical expenses adequate to meet the SD are incurred.

Step 17 Subtract from the SD any medical expenses incurred during the budget period as they are provided by the AU, according to the date incurred.

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

- Determine actual income already received during the budget period.

- Recalculate the SD using the actual income and any income anticipated to be received in the remainder of the budget period.

Step 18 If the recalculated SD is met, approve the AU for FM-MN, completing actions outlined in Step 13.

Step 19 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 renewal period.

Step 20 Subtract from the SD any medical expenses incurred during the budget period as they are provided by the AU, according to the date incurred. If there is a question as to whether or not the medical expense can be used, please consult Supervisor or Medicaid Field Programs Specialists.

If the SD is met, approve FM-MN according to procedures outlined in Step 15.

Step 21 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. A renewal of the case must be completed every six months for continued eligibility.

PROCEDURES (cont.)

NOTE: SD that remains in suspense status should be closed with the correct closure codes to refer to the Federally Facilitated Marketplace (FFM).

SPECIAL CONSIDERATIONS

Applicants may apply for PCK the following ways:

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 FMMN SD.

Medical Expenses

- Services provided by the following:
  - hospital
  - registered nurse
  - medical clinic
  - licensed practical nurse
  - physician
  - dentist
  - psychiatrist
  - osteopath
  - mental health clinic
  - oculist
  - personal attendant (sitter)
  - nursing assistant
  - optician
  - optometrist
  - hospice
  - chiropractor

- Medical care purchases, such as the following:
  - medical tests
  - eye glasses
  - hearing aids
  - contact lens
  - prescription drugs
  - medical supplies (bandages, tape, syringes, etc.)
  - dentures
  - other-the-counter drugs
  - prosthetic devices
  - immunizations
  - transportation costs to medical services (allow current mileage reimbursement rate, or actual cost, whichever is less) Refer to Appendix A2.

SPECIAL CONSIDERATIONS (cont.)

Medical Expenses (cont.)

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

NOTE: These lists are not all inclusive.

Verification of Medical Expenses

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

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/ non- covered and paid/unpaid medical expenses
- health insurance statement listing amount paid
- odometer reading for mileage expense
- other sources deemed appropriate.

NOTE: A doctor's statement (written or verbal) indicating anticipated Medicare TPL may be used as verification until such time as the Medicare Explanation of Benefits (EOB) is received.

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. • Unpaid bills that a BG member remains liable for paying. • 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. • Bills that a BG member incurred during the budget period, whether paid or unpaid. • 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. • Medical bills NOT used in Aged, Blind, Disabled MN budgets in the spenddown process. • 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. • For prior months MN budget period only: past medical debts, which have been written off subsequent to the budget period. **NOTE:** If the bill was forgiven or written off prior to the end of the budget period, it is not allowed. • 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. **NOTE:** Monthly payments to a collection agency cannot be deducted. • Medical expenses related to pregnancy: allow when BG becomes obligated for payment of the expense	• Medical bills past or present, which will be paid by a liable third party. **EXCEPTIONS:** Deductibles and co-pays to be paid by the BG are allowed. 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. 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 or 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. Verify the source of the funding to ensure there are no federal funds used. **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. For ongoing MN budget periods, past 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.

CHART 2196.1 – ALLOWABLE MEDICAL EXPENSES FOR FM-MN (CONT.)	
ALLOWABLE	**NOT ALLOWABLE**
- include prepayment of delivery fees or admission fees by the hospital. - 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 expenses paid by Medicaid under three months-prior coverage. Medical bills applied in another budget period in which spenddown is met.

Use the following chart to determine procedures for the use of Form 400 and 962 in MN.

CHART 2196.2 – MN instructions on forms 400 and 962

IF	THEN ISSUE ACTION/REQUEST/ CERTIFICATION Form 962	THEN ISSUE DMA FORM 400	THEN ISSUE MEMBER NOTIFICA-TION
There was spenddown at the time of application but it was met with bills incurred prior to the budget period.	To member for providers if unable to enter in system. Fax form 962 to DXC to manually update on GAMMIS. Put an "N" for no on the form DMA400 being required in the Medically Needy Information section. Retain a copy for the case record.	Not required.	No first day liability is put on the form if system notice not used.
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 member for providers if unable to enter in system. Fax form 962 to DXC to be manually updated on GAMMIS. Note in the Medically Needy Information section regarding the DMA400 being 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 member for that bill. To every Medicaid provider with a subsequent bill on the BAD, show the amount to be paid by the member as zero. In both of the above situations, keep a copy of each form DMA 400 in the case record.	If system notice not used, 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	To A/R for providers if unable to enter in system. Put an "N" for no on the form DMA400 being required in the	Not required.	No first day liability is put on the form if system notice not used.

CHART 2196.2 – MN instructions on forms 400 and 962 (cont.)			
IF	**THEN ISSUE ACTION/REQUEST/ CERTIFICATION Form 962**	**THEN ISSUE DMA FORM 400**	**THEN ISSUE MEMBER NOTIFICA-TION**
not covered by Medicaid.	Medically Needy Information section. Retain a copy for the case record.		