12VAC30-30-60. Requirements Relating to Determining Eligibility for Medicare Prescription Drug Low-Income Subsidies

The agency provides for making Medicare prescription drug Low Income Subsidy determinations under Section 1935(a) of the Social Security Act.

1. The agency makes determinations of eligibility for premium and cost-sharing subsidies under and in accordance with section 1860D-14 of the Social Security Act;

   a. The Social Security Administration's subsidy application (SSA-1020) will be used as the official application form for individuals to request that the state determine eligibility for the Low Income Subsidy.

   b. The application must be filed at the local department of social services in the city or county where the applicant resides. A face-to-face interview is not required.

   c. The applicant may be represented by an individual who is authorized to act on behalf of the applicant; if the applicant is incapacitated or incompetent, someone acting responsibly on his or her behalf; or an individual of the applicant's choice who is requested by the applicant to act as his or her representative in the application process. The person acting responsibly on behalf of, or acting as the representative of the applicant is required to attest to the accuracy of the information on the application.

   d. Applications must be acted on within 45 days from the date the application is received by the local department of social services. A determination of eligibility or ineligibility must be made and the applicant must be sent written notice of his

approval or denial of assistance under the Low Income Subsidy program as well as the reasons for such findings.

e. Redeterminations of eligibility must be made in the same manner and frequency as redeterminations are required under the State's Medicaid Plan.

f. Family Size The following persons are counted in the family size: the applicant; the applicant's spouse, if living with the applicant; and any persons who are related by blood, marriage or adoption, who are living with the applicant and spouse and who are dependent on the applicant or spouse for at least one half of their financial support.

g. Financial Requirements. Regulations at 20 CFR §416 Subparts K and L are used to evaluate income and resources for subsidy eligibility. Current SSI policy can be found in the online Program Operations Manual System (POMS) on the Social Security Administration website. Less restrictive rules the State uses for Medicaid determinations are not used for the Low Income Subsidy determination.

h. The subsidy applicant may appeal his or her Low-Income Subsidy determination according to the appeal procedures found in the State's Medicaid State Plan.

2. The agency provides for informing the Secretary of such determinations in cases in which such eligibility is established or redetermined;

3. The agency provides for screening of individuals for Medicare cost-sharing described in Section 1905(p)(3) of the Act and offering enrollment to eligible individuals under the State plan or under a waiver of the State plan.

CERTIFIED: I hereby certify that these regulations are full, true, and correctly dated.

| ________________________ | ________________________________ |
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| Date | Patrick W. Finnerty, Director<br>Dept. of Medical Assistance Services |

12VAC30-40-10. General conditions of eligibility.

Each individual covered under the plan:

1. Is financially eligible (using the methods and standards described in Parts II and III of this chapter) to receive services.

2. Meets the applicable nonfinancial eligibility conditions.

a. For the categorically needy:

(i) Except as specified under items (ii) and (iii) below, for AFDC-related individuals, meets the nonfinancial eligibility conditions of the AFDC program.

(ii) For SSI-related individuals, meets the nonfinancial criteria of the SSI program or more restrictive SSI-related categorically needy criteria.

(iii) For financially eligible pregnant women, infants or children covered under §1902(a)(10)(A)(i)(IV), 1902(a)(10)(A)(i)(VI), 1902(a)(10)(A)(i)(VII), and 1902(a)(10)(A)(ii)(IX) of the Act, meets the nonfinancial criteria of §1902(l) of the Act.

(iv) For financially eligible aged and disabled individuals covered under §1902(a)(10)(A)(ii)(X) of the Act, meets the nonfinancial criteria of §1902(m) of the Act.

b. For the medically needy, meets the nonfinancial eligibility conditions of 42 CFR 435.

c. For financially eligible qualified Medicare beneficiaries covered under §1902(a)(10)(E)(i) of the Act, meets the nonfinancial criteria of §1905(p) of the Act.

d. For financially eligible qualified disabled and working individuals covered under §1902(a)(10)(E)(ii) of the Act, meets the nonfinancial criteria of §1905(s).

3. Is residing in the United States and:

a. Is a citizen; or

b. Is a qualified alien as defined under Public Law 104-193 who arrived in the United States prior to August 22, 1996;

c. Is a qualified alien as defined under Public Law 104-193 who arrived in the United States on or after August 22, 1996, and whose coverage is mandated by Public Law 104-193;

d. Is an alien who is not a qualified alien, or who is a qualified alien who arrived in the United States on or after August 22, 1996, whose coverage is not mandated by Public Law 104-193 (coverage must be restricted to certain emergency services).

4. Is a resident of the state, regardless of whether or not the individual maintains the residence permanently or maintains it a fixed address.

The state has open agreement(s).

5. Is not an inmate of a public institution. Public institutions do not include medical institutions, nursing facilities and intermediate care facilities for the mentally retarded, or publicly operated community residences that serve no more than 16 residents, or certain child care institutions.

6. Is required, as a condition of eligibility, to assign rights to medical support and to payments for medical care from any third party, to cooperate in obtaining such support and payments, and to cooperate in identifying and providing information to assist in pursuing any liable third party. The assignment of rights obtained from an applicant or recipient is effective only for services that are reimbursed by Medicaid. The requirements of 42 CFR 433.146 through 433.148 are met.

An applicant or recipient must also cooperate in establishing the paternity of any eligible child and in obtaining medical support and payments for himself or herself and any other person who is eligible for Medicaid and on whose behalf the individual can make an assignment; except that individuals described in §1902(l)(1)(A) of the Social Security Act (pregnant women and women in the post-partum period) are exempt from these requirements involving paternity and obtaining support. Any individual may be exempt from the cooperation requirements by demonstrating good cause for refusing to cooperate.

An applicant or recipient must also cooperate in identifying any third party who may be liable to pay for care that is covered under the state plan and providing information to

assist in pursuing these third parties. Any individual may be exempt from the cooperation requirements by demonstrating good cause for refusing to cooperate.

7. Is required, as a condition of eligibility, to furnish his social security account number (or numbers, if he has more than one number) except for aliens seeking medical assistance for the treatment of an emergency medical condition under §1903(v)(2) of the Social Security Act (§1137(f)).

8. Is not required to apply for AFDC benefits under Title IV-A as a condition of applying for, or receiving Medicaid if the individual is a pregnant women, infant, or child that the state elects to cover under §1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Act.

9. Is not required, as an individual child or pregnant woman, to meet requirements under §402(a)(43) of the Act to be in certain living arrangements. (Prior to terminating AFDC individuals who do not meet such requirements under a state's AFDC plan, the agency determines if they are otherwise eligible under the state's Medicaid plan.)

10. Is required to apply for enrollment in an employer-based cost-effective group health plan (as determined by the state agency), if such plan is available to the individual. Enrollment is a condition of eligibility except for the individual who is unable to enroll on his own behalf (failure of a parent to enroll a child does not affect a child's eligibility).

11. Is required to apply for coverage under Medicare A, B and/or D if it is likely that the individual would meet the eligibility criteria for any or all of those programs. The state agrees to pay any applicable premiums and cost-sharing (except those applicable under

Part D) for individuals required to apply for Medicare. Application for Medicare is a condition of eligibility unless the state does not pay the Medicare premiums, deductibles or co-insurance (except those applicable under Part D) for persons covered by the Medicaid eligibility group under which the individual is applying.

CERTIFIED: I hereby certify that these regulations are full, true, and correctly dated

| ______________________ | ______________________ |
| --- | --- |
| Date | Patrick W. Finnerty, Director<br>Dept. of Medical Assistance Services |

12VAC30-50-35. Requirements Relating to Payment for Covered Outpatient Drugs for the Categorically Needy

A. Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

1. The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit –Part D. The following excluded drugs are covered:

(a) agents when used for anorexia, weight loss, weight gain (see specific drug categories in subsection (B) below)

(b) agents when used for the symptomatic relief cough and colds (see specific drug categories in subsection (B) below)

(c) prescription vitamins and mineral products, except prenatal vitamins and fluoride (see specific drug categories in subsection (B) below)

(d) nonprescription drugs (see specific drug categories in subsection (B) below)

(e) barbiturates (see specific drug categories in subsection (B) below)

(f) benzodiazepines (see specific drug categories in subsection (B) below)

B. Coverage of specific categories of excluded drugs will be in accordance with existing Medicaid policy as described in 12VAC30-50-520.

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|---|---|
| Date | Patrick W. Finnerty, Director<br>Dept. of Medical Assistance Services |

## 12VAC30-50-75. Requirements Relating to Payment for Covered Outpatient Drugs for the Medically Needy

A. Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

1. The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit –Part D. The following excluded drugs are covered:

(a) agents when used for anorexia, weight loss, weight gain (see specific drug categories in subsection (B) below)

(b) agents when used for the symptomatic relief cough and colds (see specific drug categories in subsection (B) below)

(c) prescription vitamins and mineral products, except prenatal vitamins and fluoride (see specific drug categories in subsection (B) below)

(d) nonprescription drugs (see specific drug categories in subsection (B) below)

(e) barbiturates (see specific drug categories in subsection (B) below)

(f) benzodiazepines (see specific drug categories in subsection (B) below)

B. Coverage of specific categories of excluded drugs will be in accordance with existing Medicaid policy as described in 12VAC30-50-520.

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| Date | Patrick W. Finnerty, Director<br>Dept. of Medical Assistance Services |

12VAC30-50-530. Methods of providing transportation.

A. DMAS will ensure necessary transportation for recipients to and from providers of covered medical services. DMAS shall cover transportation to covered medical services under the following circumstances:

1. Emergency air, ambulance transportation, and all other modes of transportation shall be covered as medical services under 42 CFR 431.53 and any other applicable federal Medicaid regulations. These modes include, but shall not be limited to, nonemergency air travel, nonemergency ground ambulance, stretcher vans, wheelchair vans, common user bus (intra-city and inter-city), volunteer/registered drivers, and taxicabs. DMAS may contract directly with providers of transportation or with brokers of transportation services, or both. DMAS may require that brokers not have a financial interest in transportation providers with whom they contract.

2. Medicaid provided transportation shall only be available when recipients have no other means of transportation available.

3. Recipients shall be furnished transportation services that are the most economical to adequately meet the recipients' medical needs.

4. Ambulances, wheelchair vans, taxicabs, and other modes of transportation must be licensed to provide services in the Commonwealth by the appropriate state or local licensing agency, or both. Volunteer/registered drivers must be licensed to operate a motor vehicle in the Commonwealth and must maintain automobile insurance.

B. DMAS will ensure necessary non-emergency transportation for full-benefit, dual eligible recipients to obtain medically necessary, non-covered Medicare Part D prescription drugs.

CERTIFIED: I hereby certify that these regulations are full, true, and correctly dated

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|---|---|
| Date | Patrick W. Finnerty, Director<br>Dept. of Medical Assistance Services |