NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
BISMARCK, NORTH DAKOTA
March 7, 2013

AMENDED IM 5164

TO: County Social Service Directors
Economic Assistance Policy Regional Representatives
Economic Assistance Policy Quality Control Reviewers

FROM: Carol Cartledge, Director, Economic Assistance Policy

SUBJECT: Standard Medical Expense Deduction

PROGRAMS: SNAP

EFFECTIVE: Benefit month of April 2013 for Ongoing Cases
April 1, 2013 for New Applications and Reviews

RETENTION: Until Manualized

SECTIONS AFFECTED: 430-05-55-20-07 - Actual Medical Expense versus Standard Medical Expense Deduction (New Section of Policy)

This IM is being amended to include additional clarifications. All amendments are underlined and in bold print.

Effective with the benefit month of April 2013, there is a new Standard Medical Expense Deduction (ME ST) for SNAP. If entitled to the Standard Medical Expense Deduction, a household will be allowed a medical expense of $200. The Standard Medical Expense Deduction is an option under Federal Regulations that requires program costs remain neutral. To maintain cost neutrality, the Standard Utility Allowance (HL SU) is being reduced from $589 to $569 also effective with the benefit month of April 2013.

All SNAP cases will be unauthorized for the benefit month of April 2013. The change in the HL SU will be reflected in the cases when benefits for the month of April 2013 are authorized.

The change in the HLSU and the conversion to the Standard Medical Expense Deduction are mass changes. SNAP Policy at 430-05-67-50 – Adequate Notice states, advance notice is not required for mass changes. Adequate notice must be provided.

Households responsible for allowable medical expenses greater than $35 can choose the Standard Medical Expense Deduction or actual monthly medical expenses. The household's choice must be clearly documented in the case file.

New Applications and Reviews

For new applications and reviews received on or after April 1, 2013, the worker must request verification and compute monthly medical expenses based on current policy. Medical expenses for a household member with a participation code of DI are not allowable.

If verification is not provided, the review must be pended allowing the household 30 days to provide the verification.

- **If the household does not provide the verification by the 30th day, the review is processed without allowing a medical expense deduction.**

- **If verification of medical expense is provided within 30 days and** the total of **ALL** allowable monthly medical expenses for **all** elderly and disabled household members are greater than $35 but less than $200, the household has the option of using the monthly amount or the Standard Medical Expense Deduction.

  If the household chooses the Standard Medical Expense Deduction, ME ST must be coded by only one elderly or disabled household member with a participation code other than DI. The household's choice must be documented in the case file.

  Exception:

  ME LR is not included when determining entitlement to the Standard Medical Expense Deduction as it can be allowed along with the ME ST expense. This is the only medical expense that can be allowed along with the ME ST expense. Other medical expenses can be entered if the case includes Medicaid in TECS but will not be allowed in the SNAP budget.

<u>If the household provides verification of some but not all medical expenses by the 30th day and the verified medical expenses exceed $35 but are less than $200, the Standard Medical Expense Deduction is allowed.</u>

- If the total of **ALL** allowable monthly medical expenses for **all** elderly and/or disabled household members are greater than $200, actual expenses are allowed. The medical expenses are coded by the appropriate elderly or disabled household member(s).

  Exception:

  If the household has medical expenses that are greater than $200 but chooses the Standard Medical Expense Deduction rather than actuals, this must be documented in the case file.

<u>Converting Ongoing Cases</u>

For ongoing cases with elderly and/or disabled member(s), when determining eligibility for the benefit month of April 2013, the worker will need to determine if the household is entitled to the Standard Medical Expense Deduction. Medical expenses for a household member with a participation code of DI are not allowable.

- If the total of **ALL** allowable monthly medical expenses currently being allowed on EXSA in TECS for **all** elderly or disabled household members are **<u>greater than $35 but</u>** less than $200, remove all medical expenses and allow the Standard Medical Expense Deduction (ME ST). ME ST must be coded by only one elderly or disabled household member with a participation code other than DI.

  Exception:

  ME LR can continue to be allowed along with the ME ST expense. This is the only medical expense that can be allowed along with the ME ST expense. <u>Other medical expenses can be entered if the case includes Medicaid in TECS but will not be allowed in the SNAP budget.</u>

- If the total of **ALL** medical expenses currently being allowed on EXSA in TECS for **all** elderly or disabled household members is greater than $200, these expenses will continue to be allowed until the next review.

A report of households with elderly and/or disabled members will be provided to counties the first week of March to assist workers in the conversion for April 2013. The report will include the case name, case number and medical expenses for each elderly and/or disabled member in the case.

The following policy will be incorporated into a new section of the SNAP policy manual at 430-05-55-20-07:

430-05-55-20-07 - Actual Medical Expense versus Standard Medical Expense Deduction

Households with elderly or disabled individuals who are billed and responsible for more than $35 in allowable monthly medical expenses can choose the Standard Medical Expense Deduction of $200 per month rather than actual medical expenses**. The household's choice must be clearly documented in the case file.**

Only one Standard Medical Expense Deduction can be allowed per household. The expense must be coded by an elderly or disabled individual with a participation code other than DI using the ME ST code on the EXSA screen in TECS.

The only medical expense that will be allowed in addition to the standard medical expense deduction is when a household is legally responsible for payment of expenses for an individual who was an elderly or disabled household member immediately prior to dying or entering a hospital or nursing home (ME LR). **Other medical expenses can be entered if the case includes Medicaid in TECS but will not be allowed in the SNAP budget.**

TECS will automatically deduct $35 from the total of all medical expenses for all individuals entered on the EXSA screen, **including the Standard Medical Expense Deduction.**

Initial Application

At initial application, verification of medical expenses is required. **If verification is not provided, the review must be pended allowing the household 30 days to provide the verification.**

If verification of medical expenses is not provided, no expense is allowed.

If verification of medical expenses is provided **within 30 days** and the total of **all** allowable monthly medical expenses for **all** elderly and disabled household members is greater than $35 but less than $200, the Standard Medical Expense Deduction is allowed for the household. The Standard Medical Expense Deduction must be coded by only one elderly or disabled individual with a participation code other than DI.

If the household provides verification of some but not all medical expenses within 30 days and the verified medical expenses exceed $35 but are less than $200, the Standard Medical Expense Deduction is allowed.

If verification of medical expenses is provided **within 30 days** and the total of **all** allowable monthly medical expenses for **all** elderly and disabled household members exceeds the $200 Standard Medical Expense Deduction, actual verified expenses are allowed. Actual allowable monthly medical expenses must be coded by the elderly or disabled member(s) that incurs the expense.

Exception:

If the household has medical expenses that are greater than $200 but chooses the Standard Medical Expense Deduction rather than actuals, this must be documented in the case file.

If a household also reports **and verifies** a one-time medical expense at application, the household can choose to have the one-time expense averaged over the review period or used as a one-time expense. If the household chooses to:

- Average over the review period, the one-time expense is included with other allowable monthly medical expenses in determining entitlement to the Standard Medical Expense Deduction.

- Use as a one-time expense, the one-time expense is included with other allowable monthly medical expenses. If the total is greater than $35 but less than $200, the household can choose the Standard Medical Expense Deduction.

  If the total is greater than $200, the household can choose to use actuals. The actuals must be allowed for the next month. The one-time expense must then be removed for the following month. Once removed, if monthly expenses are **greater than $35 but** less than

$200, the household can choose the Standard Medical Expense Deduction again for the following month.

Review

At review, households will remain eligible for the Standard Medical Expense Deduction if they report the total of all elderly and disabled members' allowable medical expenses are greater than $35. **Client statement of medical expenses is acceptable and must be documented in the case file.** If the household reports medical expenses that are greater than $200, verification is required. If verification of medical expenses is not provided, the Standard Medical Expense Deduction will continue to be allowed for the new review period.

If a household with elderly or disabled household members reports at review they are now incurring a medical expense or reports medical expenses in excess of $200, verification is required. If verification is not provided, the review must be pended allowing the household 30 days to provide the verification.

If the household does not provide the verification by the 30th day, the review is processed without allowing a medical expense deduction.

If verification of medical expenses is provided within 30 days and the total of all allowable monthly medical expenses for all elderly and disabled household members is greater than $35 but less than $200, the Standard Medical Expense Deduction is allowed for the household. The Standard Medical Expense Deduction must be coded by only one elderly or disabled individual with a participation code other than DI.

If the household provides verification of some but not all medical expenses within 30 days and the verified medical expenses exceed $35 but are less than $200, the Standard Medical Expense Deduction is allowed.

If verification of medical expenses is provided within 30 day and the total of all allowable monthly medical expenses for all elderly and disabled household members exceeds the $200 Standard Medical Expense Deduction, actual verified expenses are allowed. Actual allowable monthly medical expenses must be coded by the elderly or disabled member(s) that incurs the expense.

Exception:

If the household has medical expenses that are greater than $200 but chooses the Standard Medical Expense Deduction rather than actuals, this must be documented in the case file.

If a household also reports and verifies a one-time medical expense at review, the household can choose to have the one-time medical expense averaged over the review period or used as a one-time expense. If the household chooses to:

- **Average over the review period, the one-time expense is included with other allowable monthly medical expenses in determining entitlement to the Standard Medical Expense Deduction.**

- **Use as a one-time expense, the one-time expense is included with other allowable monthly medical expenses. If the total is greater than $35 but less than $200, the household can choose the Standard Medical Expense Deduction.**

  If the total is greater than $200, the household can choose to use actuals. The actuals must be allowed for the next month. The one-time expense must then be removed for the following month. Once removed, if monthly expenses are less than $200, the household can choose the Standard Medical Expense Deduction again for the following month.

Ongoing Cases

Households entitled to the Standard Medical Expense Deduction are allowed to change to actual medical expenses during the review period.
If a household reports new medical expenses that would entitle them to the Standard Medical Expense Deduction or expenses which exceed the standard, since these changes will result in an increase in benefits, the changes must be verified. Notice F419 – "Request for Verification" must be sent allowing the household 10 days from the mail date of the notice to verify the current medical expenses.

If the household provides verification within the 10-day period, the worker must act on the reported change within 10-days and send the household the appropriate notice. If the verification entitles the household to the Standard Medical Expense Deduction, the expense must be coded by only one elderly or disabled individual in the case. If the verification entitles the household

to actual medical expenses, the actual allowable expenses must be coded by the elderly or disabled member(s) that incur the expense.

If the household fails to provide verification within the 10-day period, the previously verified amount is used and the benefit stays the same.
If there is no previously verified amount (i.e. household reports now incurring medical expenses and previously had none), no change is made and the benefit stays the same.

If the household fails to provide verification within the 10-day period and provides verification at a later date, benefits are increased the month after receipt of the verification.

If a household reports **and verifies** a one-time medical expense in an ongoing case, the household can choose to have the one-time expense averaged over the remainder of the review period or used as a one-time expense.

If the household chooses to average over the remainder of the review period and the averaged amount is:

- **Greater than $35 but less than $200, the household is entitled to or continues to be eligible for the Standard Medical Expense Deduction.**

- **Greater than $200, the household is entitled to the actual averaged amount.**

If the household chooses to use as a one-time expense:

- **If the one-time expense is greater than $35 but less than $200, the household is entitled to or continues to be eligible for the Standard Medical Expense Deduction.**

- **If the one-time expense is greater than $200, the household can choose to use actuals. The actual one-time expense must be allowed for the next month. The one-time expense must then be removed for the following month. Once removed, if the household was allowed the Standard Medical Expense Deduction immediately prior to allowing the one-time expense, the Standard Medical Expense Deduction is allowed again for the following month.**

Example:

At initial application in February, a household verifies monthly medical expenses of $140 and chooses to use the Standard Medical Expense Deduction. The household is approved and certified through July. On May 5, the household timely reports and verifies a one-time medical expense of $300 for glasses. When calculating the benefits for the month of June, the household has the option of using the $300 deduction as follows:

- **Average the $300 expense over the remainder of the review period (two months) for a monthly amount of $150 per month. Since averaging the one-time expense results in an amount less than $200, the household will continue to be allowed the Standard Medical Expense Deduction.**

- **Allowed as a one-time medical expense of $300 for June. The ME ST would be removed for June. When calculating benefits for the month of July, the one-time expense is removed and the Standard Medical Expense Deduction is again allowed.**

If you have questions, please contact your Regional Representative.