



# COMMONWEALTH of VIRGINIA

## DEPARTMENT OF SOCIAL SERVICES

March 1, 2005

MEDICAID MANUAL – VOLUME XIII

TRANSMITTAL #79

The following acronyms are used in this transmittal:

- ABD – Aged, Blind, and Disabled
- AIDS – Acquired Immunodeficiency Syndrome
- CBC – Community-based Care
- CDPAS – Consumer-directed Personal Attendant Services
- CNNMP – Categorically Needy Non-Money Payment
- DD – Developmental Disabilities
- DMAS – Department of Medical Assistance Services
- E&D – Elderly and Disabled
- EDCD – Elderly or Disabled with Consumer-Direction
- F&C – Families and Children
- FAMIS – Family Access to Medical Insurance Security Plan
- FPL – Federal Poverty Level
- HIPPA – Health Insurance Payment Program
- LIFC – Low Income Families with Children
- LTC – Long-term Care
- MI – Medically Indigent
- PERS – Personal Emergency Response System
- QI – Qualified Individuals
- SS – Social Security
- SSA COLA – Social Security Administration Cost of Living Adjustment
- SSI – Supplemental Security Income
- USCIS – United States Citizenship and Immigration Services

This transmittal contains the January 2005 SSA COLA, the changes in Medicare premiums, the income limits and deeming allocations based on the SSI payment levels, and the ABD student child earned income exclusion. The new amounts, which were released in Broadcast 2944, must be used for all Medicaid eligibility determinations effective on or after January 1, 2005.

This transmittal also contains the new MI and FAMIS income limits. The new income limits were effective February 18, 2005 for all F&C MI, ABD MI without SS, and FAMIS eligibility determinations. The new income limits are effective April 1, 2005, for all ABD MI with SS eligibility determinations.

Revisions to policy in this transmittal include the consolidation of the E&D and CDPAS CBC Waivers into the EDCD Waiver, effective February 1, 2005. This information was also posted in Broadcast 3020.

Clarifications to policy in this transmittal include: that referral to HIPP is not required when the employee is not eligible for coverage under an employer's group health plan; that refugees with adjusted status may be evaluated as refugees (qualified aliens) for Medicaid eligibility determinations; that combat zone pay is excluded as income for F&C covered groups; and that ex parte renewals cannot be done when the recipient has reported having no (\$0) income. Except as noted above, all policy clarifications and updates contained in this transmittal are effective for all eligibility determinations completed on or after April 1, 2005.

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Subchapter M0130 pages 5, 6	Subchapter M0130 Pages 5, 6	Page 5 is a reprint. On page 6, clarified that HIPP information is obtained only when the employed individual is eligible for coverage under an employer's group health plan.
Subchapter M0220 pages 3, 4 pages 14a, 14b pages 19, 20 Appendix 1, page 1	Subchapter M0220 pages 3, 4 pages 14a, 14b pages 19, 20 Appendix 1, page 1	On page 3, revised the contact information for the USCIS. Page 4 is a reprint. On pages 14a, 14b and 19, clarified that an applicant who has had his Refugee status adjusted to Lawful Permanent Resident may still be considered to have Refugee status for the purposes of Medicaid eligibility. Page 20 is a reprint. In Appendix 1, revised the contact information for the USCIS.
Subchapter M0290 pages 3, 4	Subchapter M0290 pages 3, 4	On page 3, clarified that HIPP information is obtained only when the employed individual is eligible for coverage under an employer's group health plan. Page 4 is a runover page.

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Subchapter M0320 pages 11, 12	Subchapter M0320 pages 11, 12	Page 11 is a reprint. On page 12, added the COLA and Medicare premiums for January 2005.
Subchapter M0530 page 49 (Appendix 1)	Subchapter M0530 page 49 (Appendix 1)	On page 49, updated the deeming allocations based on the January 2005 SSI payment levels.
Chapter M07 Table of Contents	Chapter M07 Table of Contents	In the Table of Contents, revised the titles for the tables in M0710, Appendix 6.
Subchapter M0710 Table of Contents Appendix 6, pages 1, 2 Appendix 7, page 1	Subchapter M0710 Table of Contents Appendix 6, pages 1, 2 Appendix 7, page 1	In the Table of Contents, revised the titles for the tables in Appendix 6. In Appendix 6 and Appendix 7, updated the F&C MI income limits based on the February 18, 2005 FPL.
Subchapter M0730 page 6a	Subchapter M0730 page 6a	On page 6a, clarified that combat zone pay is not countable as income for F&C covered groups.
Subchapter M0810 pages 1, 2	Subchapter M0810 pages 1, 2	On page 1, updated the income limits for CNNMP protected groups based on the 2005 SSI payment levels. On page 2, updated the 300% SSI based on the January 2005 SSI payment and updated the ABD MI income limits based on the February 18, 2005 FPL.
Subchapter S0820 pages 29-32	Subchapter S0820 pages 29-32	Page 29 is a reprint. On page 30, updated the ABD student child earned income exclusion. On page 31, added the January 2005 figures for the ABD student child earned income exclusion. Page 32 is a reprint.

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Subchapter S1140 Table of Contents pages 25, 26	Subchapter S1140 Table of Contents pages 25, 26	Corrected a page reference in the Table of Contents. On pages 25 and 26, corrected the headers.
Subchapter M1410 pages 5-8 pages 16a-20	Subchapter M1410 pages 5-8 pages 16a-20	On page 5, added a description of the EDCD waiver, which combines and replaces the E&D and CDPAS waivers. Pages 6 and 7 are runover pages. Page 8 is a reprint. On page 16a, clarified the purpose of the pre-admission screening. On page 17, clarified requirements when an ongoing Medicaid recipient enters long-term care. Page 18 is a reprint. On page 19, clarified to whom the DMAS-122 is sent for the various waivers. Page 20 is a reprint.
Subchapter M1420 Table of Contents pages 1-5 Appendix 1, pages 1-2	Subchapter M1420 Table of Contents pages 1-5 Appendix 1, pages 1-2	In the Table of Contents, deleted the CDPAS Authorization Form. Page 1 is a reprint. On page 2, replaced the references to the E&D and CDPAS waivers with the EDCD waiver. Page 3 is a runover page. On page 4, clarified that a pre-admission screening is not needed when the individual moves from nursing facility care to the EDCD or AIDS waivers or vice versa. On page 5, clarified that screening and approval for the EDCD waiver allows evaluation for Medicaid

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Subchapter M1440 Table of Contents pages 11, 12 pages 17-18b pages 21, 22	Subchapter M1440 Table of Contents pages 11, 12 pages 17-18b pages 21, 22	<p>eligibility as an institutionalized individual but that consumer-directed services under the EDCD waiver are subject to final DMAS authorization. Appendix 1, the DMAS-96 form, is revised.</p> <p>Revised the Table of Contents, replaced the E&amp;D and CDPAS waivers with the EDCD waiver and added section M1440.213, PERS. On page 11, replaced the description of the E&amp;D and CDPAS waivers with the EDCD waiver. On page 12, added the services covered under the EDCD waiver. On page 17 and 18, deleted the CDPAS information. On Page 18a, added PERS to the list of CBC covered services. On page 18b, replaced the reference to the E&amp;D the EDCD waiver. Page 21 is a reprint. On page 22, added section M1440.213, PERS.</p>
Subchapter M1460 pages 35, 36	Subchapter M1460 pages 35, 36	<p>On page 35, updated the ABD student child earned income exclusion. Page 36 is a reprint.</p>
Subchapter M1470 Table of Contents pages 21-24 pages 29, 30 pages 49-52 Appendix 1, pages 67, 68	Subchapter M1470 Table of Contents pages 21-24 pages 29, 30 pages 49-52	<p>In the Table of Contents, deleted Appendix 1. On page 21, replaced the reference to the E&amp;D and CDPAS waivers with the EDCD waiver. On page 22, clarified that a working recipient under the EDCD waiver has a special</p>

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Subchapter M1480 pages 77, 78	Subchapter M1480 pages 77, 78	<p>earnings allowance deducted from the patient pay. On pages 23 and 24, revised the examples. On page 29, deleted the need for proof that the recipient owes the medical bill when requesting a patient pay adjustment. Page 30 is a reprint. On page 49, revised the example. On pages 50 and 51, clarified to whom the DMAS-122 is sent for the various waivers. Page 52 is a reprint. Pages 67 and 68, Appendix 1, are deleted.</p> <p>On page 77, corrected the example. On page 78, clarified that there is no Medically Needy coverage under the MR or DD waivers.</p>
Subchapter M1520 pages 1, 2 pages 5, 6 pages 9, 10 pages 23, 24 Appendix 2, pages 1-2	Subchapter M1520 pages 1, 2 pages 5, 6 pages 9, 10 pages 23, 24 Appendix 2, pages 1-2	<p>Page 1 is a reprint. On page 2, clarified that HIPP information is obtained only when the employed individual is eligible for coverage under an employer's group health plan. On page 5, clarified that a recipient who has reported no (\$0) income must complete a Medicaid Renewal form. On page 6, clarified the renewal requirement for a Certain Newborn. On page 9, clarified the notice and system requirements when acting to reduce or cancel benefits. Page</p>

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 Remove and Destroy Pages

Insert Attached Pages

 Significant Changes
 

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Chapter M21  
pages 5-8  
Appendix 1, page 1

Chapter M21  
pages 5-8  
Appendix 1, page 1

10 is a reprint. On page 23, clarified the sending locality responsibilities when transferring a case. Page 24 is a runover page. Appendix 2, page 1 (the Medicaid Renewal form) has been revised to include information on all household members, child care expenses, and authorization for the local agency to obtain information. Appendix 2, page 2 is a reprint.

Pages 5 and 8 are reprints. On pages 6 and 7, clarified the policy and procedures for determining if the cost of monthly health insurance premiums for all family members exceeds 10% of gross monthly income. In Appendix 1, updated the income limits for FAMIS based on the February 18, 2005 FPL.

Please retain this transmittal letter in the back of Volume XIII.



S. Duke Storen, Director  
Division of Benefit Programs

Attachment

- dependent child information for applicants applying as parents or caretaker-relatives of a dependent child.

See subchapter M0310 for instructions on the verification of non-financial requirements.

**D. Social Security Numbers**

Applicants must provide the Social Security number of any person for whom they request Medicaid. An individual who is applying only for others and is not applying for himself is not required to provide a Social Security number for himself.

If a Social Security number has not been issued, the applicant must cooperate in applying for such a number with the local Social Security Administration Office. An Enumeration Referral Form, form #032-03-400, must be completed by the applicant. The applicant must provide the Social Security number to the local social services department as soon as it is received and the number must be recorded in the Medicaid computer applicant file. Applicants who refuse to furnish a Social Security number or to show proof of application for a number will be ineligible for Medicaid.

In the case of a newborn child not born to a Medicaid-eligible woman, the applicant can request hospital staff to apply for a Social Security number for the child through hospital enumeration procedures. Form #SSA-2853 will be given to the applicant as proof of application for a Social Security number.

**Exceptions:**

- Children under age one born to Medicaid-eligible mothers are deemed to have applied and been found eligible for Medicaid, whether or not eligibility requirements have actually been met, so long as the mother remains eligible and they continue to live together. A child eligible in this category does not need a Social Security number.
- Aliens who are eligible for emergency Medicaid services only are not required to provide or apply for Social Security numbers (see M0220)

**E. Third Party Liability (TPL)**

Applicants must be asked to provide information about any health insurance they may have. The eligibility worker must enter that information into the Medicaid Management Information System (MMIS) TPL file. Verification of health insurance information is not required.

In the event the client is eligible for benefits to be used exclusively for the payment of medical expenses (i.e. an insurance settlement), but there is no TPL code for that benefit, the worker must forward the information to:

Department of Medical Assistance Services  
Third Party Liability Section  
600 East Broad Street, Suite 1300  
Richmond, Virginia 23219

**F. Health Insurance  
Payment Program  
(HIPP)**

If a member of the assistance unit is employed more than 30 hours per week *and is eligible for coverage under an employer's group health plan*, the applicant must be assisted in completing the HIPP Application and the Medical History Questionnaire. Applicants are to be given the Insurance Verification Form to be given to the employer (See M0290).

**G. Verification of  
Financial Eligibility  
Requirements**

The eligibility worker must verify the following financial eligibility requirements:

- the value of all countable, non-excluded resources;
- all earned and unearned income; and
- asset transfer information, including the date of transfer, asset value, and compensation received, unless the money was used to buy food or personal items and no receipt was kept, and the amount claimed by the applicant is reasonable given the applicant's circumstance.

The State Verification Exchange System (SVES) must be accessed when verification of Social Security and/or Supplemental Security Income is not readily available to the applicant. The State Data Exchange (SDX) system should only be used as an alternate method when the applicant's SSN is not required or when the SVES record is unavailable. If the SDX system is used to verify benefits the case record must be documented to show why SVES was not used.

Chapters M05 through M11 include specific instructions for the verification of resources and income. Subchapter M1450 includes instructions for verifying the transfer of assets.

**M0130.300 Eligibility Determination Process**

**A. Evaluation of  
Eligibility  
Requirements**

The eligibility determination process consists of an evaluation of an individual's situation that compares each of the individual's circumstances to an established standard or definition. The applicant must be informed of all known factors that affect eligibility.

Eligibility decisions are made following a prescribed sequence:

- The applicant must meet all non-financial requirements, including a covered group.
- If applicable to the covered group, resource limits must be met.

**3. Verification**

For an individual born outside the U.S. other than an adopted child, citizenship is verified by a certificate of derivative citizenship, passport, naturalization papers, or document issued by a U.S. Embassy or Consulate attesting that the person is a U.S. citizen born abroad, such as Form FS-240, "Report of Birth Abroad of a Citizen of the U.S." or Form I-97 "Consulate Report of Birth or Certification of Birth." If such documents are not available, citizenship must be verified through the nearest U.S. Citizenship and Immigration Services (USCIS), formerly known as Immigration and Naturalization Service (INS). Locations and telephone numbers are:

Norfolk Commerce Park  
5280 Henneman Drive  
Norfolk, Virginia 23513  
*Telephone – 1-800-375-5283*

*2675 Prosperity Avenue  
Fairfax, Virginia 22031  
Telephone – 1-800-375-5283*

For a legally adopted child born outside the U.S., citizenship is verified by the adoption papers and verification of lawful permanent resident status at the time of adoption.

**M0220.200 ALIEN IMMIGRATION STATUS****A. Introduction**

An alien's immigration status is used to determine whether the alien meets the definition of a "full benefit" alien. All aliens who meet the state residency, covered group and all other nonfinancial eligibility requirements (except SSN for illegal aliens), and who meet all financial eligibility requirements are eligible for Medicaid coverage of emergency services. "Full benefit" aliens may be eligible for all Medicaid covered services. "Emergency services" aliens may be eligible for emergency services only.

**B. Procedure**

An alien's immigration status must be verified. Use the procedures in sections M0220.201 and 202 below to verify immigration status. After the alien's immigration status is verified, use the policy and procedures in section M0220.300 to determine if the alien is a full benefit alien. If the alien is a full benefit alien and is eligible for Medicaid, use the policy and procedures in section M0220.600 to enroll the alien in Medicaid.

If the alien is an emergency services alien who is eligible for Medicaid, use the policy and procedures in section M0220.700 to enroll an eligible emergency services alien in Medicaid for emergency services only.

**M0220.201 IMMIGRATION STATUS VERIFICATION****A. Verification Procedures**

An alien's immigration status is verified by the official document issued by the USCIS and a comparison with the Systematic Alien Verification for Entitlements (SAVE) system. The EW must see the original document or a photocopy. Submission of just an alien number is NOT sufficient verification.

If the alien

- has an alien number but no *USCIS* document, or
- has no alien number and no *USCIS* document,

use the **secondary verification** SAVE procedure in M0220.202 below if the alien provides verification of his or her identity.

NOTE: If the alien claims to be an illegal alien, do not use the verification procedures in this section or the SAVE procedures. Go to section M0220.400 below to determine the illegal alien's eligibility.

**B. Documents That Verify Status**

Verify lawful permanent resident status by an Alien Registration Receipt Card (Form I-551), or for recent arrivals a temporary I-551 stamp in a foreign passport or on form I-94.

Verify lawful admission by an Alien Registration Receipt Card (Form I-551); a Re-entry Permit; or a Form I-688B with a provision of law section 274A.12(A)(1).

Form I-151, Form AR-3 and AR-3a are earlier versions of the Alien Registration Receipt Card. An alien with one of the older cards who does not have an I-551 should be referred to *USCIS* to obtain the application forms for the I-551. The forms may be ordered by calling 1-800-755-0777.

**C. Letters that Verify Status**

The *USCIS* and the Office of Refugee Resettlement (ORR) issue letters that are used in lieu of or in conjunction with *USCIS* forms to identify alien status. If the letter is the only document provided, it is necessary to verify the status of the alien. For *USCIS* letters, contact the local *USCIS* office for assistance in identifying the alien's status (see Appendix 1 of this subchapter). For ORR letters, contact the toll-free ORR Trafficking Verification Line at 866-401-5510 (see Appendix 5 of this subchapter). Do not verify ORR letters via the SAVE system.

**D. Local USCIS Office Documents**

Some *USCIS* offices have developed their own stamps. Therefore, it is possible that a locally produced stamp or legend will be on an *USCIS* form. If there is any question as to the veracity or status of the document, contact *USCIS*.

**E. Expired or Absent Documentation**

If an applicant presents an expired *USCIS* document or is unable to present any document showing his/her immigration status, refer the individual to the *USCIS* district office to obtain evidence of status **unless** he/she provides an alien registration number.

If the applicant provides an alien registration number with supporting verification of his or her identity, use the SAVE procedures in M0220.202 below to verify immigration status. If an applicant presents an expired I-551, follow procedures for initiating a primary verification. If the alien presents any expired document other than an expired I-551, follow procedures for initiating a secondary verification.

- the alien was physically present in the U.S. before 8-22-96, and
- the alien remained physically present in the U.S. from the date of entry to the status adjustment date.

The date of entry will be the first day of the verified period of continuous presence in the U.S. (see M0220.202).

**B. Services Available To Eligibles**

A qualified alien who entered the U.S. before 8-22-96 and who meets all other Medicaid eligibility requirements is eligible for the full package of Medicaid covered services available to the alien's covered group.

**C. Entitlement & Enrollment of Eligibles**

The Medicaid entitlement policy and enrollment procedures for eligible qualified aliens who entered the U.S. before 8-22-96 are found in section M0220.600 below.

**M0220.313 QUALIFIED ALIENS WHO ENTERED U.S. ON OR AFTER 8-22-96**

**A. First 7 Years of Residence in U.S.**

During the first seven years of residence in the U.S., four groups of qualified aliens (as defined in M0220.310 above) who entered the U.S. on or after 8-22-96 are eligible for the full package of Medicaid benefits available to the covered group they meet (if they meet all other Medicaid eligibility requirements). These 4 groups of qualified aliens who entered the U.S. on or after 8-22-96 are:

**1. Refugees**

Refugees under section 207 and Amerasian immigrants are full benefit aliens for 7 years from the date of entry into the U.S. Once 7 years have passed from the date the refugee entered the U.S., the refugee becomes an "emergency services" alien.

*Refugees status is usually adjusted to Lawful Permanent Resident status after 12 months in the U.S. For the purposes of establishing Medicaid eligibility, such individuals may still be considered refugees. To determine former Refugee status of a Lawful Permanent Resident, check the coding on the I-551 for codes RE-6, RE-7, RE-9, or RE-9.*

**2. Asylees**

Asylees under section 208 are full benefit aliens for 7 years from the date asylum in the U.S. is granted. Once 7 years have passed from the date the alien is granted asylum in the U.S., the asylee becomes an "emergency services" alien.

**3. Deportees**

Deportees whose deportation is withheld under section 243(h) or section 241(b)(3) are full benefit aliens for 7 years from the date withholding is granted. After 7 years have passed from the date the withholding was granted, the deportee becomes an "emergency services" alien.

NOTE: If the qualified alien is a veteran or in active duty military status, or is the spouse or the unmarried dependent child of a qualified alien who meets the conditions in M0220.313 above, the alien is a full benefit alien.

**4. Cuban or Haitian Entrants**

Cuban and Haitian entrants as defined in section 501(e) of the Refugee Education Assistance Act of 1980 are full benefit aliens for 7 years from the date they enter the U.S. After 7 years have passed from the date they entered the U.S., a Cuban or Haitian entrant becomes an "emergency services" alien.

**5. Victims of a Severe Form of Trafficking**

Victims of a severe form of trafficking as defined by the Trafficking Victims Protection Act of 2000, P.L. 106-386 are full benefit aliens for 7 years **from the date they are certified or determined eligible** by the Office of Refugee Resettlement (ORR). Victims of a severe form of trafficking are identified by either a letter of certification (for adults) or a letter of eligibility (for children under age 18 years) issued by the ORR (see Appendix 5 of this subchapter). **The date of certification/eligibility specified in the letter is the date of entry for a victim of a severe form of trafficking.** After 7 years have passed from the certification/eligibility date, a victim of a severe form of trafficking becomes an “emergency services” alien unless his status is adjusted.

**B. AFTER 5 Years of Residence in U.S.**

After five years of residence in the U.S., one group of qualified aliens (as defined in M0220.310 above) who entered the U.S. **on or after 8-22-96** is eligible for the full package of Medicaid benefits available to the covered group they meet (if they meet all other Medicaid eligibility requirements). This group of qualified aliens who entered the U.S. on or after 8-22-96 is the **lawful permanent resident who has at least 40 qualifying quarters of work.**

**1. Lawful Permanent Residents (LPRs)**

When an LPR entered the U.S. on or after 8-22-96, the LPR is an **“emergency services” alien during the first 5 years** the LPR is in the U.S., regardless of work quarters.

*Note: If the LPR had prior Refugee status, he may be considered to have Refugee status for the purposes of Medicaid eligibility. To determine former Refugee status of a Lawful Permanent Resident, check the coding on the I-551 for codes RE-6, RE-7, RE-9, or RE-9. Refer to M0220.313.A.1.*

**AFTER 5** years have passed from the date of entry into the U.S., Lawful Permanent Residents who have at least 40 qualifying quarters of work are “full benefit” aliens. Lawful Permanent Residents who **DO NOT** have at least 40 qualifying quarters of work remain emergency services aliens after 5 years have passed from the date of entry into the U.S.

**2. Qualifying Quarter**

A qualifying quarter of work means a quarter of coverage as defined under Title II of the Social Security Act which is worked by the alien and/or

- all the qualifying quarters worked by the spouse of such alien during their marriage and the alien remains married to such spouse or such spouse is deceased, and
- all of the qualifying quarters worked by a parent of such alien while the alien was under age 18 years.

See Appendix 6 to this subchapter for procedures for verifying quarters of coverage under Title II of the Social Security Act.

Any quarter of coverage, beginning after December 31, 1996, in which the alien, spouse or parent of the alien applicant received any federal means-tested public benefit (such as SSI, TANF, Food Stamps and Medicaid) **cannot** be credited to the alien for purposes of meeting the 40 quarter requirement.

- |                             |   |
|-----------------------------|---|
| 8. <b>Temporary Workers</b> | temporary workers including some agricultural contract workers;                       |
| 9. <b>Foreign Press</b>     | members of foreign press, radio, film, or other information media and their families. |

### M0220.411 QUALIFIED ALIENS WHO ENTERED U.S. ON OR AFTER 8-22-96

- |   |  |
|---|--|
| A. <b>First 5 Years of Residence in U.S.</b>                  | During the first five years of residence in the U.S., four groups of qualified aliens (as defined in M0220.310 above) who entered the U.S. on or after 8-22-96 are eligible for <b>emergency Medicaid services only</b> provided they meet all other Medicaid eligibility requirements.  |
| 1. <b>Lawful Permanent Residents (LPRs)</b>                   | An LPR who enters the U.S. on or after 8-22-96 is an “emergency services” alien during the first 5 years the LPR is in the U.S., regardless of work quarters.<br><br><i>Note: If the LPR had prior Refugee status, he may be considered to have Refugee status for the purposes of Medicaid eligibility. To determine former Refugee status of a Lawful Permanent Resident, check the coding on the I-551 for codes RE-6, RE-7, RE-8, or RE-9. Refer to M0220.313.A.1.</i> |
| 2. <b>Conditional Entrants</b>                                | A qualified Conditional Entrant who enters the U.S. on or after 8-22-96 is an “emergency services” alien.  |
| 3. <b>Parolees</b>  | A qualified parolee who enters the U.S. on or after 8-22-96 is an “emergency services” alien.  |
| 4. <b>Battered Aliens</b>                                     | A qualified battered alien who enters the U.S. on or after 8-22-96 is an “emergency services” alien.   |
| B. <b>AFTER 5 Years of Residence in U.S.</b>                  | <b>AFTER</b> 5 years have passed from the date of entry into the U.S., the following groups of aliens who entered on or after 8-22-96 are eligible for emergency services only:  |
| 1. <b>Lawful Permanent Residents Without 40 Work Quarters</b> | Lawful Permanent Residents who DO NOT have at least 40 qualifying quarters of work remain emergency services aliens after residing in the U.S. for 5 years. Lawful Permanent Residents who have at least 40 qualifying quarters of work become full benefit aliens after 5 years of residing in the U.S.   |
| 2. <b>Conditional Entrants</b>                                | A qualified Conditional Entrant who enters the U.S. on or after 8-22-96 is an “emergency services” alien.  |
| 3. <b>Parolees</b>  | A qualified parolee who enters the U.S. on or after 8-22-96 is an “emergency services” alien.  |
| 4. <b>Battered Aliens</b>                                     | A qualified battered alien who enters the U.S. on or after 8-22-96 is an “emergency services” alien.   |

**C. AFTER 7 Years of Residence in U.S.**

1. **Refugees** After 7 years of residence in the U.S., a refugee or Amerasian immigrant who entered the U.S. on or after 8-22-96 is no longer eligible for full Medicaid benefits and becomes an “emergency services” alien.
2. **Asylees** After 7 years have passed since asylum was granted, an asylee who entered the U.S. on or after 8-22-96 is no longer eligible for full Medicaid benefits and becomes an “emergency services” alien.
3. **Deportees** After 7 years have passed since deportation was withheld, a deportee who entered the U.S. on or after 8-22-96 is no longer eligible for full Medicaid benefits and becomes an “emergency services” alien.
4. **Cuban or Haitian Entrants** After 7 years of residence in the U.S., a Cuban or Haitian Entrant who entered the U.S. on or after 8-22-96 is no longer eligible for full Medicaid benefits and becomes an “emergency services” alien.

**D. Services Available To Eligibles**

An emergency services alien who meets all Medicaid eligibility requirements is eligible for Medicaid coverage of emergency services only.

**E. Entitlement & Enrollment of Eligibles**

The Medicaid entitlement policy and enrollment procedures for emergency services aliens are found in section M0220.700 below.

**M0220.500 ALIENS ELIGIBILITY REQUIREMENTS****A. Policy**

An alien must meet all other Medicaid eligibility requirements to be eligible for any Medicaid services. The eligibility requirements are:

**1. Residency**

the Virginia residency requirements (M0230);

Aliens who are visitors (non-immigrants) usually do not meet the state residency requirements because their visas will expire on a definite date. Ask the non-immigrant alien “Where do you intend to go after your visa expires?” If the visitor states in writing that he/she “intends to reside in Virginia permanently or indefinitely after his/her visa expires,” then the alien has stated his/her intent to reside in Virginia permanently or indefinitely and can meet the state residence eligibility requirement for Medicaid.

**2. SSN**

the social security number provision/application requirements (M0240);

NOTE: An illegal alien does not have to apply for or provide an SSN.

**UNITED STATES CITIZENSHIP AND IMMIGRATION SERVICES (USCIS) OFFICES**

1. Agencies corresponding with *USCIS*, 2675 Prosperity Avenue, Fairfax, VA 22031 (phone: 1-800-375-5283). These agencies use this *USCIS* address to reorder G-845 forms.

Albemarle	Fauquier	Page
Alexandria	Floyd	Patrick
Alleghany	Fluvanna	Pittsylvania
Amherst	Franklin County	Prince William
Appomattox	Frederick	Pulaski
Arlington	Galax	Radford
Bath	Giles	Rappahannock
Bedford	Grayson	Roanoke City
Bland	Greene	Roanoke County
Botetourt	Halifax	Rockbridge
Bristol	Harrisonburg	Rockingham
Buchanan	Henry	Russell
Buckingham	Highland	Scott
Campbell	King George	Shenandoah
Carroll	Lee	Smyth
Charlotte	Loudoun	Stafford
Charlottesville	Lynchburg	Staunton
Chesterfield	Madison	Tazewell
Clarke	Manassas	Warren
Craig	Manassas Park	Washington
Culpeper	Martinsville	Waynesboro
Cumberland	Montgomery	Winchester
Danville	Nelson	Wise
Dickenson	Northumberland	Wythe
Fairfax	Norton	
	Orange	

2. Agencies corresponding with *INS*, Norfolk Commerce Park, 5280 Henneman Drive, Norfolk, VA 23513 (phone: 1-800-375-5283). These agencies use this *USCIS* address to reorder G-845 forms.

Accomack	Hopewell	Petersburg
Amelia	Isle of Wight	Portsmouth
Brunswick	James City	Powhatan
Caroline	King and Queen	Prince Edward
Charles City	King William	Prince George
Chesapeake	Lancaster	Richmond City
Dinwiddie	Louisa	Richmond County
Essex	Lunenburg	Southampton
Franklin City	Mathews	Spotsylvania
Fredericksburg	Mecklenburg	Suffolk
Gloucester	Middlesex	Surry
Goochland	New Kent	Sussex
Greensville	Newport News	Virginia Beach
Hampton	Norfolk	Westmoreland
Hanover	Northampton	Williamsburg
Henrico	Nottoway	York

2. There was a family emergency or household disaster, such as a fire, flood, or tornado.
3. The parent or spouse offers a good cause beyond the parent's or spouse's control.
4. There was a failure to receive DMAS's request for information or notification for a reason not attributable to the parent or spouse. Lack of a forwarding address is attributable to the parent or spouse.
5. The required information on the group health plan could not be obtained from the employer.
6. The recipient demonstrates a medical need for a specific coverage provided by an available group health plan which does not meet the DMAS established cost-effectiveness criteria. This specific coverage is not provided by Medicaid or other group health plans which do meet the DMAS established cost-effectiveness criteria.

**F. Disenrollment  
from a Group  
Health Plan**

If an individual disenrolls from a group health plan which DMAS has determined to be cost-effective, or fails to pay the premium to maintain the group health plan, the individual loses eligibility for Medicaid. An Advance Notice of Proposed Action must be sent prior to canceling coverage.

**G. HIPP Application  
Process**

Each applicant or recipient who reports that a member of his assistance unit is employed more than 30 hours each week *and is eligible for coverage under an employer's group health plan* must be given the HIPP Fact Sheet and must complete the HIPP Application and Medical History Questionnaire. The applicant or recipient must be given the Insurance Verification Form to be given to the employer. The employer is to return the Insurance Verification Form to the HIPP Unit at DMAS.

*If the applicant or recipient reports that the employer does not offer a group health plan or the individual is not eligible for coverage under the employer's group health plan, do not obtain the HIPP Application and Medical History Questionnaire or require the applicant/recipient to give the Insurance Verification Form to the employer.*

**1. Copy  
Insurance  
Card**

If the applicant or recipient is already enrolled in the employer's group health plan, make a copy of the insurance card.

**2. If Recipient Is  
Eligible, Send  
To HIPP Unit**

If the applicant is determined to be eligible for Medicaid or the recipient is determined to remain eligible for Medicaid, complete the enrollment procedures in MMIS. Send the HIPP application, the Medical History Questionnaire, and the copy of the insurance card (if already enrolled in a group health plan) to the HIPP Unit, Department of Medical Assistance Services, Suite 1300, 600 E. Broad Street, Richmond, VA 23219.

Retain a copy of the HIPP application in the case record.

**3. HIPP Unit  
Actions**

The HIPP Unit will notify the recipient and DSS of the decision on cost-effectiveness of the group health plan and premium payment.

If the recipient is approved for HIPP payment of the group health plan premium and the recipient was not previously enrolled in the group health plan, the TPL information in MMIS will be updated by DMAS.

Payment will be made to the recipient for the employee's part of the insurance premium. **Payments to the recipient from the HIPP Program are not income to the assistance unit.**

**H. Notice of Non-cooperation**

The HIPP Unit will notify the agency if the recipient has not cooperated in enrolling in the cost-effective group health plan or paying the premiums to maintain enrollment in the group health plan. Upon receipt of this notification, if good cause for non-cooperation cannot be established, the agency must mail an "Advance Notice of Proposed Action" giving adequate notice of the cancellation of the non-cooperating individual's Medicaid coverage.

The SSI income limit reduced by one-third is used whenever an applicant/recipient lives in the home of another person throughout a month and does not pay his/her pro rata share of food and shelter expenses.

Compare total countable income to current appropriate SSI or AG income limit/payment amount as follows:

- 1) for a protected individual living with a protected or aged, blind, disabled (ABD) spouse who applies for Medicaid, compare the countable income to the current SSI payment limit for a couple. The SSI couple limit is reduced by one-third only if both members of the couple have their shelter and food provided by another person.

If income is within the appropriate limit, the individual spouse who meets the protected group criteria is eligible. If both spouses meet the protected group criteria, each is eligible as a CNNMP former SSI recipient.

The non-protected spouse's eligibility is evaluated in another covered group.

- 2) for an individual living with a spouse and/or minor dependent children who meet a families and children category or do not apply for Medicaid, count only the individual's income and the spouse's deemed income (as determined by deeming procedures in chapter M05) and compare it to the SSI limit for an individual or couple as appropriate. If all food and shelter needs are provided by the spouse or someone else, compare the countable income to the SSI limit for an individual, reduced by one-third.
- 3) for a blind or disabled child living with a parent, calculate the parent's income (as determined by deeming procedures in chapter M05) and compare the child's countable income to the SSI payment limit for an individual. If all food and shelter needs are provided by the child's parent(s) or someone else, compare the total countable income to the SSI limit for an individual, reduced by one-third.

#### 4. COLA Formula

If only the current Title II benefit amount is known OR the benefit was changed or recalculated after loss of SSI, use the formula below to figure the base Title II amount to use in determining financial eligibility. Divide the current Title II entitlement amount by the percentages given. Then follow the steps in item B.3.b. above to determine income eligibility.

Cost-of-living calculation formula:

- a.  $\frac{\text{Current Title II Benefit}}{1.027 \text{ (1/05 Increase)}} = \text{Benefit Before 1/05 COLA}$
- b.  $\frac{\text{Benefit Before 1/05 COLA}}{1.021 \text{ (1/04 Increase)}} = \text{Benefit Before 1/04 COLA}$
- c.  $\frac{\text{Benefit Before 1/04 COLA}}{1.014 \text{ (1/03 Increase)}} = \text{Benefit Before 1/03 COLA}$
- d.  $\frac{\text{Benefit Before 1/03 COLA}}{1.026 \text{ (1/02 Increase)}} = \text{Benefit Before 1/02 COLA}$
- e.  $\frac{\text{Benefit Before 1/02 COLA}}{1.035 \text{ (1/01 Increase)}} = \text{Benefit Before 1/01 COLA}$

Contact a Medical Assistance Program Specialist for amounts for years prior to 2001.

#### 5. Medicare Premiums

##### a. Medicare Part B premium amounts:

1-1-05 \$78.20  
 1-1-04 \$66.60  
 1-1-03 \$58.70  
 1-1-02 \$54.00  
 1-1-01 \$50.00

##### b. Medicare Part A premium amounts:

1-1-05 \$375.00  
 1-1-04 \$343.00  
 1-1-03 \$316.00  
 1-1-02 \$319.00  
 1-1-01 \$300.00

Contact a Medical Assistance Program Specialist for amounts for years prior to 2001.

#### 6. Classification

Individuals who are eligible when a cost-of-living increase is excluded are eligible as categorically needy non-money payment (CNNMP).

Individuals who are ineligible because of excess income after the cost-of-living increase(s) is excluded can only become Medicaid-eligible in another covered group. If they do not meet an F&C MI covered group, are not institutionalized, are not receiving CBC or do not have Medicare Part A, they must be determined eligible in a medically needy covered group.

## Deeming Allocations

The deeming policy determines how much of a legally responsible relative's income is deemed to the applicant/recipient. The allocation amount increases automatically whenever the SSI payment limit increases.

### NBD (Non-blind/disabled) Child Allocation

The NBD child allocation is equal to the difference between the SSI payment for two persons and the SSI payment for one person.

SSI payment for couple - SSI payment for one person = NBD child allocation

$$\$869 - 579 = \$290$$

### Parental Living Allowance

The living allowance for one parent living with the child is the SSI payment for one person.

SSI payment for one person = \$579

The living allowance for both parents living with the child is the SSI payment for a couple.

SSI payment for both parents = \$869

### Deeming Standard

The NABD (non-age/blind/disabled) spouse deeming standard is the difference between the SSI payment for two persons and the SSI payment for one person.

SSI payment for couple - SSI payment for one person = deeming standard

$$\$869 - 579 = \$290$$

# TABLE OF CONTENTS

## M07 FAMILIES AND CHILDREN INCOME

	SUBCHAPTER	Page
<b>GENERAL -- F&amp;C INCOME RULES .....</b>	<b>M0710.000</b>	
Overview .....	M0710.001 .....	1
Income Limits.....	M0710.002 .....	3
Net Countable Income .....	M0710.003 .....	3
Income Exclusions.....	M0710.004 .....	3
Relationship of Income to Resources .....	M0710.010 .....	4
Types of Income .....	M0710.015 .....	4
When Income is Counted .....	M0710.030 .....	5
How to Estimate Income .....	M0710.610 .....	6
Determining Eligibility Based on Income .....	M0710.700 .....	8
LIFC 185% of Need Chart.....	Appendix 1.....	1
Grouping of Localities .....	Appendix 2.....	1
F&C Monthly Income Limits.....	Appendix 3.....	1
Deleted.....	Appendix 4.....	1
Medically Needy Income Limits .....	Appendix 5.....	1
Medically Indigent <i>Child Under Age 19 (FAMIS Plus)</i>		
Income Limits .....	Appendix 6.....	1
Medically Indigent Pregnant Woman Income Limits .....	Appendix 6.....	2
185% of Federal Poverty Limits Twelve Month		
Extended/Transitional Income Limits.....	Appendix 7.....	1
<b>F&amp;C WHAT IS NOT INCOME .....</b>	<b>M0715.000</b>	
General.....	M0715.001 .....	1
Reimbursements.....	M0715.050 .....	1
Medicaid Recipient is an Agent .....	M0715.100 .....	1
Conversion or Sale of a Resource .....	M0715.200 .....	2
Income Tax Refunds .....	M0715.270 .....	2
Proceeds of a Loan .....	M0715.350 .....	2
Shelter Contributed .....	M0715.370 .....	3
Bills Paid by a Third Party .....	M0715.400 .....	3

## M07 TABLE OF CONTENTS, cont.

	SUBCHAPTER	Page
<b>F&amp;C EARNED INCOME .....</b>	<b>M0720.000</b>	
Overview .....	M0720.001 .....	1
Wages .....	M0720.100 .....	1
Income From a Corporation .....	M0720.105 .....	2
How to Count Income in the Retroactive Period .....	M0720.110 .....	2
How to Estimate Earned Income .....	M0720.155 .....	2
Income From Self-Employment .....	M0720.200 .....	5
Income From Real Property .....	M0720.250 .....	6
Income From Room and Board .....	M0720.260 .....	6
Income From Day Care .....	M0720.270 .....	7
Income From Small Business/Cash Crops .....	M0720.280 .....	8
Contract Income .....	M0720.400 .....	9
Earned Income Exclusions .....	M0720.500 .....	10
<i>Workforce Investment Act</i> Exclusion .....	M0720.505 .....	12
Student Child Earned Income Exclusion .....	M0720.510 .....	12
Standard Work Exclusion .....	M0720.520 .....	13
\$30 Plus 1/3 Earned Income Exclusion .....	M0720.525 .....	13
\$30 Earned Income Exclusion .....	M0720.526 .....	16
Child Care/Incapacitated Adult Care Exclusion .....	M0720.540 .....	16a
 Families and Children Earned Income Exclusions .....	 Appendix 1 .....	 1
 <b>F&amp;C UNEARNED INCOME .....</b>	 <b>M0730.000</b>	
Introduction to Unearned Income .....	M0730.001 .....	1
Overview of Exclusions .....	M0730.050 .....	1
Guide to Exclusions .....	M0730.099 .....	2
Major Benefit Programs .....	M0730.100 .....	6a
Unemployment Compensation .....	M0730.200 .....	7
Child/Spousal Support .....	M0730.400 .....	7
Dividends and Interest .....	M0730.500 .....	9
Rental/Room & Board Income .....	M0730.505 .....	9
Gifts .....	M0730.520 .....	10
Contributions .....	M0730.522 .....	11
Home Energy Assistance .....	M0730.600 .....	11
Contributions in Kind .....	M0730.700 .....	12
Treatment of Lump Sum Income .....	M0730.800 .....	12

## TABLE OF CONTENTS

### M07 FAMILIES AND CHILDREN INCOME

#### M0710.000 GENERAL--F & C INCOME RULES

	Section	Page
Overview .....	M0710.001 .....	1
Income Limits.....	M0710.002 .....	3
Net Countable Income .....	M0710.003 .....	3
Income Exclusions.....	M0710.004 .....	3
Relationship of Income to Resources .....	M0710.010 .....	4
Types of Income .....	M0710.015 .....	4
When Income is Counted .....	M0710.030 .....	5
How to Estimate Income .....	M0710.610 .....	6
Determining Eligibility Based on Income.....	M0710.700 .....	8
Categorically Needy .....	M0710.710 .....	8
Medically Indigent .....	M0710.720 .....	9
Categorically Needy Non-Money Payment.....	M0710.730 .....	10
Medically Needy .....	M0710.740 .....	13

#### Appendices

LIFC 185% of Need Chart.....	Appendix 1 .....	1
Grouping of Localities .....	Appendix 2 .....	1
F&C Monthly Income Limits .....	Appendix 3 .....	1
Deleted.....	Appendix 4 .....	1
Medically Needy Income Limits .....	Appendix 5 .....	1
Medically Indigent Child Under Age 19( <i>FAMIS Plus</i> )		
Income Limits.....	Appendix 6 .....	1
Medically Indigent Pregnant Woman Income Limits .....	Appendix 6 .....	2
Twelve Month Extended/Transitional Income Limits.....	Appendix 7 .....	1

<p align="center"><b>MEDICALLY INDIGENT CHILD UNDER AGE 19 (<i>FAMIS PLUS</i>) INCOME LIMITS ALL LOCALITIES <i>FEDERAL POVERTY LEVEL (FPL)</i> EFFECTIVE 2-18-05</b></p>		
<u># of Persons in Family/Budget Unit</u>	<u>100% FPL Monthly Limit</u>	<u>133% FPL Monthly Limit</u>
1	\$ 798	\$1,061
2	1,070	1,422
3	1,341	1,784
4	1,613	2,145
5	1,885	2,506
6	2,156	2,868
7	2,428	3,229
8	2,700	3,590
each add'l person add	272	362

MI Child under age 6 with income less than or equal to 100% FPL –PD 91

MI Child age 6 to 19 with income less than or equal to 100% FPL – PD 92

MI Child under age 6 with income greater than 100% FPL and less than or equal to 133% FPL – PD 90

**Insured** MI Child age 6 to 19 with income greater than 100% FPL and less than or equal to 133% FPL –PD 92

**Uninsured** MI Child age 6 to 19 with income greater than 100% FPL and less than or equal to 133% FPL PD 94

<b>MEDICALLY INDIGENT PREGNANT WOMAN                      INCOME LIMITS                      133% FPL                      ALL LOCALITIES                      EFFECTIVE 2-18-05</b>	
<u># of Persons                      in Family/Budget Unit</u>	<u>Monthly                      Limit</u>
1	\$1,061
2	1,422
3	1,784
4	2,145
5	2,506
6	2,868
7	3,229
8	3,590
each add'l person add	362

Pregnant Woman with income less than or equal to 133% FPL – PD 91

**185% of FEDERAL POVERTY LIMITS  
 TWELVE MONTH EXTENDED MEDICAID  
 INCOME LIMITS  
 ALL LOCALITIES  
 EFFECTIVE 2-18-05**

<u># of Persons in Family/Budget Unit</u>	<u>Monthly Limit</u>
1	\$1,476
2	1,978
3	2,481
4	2,984
5	3,486
6	3,989
7	4,491
8	4,994
each add'l person add	503

- b. payments made pursuant to a release of all claims in a case that entered into in lieu of the class settlement of Walker v. Bayer Corp., et.al., and that is signed by all affected parties on or before the later of
- December 31, 1997, or
  - the date that is 270 days after the date on which such release is first sent to the persons to whom the payment is to be made.

Information received by claimants in this lawsuit shows that claimants can choose to receive the payment in one of three ways – in a lump sum, a structured settlement, or a special needs trust. Regardless of which form the individual chooses, the payment(s) are excluded if the above requirements are met.

Verify the source of the funds from a letter from the individual's attorney or a copy of the check which identifies the payor as a Walker v. Bayer settlement account.

Any interest earned on these funds is NOT excluded. Any interest earned on these funds must be evaluated as unearned income in the month of receipt and as a resource thereafter.

**40. Combat Zone  
Income**

*Any amount received by or made available to household members for deployment or service in a combat zone will not count as income for Medicaid purposes unless the payment was received before the deployment. This exclusion includes items such as, but not limited to, incentive pay for hazardous duty, special pay for imminent duty or hostile fire duty or certain re-enlistment bonuses, or special pay for certain occupational or educational skills.*

**M0730.100 MAJOR BENEFIT PROGRAMS**

**A. Policy**

Annuities, pensions, retirement benefits, and disability benefits are unearned income. The amount of unearned income actually being received, not the entitlement amount, is counted as income.

EXCEPTION: When the Medicare Part B premium is deducted from the Social Security or Railroad Retirement benefits, that amount must be added to the actual benefit being received.

**GENERAL**

**M0810.001 INCOME AND ELIGIBILITY**

**A. Introduction**

The following sections explain how to treat income in the Medicaid program. This chapter explains how we count income.

**B. Policy Principles**

**1. Who is Eligible**

An individual is eligible for Medicaid if the person:

- meets a category/classification; and
- meets the nonfinancial requirements; and
- meets the classification's resource limits; and
- meets the classification's income limits.

**2. General Income Rules**

- Count income on a monthly basis.
- Not all income counts in determining eligibility.
- If an individual's countable income exceeds a classification's monthly limit, a medically needy spenddown may be established, if appropriate.

**M0810.002 INCOME LIMITS**

**A. Income Limits**

The Medicaid classification determines which income limit to use to determine eligibility.

**1. Categorically Needy**

Supplemental Security Income (SSI) and State Supplement (Auxiliary Grant) recipient's money payments meet the income eligibility criteria in the ABD Categorically Needy classification.

**2. Categorically Needy Non-Money Payment-Protected Cases Only**

<ul style="list-style-type: none"> <li>• Categorically-Needy Non-Money Payment Protected Covered Groups Which Use SSI Income Limits</li> </ul>	
Family Unit Size	Monthly Amount
1	\$579
2	869
<ul style="list-style-type: none"> <li>• For individual or couple whose total food and shelter needs are contributed to him or them</li> </ul>	
Family Unit Size	Monthly Amount
1	\$386
2	579.34

**3. Categorically  
Needy-Non  
Money  
Payment  
(CNNMP) -  
300% of SSI**

For the covered groups that use the 300% of SSI income limit, all income is counted (even excluded income) when screening at 300% of SSI. Do not count any monies which are defined as “what is not income” in S0815.000.

<ul style="list-style-type: none"> <li>Categorically Needy-Non Money Payment 300% of SSI</li> </ul>	
Family Size Unit 1	Monthly Amount \$1,737

**4. Medically  
Needy**

<b>a. Group I</b>		
Family Unit Size	Semi-annual	Monthly
1	\$ 1,409.47	\$ 234.91
2	1,794.91	299.15
<b>b. Group II</b>		
Family Unit Size	Semi-annual	Monthly
1	\$ 1,626.31	\$ 271.05
2	2,002.90	333.81
<b>c. Group III</b>		
Family Unit Size	Semi-annual	Monthly
1	\$ 2,114.20	\$ 352.36
2	2,549.20	424.86

**5. ABD  
Medically  
Indigent**

**For:  
ABD 80%  
FPL, QMB,  
SLMB, & QI  
without Social  
Security (SS)  
and QDWI,  
effective  
2/18/05; and  
ABD 80%  
FPL, QMB,  
SLMB, & QI  
with SS,  
effective  
4/01/05**

ABD 80% FPL	Annual	Monthly
1	\$ 7,656	\$638
2	10,264	856
QMB 100% FPL	Annual	Monthly
1	\$ 9,570	\$ 798
2	12,830	1,070
SLMB 120% of FPL	Annual	Monthly
1	\$ 11,484	\$ 957
2	15,396	1,283
QI 135% FPL	Annual	Monthly
1	\$12,920	\$1,077
2	17,321	1,444
QDWI 200% of FPL	Annual	Monthly
1	\$19,140	\$1,595
2	25,660	2,139

**C. Procedure**

- 1. Verification**
- a. Verify these payments by examining documents in the individual's possession which reflect:
    - the amount of the payment,
    - the date(s) received, and
    - the frequency of payment, if appropriate.
  - b. If the individual has no such evidence in his possession, contact the source of the payment.
  - c. If verification cannot be obtained by the above means, accept any evidence permitted by either S0820.130 A. or S0820.220.

- 2. Assumption**
- Assume that any honoraria received is **in consideration of services rendered**, absent evidence to the contrary. Evidence to the contrary would include a statement or document indicating that part or all of the honoraria is for something other than services rendered (e.g., travel expenses or lodging).

- 3. Expenses of Obtaining Income**
- DO NOT DEDUCT any expenses of obtaining income from royalties or honoraria that are earned income. (Such expenses are deductible from royalties/honoraria that are unearned income.)

- 4. Documentation**
- Document the file by including copies of documents or indicating in the file information provided by the payment source concerning the amount and, if appropriate, frequency of payment.

**D. References**

- Royalties as unearned income, S0830.510.
- To determine deductible IRWE/BWE, see S0820.535 - .565.

## EARNED INCOME EXCLUSIONS

### S0820.500 GENERAL

#### A. Policy

1. **General**                      The source and amount of all earned income must be determined, but not all earned income counts when determining Medicaid eligibility.
  
2. **Other Federal Laws**                      First, income is excluded as authorized by other Federal laws.
  
3. **Other Earned Income**                      Then, other income exclusions are applied, in the following order, to the rest of earned income in the month:
  - a. Federal earned income tax credit payments
  - b. Up to \$10 of earned income in a month if it is infrequent or irregular
  - c. Up to \$1,410 per month, but not more than \$5,670 in a calendar year, of the earned income of a blind or disabled student child
  - d. Any portion of the \$20 monthly general income exclusion which has not been excluded from unearned income in that same month
  - e. \$65 of earned income in a month
  - f. Earned income of disabled individuals used to pay impairment-related work expenses
  - g. One-half of remaining earned income in a month
  - h. Earned income of blind individuals used to meet work expenses
  - i. Any earned income used to fulfill an approved plan to achieve self-support.
  
4. **Unused Exclusion**                      Earned income is never reduced below zero. Any unused earned income exclusion is never applied to unearned income.  
  
Any unused portion of a monthly exclusion cannot be carried over for use in subsequent months.
  
5. **Couples**                      The \$20 general and \$65 earned income exclusions are applied only once to a couple, even when both members (whether eligible or ineligible) have income, since the couple's earned income is combined in determining Medicaid eligibility.

#### B. References

For exclusions which apply to both earned and unearned income, see:

- S0810.410 for infrequent/irregular income
- S0810.420 \$20 general exclusion
- S0810.430 amount to fulfill a plan for achieving self-support

For exclusions applicable only to earned income, see S0820.510 - S0820.570.

## S0820.510 STUDENT CHILD EARNED INCOME EXCLUSION

### A. Policy

- 1. General** For a blind or disabled child who is a student regularly attending school, earned income is excluded under this provision, limited to the maximum amounts shown below.

<b>For Months a calendar year</b>	<b>Up to per month</b>	<b>But not more than in</b>
In calendar years before 2001	\$ 400	\$1,620
In calendar year 2001	\$1,290	\$5,200
In calendar year 2002	\$1,320	\$5,340
In calendar year 2003	\$1,340	\$5,410
In calendar year 2004	\$1,370	\$5,520
<i>In calendar year 2005</i>	<i>\$1,410</i>	<i>\$5,670</i>

- 2. Qualifying for the Exclusion** The individual must be:
- a child under age 22; and
  - a student regularly attending school.
- 3. Earnings Received Prior to Month of Eligibility** Earnings received prior to the month of eligibility do not count toward the yearly limit.
- 4. Future Increases** The monthly and yearly limits will be adjusted annually based on increases in the cost of living index. Under this calculation, these amounts will never be lower than the previous year's amounts. However, there may be years when no increases result from the calculation.

### B. Procedure

- 1. Application of the Exclusion** Apply the exclusion:
- consecutively to months in which there is earned income until the exclusion is exhausted or the individual is no longer a child; and
  - only to a student child's own income.
- 2. School Attendance and Earnings** Develop the following factors and record them:
- whether the child was regularly attending school in at least 1 month of the current calendar quarter, or expects to attend school for at least 1 month in the next calendar quarter, and
  - the amount of the child's earned income (including payments from Neighborhood Youth corps, Work-Study, and similar programs).

Verify wages of a student child even if they are alleged to be \$65 or less per month.

**C. References**

- Grants, scholarships and fellowships, S0830.455.
- Educational assistance with Federal funds involved, S0830.460.

**D. Example**  
*(Using April  
2002 Figures)*

Jim Thayer, a student child, starts working in June at a local hardware store. He had no prior earnings during the year, and he has no unearned income. Jim earns \$1,600 a month in June, July and August. In September, when he returns to school, Jim continues working part-time. He earns \$800 a month in September and October. Jim's countable income computation for June through October is as follows:

June, July and August

\$1600.00	gross earnings
<u>- 1320.00</u>	student child exclusion
\$ 280.00	
<u>- 20.00</u>	general income exclusion
\$ 260.00	
<u>- 65.00</u>	earned income exclusion
\$ 195.00	
<u>- 97.50</u>	one-half remainder
\$ 97.50	countable income

Jim has used up \$3,960 of his \$5,340 yearly student child earned income exclusion (\$1,320 in each of the three months).

September

\$800.00	gross earnings
<u>- 800.00</u>	student child exclusion
0	countable income

Jim has now used up \$4,760 of his \$5,340 yearly student child earned income exclusion.

October

\$800.00	gross earnings
<u>- 580.00</u>	student child exclusion <i>remaining (\$5,340-\$4,760=\$580)</i>
\$220.00	
<u>- 20.00</u>	general income exclusion
\$200.00	
<u>- 65.00</u>	earned income exclusion
\$135.00	
<u>- 67.50</u>	one-half remainder
\$ 67.50	countable income

Jim has exhausted his entire \$5,340 yearly student child earned income exclusion. The exclusion cannot be applied to any additional earnings during the calendar year.

**TABLE OF CONTENTS**

**S1140.000 TYPES OF COUNTABLE RESOURCES**

**Section Page**

**GENERAL RULES ON COUNTABLE RESOURCES**

Purpose of Subchapter .....S1140.001 ..... 1  
 General Verification Requirements - Initial Application.....M1140.010 ..... 1  
 General Verification Requirements - Posteligibility.....M1140.020 ..... 3  
 Ownership.....S1140.030 ..... 4  
 Determining Equity Value .....S1140.042 ..... 5  
 Resources With Zero Value .....S1140.044 ..... 5

**REAL PROPERTY**

Non-home Real Property.....S1140.100 ..... 6  
 Other Property Rights.....S1140.110 ..... 11  
 Life Estate and Remainder Interest Tables.....S1140.120 ..... 13

**FINANCIAL INSTITUTION ACCOUNTS**

Checking and Savings Accounts -- General.....S1140.200 ..... 16  
 Joint Checking and Savings Accounts .....S1140.205 ..... 19  
 Time Deposits .....S1140.210 ..... 20  
 ConservatorshipAccounts .....S1140.215 ..... 21a

**OTHER COMMON INVESTMENT VEHICLES**

Stocks .....S1140.220 ..... 22  
 Mutual Fund Shares .....S1140.230 ..... 23  
 U.S. Savings Bonds.....S1140.240 ..... 24  
 Municipal, Corporate and Government Bonds.....S1140.250 ..... 25  
 Annuities .....M1140.260 ..... 26

**CONTRACTS**

Promissory Notes, Loans, and Property Agreements.....S1140.300 ..... 26a  
 Life Insurance.....M1140.310 ..... 28

**TRUSTS**

Trust Established By A Will .....M1140.400 ..... 29  
 Trusts Which Were Not Created by a Will .....M1140.401 ..... 29  
 Medicaid Qualifying Trust (Created Prior to August 11, 1993).....M1140.402 ..... 30  
 Trusts Created After July 1, 1993 and Before  
     August 11, 1993 With Corpus In Excess of \$25,000.....M1140.403 ..... 31  
 Trust Established on or After August 11, 1993 .....M1140.404 ..... 32

**RESOURCE GUIDE**

Resources Guide -- Optional Desk Guide .....S1140.990 ..... 34

3. **Value**
  - a. **Series E, EE, and I paper bonds**
    - **On-line Verification at:**  
<http://www.publicdebt.treas.gov/sav/savcalc.htm>
    - Current copy of the Table of Redemption Values for US Savings Bonds
    - **Bank Verification** As a last alternative, obtain the value by telephone from a local bank and record it. The bank will need the series, denomination, date of purchase and/or date.
  - b. **Series E, EE, and I electronic bonds**
    - Ask individual to obtain his “Current Holdings” list from the Treasury web site at: <http://www.savingsbonds.gov/>
    - Use Current Holding Summary to verify number of bonds, face value, issue dates, confirmation numbers and value.
  - c. **Series H and HH Bond After Maturity**

After maturity, the redemption value of a series H or HH bond is its face value. Verification of value per a. or b. above is unnecessary.
4. **Photocopy**

Document the file with a photocopy or certification of the bond(s). See **S1140.010 C.** on photocopying U.S. Government obligations.
5. **Follow-up, if Appropriate**

If an individual owns a U.S. Savings Bond which, upon maturity, may cause countable resources to exceed the limit, recontact the recipient shortly before the bond matures in order to redevelop the value of countable resources.

## S1140.250 MUNICIPAL, CORPORATE, AND GOVERNMENT BONDS

### A. Introduction

1. **Bond**

A bond is a written obligation to pay a sum of money at a specified future date. Bonds are negotiable and transferable.
2. **Municipal Bond**

A municipal bond is the obligation of a State or a locality (county, city, town, villages or special purpose authority such as a school district).
3. **Corporate Bond**

A corporate bond is the obligation of a private corporation.
4. **Government Bond**

A government bond, as distinct from a U.S. Savings Bond (see S1140.240), is a **transferable** obligation issued or backed by the Federal Government.

- B. Operating Policy** Municipal corporate, and government bonds are negotiable and transferable. Therefore, their value as a resource is their CMV. Their redemption value, available only at maturity, is immaterial.

- C. Development and Documentation** Development and documentation instructions for stocks (S1140.220) also apply to bonds.

## M1140.260 ANNUITIES (Effective for All Applications Received On or After December 1, 2004)

### A. Introduction

An annuity is a sum paid yearly or at other specific times in return for the payment of a fixed sum. Annuities may be purchased by an individual or by an employer. For Medicaid purposes, an annuity is a contract reflecting payment to an insurance company, bank or other registered or licensed entity by which one receives fixed, non variable payments on an investment for a lifetime or a specified number of years.

### B. Operating Policy

1. An annuity containing a balloon payment is considered an available resource, and the value of the annuity is counted.
2. An annuity that names revocable beneficiaries is considered to be an available resource because it can be surrendered, cashed in, assigned, transferred or have the beneficiary changed. Annuities are presumed to be revocable when the annuity contract does not state that it is irrevocable.
3. A non-employment related annuity purchased by or for an individual using that individual's assets will be considered an available resource unless it meets all of the following criteria: the annuity (a) is irrevocable; (b) pays out principal and interest in equal monthly installments (no balloon payment) to the individual over the total number of months that equals the actuarial life expectancy of the annuitant; (c) names the Commonwealth of Virginia as the residual beneficiary of funds remaining in the annuity not to exceed the amount of any Medicaid funds expended on the individual during his lifetime; and (d) is issued by an insurance company, bank, or other registered or licensed entity approved to do business in the jurisdiction in which the annuity is established. Payments from the annuity to the Commonwealth of Virginia cannot exceed the total amount of funds for long-term care services expended on behalf of the individual.
4. Annuities issued prior to 12-01-04 which do not: (a) provide for the payout of principal and interest in equal monthly installments and (b) for which documentation is received from the issuing company that the payout arrangements cannot be changed will be considered to meet the above requirements once amended to name the Commonwealth of Virginia as the primary beneficiary of funds remaining in the annuity, not to exceed the amount of any Medicaid funds expended on the individual during his lifetime.
5. Have the individual submit documentation showing ownership of an annuity. If the owner is the Medicaid applicant or the applicant's spouse, the value of the annuity is a countable resource unless it meets the criteria listed in B.3 above.

- 6. Rehabilitation Hospitals** A hospital certified as a rehabilitation hospital, or a unit of a hospital certified by the Department of Health as excluded from the Medicare prospective payment system, which provides inpatient rehabilitation services.

## M1410.040 COMMUNITY-BASED CARE WAIVER SERVICES

- A. Introduction** Medicaid covers long-term care in a community-based setting to individuals whose mental or physical condition requires nursing supervision and assistance with activities of daily living.
- This section provides general information about the Community-based Care (CBC) Waiver Services covered by Medicaid. The detailed descriptions of the waivers and the policy and procedures specific to patients in CBC are contained in subchapter M1440.
- B. Community-Based Care Waivered Services (CBC)** Community-Based Care Waiver Services or Home and Community-based Care or CBC are titles that are used interchangeably. These terms are used to mean a variety of in-home and community-based services reimbursed by the Department of Medical Assistance Services (DMAS) that are authorized under a Section 1915(c) waiver designed to offer individuals an alternative to institutionalization. Individuals may be preauthorized to receive one or more of these services either solely or in combination, based on the documented need for the service or services to avoid nursing facility placement.
- C. Virginia's Waivers** Virginia has approved Section 1915(c) home and community-based *care* waivers. These waivers contain services that are otherwise not available to the general Medicaid population. The target population and service configuration for each waiver is outlined in subchapter M1440. An individual cannot receive services under two or more waivers simultaneously; the individual can receive services under only one waiver at a time.
- 1. Elderly or Disabled with Consumer-Direction Waiver** *The Elderly or Disabled with Consumer-Direction (EDCD) waiver serves aged individuals and disabled individuals who would otherwise require institutionalization in a nursing facility. The recipient may choose to receive agency-directed services, consumer-directed services or a combination of the two. Under consumer-directed services, supervision of the personal care aide is furnished directly by the recipient and/or the person directing the care for the recipient. If an individual is incapable of directing his own care, a spouse, parent, adult child, or guardian may direct the care on behalf of the recipient. Services available through this waiver include:*
- *agency-directed and consumer-directed personal care*
  - *adult day health care*
  - *agency-directed respite care (including skilled respite) and consumer-directed respite care*
  - *Personal Emergency Response System (PERS).*

**2. Mental Retardation Waiver**

The Mental Retardation (MR) Waiver program is targeted to provide home and community-based services to individuals with mental retardation and individuals under the age of six years at developmental risk who have been determined to require the level of care provided in an ICF/MR, and to individuals with related conditions currently residing in nursing facilities who require specialized services. Services available through the MR waiver include:

- day support
- supported employment
- residential support
- therapeutic consultation
- personal assistance
- respite care
- nursing services
- environmental modification
- assistive technology

**3. AIDS Waiver**

The AIDS Waiver provides services to individuals with HIV infection, who have been diagnosed and are experiencing the symptoms associated with AIDS (Acquired Immunodeficiency syndrome) or who are HIV positive and are symptomatic; the services provided through the waiver are expected to prevent placement in a hospital or nursing facility.

Services available to recipients of the AIDS Waiver include:

- case management
- nutritional supplements
- private duty nursing
- personal care
- respite care

**4. Technology-Assisted Individuals Waiver**

"Technology-Assisted" individual is one who is chronically ill or severely impaired, who needs both a medical device to compensate for the loss of a vital body function and substantial and ongoing skilled nursing care to avert death or further disability. The services provided through the waiver are expected to prevent placement, or to shorten the length of stay, in a hospital or nursing facility.

The services provided under this waiver include:

- private duty nursing
- respite care
- nutritional supplements
- medical supplies and equipment not otherwise available under the Medicaid State Plan.

**5. Individual and Family Developmental Disabilities Support Waiver (DD Waiver)**

The Individual and Family Developmental Disabilities (DD) waiver provides home and community-based services to individuals with developmental disabilities who do not have a diagnosis of mental retardation. The developmental disability must have manifested itself before the individual reached age 21 and must be likely to continue indefinitely.

The services provided under this waiver include:

- support coordination (case management)
- adult companion services
- assistive technology
- crisis intervention/stabilization
- environmental modifications
- residential support
- skilled nursing
- supported employment
- therapeutic consultation
- respite care
- personal attendant services
- consumer-directed personal and respite care.

**M1410.050 FINANCIAL ELIGIBILITY REQUIREMENTS**

**A. Introduction**

An individual in LTC must meet the financial eligibility requirements that are specific to institutionalized individuals; these requirements are contained in this chapter:

**B. Asset Transfer**

The asset transfer policy is found in subchapter M1450.

**C. Resources**

The resource eligibility policy for individuals in LTC who do not have community spouses is found in subchapter M1460 of this chapter.

The resource eligibility requirements for married individuals in LTC who have community spouses are found in subchapter M1480 of this chapter.

**D. Income**

The income eligibility policy for individuals in LTC who do not have community spouses is found in subchapter M1460 of this chapter.

The income eligibility policy for individuals in LTC who have community spouses is found in subchapter M1480.

## M1410.060 POST-ELIGIBILITY TREATMENT OF INCOME (PATIENT PAY)

- A. Introduction** Medicaid-eligible individuals must pay a portion of their income to the LTC provider; Medicaid pays the remainder of the cost of care. The portion of their income that must be paid to the provider is called “patient pay.”
- B. Patient Pay** The policies and procedures for patient pay determination are found in subchapter M1470 of this chapter for individuals who do not have community spouses, and in subchapter M1480 for individuals who have community spouses.

## M1410.100 LONG-TERM CARE APPLICATIONS

- A. Introduction** The general application requirements applicable to all Medicaid applicants/recipients found in *chapter M01* also apply to applicants/recipients who need LTC services. This section provides those additional or special application rules that apply only to persons who meet the institutionalization definition.
- B. Responsible Local Agency** The local social services department in the Virginia locality where the institutionalized individual (patient) last resided outside an institution retains responsibility for receiving and processing the application.
- If the patient did not reside in Virginia prior to admission to the institution, the local social services department in the county/city where the institution is located has responsibility for receiving and processing the application.
- Community-Based Care (CBC) applicants apply in their locality of residence.
- ABD patients in state Mental Health Mental Retardation (MHMR) facilities for more than 30 days have eligibility determined by Medicaid technicians located in the state MHMR facilities. When an enrolled ABD Medicaid recipient is admitted to a state MHMR facility, the local department of social services transfers the case to the Medicaid technician after the recipient has been in the facility for 30 days or more. See section M1520.600 for case transfer policy.
- C. Who Can Apply** The individual, his/her authorized representative (person authorized to conduct business for the applicant) can file the application for Medicaid and make the assignment of rights and the declaration of citizenship.

individuals who receive any type of long-term care. Individuals who are ineligible for Medicaid payment of LTC may remain eligible for other Medicaid-covered services.

**B. Pre-admission Screening**

A pre-admission screening is used to determine if an individual living outside of a nursing facility meets the level of care for *Medicaid payment for LTC* services. Medicaid recipients living outside a nursing facility must be screened and approved before Medicaid will authorize payment for LTC services.

**C. Recipient Enters LTC**

*A re-evaluation of eligibility must be done when the EW learns that a Medicaid recipient has started receiving LTC services. If an annual renewal has been done within the past 6 months, a partial review to address factors pertinent to receipt of LTC, such as asset transfer, spousal resource assessment, etc., must be done. If an annual renewal has not been done within the past 6 months, a complete renewal must be done. A new application is not required; use the Medicaid Redetermination for Long-Term Care form (032-03-369). Appendix 5 contains a copy of the form.*

- *A re-evaluation of eligibility for an SSI recipient who has no community spouse and owns no countable real property can be done by verifying continued receipt of SSI through SVES and documenting the case record. See section M1430.104 for additional information regarding an SSI recipient who enters a nursing facility.*
- *Rules for married institutionalized recipients who have a community spouse are found in subchapter M1480.*

**D. Notification**

When the *re-evaluation* is done, the EW must complete *and send all required* notices. See section 1410.300 below.

## M1410.300 NOTICE REQUIREMENTS

### A. Introduction

A notice to an applicant or recipient provides formal notification of the intended action or action taken on his/her case, the reason for this action and the authority for proposing or taking the action. The individual needs to clearly understand when the action will take place, the action that will be taken, the rules which require the action, and his right for redress.

Proper notice provides protection of the client's appeal rights as required in 1902(a)(3) of the Social Security Act.

Notice of Action on Medicaid provides an opportunity for a fair hearing if action is taken to deny, suspend, terminate, or reduce services.

The DMAS-122 form is the formal notice to the LTC provider of the recipient's eligibility for Medicaid and for Medicaid payment of LTC services.

The notice requirements found in this section are used for all LTC cases.

### B. Forms to Use

#### 1. Notice of Action on Medicaid (#032-03-008)

The EW must send the Notice of Action on Medicaid to the applicant/recipient and the person who is authorized to conduct business for the Applicant to notify him of the Agency's decision on the initial Medicaid application, and on a redetermination of eligibility when a recipient starts LTC services.

Appendix 2 to this subchapter contains a copy of the Notice of Action on Medicaid.

**2. Notice of  
Obligation for  
Long-Term  
Care Costs  
(#032-03-062)**

The Notice of Obligation for Long-term Care Costs is sent to the applicant/recipient and the person managing the applicant's affairs to notify them of the amount of patient payment responsibility.

The "Agency" copy of the form should be signed and returned by the person to whom it is sent to acknowledge notification of his responsibility to pay the LTC provider. **Failure to return a signed form has no impact on the individual's eligibility status.** Processing of the application shall not be delayed pending the return of the signed form. This form is an agreement only.

*Appendix 3 to this subchapter contains a copy of the Notice of Obligation for Long-Term Care Costs.*

**3. Patient  
Information  
DMAS-122**

The Patient Information form DMAS-122:

- notifies the LTC provider of a patient's Medicaid eligibility status;
- provides the *monthly amount* an eligible patient must pay to the provider toward the cost of care;
- reflects changes in the patient's level of care;
- documents admission or discharge of a patient to an institution or community-based care services, or death of a patient;
- provides other information known to the provider that might cause a change in eligibility status or patient pay amount.

**a. When to Complete the DMAS-122**

The EW completes the DMAS-122 at the time of eligibility determination and/or the recipient's entry into LTC. The EW must complete a new DMAS-122 when the recipient's eligibility status changes, such as when the recipient's Medicaid coverage is canceled or changed to limited QMB or SLMB coverage. The EW must update the DMAS-122 and send it to the provider or case manager whenever the patient pay changes.

The EW must update the DMAS-122 and send it to the provider or case manager at least every 12 months even if the patient pay does not change. A currently dated DMAS-122 must be completed and sent to the provider or case manager when the annual redetermination is completed, if a DMAS-122 form was not sent to the provider or case manager within the past 12 months.

**b. Where to Send the DMAS-122**

1) Facility Patients

If the patient is in a nursing facility, ICF-MR, or chronic care hospital, send the DMAS-122 to the facility.

2) Medicaid CBC Waiver Patients

a) For MR waiver recipients, send the DMAS-122 to the Community Services Board (CSB) Case Manager.

b) For Technology-Assisted Individuals waiver recipients, send the DMAS-122 to:

DMAS Case Manager  
Technology Assisted Waiver Program  
DMAS  
600 E. Broad Street  
Richmond, VA 23219

c) For *EDCD* waiver recipients *who have chosen consumer-directed services*, send the DMAS-122 to the Service Facilitator. *For all other ED CD waiver recipients, follow the instructions in e) below.*

d) For DD waiver recipients, send the DMAS-122 to the Support Coordinator.

e) If the patient of any other waiver receives case management services, send the DMAS-122 to the Case Manager. If the patient does not receive case management services send the DMAS-122 to the personal care services provider *or adult day health provider*. If the patient *receives both personal care and adult day health care*, send the DMAS-122 to the personal care provider.

f) Except for Technology- Assisted Waiver patients, send a copy of the DMAS-122 to the DMAS Community-Based Care Waiver Unit **only upon request** from that unit. Upon request from the CBC Waiver Unit, send a copy of the DMAS-122 to the unit at the following address:

CBC Waiver Unit  
DMAS  
600 E. Broad Street  
Richmond, VA 23219

Appendix 4 to this subchapter contains a copy of the DMAS-122 form and instructions.

**4. Advance Notices of Proposed Adverse Action**

The recipient must be notified in advance of any adverse action that will be taken on his/her Medicaid eligibility or patient pay.

**a. Advance Notice of Proposed Action (#032-03-018) Appendix 1**

The Advance Notice of Proposed Action must be used for an adverse eligibility action when:

- eligibility for Medicaid will be canceled,
- eligibility for full-coverage Medicaid changes to QMB, SLMB, or QWDI limited coverage,
- Medicaid payment for LTC services will be terminated because of asset transfer.

**b. Advance Notice of Obligation for Long-Term Care Costs (#032-03-062) Appendix 3**

An increase in the patient pay amount is an adverse action. Send the “Notice of Obligation for Long-term Care Costs” as the advanced notice to the applicant/recipient and the person managing the applicant's affairs to notify them at least 10 days in advance of an increase in the patient pay responsibility. **Do not send the “Advance Notice of Proposed Action” when patient pay increases.**

The “Agency” copy of the form should be signed and returned by the person to whom it is sent to acknowledge notification of his responsibility to pay the LTC provider. **Failure to return a signed form has no impact on the individual’s eligibility status.**

**5. Medicaid Redetermination For Long-term Care (#032-03-369)**

The “Medicaid Redetermination for Long-term Care” form #032-03-369, is the form used to redetermine Medicaid eligibility of an individual who is in long-term care. The individual or his authorized representative completes and signs the form where indicated. The EW completes and signs the eligibility evaluation sections on the form.

Appendix 5 contains a copy of the form.

## TABLE OF CONTENTS

### LONG-TERM CARE

#### M1420.000 PRE-ADMISSION SCREENING

	Section	Page
What is Pre-admission Screening .....	M1420.100 .....	1
Pre-admission Screening .....	M1420.200 .....	1
Communication Procedures .....	M1420.300 .....	3
Screening Certification .....	M1420.400 .....	4

#### Forms

##### DMAS-96 Medicaid Funded Long-Term Care

Pre-Admission Screening Authorization.....	Appendix 1.....	1
MR Waiver Level of Care Eligibility Form .....	Appendix 2.....	1
DD Waiver Level of Care Eligibility Form .....	Appendix 3.....	1

## M1420.000 PRE-ADMISSION SCREENING

### M1420.100 WHAT IS PRE-ADMISSION SCREENING

#### A. Introduction

The Nursing Home Pre-admission Screening Program was implemented in 1977 to ensure that Medicaid eligible individuals placed in nursing facilities actually require nursing facility care. In 1982 the program was expanded to require pre-admission screening for individuals who will be eligible for Medicaid-covered Home and Community-based Care Waiver Services or institutional long-term care. *A pre-admission screening is used to determine if an individual living outside a nursing facility meets the level of care for LTC services. Once an individual is admitted to a nursing home or Medicaid CBC, the provider is responsible for certifying the individual continues to meet the level of care for LTC services.*

This subchapter describes the pre-admission screening process; the eligibility implications; the communication requirements; the inter-agency cooperation requirements; and the role of the eligibility worker within the pre-admission screening process.

#### B. Operating Policies

##### 1. Payment Authorization

A pre-admission screening provides authorization for Medicaid payment of facility (medical institution) and community-based care (CBC) long-term care services *for Medicaid recipients.*

##### 2. *When the Pre-admission Screening Form is Needed*

Pre-admission screening is used to determine if an individual entering LTC meets the *nursing facility level of care criteria or if living outside of a nursing facility is CBC waiver eligible.* The EW does not need the certification form *for an individual who is already in a nursing facility or who already meets the definition of institutionalization PRIOR to Medicaid application.*

##### 3. *Determines Applicable Eligibility Rules*

*The pre-admission screening form is used to determine the appropriate rules used for the eligibility determination (which LTC rules to use, or whether to use non-institutional Medicaid eligibility rules). An individual who is screened and approved for LTC services is treated as an institutionalized individual in the Medicaid eligibility determination. The pre-admission screening document also identifies the type of LTC service and provides information for the personal needs/maintenance allowance.*

## M1420.200 PRE-ADMISSION SCREENING

#### A. Introduction

In order to qualify for Medicaid payment for long-term care, an individual must meet both functional and medical components of the level of care criteria.

**B. Nursing Facility Screening**

This evaluation is completed by local teams composed of agencies contracting with the Department of Medical Assistance Services (DMAS) or by staff of acute care hospitals.

The local committees usually consist of the local health department director, a local health department nurse, and a local social services department service worker, plus any other professionals designated by the health department director.

Patients placed directly from acute care hospitals are usually screened by hospital screening teams. Generally, hospitals contract with DMAS to establish pre-admission screening committees to perform the screening process internally.

A state level committee is used for patients being discharged from State Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) institutions for the treatment of mental illness, and mental retardation.

Patients in a Veterans Administration Medical Center (VAMC) who are applying to enter a nursing facility are assessed by VAMC staff. VAMC discharge planning staff use their own Veterans' Administration assessment form, which serves as the pre-admission screening certification.

**C. CBC Screening**

Entities other than hospital or local health committees are authorized to screen individuals for CBC.

The following entities are authorized to screen patients for Medicaid CBC:

**1. Elderly or Disabled with Consumer-Direction (EDCD) Waiver**

Local and hospital screening committees or teams are authorized to screen individuals for the *EDCD* waiver.

**2. Technology-Assisted Individuals Waiver**

The DMAS Health Care Coordinator is authorized to screen individuals for the Technology-Assisted waiver.

**3. Mental Retardation (MR) Waiver**

Local Community Mental Health Services Boards (CSBs) and the Department of Rehabilitative Services (DRS) are authorized to screen individuals for the MR waiver. Final authorizations for MR waiver services are made by DMHMRSAS staff.

**4. AIDS Waiver**

Local and hospital screening committees or teams are authorized to screen individuals for the AIDS waiver. AIDS Services Organizations (ASOs) that have contracts with DMAS are also authorized to screen individuals for the AIDS waiver:

- Peninsula AIDS Foundation
- Northern Virginia AIDS Project
- INOVA System/Office of HIV
- Council of Community Services
- AIDS Support Group, Inc.
- Whitman Walker Clinic of Northern Virginia

**5. Individual and Family Developmental Disabilities Support (DD) Waiver**

DMAS and the Virginia Health Department child development clinics are authorized to screen individuals for the DD waiver.

## **M1420.300 COMMUNICATION PROCEDURES**

### **A. Introduction**

To ensure the eligibility determination process takes place simultaneously with screening decisions so that nursing facility placement or receipt of CBC services may be arranged as quickly as possible, prompt communication between screeners and eligibility staff must occur.

Each agency shall designate an appropriate eligibility staff member for screeners to contact. Local social services staff, hospital social services staff, and DRS staff shall be given instructions on how to contact that person.

### **B. Procedures**

#### **1. Screeners**

Screeners must inform the agency eligibility worker that the screening process has been initiated.

#### **2. EW Action**

The eligibility worker must begin to process the individual's Medicaid application when informed that the screening process has begun.

#### **3. Provider Involvement**

If the individual is found eligible and verbal assurance of approval by the screening committee has been received, the EW must provide, without delay, the facility or CBC provider with the recipient's Medicaid ID number.

#### **4. Designated DSS Contact**

The local DSS agency should designate an appropriate eligibility staff member for screeners to contact. Local social services staff,

hospital social services staff and DRS staff should be given the name of, and instructions on how to contact, that person. This will facilitate timely communication between screeners and the eligibility determination staff.

## M1420.400 SCREENING CERTIFICATION

### A. Purpose

The screening certification authorizes a local DSS to determine financial eligibility using the more liberal rules for institutionalized individuals and verifies qualification for special personal maintenance allowances for temporary stays in long-term care facilities. The screening certification is valid for one year.

### B. Procedures

#### 1. Exceptions to Screening

Pre-admission screening is NOT required when:

- the individual is a patient in a nursing facility at the time of application or has been a patient in a nursing facility for at least 30 consecutive days;
- the individual is no longer in need of long-term care but is requesting assistance for a prior period of long term care;
- the individual enters a nursing facility directly from the *EDCD* or *AIDS* waiver;
- the individual leaves a nursing facility and begins receiving *EDCD* or *AIDS* waiver services; or
- the individual enters a nursing facility from out-of-state.

#### 2. Documentation

- a. If the individual has not been institutionalized for at least 30 consecutive days, the screener's certification of approval for Medicaid long-term care must be substantiated in the case record.
- b. Substantiation is by:
  - a DMAS-96 (see Appendix 1);
  - a MR Waiver Level of Care Eligibility Form (see Appendix 2); or
  - a DD Waiver Level of Care Eligibility Form (see Appendix 3).
- c. The screening certification is valid for one year.

#### 3. DMAS-96

For an individual who has been screened and approved for the *EDCD*, Technology-Assisted, or *AIDS* waiver, the DMAS-96 "Medicaid Funded Long-term Care Pre-admission Screening Authorization" form will be signed and dated by the screener. The "Medicaid Authorization" section will have a number in the box that matches one of the numbers listed under "Nursing Home Pre-admission Screening." These numbers denote approval of Medicaid payment for a waiver service. See Appendix 1 for a copy of the DMAS-96.

- 4. EDCD Waiver Authorization for Consumer-Directed Services** *When an individual has been screened and approved for the EDCD waiver, the local DSS must determine his eligibility as an institutionalized individual and if eligible, enroll him in Medicaid. DMAS or its contractor must give final authorization for consumer-directed services. If the services are not authorized, the Service Facilitator will notify the LDSS, and the EW must re-evaluate the individual's eligibility as a non-institutionalized individual.*
- 5. MR Waiver Level of Care Eligibility Form** For an individual who has been screened and approved for the MR waiver, the "MR Waiver Level of Care Eligibility Form" will be signed and dated by the DMHMRSAS representative. The "MR Waiver Level of Care Eligibility Form" will include the individual's name, address and the date of DMHMRSAS approval. See Appendix 2 for a copy of the "MR Waiver Level of Care Eligibility Form."
- 6. DD Waiver Level of Care Eligibility Form** For an individual who has been screened and approved for the DD waiver, a "DD Waiver Level of Care Eligibility Form" authorizing Medicaid waiver services will be signed and dated by a DMAS Health Care Coordinator. The form letter will include the individual's name, address and the date of approval for waiver services. See Appendix 3 for a copy of the "DD Waiver Level of Care Eligibility Form."
- 7. LTC Authorization Not Received** If the form is not available when placement needs to be made, verbal assurance from a screener or DMAS that the form approving long-term care will be mailed or delivered is sufficient to establish the Medicaid pre-authorization. The date of receipt of such assurance and the name of the person providing the information must be entered in the case record.
- If a pre-admission screening is required and the documented or verbal assurance of screening and approval is not received, Medicaid eligibility for an individual who is living in the community must be determined as a community resident using the rules applicable to a non-institutionalized Medicaid applicant.
- 8. LTC Authorization Rescinded** The authorization for Medicaid-funded long-term care may be rescinded by the physician or by DMAS at any point that the individual is determined to no longer meet the level of care criteria for Medicaid-funded long-term care.
- When an individual is no longer eligible for a CBC Waiver service, the EW must re-evaluate his/her eligibility as a non-institutionalized individual.
- Continue to use the institutional eligibility criteria for persons who are in a medical institution even though they no longer meet the level of care criteria. If eligible, Medicaid will not make a payment to the facility for the care.

MEDICAID FUNDED LONG-TERM CARE SERVICE AUTHORIZATION FORM

I. RECIPIENT INFORMATION:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Birth Date: \_\_\_/\_\_\_/\_\_\_

Social Security \_\_\_\_\_ Medicaid ID \_\_\_\_\_ Sex: \_\_\_\_\_

II. MEDICAID ELIGIBILITY INFORMATION:

Is Individual Currently Medicaid Eligible?
1 = Yes
2 = Not currently Medicaid eligible, anticipated within 180 days of nursing facility admission OR within 45 days of application or when personal care begins.
3 = Not currently Medicaid eligible, not anticipated within 180 days of nursing facility admission

Is Individual currently Auxiliary Grant eligible?
0 = No
1 = Yes, or has applied for Auxiliary Grant
2 = No, but is eligible for General Relief

If no, has Individual formally applied for Medicaid?
0 = No 1 = Yes

Dept of Social Services: (Eligibility Responsibility) \_\_\_\_\_
(Services Responsibility) \_\_\_\_\_

III. PRE-ADMISSION SCREENING INFORMATION: (to be completed only by Level I, Level II, or ALF screeners)

MEDICAID AUTHORIZATION

Level of Care

- 1 = Nursing Facility Services
2 = PACE/LTCPHP
3 = AIDS/HIV Waiver Services
4 = Elderly or Disabled with Consumer Direction Waiver
11 = ALF Residential Living
12 = ALF Regular Assisted Living
14 = Individual/Family Developmental Disabilities Waiver

NOTE: Authorization for Nursing Facility or the Elderly or Disabled with Consumer Direction Waiver is interchangeable. Screening updates are not required for individuals to move between services because the alternate institutional placement is the same.

NO MEDICAID SERVICES AUTHORIZED

- 8 = Other Services Recommended
9 = Active Treatment for MI/MR Condition
0 = No other services recommended

Targeted Case Management for ALF

0 = No 1 = Yes
Assessment Completed
1 = Full Assessment 2 = Short Assessment

ALF provider name: \_\_\_\_\_
ALF provider number: \_\_\_\_\_
ALF admit date: \_\_\_\_\_

SERVICE AVAILABILITY

- 1 = Client on waiting list for service authorized
2 = Desired service provider not available
3 = Service provider available, care to start immediately

LENGTH OF STAY (If approved for Nursing Home)

- 1 = Temporary (less than 3 months)
2 = Temporary..(less than 6 months)
3 = Continuing (more than 6 months)
8 = Not Applicable

NOTE: Physicians may write progress notes to address the length of stay for individuals moving between Nursing Facility and the EDCD Waiver. The progress notes should provided to the local departments of social services Eligibility workers.

LEVEL I/ALF SCREENING IDENTIFICATION

Name of Level I/ALF screener agency and provider number:

1. \_\_\_\_\_
2. [Grid]

LEVEL II OR CSB 101B ASSESSMENT DETERMINATION

Name of Level II OR CSB Screener and ID number who have completed the Level II or 101B for a diagnosis of MI, MR, or RC.

1. \_\_\_\_\_
[Grid]
0 = Not referred for Level II OR 101B assessment
1 = Referred, Active Treatment needed
2 = Referred, Active Treatment not needed
3 = Referred, Active Treatment needed but individual chooses NH

Did the individual expire after the PAS/ALF Screening decision but before services were received? 1 = Yes 0 = No

SCREENING CERTIFICATION - This authorization is appropriate to adequately meet the individual's needs and assures that all other resources have been explored prior to Medicaid authorization for this recipient.

Table with 3 rows: Level I/ALF Screener, Title, Date; Level I/ALF Screener, Title, Date; Level I Physician, Date

### Instructions for completing the *Medicaid Funded Long-Term Care Service Authorization Form (DMAS-96)*

1. Enter Individual's Last Name. **Required.**
2. Enter Individual's First Name. **Required.**
3. Enter Individual's Birth Date in MM/DD/CCYY format. **Required.**
4. Enter Individual's Social Security Number. **Required.**
5. Enter Individual's Medicaid ID number if the Individual currently has a Medicaid card. This number should have either nine or twelve digits.
6. Sex: Enter "F" if Individual is Female or "M" if Individual is Male. **Required.**
7. Is Individual Currently Medicaid Eligible? Enter a "1" in the box if the Individual is currently Medicaid Eligible.  
Enter a "2" in the box if the Individual is not currently Medicaid Eligible, but it is anticipated that private funds will be depleted within 180 days after Nursing Home admission or within 45 days of application or when personal care begins.  
Enter a "3" in the box if the Individual is not eligible for Medicaid and it is not anticipated that private funds will be depleted within 180 days after Nursing Home admission
8. If no, has Individual formally applied for Medicaid? Formal application for Medicaid is made when the Individual or a family member has taken the required financial information to the local Eligibility Department and completed forms needed to apply for benefits. The authorization for long-term care can be made regardless of whether the Individual has been determined Medicaid-eligible, but placement may not be available until the provider is assured of the Individual's Medicaid status.
9. Is Individual currently auxiliary grant eligible? Enter appropriate code ("0", "1" or "2") in the box.
10. Dept of Social Services: The Departments of Social Services with service and eligibility responsibility may not always be the same agency. Please indicate, if known, the departments for each in the areas provided.
11. Assessment Type: Enter in the box the number that corresponds to the assessment provided. If this area is not filled in correctly, payment may not be made, may be delayed, or may be incorrect. **Required.**
12. Medicaid Authorization Enter the numeric code that corresponds to the Pre-Admission Screening Level of Care authorized. Enter only one code in this box.

**NOTE: Authorization for Nursing Facility or the Elderly or Disabled With Consumer Direction Waiver is interchangeable. Screening updates are not required for individuals to move between services because the alternate institutional placement is the same.**

- 1 = **NURSING FACILITY** authorize only if Individual meets the Nursing Facility (NF) criteria and community-based care is not an option.
- 2 = **PACE/LTC PREPAID HEALTH PLAN** authorize only if Individual meets NF criteria (pre-NF criteria does not qualify) and requires a community-based service to prevent institutionalization.
- 3 = **HIV/AIDS WAIVER** authorize only if Individual meets the criteria for AIDS/HIV Waiver services and requires AIDS/HIV Waiver services to prevent institutionalization (that is, case management, private duty nursing, personal/respite care, nutritional supplements).
- 4 = **ELDERLY OR DISABLED WITH CONSUMER DIRECTION WAIVER** authorize only if Individual meets NF criteria and requires a community-based service to prevent institutionalization.
- 11 = **ALF RESIDENTIAL LIVING** authorize only if Individual has dependency in either 1 ADL, 1 IADL or medication administration.
- 12 = **ALF REGULAR ASSISTED LIVING** authorize only if Individual has dependency in either 2 ADLs or behavior.
- 14 = **Individual/Family Developmental Disabilities** authorize only if the Individual meets the criteria for admission into an ICF/MR facility and meets the Level of Functioning screening criteria.

**If ALF is authorized**, enter, if known, in item 29, the provider number of the ALF that will admit the Individual. Enter, in item 27, the date the Individual will be admitted to that ALF.

0 = **NO OTHER SERVICES RECOMMENDED** use when the screening team recommends no services or the Individual refuses services.

12. 8 = **OTHER SERVICES RECOMMENDED** includes informal social support systems or any service excluding Medicaid-funded long-term care (such as companion services, meals on wheels, MR waiver, rehab. services, etc.)

9 = **ACTIVE TREATMENT FOR MI/MR CONDITION** applies to those Individuals who meet Nursing Facility Level of Care but require active treatment for a condition of mental illness or mental retardation and cannot appropriately receive such treatment in a Nursing Facility.

13. Targeted Case Management for ALF If ARC, ARR or ARI is authorized, you must indicate whether Targeted Case Management for ALF (quarterly visits) are also being authorized. The Individual must require coordination of multiple services and the ALF or other support must not be available to assist in the coordination/access of these services. Enter a "0" if only the annual reassessment is required.
14. Service Availability If a Medicaid-funded long-term care service is authorized, indicate whether there is a waiting list (#1) or that there is no available provider (#2), or whether the service can be started immediately (#3).
15. ALF Reassessment: If this is an ALF Reassessment enter the appropriate code for No or Yes. Then mark the appropriate box for a short reassessment or a long reassessment.
16. Length of Stay If approval of Nursing Facility care is made, please indicate how long it is felt that these services will be needed by the Individual. The physician's signature certifies expected length of stay as well as Level of Care.

**NOTE: Physicians may write progress notes to address the length of stay for individuals moving between Nursing Facility or the EDCD Waiver. The progress notes should provided to the local departments of social services Eligibility workers.**

17. Level I/ALF Screening Identification Enter the name of the Level I screening & agency or facility (for example, Hospital, local DSS, local Health, Area Agency on Aging, CSB, State MH/MR facility, CIL) and below it, in the 11 boxes provided, that entity's 8-digit provider ID and 3-digit location code.
18. on Aging, CSB, State MH/MR facility, CIL) and below it, in the 11 boxes provided, that entity's 8-digit provider ID and 3-digit location code.

For Medicaid to make prompt payments to Pre-Admission Screening committees, all of the information in this section must be completed. *Failure to complete any part of this section will delay reimbursement.*

19. If the screening is a Nursing Home Pre-Admission Screening completed in the & locality, there should be two Level I screeners, both the local DSS and local Health departments. Otherwise, there will only be one Level I screener identification entered.
20. Do NOT fill in Lines 16 and 17 or lines 18 and 19 if lines 20 and 21 are filled in. Submit a separate DMAS-96 form.
21. Level II Assessment Determination If a Level II assessment was performed (MI, & MR or Dual), enter the name of the assessor on line 20 and the provider number on line 21. Do NOT fill in line 20 and 21 if lines 16 and 17 are also filled in. Submit a separate DMAS-96 form.
22. Enter the appropriate code in the box.
23. When a Screening Committee is aware that an Individual has expired prior to receiving the services authorized by the screening committee, a "1" should be entered in this box.
24. The Level I/ALF Screener must sign and date the form. **Required.**
25. The Level I/ALF Screener must sign and date the form. **Required for all services except ALF placement.**
26. The Level I physician must sign and date the form. **Required for all services except ALF placement.**
27. Enter the date the Individual entered an ALF. Otherwise leave blank. If the Level of Care authorized is NFS, give a copy of this form to the Nursing Facility. The Nursing Facility must enter the date Medicaid Care of the Individual began in this space and place a copy of the form ON TOP of their admission packet.
28. Enter the name of the ALF in which the Individual was placed. Otherwise leave blank. If the Level of Care authorized is NFS, give a copy of this form to the Nursing Facility. The Nursing Facility must enter their name in this space and place a copy of the form ON TOP of their admission packet.
29. Enter the provider number of the ALF in which the Individual was placed. Otherwise leave blank. If the Level of Care authorized is NFS, give a copy of this form to the Nursing Facility. The Nursing Facility must enter their provider number in this space and place a copy of the form ON TOP of their admission packet.

## TABLE OF CONTENTS

### M14 LONG-TERM CARE

#### M1440.000 COMMUNITY-BASED CARE WAIVER SERVICES

	SECTION	Page
Governing Laws .....	M1440.001 .....	1
Basic Eligibility Requirements .....	M1440.010 .....	2
Institutional Status.....	M1440.020 .....	3
CBC Waiver Descriptions .....	M1440.100 .....	11
<i>Elderly or Disabled with Consumer-Direction</i> .....	M1440.101 .....	11
Waiver		
Mental Retardation Waiver .....	M1440.102 .....	13
Aids Waiver .....	M1440.103 .....	14
Technology-Assisted Individuals Waiver .....	M1440.104 .....	15
Reserved.....	M1440.105 .....	16
<i>Reserved</i> .....	M1440.106 .....	17
Individual and Family Developmental Disabilities		
Support Waiver .....	M1440.107 .....	18
Covered Services .....	M1440.200 .....	18a
Personal Care/Respite Care Services .....	M1440.201 .....	18a
Adult Day Health Services .....	M1440.202 .....	18b
Case Management Services.....	M1440.203 .....	18b
Private Duty Nursing Services.....	M1440.204 .....	19
Nutritional Supplements .....	M1440.205 .....	19
Environmental Modifications .....	M1440.206 .....	20
Residential Support Services .....	M1440.207 .....	20
Personal Assistance Services.....	M1440.208 .....	21
Assistive Technology Services.....	M1440.209 .....	21
Day Support Services.....	M1440.210 .....	21
Supported Employment Services .....	M1440.211 .....	21
Therapeutic Consultation Services .....	M1440.212 .....	22
<i>Personal Emergency Response System (PERS)</i> .....	M1440.213 .....	22

justice system?

(1) NO: he is NOT an inmate of a public institution and may be eligible for Medicaid. STOP.

(2) YES: he is an inmate of a public institution and is NOT eligible for Medicaid. STOP.

## **M1440.100 CBC WAIVER DESCRIPTIONS**

**A. Introduction** This section provides a brief overview of the Medicaid CBC waivers. The overview is a synopsis of the target populations, basic eligibility rules, available services, and the assessment and service authorization procedure for each waiver.

The eligibility worker does not make the determination of whether the individual is eligible for the waiver services; this is determined by the pre-admission screener or by DMAS. The policy in the following sections is only for the eligibility worker's information to better understand the CBC waiver services.

**B. Definitions** Term definitions used in this section are:

**1. Financial Eligibility Criteria** means the rules regarding asset transfers; what is a resource; when and how that resource counts; what is income; when and how that income is considered.

**2. Non-financial Eligibility Criteria** means the Medicaid rules for non-financial eligibility. These are the rules for citizenship and alienage; state residence; social security number; assignment of rights and cooperation; application for other benefits; institutional status; cooperation with spousal support and DCSE; and covered group and category requirements.

**3. Patient** an individual who has been approved by a pre-admission screener to receive Medicaid waiver services.

## **M1440.101 ELDERLY OR DISABLED WITH CONSUMER-DIRECTION WAIVER**

**A. General Description** The *Elderly or Disabled with Consumer-Direction (EDCD)* Waiver is targeted to provide home and community-based services to individuals age 65 or older, or who are disabled, who have been determined to require the level of care provided in a medical institution and are at risk of facility placement.

*Recipients may select agency-directed services, consumer-directed services, or a combination of the two. Under consumer-directed services, supervision of the personal care aide is furnished directly by the recipient. Individuals who are incapable of directing their own care may have a spouse, parent, adult child, or guardian direct the care on behalf of the recipient. Consumer-directed services are monitored by a Service Facilitator.*

**B. Targeted Population**

This waiver serves persons who are:

- a. age 65 and over, or
- b. disabled; disability may be established either by SSA, DDS, or a pre-admission screener (provided the individual meets a Medicaid covered group and another category).

Waiver services are provided to any individual who meets a Medicaid covered group and is determined to need an institutional level of care by a pre-admission screening. The individual does not have to meet the Medicaid disability definition.

**C. Eligibility Rules**

All individuals receiving waiver services must meet the Medicaid non-financial and financial eligibility requirements for an eligible patient in a medical institution.

The resource and income rules are applied to waiver-eligible patients as if the patients were in a medical institution.

NOTE: *EDCD* waiver services shall not be offered to any patient who resides in a nursing facility, an intermediate care facility for the mentally retarded, a hospital, or an adult care residence licensed by DSS. The income limit used for this waiver is 300% of the current SSI payment standard for one person, or the medically needy income limit (spenddown).

**D. Services Available**

LTC services available through this waiver include:

- adult day health care
- *agency-directed and consumer-directed* personal care
- *agency-directed* respite care (*including skilled respite*) and *consumer-directed* respite care
- *Personal Emergency Response System (PERS)*.

**E. Assessment and Service Authorization**

The nursing home pre-admission screeners assess and authorize *EDCD* waiver services based on a determination that the individual is at risk of nursing facility placement.

**F. PACE**

PACE (Program for All-inclusive Care for the Elderly) is a special demonstration program available to individuals living in the Tidewater area. Recipients *who meet the criteria for the ED CD waiver* may be enrolled in PACE *in lieu of the ED CD waiver*.

PACE is a pre-paid managed care health contract with a provider under which Medicaid will pay a per capita rate for a complete care package of services which is available to each elderly Medicaid recipient enrolled in the plan. The service package includes the *EDCD* waiver services listed above, as well as inpatient and outpatient hospital care, skilled and intermediate nursing care, adult care residence (ACR) care, physicians' services, pharmacy services, lab and X-ray services, etc.

The only PACE provider in Virginia is Sentara in Norfolk.

**M1440.106 RESERVED**

**M1440.107 INDIVIDUAL AND FAMILY DEVELOPMENTAL  
DISABILITIES SUPPORT WAIVER (DD WAIVER)**

**A. General  
Description**

The Individual and Family Developmental Disabilities Support Waiver (DD waiver) provides home and community-based services to individuals with developmental disabilities, who do not have a diagnosis of mental retardation. The objective of the waiver is to provide medically appropriate and cost-effective coverage of services necessary to maintain these individuals in the community and prevent placement in a medical institution.

This waiver serves persons who:

- have a diagnosis of developmental disability attributable to cerebral palsy, epilepsy or autism, or
- any condition other than mental illness, found to be closely related to mental retardation.

The developmental disability must have been manifested prior to the individual reaching age 22 and must be likely to continue indefinitely.

**B. Eligibility Rules**

All patients receiving waiver services must meet the non-financial and financial Medicaid eligibility criteria and be Medicaid eligible in a medical institution. The resource and income rules are applied to waiver eligible individuals as if the individuals were residing in a medical institution.

The income limit used for this waiver is 300% of the SSI limit (see M0810.002 A. 3.). Medically needy individuals are not eligible for this waiver. If the individual's income exceeds 300% SSI, the individual is not eligible for services under this waiver.

**C. Services  
Available**

Services available under the DD waiver are:

- support coordination (case management)
- adult companion services
- assistive technology
- crisis intervention/stabilization
- environmental modifications
- residential support
- skilled nursing
- supported employment
- therapeutic consultation
- respite care
- personal attendant services
- consumer-directed personal and respite care

<b>D. Assessment and Service Authorization</b>	The initial assessment and development of the plan is conducted by qualified individuals under contract with DMAS. DMAS staff will review the contractor's plan and authorization.
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## M1440.200 COVERED SERVICES

<b>A. Introduction</b>	This section provides general information regarding the LTC services provided under the waivers. This is just for your information, understanding, and referral purposes. The information does not impact the Medicaid eligibility decision.
<b>B. Waiver Services Information</b>	Information about the services available under a waiver is contained in the following sections: <ul style="list-style-type: none"><li>• M1440.201 Personal Care/Respite Care Services</li><li>• M1440.202 Adult Day Health Services</li><li>• M1440.203 Case Management Services</li><li>• M1440.204 Private Duty Nursing Services</li><li>• M1440.205 Nutritional Supplements</li><li>• M1440.206 Environmental Modifications</li><li>• M1440.207 Residential Support Services</li><li>• M1440.208 Personal Assistance Services</li><li>• M1440.209 Assistive Technology Services</li><li>• M1440.210 Day Support Services</li><li>• M1440.211 Supported Employment Services</li><li>• M1440.212 Therapeutic Consultation Services</li><li>• <i>M1440.213 Personal Emergency Response System (PERS)</i></li></ul>

## M1440.201 PERSONAL CARE/RESPITE CARE SERVICES

<b>A. What Are Personal Care Services</b>	Personal Care services are defined as long term maintenance or support services which are necessary in order to enable the individual to remain at home rather than enter an institution. Personal Care services provide eligible individuals with aides who perform basic health-related services, such as helping with ambulation/exercises, assisting with normally self-administered medications, reporting changes in the recipient's conditions and needs, and providing household services essential to health in the home.
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- B. What are Respite Care Services** Respite Care services are defined as services specifically designed to provide temporary but periodic or routine relief to the primary caregiver of an individual who is incapacitated or dependent due to frailty or physical disability. To receive this service the individual must meet the same criteria as the individual who is authorized for Personal Care, but the focus in Respite Care is on the needs of the caregiver for temporary relief. This focus on the caregiver differentiates Respite Care from programs which focus on the dependent or disabled care receiver.
- C. Relationship to Other Services** An individual may receive Personal Care or Respite Care in conjunction with Adult Day Health Care services as needed.
- When an individual receives Hospice services, the hospice is required to provide the first 21 hours per week of personal care needed and a maximum of an additional 38.5 hours per week.
- D. Who May Receive the Service** An individual must meet the criteria of the EDCD Waiver, the AIDS Waiver, the Technology-Assisted Waiver or the MR Waiver in order to qualify for Personal/Respite Care services.

## M1440.202 ADULT DAY HEALTH CARE SERVICES

- A. What Is Adult Day Health Care** Adult Day Health Care (ADHC) is a congregate service setting where individuals receive assistance with activities of daily living (e.g., ambulating, transfers, toileting, eating/feeding), oversight of medical conditions, administration of medications, a meal, care coordination including referrals to rehabilitation or other services if needed, and recreation/social activities. A person may attend half or whole days, and from one to seven days a week, depending on the patient's capability, preferences, and available support system.
- B. Relationship to Other Services** ADHC centers may provide transportation and individuals may receive this service, if needed, to enable their attendance at the center. An individual may receive ADHC services in conjunction with Personal Care or Respite Care services as needed.
- C. Who May Receive the Service** An individual must meet the *EDCD* Waiver criteria to qualify for ADHC services.

## M1440.203 CASE MANAGEMENT SERVICES

- A. What is Case Management** Case Management services enable the continuous assessment, coordination and monitoring of the needs of the person that is HIV positive and symptomatic, or who has AIDS. Case Management services are viewed as an indirect service which enables the efficient and effective delivery of the other direct services included in the waiver. A patient may receive between 0 and 10 hours of Case Management services monthly.

These services may be provided in residential and/or non-residential settings to enable the individual to maintain the health status and functional skills necessary to live in the community and/or participate in community activities.

- B. Who May Receive the Service** Personal Assistance services cannot be offered to an individual who receives Assisted Living services in an Adult Care Residence. Personal Assistance services are available only to patients who are eligible under the MR waiver.

### **M1440.209 ASSISTIVE TECHNOLOGY SERVICES**

- A. What is Assistive Technology** Assistive Technology (AT) is any device or environmental modification that increases the independence, safety or comfort of an individual.
- AT ranges from simple devices such as a jar opener or eyeglasses to complex devices such as a voice synthesizer or a powered wheelchair.
- B. Relationship to Other Services** This service is available only to persons who are receiving at least one other waiver service along with Case Management.
- C. Who May Receive the Service** This service is provided only to recipients of the MR Waiver.
- This service may be provided in residential and/or non-residential settings.

### **M1440.210 DAY SUPPORT SERVICES**

- A. What is Day Support** Day Support services are provided primarily in non-residential settings, separate from the home or other community residence, to enable a person to acquire, improve, and maintain maximum functional abilities. This service includes a variety of training, support, and supervision. Prevocational training for patients who previously resided in a Medicaid-certified facility is included under this service.
- B. Relationship to Other Services** This service is available only to persons who are receiving at least one other waiver service along with Case Management.
- C. Who May Receive the Service** This service is available only to recipients of the MR waiver.

### **M1440.211 SUPPORTED EMPLOYMENT SERVICES**

- A. What is Supported Employment** Supported Employment is paid employment for persons with mental retardation for whom competitive employment at or above minimum wage is unlikely and who, because of the disability, need intensive ongoing

support, including supervision, training and transportation to perform in a work setting. Supported employment is conducted in a variety of community work sites where non-disabled persons are employed.

- B. Relationship to Other Services** This service is available only to recipients who are receiving at least one other waiver service along with Case Management.
- C. Who May Receive the Service** Supported Employment services are available only to recipients in the MR waiver.

## **M1440.212 THERAPEUTIC CONSULTATION SERVICES**

- A. What is Therapeutic Consultation** Therapeutic Consultation is consultation and technical assistance provided by members of psychology, behavioral analysis, therapeutic recreation, speech therapy, occupational therapy or physical therapy professions to the individual, parent/family members, and Mental Retardation Waiver service providers. These consultation services help the individual and his/her caregiver(s) to implement his/her individual plan of care.
- B. Relationship to Other Services** Behavioral Analysis may be provided in the absence of any other waiver service when the consultation given to informal caregivers is necessary to prevent institutionalization.
- C. Who May Receive the Service** Therapeutic Consultation services are available only to MR waiver recipients.

## **M1440.213 PERSONAL EMERGENCY RESPONSE SYSTEM (PERS)**

- A. What is PERS** *PERS is an electronic device that enables certain recipients who are at high risk of institutionalization to secure help in an emergency through the use of a two-way voice communication system that dials a 24-hour response or monitoring center upon activation and via the recipient's home telephone line. PERS may include medication monitoring to remind certain recipients at high risk of institutionalization to take their medications at the correct dosages and times.*
- B. Relationship to Other Services** *An individual may receive PERS services in conjunction with agency-directed or consumer-directed Personal Care or Respite Care services.*
- C. Who May Receive the Service** *PERS is available only to EDCD recipients who live alone or are alone for significant parts of the day and who have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.*

6. **Domestic Travel Tickets** Gifts of domestic travel tickets [1612(b)(15)].
7. **Victim's Compensation** Victim's compensation provided by a state.
8. **Tech-related Assistance** Tech-Related Assistance for Individuals with Disabilities [ref. P.L. 100-407].
9. **\$20 General Exclusion** \$20 a month general income exclusion for the unit.  
**EXCEPTION:** Certain veterans (VA) benefits are not subject to the \$20 income exclusion. Refer to subchapter S0830 for complete explanation of which VA payments are entitled to the \$20 general exclusion.
10. **PASS Income** Any unearned income used to fulfill an SSI approved plan to achieve self-support (PASS). See item 12 below for earned income used to fulfill a PASS [1612(b) (4)(A) & (B)].
11. **Earned Income Exclusions** The following earned income exclusions are not deducted for the 300% SSI group:
- a. Up to \$1,410 per month, but not more than \$5,670 in a calendar year, of the earned income of a blind or disabled student child [1612(b) (1)].
  - b. Any portion of the \$20 monthly general income exclusion which has not been excluded from unearned income in that same month [1612(b) (2)(A)].
  - c. \$65 of earned income in a month [1612(b) (4)(C)].
  - d. IRWE - earned income of disabled individuals used to pay impairment-related work expenses [1612(b) (4)(B)].
  - e. One-half of remaining earned income in a month [1612(b) (4)(C)].
  - f. BWE - Earned income of blind individuals used to meet work expenses [1612(b) (4)(A)].
  - g. Earned income used to fulfill an SSI approved plan to achieve self-support (PASS) [1612(b) (4)(A) & (B)].
12. **Child Support** Child support payments received from an absent parent for a blind or Disabled child [1612(b) (9)].

**13. Native American Funds**

The following Native American funds (only exclude for ABD MN groups):

- a. Puyallup Tribe [ref. P.L. 101-41]
- b. White Earth Reservational Land Settlement [ref. P.L. 99-264]
- c. Chippewas of Mississippi [ref. P.L. 99-377]
- d. Saginaw Chippewas of Michigan [ref. P.L. 99-346]
- e. Shoalwater Bay Indian Tribe [ref. P.L. 98-432]
- f. Wyandotte Tribe [ref. P.L. 98-602]
- g. Chippewas of Lake Superior [ref. P.L. 99-146]
- h. Cow Creek Band of Umpqua [ref. P.L. 100-139]
- i. Coushatta Tribe of Louisiana [ref. P.L. 100-411]
- j. Wisconsin Band of Potawatomi [ref. P.L. 100-581]
- k. Seminole Indians [ref. P.L. 101-277]
- l. receipts from land distributed to:
  - Pueblo of Santa Ana [ref. P.L. 95-498]
  - Pueblo of Zia [ref. P.L. 95-499].

**14. State/Local Relocation**

State or local relocation assistance [1612(b) (18)].

**15. USC Title 37 Section 310**

Special pay received pursuant to section 310 of title 37, United States Code [1612(b)(20)].

NOTE: For additional F&C medically needy (MN) income exclusions, go to Chapter M07. For additional ABD medically needy (MN) income exclusions, go to Chapter S08.

**M1460.620 RESERVED****M1460.640 INCOME DETERMINATION PROCESS FOR STAYS LESS THAN 30 DAYS****A. Policy - Individual in An Institution for Less Than 30 Days**

This subsection is applicable ONLY if it is known that the time spent in the institution has been, or will be, less than 30 days. If the individual is institutionalized for less than 30 days, Medicaid eligibility is determined as a non-institutionalized individual because the definition of “institutionalization” is not met. If there is no break between a hospital stay and admission to a nursing facility or Medicaid CBC waiver services, the hospital days count toward the 30 days in the “institutionalization” definition.

**B. Recipient**

If a Medicaid recipient is admitted to a medical institution for less than 30 days, go to subchapter M1470 for patient pay policy and procedures.

**C. Applicant**

If the individual is NOT a Medicaid recipient and applies for Medicaid determine the individual’s income eligibility as a non-institutionalized individual. Go to Chapter M07 for F&C or S08 for ABD to determine the individual’s income eligibility.

## TABLE OF CONTENTS

### M14 LONG-TERM CARE

#### M1470 PATIENT PAY--POST-ELIGIBILITY TREATMENT OF INCOME

	Section	Page
Overview .....	M1470.001	1
Available Income for Patient Pay .....	M1470.100	1
Facility Patients - Allowable Deductions from Income .....	M1470.200	3
Facility Personal Needs Allowance.....	M1470.210	4
Dependent Child Allowance .....	M1470.220	6
Facility - Noncovered Medical Expenses .....	M1470.230	7
Facility - Home Maintenance Deduction .....	M1470.240	14
Facility Patients .....	M1470.300	14
Facility Admission from a Community Living Arrangement.....	M1470.310	15
Medicaid CBC Recipient Entering A Facility .....	M1470.320	16
Reserved.....	M1470.330	17
Facility Admission from Another Facility .....	M1470.340	17
Patient Pay for Facility Stay of Less Than 30 Days.....	M1470.350	18
Medicaid CBC Patients - Allowable Deductions from Income .....	M1470.400	20
Medicaid CBC Personal Maintenance Allowance .....	M1470.410	21
Dependent Child Allowance.....	M1470.420	23
Medicaid CBC - Noncovered Medical Expenses .....	M1470.430	24
Medicaid CBC Patients .....	M1470.500	32
Community Living Arrangement Admission To Medicaid CBC		
Waiver Services.....	M1470.510	33
Facility Patient Entering Medicaid CBC Waiver Services .....	M1470.520	34
Reserved.....	M1470.530	35
MN Patients - Spenddown Liability .....	M1470.600	35
Facility Patients--Spenddown Liability Less Than Or Equal		
To Medicaid Rate.....	M1470.610	37
Facility Patients--Spenddown Liability Greater Than		
Medicaid Rate .....	M1470.620	41
CBC Patients With Spenddown Liability .....	M1470.630	45

Completing the DMAS-122 Form.....	M1470.800 .....	50
Medicare Part A SNF Coverage .....	M1470.810 .....	51
Other Health Insurance Coverage.....	M1470.820 .....	53
VA Contract Coverage .....	M1470.830 .....	53
 Adjustments and Changes.....	M1470.900 .....	54
Retroactive Adjustments for Prior Months.....	M1470.910 .....	57
LTC Provider Change Within A Month.....	M1470.920 .....	57
Death or Discharge From LTC.....	M1470.930 .....	58
 Lump Sum Payments.....	M1470.1000 .....	59
Lump Sum Reported in Receipt Month .....	M1470.1010 .....	59
Lump Sum Not Reported Timely .....	M1470.1020 .....	60
Patient Pay Determination for Lump Sums .....	M1470.1030 .....	60
 Reduction of Excess Resources .....	M1470.1100 .....	62
 Incorrect Payments to Provider.....	M1470.1200 .....	64
Adjustments Not Allowed.....	M1470.1210 .....	65
Adjustments Allowed.....	M1470.1220 .....	65

**APPENDIX**

<i>Deleted</i> .....	Appendix 1.....	67
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**B. Procedure** Subtract the deduction(s) from gross monthly income in the order presented below:

1. Medicaid CBC Personal Maintenance Allowance (M1470.410)
2. Dependent Child Allowance (M1470.420)
3. Medicaid CBC - Incurred Medical Expenses (M1470.430)

**C. Appeal Rights** The patient or his representative has the right to appeal the patient pay determination, the amounts used in the calculation and denial of any request for adjustment. If a recipient or his representative appeals the patient pay, the EW who made the decision prepares the appeal summary and attends the hearing.

## M1470.410 MEDICAID CBC - PERSONAL MAINTENANCE ALLOWANCE

**A. Individuals** For the month of entry and subsequent months, deduct from the patient's gross monthly countable income a personal maintenance allowance. The amount of the allowance depends upon under which Medicaid CBC waiver the patient receives LTC services.

1. **Basic Maintenance Allowance**
  - a. **Elderly or Disabled with Consumer-Direction (EDCD) Waiver, Mental Retardation (MR) Waiver, Technology-Assisted Individuals Waiver, and Individual and Family Developmental Disabilities Support (DD) Waiver**

Patients receiving Medicaid CBC under the following waivers are allowed a monthly basic personal maintenance allowance deduction that equals the monthly SSI individual payment limit (see M0810.002 A. 2.)

- *EDCD* Waiver,
- MR Waiver,
- Technology-Assisted Individuals Waiver,
- DD Waiver.

**b. AIDS Waiver**

Patients under the AIDS waiver are allowed a monthly basic personal maintenance allowance that equals 300% of the SSI payment limit for one person (see M0810.002 A. 3.).

2. **Guardianship Fee** Deduct an amount up to 5% of the patient's gross monthly income (including amounts not counted as income and excluded income) for guardianship fees, if the patient has a legally appointed guardian or conservator AND the guardian or conservator charges a fee. Document how you determined that the guardian/conservator charges a fee and the amount of the fee.

NOTE: The guardianship filing fees CANNOT be deducted from the individual's income.

NOTE: No deduction is allowed for "power of attorney" fees or expenses.

**3. Special  
Earnings  
Allowance for  
Recipients in  
EDCD, DD, or  
MR Waivers**

Deduct the following special earnings allowance if the patient is working (the work does NOT have to be part of treatment). The special earnings allowance is deducted from earned income only. Deduct:

- 1) for individuals employed 20 hours or more per week, all earned income up to 300% of SSI (see M0810.002 A. 3.) per month.
- 2) for individuals employed at least 8 but less than 20 hours per week, all earned income up to 200% of SSI per month.

*The total amount of the personal maintenance allowance and the special earnings allowance cannot exceed 300% SSI.*

**EXAMPLE #9: (Using January 2005 figures)**

A working patient *receiving EDCD waiver services* is employed 18 hours per week. His income is gross earnings of \$928.80 per month and SSA of \$300 monthly. His special earnings allowance is calculated first:

\$ 928.80	gross earned income
- <u>1,158.00</u>	200% SSI maximum
\$ 0	remainder

\$ 928.80 = special earnings allowance

His personal maintenance allowance is computed as follows:

\$ 579.00	CBC personal maintenance allowance
+ <u>928.80</u>	special earnings allowance
\$ 1,507.80	total personal maintenance allowance

**B. Couples**

The Medicaid CBC waivers do not specify personal maintenance allowances for a married couple living together when both spouses receive Medicaid CBC because each spouse is considered an individual for patient pay purposes. The individual maintenance allowance in section M1470.410 applies to each spouse in a couple when each receives Medicaid CBC.

**M1470.420 DEPENDENT CHILD ALLOWANCE**

**A. Unmarried Individual, or Married Individual With No Community Spouse**

For an unmarried Medicaid CBC patient, or a married Medicaid CBC patient without a community spouse, who has a dependent child(ren) under age 21 years in the community:

- Calculate the difference between the appropriate MN income limit for the **child's** home locality for the number of children in the home and the child(ren)'s gross monthly income. If the children are living in different homes, the children's allowances are calculated separately using the MN income limit for the number of the patient's dependent children in each home.

The result is the dependent child allowance. If the result is greater than \$0, deduct it from the patient's income as the dependent child allowance. If the result is \$0 or less, do not deduct a dependent child allowance.

Do not deduct an allowance if the child(ren)'s monthly income exceeds the MN income limit in the child's home locality for the number of dependent children in the home.

Do not deduct an allowance for any other family member.

**1. Example--Two Dependent Children In One Home**

**EXAMPLE #10: (Using January 2005 figures)**

Mr. H is a single individual with gross monthly income of \$920, living in the community in Group II and receiving Medicaid CBC. He is divorced and has two children under age 18 who live with his ex-wife in Group I. His two children each receive \$75 SSA.

The allowance for his dependent children is calculated as follows:

\$ 299.15	MN limit for 2 (Group I)
<u>- 150.00</u>	children's SSA income
\$ 149.15	dependent children's allowance

**2. Example--  
Three  
Dependent  
Children In  
Two Homes**

**EXAMPLE #11: (Using January 2005 figures)**

Mrs. K is a married individual who lives at home in a Group II locality and receives Medicaid CBC. Her spouse is in a medical facility and is not a community spouse. One of their three dependent children lives with Mrs. K. The other two children live with her sister in a Group III locality. The children each receive \$95.00 per month SSA.

The allowance for the dependent children is calculated as follows:

\$ 271.05	MN limit for 1 (Group II)
<u>- 95.00</u>	child's SSA income
\$ 176.05	child's allowance

\$ 424.86	MN limit for 2 (Group III)
<u>- 190.00</u>	children's SSA income
\$ 234.86	children's allowance

\$ 176.05	children's allowance
<u>+ 234.86</u>	child's allowance
\$ 410.91	total dependent children's allowance

NOTE: If Mrs. K's institutionalized spouse is eligible for Medicaid, an allowance for their children may also be deducted from his income in determining his patient pay. However, the allowance the children receive from Mrs. K will be counted as part of their income when determining any allowance from Mr. K's income.

**B. Married With a  
Community  
Spouse**

For a married patient with a community spouse, go to subchapter M1480 to determine the dependent child's (family member's) allowance.

A community spouse is a person who is not an inpatient in a medical facility and who is married to an institutionalized person.

**M1470.430 MEDICAID CBC - NONCOVERED MEDICAL EXPENSES**

**A. Policy**

Amounts for incurred medical and dental expenses not covered by Medicaid or another third party are deducted from the patient's gross monthly income when determining patient pay.

- b. TED stockings (billed separately as durable medical supplies),
- c. acupuncture treatment,
- d. massage therapy,
- e. personal care items, such as special soaps and shampoos,
- f. physical therapy,
- g. speech therapy,
- h. occupational therapy.

#### **4. Documentation Required**

##### **a. Requests For Adjustments From A Patient or An Authorized Representative**

Request the following documentation from the patient or his representative:

- a copy of the bill;
- if applicable, the amount owed that was not covered by the patient's insurance;
- proof that the service was medically necessary. Proof may be the prescription, doctor's referral or a statement from the patient's doctor or dentist.

##### **b. Requests For Adjustments From CBC Providers**

If the request for an adjustment to patient pay to deduct a noncovered expense is made by a Medicaid CBC waiver service provider or case manager, the request must be accompanied by:

- 1) the recipient's correct Medicaid ID number;
- 2) the current physician's order for the non-covered service (not required for replacement of hearing aid batteries or eyeglass frames or for repair of hearing aids or eyeglasses);
- 3) actual cost information;
- 4) documentation that the recipient continues to need the equipment for which repair, replacement, or battery is requested; and
- 5) a statement of denial or non-coverage by other insurance. The denial may be from the insurance carrier or may be a written statement from the facility that the insurance company was contacted and the item/service is not covered.

If the request from a provider or case manager does not include all the above documentation, return the request to the provider or case manager asking for the required documentation.

## 5. Procedures

### a. Determine Deduction

Determine if the expense is deducted from patient pay using the following sequential steps:

- 1) Upon receipt of the requested documentation, determine the amount of the bill that is a valid deduction. Do not deduct more than the available income that remains after the personal needs, dependent child

If a noncovered service is already being deducted leaving no patient pay, and a new deduction for another noncovered service is requested, deduct the new noncovered services after the first noncovered service deductions have been completed.

- 2) Subtract the deduction for the current month. If the deduction exceeds the available income, the remaining balance can be carried over to the following month(s).

### b. Notice Procedures

Upon the final decision to allow the deduction, take the following actions:

- 1) Prepare a DMAS-122 for the adjusted patient pay obligation.
- 2) Copies of the DMAS-122 are:
  - filed in the case record,
  - sent to the LTC provider.
- 3) Prepare and send the "Notice of Obligation for LTC Costs" form to the patient (and the patient's representative, if appropriate). This form notifies the patient of the adjustment in the patient pay and the right to appeal the adjustment decision.

**6. CBC with  
Special  
Earnings  
Allowance**

**EXAMPLE #20: (Using January 2000 figures)**

Mr. R. lives in Group III and is approved by the screener for Medicaid CBC under a waiver with a special earnings allowance (see M1470.410.A.3). He applied for Medicaid on January 3. He has no spouse or dependent child. He has Medicare Parts A & B. He works 22 hours a week. His income is \$800 monthly SSA and \$2,000 gross earnings, which exceeds the CNNMP 300% of SSI limit.

His monthly countable earnings for January are determined:

\$2,000.00	gross earnings
<u>- 65.00</u>	exclusion
1,935.00	remainder
<u>- 967.50</u>	½ the remainder
\$ 967.50	countable earnings

His spenddown liability is calculated:

\$ 967.50	countable earnings
<u>+ 800.00</u>	SSA
1,767.50	total MN income
<u>- 20.00</u>	general income exclusion
\$1,747.50	countable income
<u>- 325.00</u>	MNIL for Group III
\$1,422.50	spenddown liability

He is placed on a 1-month spenddown for each month in the certification period of January 1 through December 31. On February 1, Mr. R. requests that his January spenddown be re-evaluated and he submits his medical bills. He received personal care services for 5 hours per day, seven days per week, on all days in January. The private rate for his care was \$100 per day. The private cost of care in January was \$3,100. Because the cost of care was greater than his spenddown liability, he met the spenddown in January by the cost of care alone. Mr. R is enrolled in Medicaid effective January 1 through January 31, eligibility Type 4. To determine his patient pay for January, the worker calculated his personal needs allowance first:

\$1,536.00	special earnings exclusion (M1470.410)
<u>+ 512.00</u>	basic personal allowance
\$2,048.00	personal maintenance allowance

His January patient pay is calculated as follows:

\$2,800.00	total gross monthly income
<u>-2,048.00</u>	personal maintenance allowance
<u>- 75.00</u>	health insurance premium paid on January 1
\$ 677.00	remaining income for patient pay for (January)

The worker compares the Medicaid rate for CBC waiver services of \$1,627.50 (155 hours in *January* multiplied by \$10.50 per hour) to the remaining income of \$677. Because the remaining income is less than the Medicaid rate, Mr. R's patient pay for *January* is \$677.

## M1470.800 COMPLETING THE DMAS-122 FORM

### A. Introduction

The DMAS-122 is the service provider's authorization to bill Medicaid for the patient's long-term care. The DMAS-122 form shows the provider how much of the cost of care is paid by the patient (patient pay). The patient pay amount will not be paid by Medicaid; the provider must collect the patient pay from the patient or his authorized representative.

### B. Purpose

Use the DMAS-122 to keep the provider informed on a current basis of the amount to be paid by or on behalf of the patient for care (the patient pay). The DMAS-122 must be completed and sent to the provider no later than 45 days from the date of application and 30 days from the date of a reported change.

The DMAS-122 is also used by the provider to inform the local DSS of a patient's admission to care, to request patient pay information and to inform the local DSS about changes in the patient's circumstances.

#### 1. When to Use

The EW completes the DMAS-122 at the time of eligibility determination and/or the recipient's entry into LTC. The EW must complete a new DMAS-122 when the recipient's eligibility status changes, when the recipient's Medicaid coverage is canceled or changed to limited coverage, such as QMB. The EW must update the DMAS-122 and send it to the provider or case manager whenever the patient's income or deductions change and must update the DMAS-122 at least every 12 months even if the patient's income and deductions do not change.

A currently dated DMAS-122 must be completed and sent to the provider or case manager when the annual redetermination is completed, if a DMAS-122 form was not sent to the provider or case manager within the past 12 months.

#### 2. Where to Send

##### a. Facility Patients

If the patient is in a nursing facility, ICF-MR, or chronic care hospital, send the DMAS-122 to the facility.

##### b. CBC Waiver Patients

- 1) For MR waiver recipients, send the DMAS-122 to the Community Services Board (CSB) Case Manager.
- 2) For Technology-Assisted Individuals waiver recipients, send the DMAS-122 to:

DMAS Case Manager  
 Technology Assisted Waiver Program  
 Division of Appeals & Long-term Care  
 DMAS  
 600 E. Broad Street  
 Richmond, VA 23219

- 3) For *EDCD* recipients who have chosen consumer-directed services, send the DMAS-122 to the Service Facilitator. For all other *EDCD* waiver recipients, follow the instructions in 4) below.
- 4) If the patient of any other waiver receives case management services, send the DMAS-122 to the Case Manager. If the patient does not receive case management services:
  - a) send the DMAS-122 to the personal care services provider *or adult day health care provider*.
  - b) If the patient *receives both* personal care and *adult day health care*, send the DMAS-122 to the *personal care provider*.
- 5) Except for Technology- Assisted Waiver patients, send a copy of the DMAS-122 to the DMAS Community-Based Care Unit **only upon request** from that unit. Upon request from the CBC Unit, send a copy of the DMAS-122 to that unit at the following address:

CBC Unit  
 DMAS Division of Appeals & Long-term Care  
 600 E. Broad Street  
 Richmond, VA 23219.

## M1470.810 MEDICARE PART A SNF COVERAGE

### A. Introduction

When a Medicaid recipient's skilled nursing facility (SNF) care is covered by Medicare Part A and/or a Medicare supplement policy, the DMAS-122 to the provider must note this information. The DMAS auditors will use the DMAS-122s when auditing the providers to ensure that DMAS has not duplicated the third party payments.

### B. Medicare Part A SNF Coverage

Medicare Part A will cover the first 100 days of skilled nursing facility (SNF) care when the patient is admitted to a SNF directly from a hospital. Medicare covers (pays) in full the first 20 days of SNF care. For the 21st through 100th day of SNF care, Medicare pays all but the daily Medicare coinsurance amount. Medicaid pays any Medicare coinsurance amount that remains after the patient pay for the month is deducted.

#### 1. QMB Only Recipients

For a QMB-only Medicaid recipient who remains QMB-only throughout the admission, Medicaid will cover the Medicare SNF coinsurance for the 21st through 100th day. Medicaid will NOT cover SNF care beyond 100 days for

a QMB-only recipient. Medicaid does not cover SNF care for the SLMB, QDWI, QI-1 or QI-2 covered groups.

When a QMB-only recipient is admitted and remains QMB-only throughout the admission, and Medicare covers the SNF care, the worker must determine patient pay for the month(s) in which the 21st through the 100th days occur, according to M1470.200 and M1470.310, and must send a DMAS-122 to the facility. When the QMB-only recipient has Medicare and Medicaid and no other insurance, check the box on the DMAS-122 "has Medicare Part A insurance". When the QMB-only recipient has other health insurance that supplements Medicare, check the boxes on the DMAS-122 "has Medicare Part A insurance" and "has other health insurance".

If the QMB-only recipient is admitted to a SNF and Medicare is NOT covering the care, send a DMAS-122 to the facility provider and check the box on the DMAS-122 "is eligible for QMB Medicaid only". Do not show any patient pay information on the DMAS-122.

## 2. All Other Recipients

For all Medicaid recipients except the ABD MI covered groups, Medicaid will cover the Medicare coinsurance for the 21st through the 100th day, and medically necessary SNF care after 100 days. The worker must determine patient pay for the month(s) in which the recipient is a patient in the facility, according to sections M1470.200 and M1470.310, and must send a DMAS-122 to the facility.

### a. Medicare & Medicaid Only

For Medicaid recipients who have Medicare Part A but no Medicare supplement or other health insurance, check the box on the DMAS-122 "has Medicare Part A insurance."

### b. Medicare and Medicare Supplement Health Insurance

For Medicaid recipients who have Medicare Part A and Medicare supplement or other health insurance that covers SNF care, check the boxes on the DMAS-122 "has Medicare Part A" and "has other health insurance".

## C. Example

**EXAMPLE #21:** A QMB-only Medicaid recipient from a Group III locality is admitted to a SNF directly from a hospital on June 4. He remains QMB-only because his resources exceed \$2,000 but are less than the \$4,000 QMB resource limit. He has a Medicare supplement health insurance policy. His only income is \$678 SSA. He is already on the Medicare Buy-in. The DMAS-122 for June and July is completed and the boxes stating the patient "is eligible for QMB Medicaid only", "has Medicare Part A" and "other health insurance" are checked. No patient pay information is entered.

1,400.00	total gross income
- 30.00	PNA (personal needs allowance)
-106.25	community spouse monthly income allowance
<u>-468.75</u>	family member's monthly income allowance
795.00	
-120.50	Medicare premium & health insurance premium
<u>- 200.00</u>	old bills
\$ 474.50	remaining income for patient pay ( <i>July</i> )

The facility's Medicaid per diem is \$50. The facility's Medicaid rate for *July* is \$1,550. Mrs. Bay's remaining income for patient pay is less than the Medicaid rate for *July*. Therefore, her patient pay for *July* is \$474.50.

Her patient pay for *August* is calculated as follows:

\$1,000.00	SSA
+ 400.00	private pension
1,400.00	total gross income
- 30.00	PNA (personal needs allowance)
- 106.25	community spouse monthly income allowance
<u>- 468.75</u>	family member's monthly income allowance
795.00	
-120.50	Medicare premium & health insurance premium
\$ 674.50	remaining income for patient pay ( <i>August</i> )

The facility's Medicaid per diem is \$50. The facility's Medicaid rate for *August* is \$1,550. Her remaining income for patient pay is less than the Medicaid rate for *August*; therefore, her patient pay for *August* is \$674.50.

Mrs. Bay's patient pay for *September* is calculated as follows:

\$1,000.00	SSA
+ 400.00	private pension
1,400.00	total gross income
- 30.00	PNA (personal needs allowance)
- 106.25	community spouse monthly income allowance
<u>- 468.75</u>	family member's monthly income allowance
795.00	
- 75.00	health insurance premium
\$ 720.00	remaining income for patient pay ( <i>September</i> )

The facility's Medicaid rate for *September* is \$1,550. Her remaining income for patient pay is less than the Medicaid rate for *July*; therefore, Mrs. Bay's patient pay for *September* is \$720.00. The worker completes a DMAS-122 showing her patient pay for *July, August and September* and sends it to the facility. The worker completes and sends a "Notice of Obligation" to Mr. Bay showing Mrs. Bay's patient pay for *July, August and September* and each month's patient pay calculation.

**M1480.440 MEDICALLY NEEDY PATIENT PAY****A. Policy**

When an institutionalized spouse has income exceeding 300% of the SSI payment level for one person, he is classified as medically needy (MN) for income eligibility determination. Because the 300% SSI income limit is higher than the MN income limits, an institutionalized spouse whose income exceeds the 300% SSI limit will be on a spenddown. He must meet the spenddown liability to be eligible for Medicaid as MN. See sections M1480.330, 340 and 350 above to determine countable income, the spenddown liability, and to determine when an institutionalized spouse's spenddown is met.

Section 1924 (d) of the Social Security Act contains rules which protect portions of an institutionalized spouse's income from being used to pay for the cost of institutional care. Protection of this income is intended to avoid the impoverishment of a community spouse. In order to insure that an institutionalized spouse will have enough income for his personal needs or maintenance allowance, the community spouse income allowance and the family members' income allowance, an institutionalized spouse who meets a spenddown is granted a full month's eligibility. The spenddown determinations are made monthly, retrospectively, after the month has passed and the expenses have actually been incurred. An institutionalized spouse's resources and income must be verified each month before determining if the spenddown has been met. When the spenddown is met, an institutionalized spouse's patient pay for the month is calculated.

**1. Patient Pay Deductions**

Medicaid must assure that enough of an institutionalized spouse's income is "protected" for his personal needs, the community spouse and family member's income allowances, and noncovered medical expenses, NOT including the facility or CBC cost of care.

**2. When Patient Pay Is Not Required**

Patient pay for medically needy recipients, a must be determined using the procedures and policy in this section UNLESS the institutionalized spouse is an IMD patient or an MR waiver services recipient. LTC services are not covered for medically needy IMD patients and medically needy MR waiver recipients; therefore, a patient pay determination is not required.

**B. MR/DD Waiver Recipients**

Patients receiving services under the MR Waiver *or* DD Waiver can be enrolled as medically needy although Medicaid coverage for MR *and* DD waiver services is not available to medically needy recipients (persons whose income exceeds 300% of the SSI payment limit for one person). If eligible as MN, these individuals receive all other Medicaid-covered services. The cost of the MR waiver services are deducted from the spenddown liability to determine eligibility.

**C. IMD Patients**

A patient in an IMD (Institution for Treatment of Mental Diseases) whose income exceeds 300% of the SSI payment limit for one person may be eligible for Medicaid as MN if he meets the spenddown liability. However, IMD care is NOT a covered service for:

## M1520.000 MEDICAID ELIGIBILITY REVIEW

### M1520.001 GENERAL PRINCIPLE

#### A. Policy

A Medicaid recipient's eligibility must be partially reviewed whenever the agency becomes aware of any change in the recipient's circumstances that might *affect the recipient's continued Medicaid eligibility*.

*An annual review of all of the recipient's Medicaid eligibility requirements is called a "renewal." A renewal of the recipient's eligibility must be completed at least once every 12 months.*

When a Medicaid recipient no longer meets the requirements for the covered group under which he is enrolled, the eligibility worker must evaluate the individual's eligibility in all other covered groups prior to canceling his Medicaid coverage.

*The recipient must be informed of the findings of partial reviews and renewals and the action taken. The Notice of Action is used to inform the recipient of continued eligibility and the next scheduled renewal. The Advanced Notice of Proposed Action is used to inform the recipient of a reduction in benefits or termination of eligibility.*

#### B. Procedures For Partial Review and Renewals

The policy and procedures in this subchapter are contained in the following sections:

- the requirements for partial reviews are in section M1520.100;
- the requirements for *renewals* are in section M1520.200;
- the policy and procedures for canceling a recipient's Medicaid coverage or reducing the recipient's Medicaid services (benefit package) are in section M1520.400;
- the policy and procedures for extended Medicaid coverage are in section M1520.500;
- the policy and procedures for transferring cases within Virginia are in section M1520.600.

**M1520.100 PARTIAL REVIEW****A. Recipient's  
Responsibility**

The recipient has a responsibility to report changes in his circumstances which may affect his eligibility, patient pay or HIPP premium payments within 10 days from the day the change is known.

**B. Eligibility  
Worker's  
Responsibility**

The eligibility worker has a responsibility for keeping a record of changes that may be anticipated or scheduled, and for taking appropriate action on those changes. The worker can set a follow-up review in the MMIS for anticipated changes. Examples of anticipated changes include, but are not limited to, the receipt of SSA benefits and the delivery date for a pregnant woman.

When changes in a recipient's situation are reported by the recipient or when the agency receives information indicating a change in a recipient's circumstances (i.e. SSI purge list, reported transfer of assets), the worker must take action to partially review the recipient's continued eligibility. A reported increase in income and/or resources can be acted on without requiring verification. When a reported change causes the individual to move from a limited-benefit covered group to a full-benefit covered group the reported change must be verified.

A HIPP Application and Medical History Questionnaire must be completed when it is reported that a member of the assistance unit is employed more than 30 hours per week *and is eligible for coverage under an employer's group health plan*. The eligibility worker must report to the HIPP Unit at DMAS any changes in a recipient's situation that may affect the premium payment.

**C. Time Standard**

Appropriate agency action on a reported change must be taken within 30 days of the report.

**D. Covered Group  
Changes****1. Newborn  
Child**

When a child is born to a Medicaid-eligible woman (including an emergency services alien certified for Medicaid payment for labor and delivery), the only information needed to enroll the child in Medicaid (Child Under One covered group) is the child's name, gender and date of birth and that the child is living with the mother. This information may be reported through any reliable means, such as the hospital where the child was born, the medical practitioner, or the mother's managed care organization. The agency may not require that only the mother make the report.

programs. The agency has ready access to Food Stamp and TANF records, some wage and payment information, information from SSA through the SVES, SDX and Bendex, and child support and child care files. Income verification less than 6 months old can be used unless the agency has reason to believe it is no longer accurate.

*When the recipient has reported that he has no income (\$0 income), the recipient must be given the opportunity to report income on a renewal form. Do not complete an ex parte renewal when the recipient has reported \$0 income.*

The renewal for an SSI recipient who has no countable real property can be completed by verifying continued receipt of SSI through SVES and documenting the case record. The ex parte process cannot be used for an SSI recipient who owns non-exempt real property. He is subject to a resource evaluation and the agency has no internal means to verify all his resources.

When an ongoing F&C Medicaid recipient applies for Food Stamps or TANF, the income information obtained for the application can be used to complete an early Medicaid renewal and extend the Medicaid renewal to coincide with the Food Stamp certification period. However, failure to complete an early renewal must not cause ineligibility for Medicaid.

**The recipient is not required to complete and sign a renewal form when all information necessary to redetermine Medicaid eligibility can be obtained through an ex parte renewal process.**

## **2. Medicaid Renewal Form**

When a Medicaid Renewal form is required, the form must be sent to the recipient no later than the 11<sup>th</sup> month of eligibility. The Medicaid Renewal form can be completed by the worker and sent to the recipient to sign and return or can be mailed to the recipient for completion. The eligibility worker must allow at least 10 days for receipt of the necessary verifications, but additional time may be allowed depending on the type of information requested. The specific information requested and the deadline for receipt of the verification must be documented.

If information necessary to redetermine eligibility is not available through on-line information systems available to the agency and the recipient has been asked, but failed to provide the information, the renewal must be denied and the coverage cancelled due to the inability to determine continued eligibility.

## **C. Special Requirements for Certain Covered Groups**

### **1. Pregnant Woman**

A renewal of eligibility of an MI pregnant woman is not required during her pregnancy. Cancel her coverage as a pregnant woman effective the last day of the month in which the 60<sup>th</sup> day following the end of her pregnancy occurs. Reinstate coverage in the Family Planning Services (FPS) limited-coverage group effective the first day of the following

month unless information available to the agency establishes her eligibility in a full-benefit covered group. Do not use change transactions to move an individual between full and limited coverage

2. **FPS**

The Medicaid eligibility of women in the FPS covered group must be evaluated 12 months following the end of the pregnancy. If eligible in a full-benefit covered group, cancel her FPS coverage in the MMIS using cancel code “008” effective the last day of the month prior to the month of eligibility for full coverage, and reinstate full coverage the first day of the month of eligibility for full coverage. If eligible only for FPS, she is entitled to an additional 12 months of FPS coverage.

3. **Newborn  
Child Turns  
Age 1**

*A renewal for a child enrolled as a Newborn Child Under Age 1 must be done before MMIS cut-off in the last month in which the child meets the Newborn Child Under Age 1 covered group and must include:*

- *an application (see M0120.300)*
- *SSN or proof of application*
- *verification of income*
- *verification of resources for the MN child.*

4. **Child Under  
Age 19  
(FAMIS Plus)**

The Medicaid eligibility of children in the MI Child Under Age 19 (FAMIS Plus) covered group must be renewed at least once every 12 months.

When an enrolled MI child no longer meets the MI income limits, evaluate the child for the Family Access to Medical Insurance Security Plan (FAMIS) using the eligibility requirements in chapter M21. If the child is eligible for FAMIS, send the family an Advance Notice of Proposed Action that Medicaid will be cancelled effective the last day of the month in which the 10-day advance notice expires and the FAMIS coverage will begin the first day of the month following the Medicaid cancellation. Use cancel reason “042” when the child loses eligibility in Medicaid and is enrolled in FAMIS and there is no break in coverage. **Do not use change transactions to move a child between Medicaid and FAMIS.** If the child is not eligible for FAMIS, the worker must provide an opportunity for the child to be evaluated as medically needy prior to sending an advance notice and canceling the child’s Medicaid coverage

5. **MI Child  
Turns Age 19**

When an MI child turns age 19, redetermine the child's continuing Medicaid eligibility in other covered groups.

If the child does not meet a definition for another covered group, send an advance notice and cancel the child's Medicaid coverage because the child does not meet a Medicaid covered group.

6. **Child Turns  
Age 21**

When a recipient who is enrolled as a child under age 21 attains age 21, determine if the recipient meets the definition for another covered

**M1520.400 MEDICAID CANCELLATION OR SERVICES REDUCTION****M1520.401 NOTICE REQUIREMENTS****A. Policy**

Following a determination that eligibility no longer exists or that the recipient's Medicaid services must be reduced, the "Advance Notice of Proposed Action" must be sent to the recipient at least 10 days plus one day for mail, before action is taken to cancel or reduce Medicaid coverage. *If the action to cancel or reduce benefits cannot be taken in the current month due to MMIS cut-off, then the action must be taken by MMIS cut-off in the following month. The "Advance Notice of Proposed Action" must inform the recipient of the last day of Medicaid coverage.*

**B. Change Results in  
Adverse Action****1. Services  
Reduction**

When information is secured that results in a reduction of Medicaid services to the recipient or a reduction in the Medicaid payment for the recipient's services (when the patient pay increases), the "Advance Notice of Proposed Action" must be sent to the recipient at least 10 days plus one day for mail, before the adverse action is taken. The adverse action must not be taken, however, if the recipient requests an appeal hearing before the effective date of the action. The DMAS Chief Hearing Officer notifies the local agency of whether the appeal was filed before the action date.

If the recipient requests an appeal hearing before the effective date, the recipient may choose to have eligibility continued at the current level of services until a decision is reached after a hearing. In the event the decision is adverse to the recipient, the amount Medicaid paid on the services being appealed that were received by the recipient during the continuation is subject to recovery by the Department of Medical Assistance Services (DMAS).

Medicaid coverage at the prior level is not continued when a request for appeal is filed on or after the effective date of the action.

**2. Adverse  
Action  
Resulting from  
Computer  
Matches**

When adverse action is taken based on information provided by computer matches from any source, such as IEVS, the Virginia Employment Commission (VEC) or SAVE, notice must be mailed at least ten (10) days before the effective date of the action, excluding the date of mailing and the effective date.

**M1520.600 CASE TRANSFERS**

- A. Introduction** Applications and ongoing cases are transferred only when the individual retains residence in Virginia.
- B. Nursing Facility and Assisted Living Facility (ALF)**
- When an applicant/recipient is admitted to a nursing facility or an ALF from a community living arrangement, the case is not transferred, but remains with the Virginia locality in which the individual last lived outside of an institution. Community living arrangements do not include medical facilities, ALFs or group homes with four or more beds.
- When an applicant/recipient is discharged from a nursing facility or ALF to a community living arrangement not in the Virginia locality that had responsibility for the individual's case while he was in the nursing facility or ALF, the case is transferred to the new locality.
- C. DMHMRSAS Facilities** The procedures for transfer of Medicaid cases of ABD patients admitted to or discharged from DMHMRSAS facilities are in subchapter M1550. F&C cases are not transferred.
- D. DMAS Medicaid Unit (FAMIS Plus Unit) FIPS 976**
- The Medicaid cases approved by the DMAS Medicaid unit, FIPS 976, must be transferred to the local agency where the recipient lives. The receiving agency must confirm receipt of the case by completing the Case Record Transfer Form and returning the copy to the DMAS Medicaid unit. Cases from the DMAS Medicaid unit do not require a re-evaluation until the annual renewal is due.
- Medicaid cases are not transferred from local agencies to FIPS 976.
- E. Locality to Locality**
- When a Medicaid applicant/recipient (including a Medicaid CBC waiver services recipient) moves from one locality to live in a community living arrangement (not a medical facility, an ALF, or a group home with 4 or more beds) in another locality within the State of Virginia, the following procedures apply:
- 1. Sending Locality Responsibilities**
- The sending locality must *make certain the case is current and complete before transferring the case. If the annual renewal has been completed within the past 11 months, a partial review based on known information, as to whether or not the recipient will meet a covered group and the income and resource limits in the new locality, must be completed.*
- If the annual renewal is due, it must be completed if an ex parte renewal can be done; however, if an ex parte renewal cannot be done, do not delay transferring the case. Send the Medicaid Renewal form to the recipient with instructions to return it to the local agency in the new locality and note the pending renewal on the Case Record Transfer Form.*
- If the *annual renewal or the partial review* finds that eligibility no longer exists, the agency must take the necessary action, including advance notice to the individual, to cancel coverage and to cancel the case in the MMIS.

If the *renewal or the* partial review indicates that the recipient will continue to be eligible for Medicaid in the new locality, the sending locality must update the MMIS that the new locality can accept the case for transfer. The sending locality must prepare the "Case Record Transfer Form" and forward it, with the case record, to the department of social services in the new locality of residence.

Pending applications must be transferred to the new locality for an eligibility determination.

Foster care and adoption assistance Medicaid cases are not transferred unless custody or responsibility for services and/or payment is transferred.

The eligibility record must be sent by certified mail, delivered personally and a receipt obtained or at the agency's discretion the case may be sent via the courier pouch.

**2. Receiving  
Locality  
Responsibilities**

The receiving agency must confirm receipt of the case by completing the Case Record Transfer Form and returning the copy to the sending agency.

When a pending application is transferred, the receiving agency makes the eligibility determination and takes all necessary action, including sending the notice and enrolling eligible individuals in the MMIS.

**F. Spenddown Cases**

Cases in spenddown status (denied or canceled and placed on a spenddown) must be transferred when the applicant notifies the agency that he/she has moved to a new Virginia locality.

**1. Sending  
Locality  
Responsibilities**

Within 10 working days of notification that the applicant has moved, the case must be transferred to the new locality, using the "Case Record Transfer Form." The sending agency must:

- inform the applicant of the receiving agency's name, address, and telephone number;
- deduct all known spenddown items from the spenddown balance on the worksheet before sending the case record;
- note the spenddown period and balance on the case transfer form.

**2. Receiving  
Locality  
Responsibilities**

The receiving locality logs the case record on file, but does not open it statistically. The receiving locality must review the spenddown to determine if a recalculation based on a different income limit is required.

If the spenddown is met, the application is recorded statistically as taken, approved, and added to the caseload at that time.

Commonwealth of Virginia
Department of Social Services (DSS)
Medicaid Program

MEDICAID RENEWAL

DATE MAILED
DSS WORKER
DSS WORKER TELEPHONE
LOCAL AGENCY ADDRESS
CASE NUMBER

Name: Address:

Please answer questions where the block is checked. If you have any questions or need help completing the form, please call the worker listed above. Please return this form to your eligibility worker by:

1. Has anyone moved into or out of your household since your last eligibility determination?
No Yes If yes, tell us who moved in and who moved out.

2. List all the income received during the past month and attach proof. Include income from sources such as wages, support, disability, retirement, Veteran's benefits, unemployment, rental property, etc.

Table with 3 columns: Who Receives Income, Source, Amount. Includes dollar signs and blank lines for entry.

3. Do you have child care expenses? No Yes If yes, list child and child care costs.

4. If you have a child under age 19 who is working, is your child still in school? No Yes

5. Have you had a change in your health insurance since your last eligibility determination?
No Yes If yes, list the company, coverage type, policy number and explain change.

6. Do you or anyone for whom your are applying have any resources such as bank accounts, vehicles, life insurance, burial arrangements and/or real property? No Yes If yes, list each resource and attach proof of the current value. Have you sold or given away any resources? No Yes If yes, explain what you sold or gave away, the date you did this, and what you received in return.

I have given true and correct information on this form to the best of my knowledge and belief. I understand that if I give false information, withhold information, or fail to report a change, I may be breaking the law and could be prosecuted. I authorize DSS and the Department of Medical Assistance Services (DMAS) to obtain any information needed to review my eligibility.

Signature of Recipient or Authorized Representative

Date

Relationship to Recipient

Telephone Number

Voter Registration. Check one of the following:

- ( ) I am not registered to vote where I currently live, and I would like to register to vote here today. I certify that a voter registration form was given to me to complete. (If you would like help in filling out the voter registration, we will help you. The decision to have us help you is yours. You also have the right to complete your form in private.)
( ) I am registered to vote at my current address. (If already registered at your current address, you are not eligible to register to vote.)
( ) I do not want to apply to register to vote.
( ) I do want to apply to register to vote. Please send me a voter registration form.

Applying to register or declining to register to vote will not affect the assistance or services that you will be provided by this agency. A decision not to apply to register to vote will remain confidential. A decision to apply to register to vote and the office where your application was submitted will also remain confidential and may only be used for voter registration purposes. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register to

## Medicaid Renewal

FORM NUMBER - 032-03-669

PURPOSE AND USE OF FORM - To report information needed to complete Medicaid renewal.

NUMBER OF COPIES - One.

DISPOSITION OF FORM - The completed form is to be retained in the case file.

INSTRUCTIONS FOR PREPARATION OF FORM – If the form is mailed, it must be sent to the recipient no later than the 11<sup>th</sup> month of eligibility. The form may be completed by an agency representative during a telephone interview and sent to the recipient for a signature or mailed to the recipient for completion. The form may also be completed by the client during an in-office interview although a face-to-face interview is not required.

Verification of income or resources will normally be required.

Upon completion of the form, the EW must evaluate the information to determine continued eligibility for Medicaid. Recipient must be sent notice of action on the renewal.

If the form is completed and returned to the agency timely and additional information and/or verification is needed, the recipient must be notified in writing of the information and/or verification needed. If the household does not complete and return the form by VaMMIS cut-off in the 12<sup>th</sup> month of eligibility, the agency must send the Advance Notice of Proposed Action to close the case effective at the end of the 12<sup>th</sup> month.

- dental only or vision only insurance;
- specified disease insurance;
- hospital confinement indemnity coverage;
- limited benefit health coverage;
- coverage issued as a supplement to liability insurance;
- insurance arising out of workers' compensation or similar law;
- automobile medical payment insurance; or
- insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

**5. Insured** means having creditable health insurance coverage or coverage under a health benefit plan.

**6. Uninsured** means having no insurance; having insurance that is not creditable; having coverage which is not defined as a health benefit plan, or having a health insurance plan that does not have a network of providers in the area where the child resides.

**C. Policy** A nonfinancial requirement of FAMIS is that the child be uninsured. A child **cannot**:

- have creditable health insurance coverage;
- have coverage under a group health plan (*TRICARE*, federal employee benefit plan, private group insurance such as *Anthem*, etc.);
- be a member of a family eligible for health benefits coverage under a State Employee Health Insurance Plan (a full-time, salaried, classified State employee or a permanent, full-time, salaried State education institution faculty member) [see Appendix 3 to this chapter];
- be a member of a family eligible for health benefits coverage on the basis of a family member's employment with a public agency in the State that participates in the Local Choice Program and the employer contributes to the cost of dependent health insurance (see Appendix 2 to this chapter), or
- without good cause, have had creditable health insurance coverage terminated within 4 months prior to the month of application.

Good cause reasons are listed in E. below.

**D. Health  
Insurance  
Coverage  
Discontinued**

A child is ineligible for FAMIS coverage if his creditable health insurance coverage was terminated without good cause within 4 months prior to the month for which eligibility is being established.

**Example:** A child's health insurance was terminated without good cause in November. A FAMIS application was filed the following February. The child is ineligible for February because his health insurance was terminated within 4 months of November. He may be eligible in March because his insurance was terminated more than 4 months prior to March.

NOTE: For purposes related to FAMIS eligibility, a child is NOT considered to have been insured if health insurance coverage was provided under Medicaid, HIPP, FAMIS, or if the insurance plan covering the child does not have a network of providers in the area where the child resides.

**E. Good Cause for  
Dropping Health  
Insurance**

The ineligibility period can be waived if there is good cause for the discontinuation of the health insurance. A parent, guardian, legal custodian, authorized representative, or adult relative with whom the child lives may claim to have good cause for the discontinuation of the child(ren)'s health insurance coverage. The local agency will determine that good cause exists and waive the period of ineligibility if the health insurance was discontinued for one of the following reasons:

- The family member who carried insurance changed jobs or stopped employment, and no other family member's employer contributes to the cost of family health insurance coverage. Verification is not required.
- The employer stopped contributing to the cost of family coverage and no other family member's employer contributes to the cost of family health insurance coverage. Verification is not required.
- The child's coverage was discontinued by an insurance company for reasons of uninsurability, e.g. the child has used up lifetime benefits or the child's coverage was discontinued for reasons unrelated to payment of premiums. Verification is required from the insurance company.
- Insurance was discontinued by a family member who was paying the full cost of the insurance premium under a COBRA policy AND no other family member's employer contributes to the cost of family health insurance coverage. Verification is not required.
- Insurance on the child is discontinued by someone other than the child (if 18 years of age), or, if under age 18, the child's parent or stepparent, e.g. the insurance was discontinued by the child's grandparent, aunt, uncle, godmother, etc. Verification is not required.
- Insurance on the child is discontinued because the cost of the *health insurance premiums for all family members* exceeds 10% of the family's GROSS monthly income or exceeded 10% of the family's GROSS monthly income at the time the insurance was discontinued.

Documentation of the amount of the monthly *health insurance* premiums *for all family members* is required. If the amount of the premium is less than or equal to 10% of the family's current gross monthly income, a declaration from the family will be requested as to the amount of gross monthly income received at the time the *child(ren)*'s insurance was discontinued.

1. Use the applicant's month-prior-to-application gross income verification.
2. Calculate 10% of the family's gross monthly income.
3. Compare to *total amount of* monthly premiums.
4. If monthly premium is less than or equal to 10% of current gross monthly income:
  - a. Ask applicant "what was your family's gross income in the month in which you discontinued the health insurance (include all amounts of income received in that month)?" Document the applicant's statement in the record.
  - b. Calculate 10% of the family's gross monthly income (in the month in which the insurance was discontinued).
  - c. Compare to *total amount of* monthly premiums.
    - 1) If monthly premiums *are* less than or equal to 10% of this gross monthly income, good cause is NOT met. The children are not eligible for 4 months following the discontinuance of the insurance.
    - 2) If monthly premiums *are* more than 10% of this gross monthly income, good cause is met and there is no waiting period for FAMIS.
5. If monthly premiums *are* more than 10% of current gross monthly income, good cause is met and there is no waiting period for FAMIS.

## M2120.300 NO CHILD SUPPORT REQUIREMENTS

A. Policy There are no child support requirements for FAMIS.

## M2130.100 FINANCIAL ELIGIBILITY

### A. Financial Eligibility

1. **FAMIS Assistance Unit**

The FAMIS assistance unit consists of:

- the child applicant under age 19;
- the parent(s) and stepparent who live in the home with the child; and
- any siblings, half-siblings, and stepsiblings under age 19 who live in the home with the child.

NOTE: Medicaid family/budget unit rules do not apply to FAMIS. A child who is pregnant is counted as 1 individual; DO NOT COUNT the unborn child.

2. **Asset Transfer**

Asset transfer rules do not apply to FAMIS.

3. **Resources**

Resources are not evaluated for FAMIS.

4. **Income**

The FAMIS income limit is 200% of the FPL (see Appendix 1 to this chapter) for the number of individuals in the FAMIS assistance unit.

The source and amount of all income other than Job Training Partnership Act (JPTA), Workforce Investment Act, and student income must be verified and counted. FAMIS uses the same income types and methods for estimating income as Medicaid (see chapter M07). There are no income disregards and no budget units in FAMIS.

5. **Spenddown**

Spenddown does not apply to FAMIS. If the family's gross income exceeds the FAMIS income limits, the child is not eligible for the FAMIS program regardless of medical expenses.

## M2140.100 APPLICATION and CASE PROCEDURES

A. **Application Requirements**

The Application for Children's Health Insurance in Virginia (see Appendix 4) is the application form for FAMIS. The Application for Benefits or the ADAPT Statement of Facts *are also acceptable application/renewal forms* for FAMIS.

<p align="center"><b>FAMILY ACCESS TO MEDICAL INSURANCE SECURITY PLAN (FAMIS) INCOME LIMITS ALL LOCALITIES EFFECTIVE 2/??/05</b></p>				
<p># of Persons in FAMIS Assistance Unit</p>	<p>FAMIS 150% FPL</p>		<p>FAMIS 200% FPL</p>	
	<p>Annual Limit</p>	<p>Monthly Limit</p>	<p>Annual Limit</p>	<p>Monthly Limit</p>
1	<i>\$13,965</i>	<i>\$1,164</i>	<i>\$18,620</i>	<i>\$1,552</i>
2	<i>18,735</i>	<i>1,562</i>	<i>24,980</i>	<i>2,082</i>
3	<i>23,505</i>	<i>1,959</i>	<i>31,340</i>	<i>2,612</i>
4	<i>28,275</i>	<i>2,357</i>	<i>37,700</i>	<i>3,142</i>
5	<i>33,045</i>	<i>2,754</i>	<i>44,060</i>	<i>3,672</i>
6	<i>37,815</i>	<i>3,152</i>	<i>50,420</i>	<i>4,202</i>
7	<i>42,585</i>	<i>3,549</i>	<i>56,780</i>	<i>4,732</i>
8	<i>47,355</i>	<i>3,947</i>	<i>63,140</i>	<i>5,262</i>
each add'l person add	<i>4,770</i>	<i>398</i>	<i>6,360</i>	<i>530</i>