



COMMONWEALTH of VIRGINIA

DEPARTMENT OF SOCIAL SERVICES

July 1, 2007

MEDICAID MANUAL – VOLUME XIII

TRANSMITTAL #87

The following acronyms are used in this transmittal:

- ADAPT – Application Benefit Delivery Automation Project
- ABD – Aged, Blind, Disabled
- BCCPTA – Breast and Cervical Cancer Prevention and Treatment Act
- CBC – Community-based Care
- CMS – Centers for Medicare and Medicaid Services
- DMAS – Department of Medical Assistance Services
- F&C – Families and Children
- FAMIS – Family Access to Medical Insurance Security Plan
- FPL – Federal Poverty Level
- HIPP – Health Insurance Premium Payment
- ICAMA – Interstate Compact for Adoption and Medical Assistance
- ICF-MR – Intermediate Care Facility for the Mentally Retarded
- LDSS – Local Department of Social Services
- LIFC – Low-income Families with Children
- LTC – Long-term Care
- MI – Medically Indigent
- MN – Medically Needy
- QI – Qualified Individuals
- SOLQ-I – State Online Query Internet
- SSDI – Social Security Disability Insurance
- SSI – Supplemental Security Income

Medicaid Transmittal #87 contains new and revised Medicaid eligibility policy as outlined within this letter.

New Policy

This transmittal includes the procedures for enrolling eligible individuals in MEDICAID WORKS, which were posted in Broadcast 4229. MEDICAID WORKS is the Medicaid buy-in program

available to eligible disabled working individuals that allows Medicaid coverage to be retained as long as the individuals' earned income does not exceed 200% of the FPL.

Policy has been added regarding the treatment of Worker's Compensation Medicare Set-aside Arrangement accounts. These arrangements are approved by CMS and stipulate that settlements paid on an individual's Worker's Compensation claim for a work-related injury are to offset the amount that Medicare will pay for treatment of an individual's work-related injury. Funds paid under these arrangements are considered countable income in the month of receipt, and any amount retained after the month of receipt is a resource.

Revised Policy

Transmittal #87 contains the changes in the policy on newborns of emergency services alien mothers that were published in Broadcast 4163. Newborns born to emergency services alien mothers who were determined eligible for Medicaid on the date of the children's births meet the "child under age 1" covered group as long as the children live with their mothers and are under the age of one. No application is required for these newborns and the special birth verification procedures for these newborns contained in Medicaid Transmittal #86 have been deleted.

This transmittal includes several revisions to the policies on the documentation of citizenship and identity that were previously implemented in the Citizenship and Identity Procedures posted on the Local Agency Intranet and published in Broadcast 4090. The revisions include a clarification of the reasonable opportunity period for individuals who are making a good faith effort to obtain documentation of citizenship and/or identity. The list of individuals who are exempt from the citizenship and identity documentation requirements has been revised to include additional groups. In addition to Medicare beneficiaries and SSI recipients, recipients of SSDI and all foster care children are now exempt, as are Title IV-E Adoption Assistance children. Non-IV-E (state and local) Adoption Assistance children are not exempt from the requirements at this time.

The 2007 Virginia General Assembly approved an increase in the personal needs allowance deducted from the LTC patient pay for individuals in nursing facilities from \$30 per month to \$40 per month. This change will result in an increase in the amount of income that individuals in nursing facilities and ICF-MRs may retain to meet their personal needs. Patient pay for individuals in nursing facilities must be adjusted for July to account for the increased personal needs allowance. A new DMAS-122 is to be completed for these individuals and mailed to the provider, and a new Notice of Obligation is to be sent to the enrollee or authorized representative. Please refer to [M1470.900](#) of the Medicaid Eligibility Manual for additional information on adjusting the patient pay.

Other revisions to policy regarding individuals in LTC include a reorganization of the asset transfer policy in subchapter M1450. Additional examples of how to calculate a penalty period and a flow chart for determining the policy that applies to an asset transfer have been added. A section on Services Contracts has also been added. In subchapter M1480, the procedures for claiming undue hardship when an applicant cannot complete a resource assessment have been revised.

The income limit for the FAMIS MOMS Program is revised in this transmittal. The 2007 Virginia General Assembly approved an increase in the FAMIS MOMS income limits from 166% of the FPL to 185% of the FPL, effective July 1, 2007.

Clarifications

Clarifications to policy contained in this transmittal include the following:

- Application and eligibility policy for Title IV-E and Non-IV-E Adoption Assistance children from other states;
- Pursuit of medical support;
- HIPPA policy and procedures;
- Hospice services and the Hospice covered group;
- The treatment of fluctuating income and the child care deduction for F&C eligibility determinations;
- The treatment of alleged equitable ownership of real property and retirement funds for ABD eligibility determinations;
- Retroactive and ongoing eligibility for CBC recipients;
- Notice requirements for partial reviews, Quality Control reviews, and renewals; and
- Procedures for cancelling coverage when an enrollee is deceased.

Updates

This transmittal contains the ABD, F&C MI, and FAMIS income limits that were previously announced in Broadcast 4081. The income limits were effective January 24, 2007 for individuals without Social Security income and those being evaluated for FAMIS, and March 1, 2007 for Social Security recipients. This transmittal also contains the July 1, 2007, increases in the LIFC 185%, F&C and MN income limits and the LTC monthly maintenance needs standard and excess shelter standard. The income limits will be updated in ADAPT as appropriate.

The revised income and resource limits, as well as the cost sharing amounts, for Extra Help Medicare Part D low-income subsidy have been included in this transmittal. The Social Security Administration determines eligibility for Extra Help for the vast majority of applicants who are not deemed eligible for Extra Help on the basis of eligibility for Medicaid. While it is unlikely that LDSS staff will need to determine eligibility for Extra Help, LDSS are reminded that an individual may ask for eligibility to be determined by the LDSS.

Effective Date

Unless otherwise specified in this transmittal letter, the new policy, policy revisions, clarifications, and updates contained in this transmittal are effective for all eligibility determinations completed on or after July 1, 2007.

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Subchapter M0120 Table of Contents pages 5-8	Subchapter M0120 Table of Contents pages 5-8a Appendix 3	Updated the Table of contents. Page 5 is reprinted. On pages 6 and 7, revised the application policy for Non-Title IV-E Adoption Assistance children. Pages 8 and 8a are runover pages. Added Appendix 3, the list of ICAMA Member States and Reciprocity.
Subchapter M0130 pages 3-6	Subchapter M0130 pages 3-6	On page 3, changed the order of text in M0130.100 C. On pages 4 and 5, deleted section B.1 regarding

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Significant Changes

Subchapter M0210
pages 3, 4

Subchapter M0210
pages 3, 4

required verification procedures for newborns of emergency services alien mothers. Page 6 is a runover page.

On page 3, clarified that an uncompensated asset transfer causes ineligibility for the Medicaid payment of long-term care services only. On page 4, revised the text in M0210.150 C. to improve its clarity.

Subchapter M0220
Table of Contents
pages 1, 2
pages 4a-4d
pages 4i-4p

Subchapter M0220
Table of Contents
pages 1, 2
pages 4a-4d
pages 4i-4p

Updated the Table of Contents. On pages 1, 4b, 4d, 4i and others in this transmittal, replaced the abbreviation “U.S.” with “United States.” On page 2, clarified the exceptions to the citizenship verification policy for SSDI beneficiaries, foster care children and Title-IV-E Adoption Assistance children; non-Title IV-E adoption assistance children must verify citizenship. On page 4a, corrected the spelling of “identification” in section D. On page 4c, added plastic birth cards to the public birth records that are valid citizenship verification documents. On page 4j, clarified the identity rules for foster care children and the identity affidavit, and clarified section D.1. Page 4k is reprinted. On page 4l, added birth certificates viewed by another state’s agency, and added the SOLQ-I verification system to SSI and Medicare beneficiaries. On pages 4m and 4n, clarified the reasonable opportunity policy. On page 4o, clarified the reporting requirements. Page 4p is a runover page.

Subchapter M0250
pages 3, 4

Subchapter M0250
pages 3, 4

On pages 3 and 4, clarified the pursuit of medical support policy.

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Subchapter M0280 pages 1, 2	Subchapter M0280 pages 1, 2	On page 1, added reference to assistance unit policy for institutionalized children. Page 2 is reprinted.
Subchapter M0290 pages 1-4	Subchapter M0290 pages 1-4	On pages 1-4, clarified the referral process for the HIPPP Program.
Chapter M03 Table of Contents	Chapter M03 Table of Contents	Updated the Chapter M03 Table of Contents.
Subchapter M0310 pages 3, 4 pages 11, 12 pages 29, 30 pages 35, 36 page 39	Subchapter M0310 pages 3, 4 pages 11, 12 pages 29, 30 pages 35, 36 page 39	On page 3, deleted the reference to the obsolete QI-2 covered group. On page 4, updated the reference to aid categories. On page 11, deleted the word “deprived” from the definition of dependent child. Pages 12 and 29 are reprinted. On page 30, clarified that hospice services may be provided in a nursing facility. Page 35 is reprinted. On Page 36, clarified that verifications of pregnancy from physicians, nurses and similar health practitioners are acceptable. On page 39, revised the age range for women in the BCCPTA covered group.
Subchapter M0320 pages 31-34 pages 45-46f pages 65-68	Subchapter M0320 pages 31-34 pages 45-46f pages 65-68	On pages 31, 32, and 33, clarified that an individual enrolled in the ABD Hospice covered group cannot be eligible in any other full coverage group. On page 34, revised the aid category numbers. On page 45, clarified that SSI recipients meet the income requirements for MEDICAID WORKS. On page 46, clarified the description of a WIN Account. On pages 46a-46c, clarified the policy on excluded resources. On pages 46d-46e, added procedures for enrolling individuals into MEDICAID WORKS. On page 46f, clarified that a newborn child born to a mother eligible for

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Subchapter M0530 pages 17, 18	Subchapter M0530 pages 17, 18	Medicaid payment of emergency services only is a certain newborn. Pages 65 and 67 are reprinted. On pages 66 and 68, clarified that an individual enrolled in the F&C Hospice covered group cannot be eligible in any other full coverage group. On pages 17 and 18, corrected the lettering on the column headings.
Subchapter M0710 pages 5, 6 Appendix 1 Appendix 3 Appendix 5 Appendix 6 Appendix 7	Subchapter M0710 pages 5, 6 Appendix 1 Appendix 3 Appendix 5 Appendix 6 Appendix 7	Page 5 is reprinted. On page 6, added policy for averaging fluctuating income. In Appendix 1, updated the LIFC 185% of standards of need. In Appendix 3, updated the F&C monthly income limits. In Appendix 5, updated the MN income limits. In Appendix 6, updated the MI income limits. In Appendix 7, updated the Twelve Month Extended income limits.
Subchapter M0720 pages 3-6 pages 17-19	Subchapter M0720 pages 3-6 pages 17-19	Pages 3, 5, 6, 17 and 19 are runover pages. On page 4, added policy to limit averaging income to 3 months. On page 18, clarified the exclusion for child or incapacitated adult care expenses.
Subchapter M0810 pages 1, 2	Subchapter M0810 pages 1, 2	Page 1 is reprinted. On page 2, updated the MI and MN income limits.
Chapter S11 Table of Contents	Chapter S11 Table of Contents	Updated the Table of Contents.
Subchapter S1110 pages 9, 10 pages 15, 16	Subchapter S1110 pages 9, 10 pages 15, 16	Pages 9 and 16 are reprinted. On page 10, clarified the definition of current market value. On page 15, clarified the explanation of equitable home ownership.
Subchapter S1120 pages 25, 26	Subchapter S1120 pages 25, 26	On page 25, added a subsection on the development and

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Subchapter S1140 Table of Contents pages 32a-34	Subchapter S1140 Table of Contents, pages i-ii pages 32a, 32b pages 33, 34	documentation of a retirement fund. Page 26 is reprinted. Updated the Table of Contents. Page 32 a is reprinted. Page 32b is a runover page. On page 33, added new section on Workers' Compensation Medicare Set-aside Arrangement accounts. Page 34 is reprinted.
Chapter S11 Appendix 1, pages 5-6 Appendix 2, pages 5-6	Chapter S11 Appendix 1, pages 5-6 Appendix 2, pages 5-6	Appendix 1, page 5 is reprinted. On Appendix 1, page 6, clarified the explanation of equitable home ownership. On Appendix 2, page 5, clarified the explanation of equitable home ownership. Appendix 2, page 6 is reprinted.
Subchapter M1410 pages 1, 2 pages 13-16a	Subchapter M1410 pages 1, 2 pages 13-16a	On page 1 and 2, clarified that an individual who was screened and approved for CBC must begin receiving Medicaid-covered CBC within 30 days. Page 13 is reprinted. On page 14, clarified that an invalid application is not entered into MedPend. Page 15 is a runover page. On pages 16 and 16a, clarified that for retroactive coverage, the individual must have received care in a medical institution for at least 30 days.
Subchapter M1450 Table of Contents pages 1-40 Appendix 1	Subchapter M1450 Table of Contents pages 1-43 Appendix 1 Appendix 4, pages 1-3	Updated the Table of Contents. On page 1, clarified that the asset transfer policy also applies to recipients. On page 2, added an adequate compensation definition. On page 3, clarified the income and institutionalized individual definitions. On page 4, clarified the legally binding contract definition. On page 5, clarified that the policy also applies to renewals and changes; clarified the payment foreclosed definition. On page 6, clarified the uncompensated value

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Significant Changes

definition and added an undue hardship definition. On page 6a, added a transfer of assets flow chart. Page 7 is a runover page. On page 8, clarified that the policy also applies to a recipient, and deleted the text listing personal effects and household items that are not resources for the asset transfer rule. Page 9 is a runover page. On pages 10 and 11, clarified the policy for asset transfers that do not affect eligibility for LTC payment. Page 12 is a runover page. On pages 13 and 14, added policy for other transfers, clarified that the policy also applies to renewals and changes, and clarified the beneficiary requirements for purchase of an annuity by the community spouse. On page 15, clarified policy for transfers that affect eligibility. Page 16 is a runover page. On page 17, corrected formatting. On pages 18 and 19, clarified the policy for the purchase of an annuity on or after February 8, 2006. Page 20-22 are runover pages. On pages 23 and 24, added policy for Service Contracts. On page 25, clarified the penalty period determination. On pages 25 and 26, clarified the policy for an uncompensated transfer. On pages 29-31, added real property transfer policy and examples. Pages 32-35 are runover pages. On page 36, clarified that the policy also applies to renewals and changes. On pages 37 and 38, clarified the partial month penalty period. On pages 39-41, revised section references and clarified policy for claiming undue hardship. On page 42, revised section

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Significant Changes

Subchapter M1460
pages 31, 32
pages 37, 38

Subchapter M1460
pages 31, 32
pages 37, 38

references. Page 43 is a runover page. Revised Appendix 1. Added Appendix 4, Settlement Statement.

On pages 31 and 32, clarified that the policies in C.1.a and C.1.e apply to LTC recipients in any state veteran's care center. On page 37, clarified that an individual who lived outside a nursing facility during the retroactive period must have retroactive eligibility determined as a non-institutionalized person. Page 38 is a runover page.

Subchapter M1470
pages 3-6
pages 13, 14
pages 15-18

Subchapter M1470
pages 3-6
pages 13, 14
pages 15-18

Page 3 is reprinted. On pages 4 and 5, updated the personal needs allowance amount. Page 6 is reprinted. On page 13, clarified the acronym for "prescription drug plan." On page 14, clarified that a DMAS-96 is considered a physician's written statement. On pages 15 and 17, updated the personal needs allowance amount. Pages 16 and 18 are reprinted.

Subchapter M1480
Table of Contents, pages i-ii
pages 8a, 8b
pages 11, 12
page 50a
pages 65-70

Subchapter M1480
Table of Contents, pages i-ii
pages 8a-8c
pages 11, 12
page 50a, 50b
pages 65-70

Updated the Table of Contents. On pages 8a and 8b, added procedures for processing an undue hardship claim when the applicant is unable to provide the information necessary for the completion of a resource assessment. Page 8c is a runover page. On page 11, clarified that all countable resources must be verified. Page 12 is reprinted. Page 50a is reprinted. On page 50b, clarified that countable income is used for the 80% FPL covered group. Page 65 is reprinted. On page 66, updated the monthly maintenance needs standard and the excess shelter standard. On page 67, deleted the reference to the

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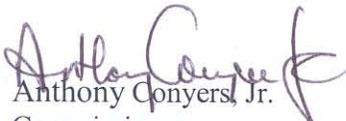
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Significant Changes

		discretionary use of the online Patient Pay Workbook. Page 70 is reprinted. On pages 68 and 69, updated the personal needs allowance.
Subchapter M1510 pages 15-17	Subchapter M1510 page 15	Page 15 is reprinted. Pages 16 and 17 were deleted because the policy on newborn children of emergency services aliens is obsolete.
Subchapter M1520 Table of Contents pages 1-4 pages 9, 10	Subchapter M1520 Table of Contents pages 1-4a pages 9-10a	Revised the Table of Contents. On page 1, clarified the type of notice that is required when eligibility is reviewed because of a reported change and at the time of renewal. On page 2, added information about program integrity reviews. On page 3, clarified that the Newborn Child covered group includes newborn children of emergency-services aliens. On page 4, clarified what information is needed at the time of renewal. Page 4a is a runover page. On page 9, corrected the formatting. On page 10, added new procedures to be followed upon the death of an enrollee. On page 10a, revised the formatting.
Chapter M20 pages 3-6 pages 15, 16 Appendix 1, page 1 Appendix 2, page 1 Appendix 3, page 1 Appendix 4, page 1 Appendix 6, pages 1-2 Appendix 7, pages 1-2	Chapter M20 pages 3-6 pages 15, 16 Appendix 1, page 1 Appendix 2, page 1 Appendix 3, page 1 Appendix 4, page 1 Appendix 6, pages 1-2 Appendix 7, pages 1-2	On pages 3, 6, and 15, updated the resource limits for Extra Help. On page 4, deleted the reference to 2006 under item F. Pages 5 and 16 are reprinted. On page 1 of Appendices 1-4, updated the resource and income limits for Extra Help. On page 1 of Appendix 4, also updated the subsidy benefit amounts. On page 1 of Appendices 6 and 7, revised the reference to income being denied because it is equal to or exceeds 150% of the FPL. Page 2 of Appendices 6 and 7 are reprinted.

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Chapter M21 Appendix 1	Chapter M21 Appendix 1	Updated the FAMIS income limits in Appendix 1.
Chapter M22 pages 1, 2 pages 5, 6 Appendix 1	Chapter M22 pages 1, 2 pages 5, 6 Appendix 1	On pages 1, 2 and 6, changed the income limit for FAMIS MOMS to 185% of the FPL. Page 5 is reprinted. Updated Appendix 1 with the 185% FPL income limits.

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


Anthony Conyers, Jr.
Commissioner

Attachment

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M01 MEDICAID APPLICATION

M0120.000 MEDICAL ASSISTANCE APPLICATION

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Appendices

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The Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) Medicaid Application, form #032-03-384.....	Appendix 2.....	1
<i>Interstate Compact on Adoption and Medical Assistance (ICAMA) Member States and Reciprocity.....</i>	<i>Appendix 3.....</i>	<i>1</i>

**C. Applicants Under
Age 18****1. Child Applicant**

A child under age 18 years is not legally able to sign his own Medicaid application unless he is legally emancipated from his parents. If the child is not legally emancipated, one of the following individuals *who is age 18 or older* must sign the application:

- his parent,
- legal guardian,
- authorized representative, or
- an adult related by blood or marriage with whom the child lives (documentation of the relationship is not required).

If the child under 18 years of age is married and living with his spouse who is age 18 or older, the child's spouse may sign the application.

a. No Guardian or Legal Custody

If the child does not live with a parent or an adult relative and no adult is the child's guardian or has legal custody of the child, whomever the child is living with is responsible for seeking custody or guardianship of the child in the Juvenile and Domestic Relations court. Determine if the person submitting the application, or another person, has begun the process to obtain legal guardianship or custody of the child applicant.

b. Action Is Initiated To Appoint Guardian/Award Custody

If action has been initiated to appoint a guardian for or seek legal custody of the child, meaning a court guardianship or custody hearing is scheduled on the court docket, request verification that the action is on the court docket. Give 10 calendar days for this verification to be provided.

If the verification is provided within the 10-calendar-day period, continue to pend the application until a guardian is appointed or custody is awarded. If the application pends for 45 calendar days, send a notice to the applicant explaining that the application pending period will be extended.

Once the guardian has been appointed or custody awarded, request verification of the appointment or award and that the application be signed by the guardian or adult who was awarded custody. Allow 10 calendar days for the signed application and guardianship or custody papers to be returned.

If the court refuses to appoint a guardian or custodian and there is no adult who is legally able to sign an application for the child, deny the application as invalid.

c. Action Not Initiated – Refer to Child Welfare Services

If guardianship or custody procedures have not begun or have not been verified as being on the court docket, refer the child to the appropriate Family Services worker.

Continue to pend the application until the service investigation is completed and any court proceedings are completed. Once the guardian has been appointed or custody awarded, request verification of the appointment or award and that the application be signed by the guardian or adult who was awarded custody. Retain a copy of the application and mail the original application to the guardian or custodian. Allow 10 calendar days for the signed application and guardian or custody papers to be returned.

If the child was emancipated by the court, request the child's signature on the application. If the application is mailed to the child, allow 10 calendar days for the signed application form to be returned.

If the application form is not signed by the applicant, the guardian, the custodial adult, or the emancipated child and returned to the agency by the specified date, deny the application because it is invalid.

2. Minor Parent Applying for His Child

A parent under age 18 years may apply for Medicaid for his own child because he is the parent of the child.

3. Foster Care Child**a. IV-E**

The Title IV-E Foster Care & Medicaid Application/Redetermination form #032-03-636 is used for the IV-E Foster Care eligibility determination. A separate Medicaid application is not required for a child who has been determined eligible for Title IV-E Foster Care. However, if there is a non-custodial agreement for the IV-E eligible child, the parent or legal guardian must sign a Medicaid application for the child.

b. Non-IV-E

*The Title IV-E Foster Care & Medicaid Application/Redetermination form #032-03-636 is also used for the **non-IV-E** Foster Care eligibility determination. The Medicaid application for a non-IV-E child who is in foster care must be signed by an authorized employee of the public or private agency that has custody of the child. If there is a non-custodial agreement, a Medicaid application form (*Application for Benefits or Health Insurance for Children and Pregnant Women form*) must be filed and the parent or legal guardian must sign the Medicaid application.*

4. Adoption Assistance & Special Medical Needs Children**a. IV-E**

A separate Medicaid application is not required for a child who has been determined eligible for Title IV-E Adoption Assistance, regardless of which state has the adoption assistance agreement with the adoptive parents. IV-E Adoption Assistance children who have been placed for adoption through the Interstate Compact for Adoption and Medical

Assistance (ICAMA) should have an ICAMA form 6.01 which verifies their Title IV-E eligibility for Medicaid. The ICAMA form 6.01 serves as the Medicaid application form.

b. Non-IV-E

Non-IV-E Adoption Assistance children include Non-IV-E Special Medical Needs children.

1) Placed by a Virginia agency

A Medicaid application is required for all non-IV-E Adoption Assistance and Non-IV-E Special Medical Needs children whose parents have adoption assistance agreements with a Virginia public or private child-placing agency.

2) Placed by another state

Non-IV-E Adoption Assistance children who have been placed for adoption through the Interstate Compact for Adoption and Medical Assistance (ICAMA) should have an ICAMA form 6.01 which verifies their adoption assistance status (IV-E or non-IV-E). The ICAMA form 6.01 serves as the Medicaid application form and a separate Medicaid application is not required when:

- *the other state is an ICAMA member state, and*
- *the ICAMA member state **reciprocates** Medicaid coverage of Virginia Non- Title IV-E Adoption Assistance children.*

All states and territories EXCEPT Vermont, Wyoming, Puerto Rico and Virgin Islands are members or associate members of ICAMA. A list of the ICAMA member states and whether they reciprocate Medicaid coverage for Non-IV-E Adoption Assistance children is in M0120, Appendix 3.

A Medicaid application must be filed for Non-IV-E Adoption Assistance children from non-member states and ICAMA member or associate member states which do NOT reciprocate.

D. Deceased Applicant

An application may be made on the behalf of a deceased person within a three-month period subsequent to the month of his death if both of the following conditions were met:

- the deceased received a Medicaid-covered service on or before the date of death, and
- the date of service was within a month covered by the Medicaid application.

If the above conditions were met, an application may be made by any of the following:

- his guardian or conservator,

- attorney-in-fact,
- executor or administrator of his estate,
- his surviving spouse, or
- his surviving family member, in this order of preference: adult child, parent, adult brother or sister, adult niece or nephew, or aunt or uncle.

Under no circumstances can an employee of, or an entity hired by, the medical service provider who stands to obtain Medicaid payment file a Medicaid application on behalf of a deceased individual.

Medicaid coverage can begin no earlier than three months prior to the application month. The entitlement rules for retroactive coverage apply to the application's retroactive period.

E. Unsigned Application

An application that bears no signature is invalid. Return the application to the applicant with a letter requesting a signature.

F. Invalid Signature

An application that is signed by an individual who is not authorized to sign on behalf of the applicant is invalid. Return the application with a letter indicating who must sign the application to the individual who filed the application on behalf of the applicant. See M0120, Appendix 1 for a sample letter.

M0120.300 Medical Assistance Application Forms

A. General Principle – Application Required

A signed application is required for all initial requests for medical assistance, except for:

- IV-E Foster Care/Adoption Assistance children
- Auxiliary Grant (AG) applicants
- Newborn children under age 1 born to a Medicaid-eligible mother.

1. Exception for Certain Newborns

EXCEPTION: A child born to a mother who was Medicaid eligible at the time of the child's birth (including a child born to an emergency-services-only alien mother) is deemed to have applied and been found eligible for Medicaid on the date of the child's birth (see M0320.301). An application for the child is not required. The child remains eligible for Medicaid to age 1 year as long as the mother remains eligible for Medicaid, or would be eligible if she were still pregnant, and they live together.

2. ADAPT Request for Assistance

The Request for Assistance – ADAPT, form #032-03-875 available at: <http://localagency.dss.virginia.gov/divisions/bp/files/fs/forms/general/032-03-0875-08-eng.pdf> may be used to establish and preserve the application date for 30 calendar days, but a signed application must be submitted within 30 calendar days in order for eligibility to be determined.

**B. Medicaid and
FAMIS Application
Forms**

Medical assistance must be requested on a form prescribed (published) by the Department of Medical Assistance Services (DMAS) and the Virginia Department of Social Services (VDSS).

An applicant may obtain a prescribed application form from a number of sources, including a variety of human service agencies, hospitals, and the internet.

There are specialized forms intended for use with certain covered groups, including pregnant women, children, SSI recipients, and women who have been screened under the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA). These forms should be used whenever possible because they do not ask the applicant to provide information that is not used in the eligibility determination for those specific covered groups.

The following forms have been prescribed as application forms for Medicaid and FAMIS:

**1. Application For
Benefits**

Application for Benefits, form #032-03-824, also referred to as the Combined Application, may be used by any applicant (available at: <http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi>). Eligibility for all medical assistance programs can be determined with this application form.

*Interstate Compact on Adoption and Medical Assistance (ICAMA) Member States and
Reciprocity*

STATE	COBRA OPTION*	RECIPROCITY**	COMMENT
Alabama	Yes	Yes	Reciprocity with ICAMA member states only
Alaska	Yes	Yes	Reciprocity with all states
Arizona	Yes	Yes	Reciprocity with all states
Arkansas	Yes	Yes	Reciprocity with all states
California	Yes	Yes	Reciprocity with all states
Colorado	Yes	Yes	Reciprocity with all states
Connecticut	Yes	Yes	Reciprocity with ICAMA member states only
Delaware	Yes	Yes	Reciprocity with all states
District of Columbia	Yes	No	
Florida	Yes	Yes	Reciprocity with ICAMA member states only
Georgia	Yes	Yes	Reciprocity with all states
Hawaii	Yes	No	
Idaho	Yes	Yes	Reciprocity with all states
Illinois	Yes	No	
Indiana	Yes	Yes	Reciprocity with all states
Iowa	Yes	No	
Kansas	Yes	Yes	Reciprocity with all states
Kentucky	Yes	Yes	Reciprocity with ICAMA member states only
Louisiana	Yes	Yes	Reciprocity with all states
Maine	Yes	Yes	Reciprocity with all states
Maryland	Yes	Yes	Reciprocity with all states
Massachusetts	Yes	Yes	Reciprocity with all states
Michigan	Yes	Yes	Reciprocity with all states
Minnesota	Yes	Yes	Reciprocity with all states
Mississippi	Yes	Yes	Reciprocity with all states
Missouri	Yes	Yes	Reciprocity with all states
Montana	Yes	Yes	Reciprocity with ICAMA member states only
Nebraska	Yes	No	
Nevada	Yes	No	
New Hampshire	Yes	No	
New Jersey	Yes	Yes	Reciprocity with ICAMA member states only
New Mexico	No	No	
New York ***	Yes	No	
North Carolina	Yes	Yes	Reciprocity with ICAMA member states only
North Dakota	Yes	Yes	Reciprocity with ICAMA member states only
Ohio	Yes	Yes	Reciprocity with all states
Oklahoma	Yes	Yes	Reciprocity with all states
Oregon	Yes	Yes	Reciprocity with all states

STATE	COBRA OPTION*	RECIPROCITY**	COMMENT
Pennsylvania	Yes	Yes	Reciprocity with all states
Rhode Island	Yes	Yes	Reciprocity with ICAMA member states only
South Carolina	Yes	Yes	Reciprocity with all states
South Dakota	Yes	Yes	Reciprocity with all states
Tennessee	Yes	Yes	Reciprocity with all states
Texas	Yes	Yes	Reciprocity with all states
Utah	Yes	Yes	Reciprocity with ICAMA member states only
Vermont			
Virginia	Yes	Yes	Reciprocity with ICAMA member states only
Washington	Yes	Yes	Reciprocity with all states
West Virginia	Yes	Yes	Reciprocity with all states
Wisconsin	Yes	Yes	Reciprocity with all states
Wyoming			

* *per COBRA 1985 law, the ICAMA member state's Medicaid program covers its own Non-IV-E (state-local) Adoption Assistance [AA] children).*

** *the ICAMA member state's Medicaid program covers Non-IV-E AA children who have adoption assistance agreements with another state and move to the state.*

*** *ICAMA Associate Member State*

ICAMA Non-Member State (Vermont, Wyoming)

When an application is delayed after 90 days because of a disability decision and the agency has determined that excess resources exist at the time the delay notice is sent, the NOA must inform the applicant that he/she has excess resources and the amount. The notice must also state that:

- a final action cannot be taken until the disability decision is made;
- if the applicant is determined to be disabled, he/she will not be eligible unless the excess resources are reduced; and
- he will be notified when the disability decision is made.

C. Application for Retroactive Coverage

Retroactive Medicaid eligibility must be determined when an applicant for Medicaid or other medical assistance reports that he, or anyone for whom he requests assistance, received a medical service within the three months prior to application. Eligibility for SLH must be determined when the individual is not eligible for Medicaid if the applicant reports receiving a **hospital** service within the 30 days prior to the application date.

The retroactive period is based on the month in which the application is filed with the agency. The retroactive period is the three months prior to the application month.

Retroactive coverage can be requested at any time subsequent to an application even if the application was denied or the applicant signed a statement saying he did not want retroactive coverage. The retroactive period is based on the application month regardless of whether the application was denied or approved.

If the application was denied, the application is reopened for determination of eligibility in the three months prior to the application month. The applicant must provide all verifications necessary to determine eligibility during that period.

If the applicant is found eligible for retroactive coverage and a Medicaid-covered medical service was received over one year prior to the date the retroactive eligibility is determined, the applicant must be given an "Eligibility Delay" letter to give to the medical provider so that Medicaid will pay the claim (use the sample letter on the intranet at: <http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi>). Once retroactive eligibility is established, Medicaid coverage begins the first day of the earliest retroactive month in which eligibility exists.

M0130.200 Required Information and Verifications

A. Identifying Information

An application must contain basic identifying information about the applicant. Basic identifying information is the applicant's name, address, Social Security number (SSN) or a statement that the individual applied for the SSN, and date of birth.

1. Name

The name entered in the official case record and computer enrollment systems for *an* applicant must match the *applicant's* name on his Social

Security card or Social Security Administration (SSA) record verification. If the individual says his name is different from the name on his Social Security card, he must first notify SSA and have his name changed on SSA records. When SSA changes his name and SSA verification of the name change is received, the worker can change his name in the case record and on the eligibility and MMIS computer systems.

For purposes of the case record only, the agency may choose to set up the case in the individual's alleged name before it is changed on the Social Security card.

2. SSN

The SSN of an individual for whom Medicaid or other medical assistance is requested must be provided by the applicant and verified by the worker through SSA.

B. Required Verifications

An individual must provide verifications of most Medicaid eligibility requirements. Before taking action on the application, the applicant must be notified in writing of the required information.

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 verifications must be documented in the case record.

1. Copy Verification Documents

Legal documents and documents that may be needed for future eligibility determinations must be copied and preserved for the record. These include citizenship and identity documents, alien status documentation, verification of legal presence, trusts, annuities, contracts, wills, and life insurance policies.

It is not necessary to retain a copy of verifications of income or the current value of resources in the case record. However, if a copy is not retained, the worker must document the date and method used to obtain the information (viewed, telephone call, etc.), the type of verification, the source, and a description of the information.

2. Information Not Provided

If information necessary to make an eligibility determination is requested but not provided by the applicant and cannot be obtained from any other source, the application must be denied or the coverage cancelled due to the inability to determine eligibility.

C. Verification of Nonfinancial Eligibility Requirements

The applicant's statements on the application may be accepted for the following identifying information and nonfinancial eligibility requirements unless the eligibility worker has reason to question the applicant's statements:

1. Verification Not Required

Verification is not required for:

- Virginia state residency,
- application for other benefits,
- institutional status,
- age for children under age 19,

- health insurance information (see sections F and G below), and
- dependent child information for individuals applying as parents or the caretaker-relative of a dependent child.

2. Verification Required

The following information must be verified:

- citizenship and identity;
- Social Security number (see section D below);
- legal presence in the U.S. of applicants age 19 or older;
- age of applicants age 65 and older;
- disability and blindness; and
- pregnancy.

See item E. below for instructions on the verification of legal presence. See subchapter M0220 for instructions on the verification of identity and citizenship. See subchapter M0310 for instructions on the verification of age, disability and pregnancy.

D. Social Security Numbers

Applicants must provide the Social Security number (SSN) 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 an SSN for himself.

1. 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, as long as the mother *is eligible for Medicaid or* would still be eligible for Medicaid had the pregnancy not ended and the mother and child continue to live together. A child eligible in this covered group does not need a Social Security number.
- Illegal aliens who are eligible only for Medicaid payment of emergency services are not required to provide or apply for SSNs (see M0220).

2. SSN Not Yet Issued

If an SSN has not been issued, the applicant must cooperate by applying for a number with the local Social Security Administration Office (SSA). An Enumeration Referral Form, form #032-03-400, available at: <http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi> must be completed by the applicant. The applicant must provide the SSN to the local social services department as soon as it is received and the number must be entered in the MMIS. Applicants who refuse to furnish an SSN or to show proof of application for a number will be ineligible for Medicaid.

In the case of a newborn child not eligible in a child under 1 covered group, the applicant can request hospital staff to apply for an SSN for the child through hospital enumeration procedures. Form #SSA-2853 will be given to the applicant as proof of application for an SSN.

When entering the individual in ADAPT or MedPend, use the date the individual applied for an SSN, or the individual's date of birth, preceded by "APP" as the individual's SSN. For example, an individual applied for an

SSN on October 13, 2006, enter "APP101306" as the individual's SSN. If entering the individual directly in MMIS, use the date the individual applied for an SSN, or the individual's date of birth, preceded by "888" as the individual's SSN. For example, an individual applied for an SSN on October 13, 2006, enter "888101306" as the individual's SSN.

**E. Legal Presence
(Effective January
1, 2006)**

Effective January 1, 2006, Section 63.2-503.1 of the Code of Virginia requires most applicants for or recipients of public assistance who are age 19 or older to provide proof of citizenship or legal presence in the U.S. Applicants or recipients age 19 or older for whom medical assistance is requested must prove their citizenship or legal presence.

Individuals who, on June 30, 1997, were Medicaid-eligible and were residing in long-term care facilities or participating in home and community-based waivers, and who continue to maintain that status (eligible for Medicaid and reside in long-term care facilities or participate in home and community-based

- E. Individual Who Refuses to Pursue Support From an Absent Parent** An individual, other than a medically indigent pregnant woman, applying for Medicaid for herself and on behalf of a child who refuses to cooperate in the pursuit of support from an absent parent, is not eligible for Medicaid. Eligibility could exist if the individual meets a covered group and the individual chooses not to apply for the child.
- F. Individual Found Guilty of Medicaid Fraud** An individual found guilty by a court of Medicaid fraud is not eligible for Medicaid. Ineligibility will last for a period of 12 months beginning with the month of conviction.
- G. Individual Who Has Transferred Assets** An individual who transferred *assets*:
- to become or remain eligible for Medicaid,
 - who did not receive adequate compensation, and
 - who did not meet one of the asset transfer exceptions
- is ineligible for Medicaid payment for long-term care services for a specified period of time unless adequate compensation is received before the time period is over. See Chapter M1450 for asset transfer policy.
- H. Individual Who Refuses to Supply or Apply For an SSN** Any individual, except a child under age 1 born to a Medicaid-eligible mother or an illegal alien, who does not apply for an SSN account number or who fails or refuses to furnish all SSNs to the Department of Social Services is not eligible for Medicaid.

M0210.150 LEGAL PRESENCE

- A. Legal Presence (Effective January 1, 2006)** Effective January 1, 2006, Section 63.2-503.1 of the Code of Virginia requires most applicants for or recipients of public assistance who are age 19 or older to provide proof of citizenship or legal presence in the U.S. Applicants or recipients age 19 or older for whom medical assistance is requested must prove their citizenship or legal presence. Individuals who, on June 30, 1997, were Medicaid eligible and were residing in long-term care facilities or participating in home and community-based waivers, and who continue to maintain that status (eligible for Medicaid and reside in long-term care facilities or participate in home and community-based waivers) are **exempt** from this requirement. **Non-citizens applying for Medicaid payment for emergency services are not subject to the legal presence requirement.**
- An individual who is applying on behalf of another and is not requesting assistance for himself is not subject to the legal presence requirement.
- B. Documents That Demonstrate Legal Presence** An applicant may demonstrate legal presence by presenting one of the following documents:
- valid evidence of U.S. citizenship;
 - valid evidence of legal permanent resident status;
 - valid evidence of conditional resident alien status;
 - a valid SSN verified by the Social Security Administration (SSA);
 - a U.S. non-immigrant visa;
 - a Resident Alien Card, form I-551, showing lawful permanent residence (green card);
 - a pending or approved application for legal asylum;

- a refugee or temporary protected status document; or
- a pending application for an adjustment of residence status.

**C. Failure to
Provide Proof of
Legal Presence**

At the time of application, an applicant who cannot provide documentation that he is a citizen or legally present must sign an affidavit under oath attesting that he is a U.S. citizen or legally present in the *United States* in order to meet the requirement for proof of legal presence for either:

- a period of 90 days or until it is determined that he is not legally present in the U.S., whichever is earlier; or
- indefinitely if the applicant provides a copy of a completed application for a birth certificate *within the United States or its territories* that has been filed and is pending. *The affidavit's validity shall terminate upon the applicant's receipt of a birth certificate or determination that a birth certificate does not exist because the applicant is not a citizen of the United States.*

The affidavit form is in Appendix 2 to this subchapter. NOTE: The individual's address on the affidavit form must be the individual's **residence** address, not the mailing address.

**D. Relationship to
Other Medicaid
Requirements**

Providing proof of legal presence or submitting a signed affidavit meets the legal presence eligibility requirement. To be eligible for Medicaid, however, the individual must meet all other state and federal Medicaid eligibility requirements. Submission of the affidavit without proof of application for an SSN as required by M0130.200.D does **NOT** meet the SSN requirement.

M0210.200 COVERED GROUPS

A. Introduction

An individual who meets the nonfinancial eligibility requirements must also meet the definition for a Medicaid covered group. Covered groups include individuals who are age 65 or older, blind, disabled, under age 19, pregnant women, and the parent(s) or caretaker-relative of a dependent child. Medicaid financial eligibility requirements vary depending upon the covered group for which eligibility is being determined.

See chapter M03 for the covered groups' definitions, policy and procedures.

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M0220.000 CITIZENSHIP & ALIEN REQUIREMENTS

M0220.001 GENERAL PRINCIPLES

A. Introduction

The federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) made major changes to the Medicaid eligibility of non citizens of the UNITED STATES. These changes eliminated the permanently residing under color of law (PRUCOL) category of aliens. The level of Medicaid benefits for aliens is based on whether the alien is a “qualified” alien and the alien’s date of entry into the *United States*.

As a result of these federal changes in Medicaid eligibility for aliens, the 1997 Virginia General Assembly enacted legislation to protect Medicaid eligibility for certain aliens who would otherwise lose their Medicaid benefits.

This subchapter (M0220), effective on July 1, 1997, explains in detail how to determine if an individual is a citizen or alien eligible for full Medicaid benefits (referred to as “full benefit aliens”) or emergency services only (referred to as “emergency services aliens”). It contains the entitlement and enrollment procedures for full benefit aliens and emergency services aliens who meet all other Medicaid eligibility requirements.

B. Declaration of Citizenship/Alien Status

The Immigration Reform and Control Act (IRCA) requires as a condition of eligibility that the adult applicant who is head of the household (with exceptions below) declare in writing under penalty of perjury whether or not the individual(s) for whom he is applying is a citizen or national of the United States, and if not, that the individual is a lawfully admitted alien. For children under 18 years of age, the declaration is made by an adult family member. *The declaration statement is on the application form.*

EXCEPTION: An individual who is an “unqualified” alien (as defined in section M0220.410) does NOT complete the declaration.

Individuals who are required to sign the declaration and who fail or refuse to sign are NOT eligible for any Medicaid services.

C. Procedures

The policy and procedures for determining whether an individual is a citizen or a “full benefit” or an “emergency services” alien are contained in the following sections:

M0220.100 Citizenship & Naturalization;
M0220.200 Alien Immigration Status;
M0220.300 Full Benefit Aliens;
M0220.400 Emergency Services Aliens;
M0220.500 Aliens Eligibility Requirements;
M0220.600 Full Benefit Aliens Entitlement & Enrollment;
M0220.700 Emergency Services Aliens Entitlement & Enrollment.

M0220.100 CITIZENSHIP AND NATURALIZATION

A. Introduction

A citizen or naturalized citizen of the *United States* meets the citizenship requirement for Medicaid eligibility, and is eligible for all Medicaid services if he meets all other Medicaid eligibility requirements.

1. ***Citizenship and Identity Verification Required***

The Deficit Reduction Act (DRA) of 2005 requires that effective July 1, 2006, all Medicaid applicants and enrollees who declared citizenship at the time of application, or for whom citizenship was declared at the time of application, present satisfactory evidence of citizenship and identity.

Non-IV-E Special Medical Needs (Adoption Assistance) children who apply for or receive Medicaid must have in their case record a declaration of citizenship or qualified immigration status AND documentary evidence of the children's citizenship or declared qualified immigration status. *Non-IV-E Special Medical Needs* children *must also* verify identity.
2. ***Exceptions to Verification Requirements***

The *citizenship and identity of the following groups of individuals do NOT need verification:*

 - a. *all foster care children and IV-E Adoption Assistance children;*
 - b. *newborns who meet the Medically Indigent (MI) Newborn Children in section M0320.301 or Medically Needy (MN) Newborn Children in section M0330.302, covered groups because a Medicaid application is not required for these newborns;*
 - c. *Medicare beneficiaries, Social Security Disability Insurance (SSDI) beneficiaries and SSI recipients, including former SSI recipients, if the local department of social services (LDSS) has verification from the Social Security Administration (such as a SVES response) of the individual's Medicare enrollment, SSDI entitlement or current or former SSI recipient status.*

NOTE: A parent or caretaker who is applying for a child, but who is NOT applying for Medicaid for himself is NOT required to verify his or her citizenship and identity; the parent or caretaker must verify only the child's citizenship and identity, unless the parent signs an Affidavit of Citizenship on Behalf of Medicaid Applicants and Recipients attesting to a Medicaid applicant/recipient's citizenship.

B. Procedures

1. Individual Born in the United States

An individual born in the United States, any of its territories (Guam, Puerto Rico, *United States* Virgin Islands, or Northern Mariana Islands), American Samoa, or Swain's Island is a *United States* citizen.

A child born to an emergency services alien mother, who is eligible only for Medicaid payment of her labor and delivery services, must have a valid application filed in order to be enrolled in Medicaid. Once a valid application is obtained, the child **may** be enrolled prior to obtaining documentation of citizenship and identity. See section M0130.200 B for detailed policy and procedures.

NOTE: A child born in the *United States* to non-citizen parents who are in the *United States* as employees of a foreign country's government may not meet the *United States* citizen requirement. When a child born in the *United States* to non-citizen parents is a *United States* citizen by birth, the child may not meet the Virginia residency requirements in M0230.201 because of the parents' temporary stay in the *United States*.

documents in Level 4, he has verified his citizenship, but not his identity. He must present a document from Chart 5 to verify his identity.

If the individual does not present one of the Level 4 documents to verify citizenship, he is not eligible for Medicaid because he has failed to provide documentary evidence of citizenship. **However, see section E that follows before denying or cancelling Medicaid because of failure to verify citizenship.**

5. How to Verify Identity

If the individual presents the original of one of the documents in Levels 2, 3, or 4, he has verified his citizenship, but not his identity. He must present a document from Chart 5 to verify his identity, which includes a written affidavit for a child under age 16 if an affidavit was not used to prove the child's citizenship. The Affidavit of Identity for Medicaid Applicants and Recipients Under Age 16 is on the intranet at: <http://localagency.dss.virginia.gov/divisions/bp/files/me/citizenship/forms/032-03-0282-02-eng.pdf>.

NOTE: An affidavit of identity for a child under 16 cannot be used if an affidavit was used to verify the child's citizenship. An affidavit of identity cannot be used for an individual age 16 or older. If the applicant is age 16 or older, the agency must assist the applicant in obtaining an identity document.

If the individual does not present one of the documents in Chart 5 to verify identity, he is not eligible for Medicaid because he has failed to provide documentary evidence of identity. **See section E below before denying or cancelling Medicaid because of failure to verify identity.**

D. Hierarchy of Documentation

The agency's contact with the client about citizenship documents must follow the hierarchy of documentation. If the client does not have a Level 1, Level 2 or Level 3 citizenship document, the client must tell the agency why he or she cannot obtain these documents. The agency must write in the case record why the client cannot get Level 1, 2 or 3 document in order to explain why a Level 4 document was used (Level 4 includes the affidavits of citizenship).

NOTE: Applicants or recipients born outside the *United States* must submit a document listed under Level 1 - **primary evidence** of *United States* citizenship.

There is no hierarchy for the documentation of identity. For children under age 16, an affidavit of identity signed by the parent is acceptable whether or not other forms of *identification* may exist (see M0220.100 D.5 below).

1. LEVEL 1 – Primary Documents to Establish Both *United States* Citizenship and Identity

Level 1 primary evidence of citizenship and identity is documentary evidence of the highest reliability that conclusively establishes that the person is a *United States* citizen. Obtain primary evidence of citizenship and identity before using secondary evidence. Accept any of the documents listed in the Level 1 table as primary evidence of both *United States* citizenship and identity if the document meets the listed criteria and there is nothing indicating the person is not a *United States* citizen (e.g., lost *United States* citizenship).

NOTE: Persons born in American Samoa (including Swain's Island) are generally *United States* non-citizen nationals. References in this guidance to "citizens" should be read as references to non-citizen nationals.

NOTE: References to documents issued by the Department of Homeland Security (DHS) include documents issued by its predecessor, the Immigration and Naturalization Services (INS). On March 1, 2003, the former INS became part of DHS, and its naturalization function was assumed by *United States* Citizenship and Immigration Services (USCIS) within DHS. However, even documents issued after this date may bear INS legends.

Applicants or recipients born outside the *United States* who were not citizens at birth must submit a document listed under primary evidence of *United States* citizenship.

LEVEL 1 – Primary Documents	Explanation – Level 1
* <i>United States</i> Passport	<p>The Department of State issues this. A <i>United States</i> passport does not have to be currently valid to be accepted as evidence of <i>United States</i> citizenship, as long as it was originally issued without limitation.</p> <p>Note: Spouses and children were sometimes included on one passport through 1980. <i>United States</i> passports issued after 1980 show only one person. Consequently, the citizenship and identity of the included person can be established when one of these passports is presented.</p> <p>Exception: Do not accept any passport as evidence of <i>United States</i> citizenship when it was issued with a limitation. However, such a passport may be used as proof of identity.</p>
* Certificate of Naturalization (N-550 or N-570)	<p>Department of Homeland Security issues this document for naturalization. NOTE: A Certificate of Naturalization may not have a number on it. Form numbers N-550 and N-570 are no longer used. DHS now uses form number N-565. The application form for naturalization is now N-400.</p>
* Certificate of Citizenship (N-560 or N-561)	<p>Department of Homeland Security issues certificates of citizenship to individuals who derive citizenship through a parent.</p>

2. LEVEL 2 - Secondary Documents to Establish *United States* Citizenship

Level 2 secondary evidence of citizenship is documentary evidence of satisfactory reliability that is used when primary evidence of citizenship is not available. Available evidence is evidence that exists and can be obtained within the application processing time frame (see section M0130.100). **A second document establishing identity MUST also be presented (see Chart 5, Evidence of Identity).**

Accept any of the documents listed in the Level 2 table as secondary evidence of *United States* citizenship if the document meets the listed criteria and there is nothing indicating the person is not a *United States* citizen (e.g., lost *United States* citizenship).

NOTE: Applicants or recipients born outside the *United States* must submit a document listed under **primary evidence** of *United States* citizenship.

LEVEL 2 – Secondary Documents	Explanation – Level 2
<p>A <i>United States</i> public birth record</p>	<p>A <i>United States</i> public birth record showing birth in:</p> <ul style="list-style-type: none"> • one of the 50 <i>United States</i>; • District of Columbia; • *Puerto Rico (if born on or after January 13, 1941); • Guam (on or after April 10, 1899). • *Virgin Islands of the <i>United States</i> (on or after January 17, 1917); • American Samoa; • Swain's Island; or <p>*Northern Mariana Islands (after November 4, 1986 (NMI local time)).</p> <p>The birth record document may be issued by the State, Commonwealth, Territory or local jurisdiction. It must have been issued before the person was 5 years of age. An amended birth record document that is amended after 5 years of age is considered fourth level evidence of citizenship.</p> <p><i>Plastic birth certificate cards issued by the Virginia Department of Health are valid birth certificates. A copy of the card is to be placed in the case record, with a note that the original card was viewed. Other states may have issued similar plastic birth certificate cards. If an individual presents a plastic birth certificate card from another state, verify with that state's office of vital records that such cards are issued by the state.</i></p>
	<p>NOTE: Individuals born to foreign diplomats residing in one of the states, the District of Columbia, Puerto Rico, Guam or the Virgin Islands are not citizens of the United States.</p> <p>If the document shows the individual was born in Puerto Rico, the Virgin Islands of the <i>United States</i>, or the Northern Mariana Islands before these areas became part of the <i>United States</i>, the individual may be a collectively naturalized citizen. Collective naturalization occurred on the dates listed for each of the Territories. The following will establish <i>United States</i> citizenship for collectively naturalized citizens:</p> <p>a. Puerto Rico:</p> <ol style="list-style-type: none"> 1) Evidence of birth in Puerto Rico on or after April 11, 1899 and the applicant's statement that he or she was residing in the <i>United States</i>, a <i>United States</i> possession or Puerto Rico on January 13, 1941; or 2) Evidence that the applicant was a Puerto Rican citizen and the applicant's statement that he or she was residing in Puerto Rico on March 1, 1917 and that he or she did not take an oath of allegiance to Spain. <p>b. <i>United States</i> Virgin Islands:</p> <ol style="list-style-type: none"> 1) Evidence of birth in the <i>United States</i> Virgin Islands, and the applicant's statement of residence in the <i>United States</i>, a <i>United States</i> possession or the <i>United States</i> Virgin Islands on February 25, 1927; or

LEVEL 2 – Secondary Documents	Explanation – Level 2
<p>A <i>United States</i> public birth record</p>	<p>2) The applicant's statement indicating residence in the <i>United States</i> Virgin Islands as a Danish citizen on January 17, 1917 and residence in the <i>United States</i>, a <i>United States</i> possession or the <i>United States</i> Virgin Islands on February 25, 1927, and that he or she did not make a declaration to maintain Danish citizenship; or</p> <p>3) Evidence of birth in the <i>United States</i> Virgin Islands and the applicant's statement indicating residence in the <i>United States</i>, a <i>United States</i> possession or Territory or the Canal Zone on June 28, 1932.</p> <p>c. Northern Mariana Islands (NMI) (formerly part of the Trust Territory of the Pacific Islands (TTPI)):</p> <p>1) Evidence of birth in the NMI, TTPI citizenship and residence in the NMI, the <i>United States</i>, or a <i>United States</i> Territory or possession on November 3, 1986 (NMI local time) and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time); <i>or</i></p> <p>2) Evidence of TTPI citizenship, continuous residence in the NMI since before November 3, 1981 (NMI local time), voter registration prior to January 1, 1975 and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time); or</p> <p>3) Evidence of continuous domicile in the NMI since before January 1, 1974 and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time).</p> <p>4) NOTE: If a person entered the NMI as a nonimmigrant and lived in the NMI since January 1, 1974, this does not constitute continuous domicile and the individual is not a <i>United States</i> citizen.</p>
<p>*Certification of Report of Birth (DS-1350)</p>	<p>The Department of State issues a DS-1350 to <i>United States</i> citizens in the <i>United States</i> who were born outside the <i>United States</i> and acquired <i>United States</i> citizenship at birth, based on the information shown on the FS-240. When the birth was recorded as a Consular Report of Birth (FS-240), certified copies of the Certification of Report of Birth Abroad (DS-1350) can be issued by the Department of State in Washington, D.C. The DS-1350 contains the same information as that on the current version of Consular Report of Birth FS-240. The DS-1350 is not issued outside the <i>United States</i></p>

The identity documents do not have a hierarchy of reliability. For applications or renewals that include children under age 16, the LDSS workers can send an Affidavit of Identity for Medicaid Applicants and Recipients Under Age 16 with the application or renewal forms.

CHART 5 – Identity Documents	Explanation – Chart 5
Driver's license	A driver's license issued by State or Territory either with a photograph of the individual, or other identifying information such as name, age, sex, race, height, weight or eye color, is acceptable.
School identification card	A school identification card with the name and photograph of the individual is acceptable. The school ID card must be an official ID card issued by the school; unofficial ID cards such as those provided as a courtesy with school photographs, are not acceptable.
<i>United States</i> military card or draft record	<i>United States</i> military card or draft record is acceptable.
Identification card issued by the Federal, State, or local government	An identification card issued by the Federal, State, or local government with the same information included on driver's licenses is acceptable. At a minimum, the ID must have the individual's name, address and photo. For photo ID cards, the photo must have been affixed to the ID card by the government agency that issued it. ID cards issued by a government agency that just have a space for the individual to attach a photo are NOT acceptable.
Military dependent's ID card	A military dependent's identification card is acceptable.
Native American Tribal document	A Native American Tribal document is acceptable.
<i>United States</i> Coast Guard Merchant Mariner card	A <i>United States</i> Coast Guard Merchant Mariner card is acceptable.
Certificate of Degree of Indian Blood, or other <i>United States</i> American Indian/Alaska Native tribal document	A Certificate of Degree of Indian Blood, or other <i>United States</i> American Indian/Alaska Native tribal document with a photograph or other personal identifying information relating to the individual is acceptable.
State Agency Computer Data	Identifying information from a Virginia state governmental data system can be used to provide identity verification for applicants and recipients. A copy of the screen(s) from a state data system that shows the individual's name, DOB, gender and SSN is acceptable documentation of the individual's identity if the agency establishes the true identity of the individual.
Special identity rules for children under age 16	For children under 16, school records may include nursery or child care records. The school, nursery or daycare record must contain the child's name, date of birth, place of birth and the parents' names. The form agencies should use to request the school, nursery or daycare

<p>Special identity rules for children under age 16</p>	<p>record is posted on the intranet. The school record request form workers can give to a child’s parent or guardian to give to the school is posted to the intranet at http://localagency.dss.virginia.gov/divisions/bp/me/citizenship/forms.cgi.</p> <p>a. Foster Care Children</p> <p><i>All foster care children are excluded from the citizenship and identity verification requirements.</i></p> <p>b. Written affidavit of identity</p> <p>For children under 16 only, an affidavit of identity may be used. An affidavit is only acceptable if it is signed under penalty of perjury by a parent or guardian stating the date and place of the birth of the child and cannot be used if an affidavit for citizenship was provided for the child. The Affidavit of Identity for Medicaid Applicants and Recipients Under Age 16 is available on the LDSS Intranet at: http://localagency.dss.virginia.gov/divisions/bp/files/me/citizenship/forms/032-03-0282-02-eng.pdf and may be sent to the parent with the application or renewal form when the agency is aware that a child under age 16 is in the home.</p> <p>The Application for Health Insurance for Children and Pregnant Women (FAMIS 1) and the Medicaid Renewal form (#032-03-0669) available on the LDSS Intranet contain an area for the parent to attest to the identity of a child under age 16. A separate affidavit of identity is not necessary when the parent has attested to identity on the application or renewal form.</p> <p><i>The affidavit of identity, or the attestation of identity on the original application form, remains valid when the child reaches age 16 or older, as long as the child remains continuously enrolled in Medicaid. If the child’s enrollment is canceled and he reapplies after turning age 16, his identity must be verified.</i></p>
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D. Agency Action

1. Documentation From Case Record and Individual

Documentation of citizenship and/or identity may be obtained from a number of different sources including the following:

- Existing LDSS agency records as long as the documentation conforms to Medicaid policy for citizenship and identity verification in M0220 of the Medicaid Eligibility Manual.
- Applicants and Recipients. All applicants and recipients, **except** SSI recipients, Medicare beneficiaries, *SSDI beneficiaries*, *all foster care children and IV-E Adoption Assistance children*, must provide documents that show proof of *United States* citizenship and proof of the person’s identity. Contact information for obtaining the various acceptable documents is available on the VDSS local agency intranet and the DSS public website and may be given to individuals to facilitate their obtaining documentation.

Original documents may be viewed by all eligibility, administrative, and services staff of the LDSS as long as the person viewing the document makes a copy of the document, notes that the original was viewed, and signs and dates the copy.

2. Authorized Representative

For individuals who have authorized representatives, such as the disabled or individuals who are institutionalized, initiate efforts to assist in securing documentation with the appropriate representative.

In those instances in which an authorized representative lives in another locality than the Medicaid enrollee and the authorized representative's LDSS is more convenient to them than the locality where the case is maintained, a LDSS may copy and verify an original document for an authorized representative. The LDSS is not to give the copy to the client's representative; the agency staff must send it to the LDSS that holds the Medicaid enrollee's case. In this way, the "chain of evidence" is not broken—it has always stayed within DSS.

A local DSS agency may accept the copy as verification providing another LDSS:

- saw the original document,
- made the copy of the original,
- wrote on the copy that the staff member saw the original document on (date), and
- signed and dated the copy.

3. Documents From Other Approved Organizations

Original citizenship and identity documents can be accepted from other organizations approved by DMAS when the original document is viewed, the authorized person makes a copy and affixes a statement to the copy that has the following information:

- the original document was viewed and copied by (name and title of the individual who viewed the documentation), signature of staff member who saw the original,
- the name of the entity with which the individual is affiliated, and
- the date the documentation was viewed and copied.

DMAS has approved documentation copies from the following:

- an established outreach organization,
- local health department,
- Department of Corrections personnel for prisoners leaving the correctional system,
- Federally Qualified Health Centers (FQHC),
- hospital discharge planners or social workers.

Two lists of approved organizations are posted on the local agency intranet site: "Project Connect and Independent Outreach Projects List" and "FQHC-Virginia Primary Care Association Membership Roster".

Hospital contractors, such as Chamberlin-Edmonds, are **not** considered authorized to view original documents.

4. **DMAS FAMIS Plus Unit** Original documents can be viewed by local department of social services (LDSS) for applications handled by the Department of Medical Assistance Services (DMAS) FAMIS Plus Unit. As a service to clients, staff from any LDSS is to view an original document, make a copy, and note on the copy that the original was viewed, including the date and signature of the staff person. The LDSS are to send or fax the annotated copy to the DMAS FAMIS Plus Unit. The DMAS FAMIS Plus Unit will accept the copy and place it in the record. This process will significantly reduce the likelihood of important and possibly irreplaceable documents being misplaced or destroyed.
5. ***Birth Certificate Viewed By Out-of-State Agency*** *Local agencies are to accept copies of out-of-state birth certificates if the copies have statements on or attached to them that say the original birth certificates were viewed by staff of the issuing state's Department of Social Services or Medicaid state agency, and the statements are signed and dated by the issuing state's staff who viewed the originals.*
6. **SSI Recipients and Medicare Beneficiaries** Verify the SSI recipient's or Medicare beneficiary's entitlement to benefits through SVES or SOLQ-I. A copy of the SVES or SOLQ-I printout must be placed in the case file.
7. **Individual NOT Required to Submit Documents in Person** Individuals do not have to submit their citizenship and identity to the agency worker in person. They may mail-in the **original document** for the agency to copy and mail back to the individual, with the exception of a copy of a Virginia birth certificate, which may be furnished rather than the original. The worker must write on the copy made for the case record that "the original document was viewed on (date) and the original was mailed back to the individual on (date)."
- For individuals who need assistance securing a birth certificate, LDSS may request birth certificate verification from the Virginia Department of Health (VDH) without receiving additional approval from the recipient beyond the recipient's original signature on the individual's application for Medicaid. If VDH is unable to produce birth certificate verification, however, the individual is to be notified that documentation of citizenship is needed and allowed the reasonable opportunity period to secure the documentation (see M0220.100 D.8 below).
8. **Special Populations Needing Assistance** The agency shall assist special populations who need additional assistance, such as the homeless, mentally impaired, or physically incapacitated individual who lacks someone who can act on his behalf, to provide necessary documentation.

For individuals who are mentally impaired or physically incapacitated and lack someone who can act on their behalf, the agency should initiate action to secure the documentation for these individuals using the Virginia Department of Health (VDH) procedure for requesting birth certificate documentation described in the Citizenship and Identity Verification Procedures document posted on the LDSS Intranet.

9. Reasonable Opportunity to Verify Citizenship and Identity

a. Reasonable Opportunity

Many individuals will be able to produce the required citizenship and identity verification requirements given the maximum amount of time allowed by processing time frames. Inquiries should be made to determine if they can produce the required documentation. LDSS agencies shall assist these individuals in helping to secure the required documentation by providing information on what documentation is necessary and alerting them to agencies that may be contacted for the needed documentation.

The "reasonable opportunity period" permits exceptions from the standard time limits for processing applications when an applicant or recipient in good faith tries to present documentation, but is unable to do so because the documents are not available. In such cases, the agency should extend the application processing time limit and assist the individual in securing evidence of citizenship and/or identity.

If the individual cannot readily or easily produce citizenship documentation or it is a hardship to secure that documentation, secure the documentation for the individual using the process contained in the "Citizenship and Identity Verification Procedures" document posted on the VDSS Intranet for contact with the Virginia Department of Health for birth certificate documentation.

If the individual, legal guardian or other responsible party indicates that additional time is required, allow a reasonable amount of additional time based on the time frames below.

b. Extending the Processing Time Frames for Applicants

Applicants, with the exception of those needing a disability determination, who have attempted to obtain citizenship and identity documentation will be given additional time beyond the normal time frame for processing cases (45 days for applications, 30 days for renewals) as follows:

- An extension of 30 calendar days may be granted when the applicant has requested, but not received the required documents, or requested assistance in obtaining documents.
- An additional extension of up to 10 working days may be granted at the end of the 30-day extension when there is documentation that the information has been requested, but has not been received.

Because the processing time for applicants who require a disability determination remains 90 calendar days, which actually exceeds the extension periods listed above, **these applicants do not receive the extensions.**

Information regarding the need for the extension and agency's efforts to assist in helping obtain documentation must be included in the case file.

If the required information has not been received by the end of the extensions, appropriate action to deny coverage must be taken.

c. Extending the Processing Time Frames for Recipients

For recipients of Medicaid, the processing time frame extension is indefinite, as long as a “good faith” effort continues to be made by the recipient, his authorized representative or other person(s) acting on the recipient’s behalf to obtain appropriate documentation of citizenship and identity. The case record must be documented by the worker noting the attempts being made to secure the required verification. Providing all other Medicaid eligibility requirements are met, an existing Medicaid recipient’s case is allowed to remain open as long as a good faith effort is being made to obtain the verification.

10. Failure to Provide Requested Verifications

Failure to provide satisfactory evidence of citizenship and identity, after being provided a reasonable time to present such documentation, is to result in the denial or termination of Medicaid.

An applicant or recipient who fails to cooperate with the agency in presenting documentary evidence of citizenship may be denied or terminated. Failure to cooperate consists of failure by an applicant, recipient or that individual's representative, after being notified, to take a required action within the reasonable opportunity time period.

11. Denial or Cancellation Action

Local agencies must give the maximum allowable time for securing citizenship and identity verification permitted by the processing time frames and to pend cases of those individuals who are acting in good faith to secure the documentation not available through the agencies’ efforts.

Eligibility should only be denied or cancelled for lack of citizenship and/or identity verification reasons if there is clear and convincing evidence that the recipient has failed to present a good faith effort to produce the required documentation. Agencies are to recognize that, particularly for individuals who are aged, disabled and/or institutionalized, the intervention and assistance of authorized representatives may be needed to secure this information, and the maximum time and necessary assistance from the agency should be provided to the authorized representatives acting in good faith on behalf of the recipient.

A local agency is neither to deny nor terminate Medicaid eligibility based solely upon lack of citizenship or identity documentation without supervisory review and approval. An agency that has questions about a denial or a termination of eligibility should first consult the Medical Assistance Program Consultant assigned to the agency’s service area.

12. Notification Requirements

Prior to the termination of benefits, the enrollee must be sent the Advance Notice of Proposed Action (Form 032-03-018) at least 10 calendar days (plus one day for mailing) prior to the effective date of the closure.

A Notice of Action and appeal rights must be sent to an individual whose application is denied because of failure to provide citizenship and/or identity verification.

13. Maintain Documents in Case Record

The agency must maintain copies of the documents used to verify citizenship and identity in the individual’s case record or data base and must make the documents available for state and federal audits.

14. Reporting Requirements

Each month, agencies will report information regarding **denials** of eligibility *on cases that are not in ADAPT* when one of the reasons, or the only reason, for the *denial* was failure to verify citizenship or identity. (*Cancellations are reported from MMIS data, and denials on ADAPT cases are reported in ADAPT*).

Email the monthly report of Medicaid denials for cases not in ADAPT by the 10th of the following month to the Medical Assistance Unit, Division of Benefit Programs, staff person named in the “Citizenship and Identity Verification Procedures” document posted on the local agency intranet. Email a copy of the report to the Medical Assistance Program Consultant assigned to the LDSS’ region.

The Medical Assistance Program Consultants will also be conducting reviews of cases where Medicaid eligibility was denied or terminated because of lack of citizenship and/or identity verification.

15. Refer Cases of Suspected Fraud to DMAS

If documents are determined to be inconsistent with pre-existing information, are counterfeit, or are altered, refer the individual to DMAS for investigation into potential fraud and abuse. See section M1700.200 for fraud referral procedures.

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 a Resident Alien Card or Permanent Resident 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 a Resident Alien Card (issued from August 1989 until December 1997) or Permanent Resident 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 (Alien Registration Receipt Card – the old “green card”), Form AR-3 and AR-3a are earlier versions of the Resident Alien Card (Form I-551). 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 1-800-375-5283. When an I-151 is presented, refer the alien to USCIS, but accept the document for further verification (see M0220.201.E below).

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 immigration status, refer the individual to the USCIS district office to obtain evidence of status **unless** he provides an alien registration number.

If the applicant provides an alien registration number with supporting verification of his identity, use the SAVE procedures in M0220.202 below to verify immigration status. If an applicant presents an expired I-551 or I-151, follow procedures for initiating a primary verification. If the alien presents any expired document other than an expired I-551 or I-151, follow procedures for initiating a secondary verification.

- take any other reasonable steps to assist the state in pursuing any liable third party.

Should DMAS or the local agency request information from the individual, including information about third party liability, or otherwise require cooperation with the pursuit of medical support and/or third party liability as outlined in M0250.200 C. above, the individual must cooperate with the pursuit of medical support in order for the individual's eligibility to continue.

- 1. Waiver of Cooperation**

A waiver of the cooperation requirement in identifying and providing liable third party information is allowed if the agency finds that cooperation is against the best interests of the individual, or other person for whom he/she can assign rights, because the agency anticipates that cooperation will result in reprisal against or cause physical or emotional harm to the individual or other person.
- 2. Documentation**

Document the case record with the reason(s) the individual refuses to cooperate in identifying and providing liable third party information and the reason(s) the agency finds that cooperation is against the best interests of the individual or other person for whom he/she can assign rights.

M0250.300 PURSUIT OF MEDICAL SUPPORT FROM THE ABSENT PARENT

- A. Policy**

To be eligible for Medicaid, an individual applicant or recipient must cooperate with the agency in obtaining medical support and payments from, or derived from, the absent parent(s) of a child for whom the individual is applying, unless the individual establishes good cause for not cooperating. *The individual's non-cooperation does NOT affect the individual's child(ren)'s Medicaid eligibility.*
- B. Definition of Cooperation**
 - 1. Application**

By signing the application for Medicaid, the individual meets the eligibility requirement to cooperate in pursuing support from the absent parent(s) of the child for whom the individual is applying. No further action by the applicant is required at the time of application.

The individual is not required to contact DCSE about pursuing support from the absent parent. If the individual chooses to request DCSE services, the individual's continued cooperation with DCSE **is required** for the individual to remain eligible for Medicaid.
 - 2. Ongoing**

After the individual's application has been approved, if DCSE, DMAS or the local agency requests information from the individual about the absent parent, or otherwise requires the individual's cooperation with the pursuit of medical support from the absent parent, the individual must cooperate in order for the individual's eligibility to continue.

Medicaid enrollees who were approved for Medicaid before January 1, 2007, and who were referred to DCSE, must continue to cooperate with DCSE in the pursuit of medical support from the absent parent to remain eligible for Medicaid.

**C. Local DSS Agency
Responsibility**

1. Applicants

Explain and offer the Division of Child Support Enforcement (DCSE) services to all Medicaid applicants who apply for Medicaid for themselves and/or on behalf of children who have an absent parent. A child's parent is not considered absent if the absence is due to death, single parent adoption, artificial insemination, or termination of parental rights.

Give the applicant the DCSE Fact Sheet available on the intranet at:
<http://spark.dss.virginia.gov/divisions/bp/me/facts.cgi>.

2. Enrollees

If the local agency or DMAS requires from the enrollee information related to medical support from the absent parent, such as the policy number of the health insurance policy the absent parent has that covers the child, and the enrollee refuses to give it to the requesting agency but does not have good cause for refusing, the enrollee is no longer eligible for Medicaid because of failure to cooperate in pursuing medical support and third party liability. The child(ren) remain eligible for Medicaid.

a. Enrollees who were approved before January 1, 2007

For a Medicaid enrollee who was approved for Medicaid before January 1, 2007, and was referred to DCSE, the local agency must take action when notified by DCSE that the enrollee is not cooperating in the pursuit of medical support from the absent parent. The child(ren)'s eligibility for Medicaid is NOT affected.

b. Enrollees who applied on or after January 1, 2007

If the enrollee who applied for Medicaid on/after January 1, 2007, chooses to apply for DCSE services and DCSE opens a case for the applicant, the enrollee must cooperate with DCSE in the pursuit of medical support from the absent parent, unless there is good cause for not cooperating. If the agency is notified by DCSE that the enrollee is not cooperating, the agency worker must take appropriate action on the enrollee's Medicaid coverage; the child(ren)'s eligibility for Medicaid is NOT affected.

If the recipient wants to claim good cause for not cooperating, contact a Medical Assistance Program Consultant for instructions.

D. DCSE

DCSE District Offices have the responsibility of pursuing support from absent legally responsible parent(s), establishing paternity when the alleged father is absent from the home, and notifying the local DSS when the enrollee does not cooperate. This responsibility entails locating the parent(s), determining ability to support, collecting support from legally responsible parent(s), establishing medical support and/or health insurance covering the applicant child (ren), and court action to secure support from the absent legally responsible parent.

The booklet, "Child Support and You", form #032-01-945, gives an overview of DCSE services and the addresses for the district offices.

M0280.000 INSTITUTIONAL STATUS REQUIREMENTS**M0280.001 GENERAL PRINCIPLES****A. Introduction**

To be eligible for Medicaid, an institutionalized individual must meet the institutional status requirement. An individual does not necessarily have to live in an institution to be considered an "inmate of a public institution." Inmates of public institutions are NOT eligible for Medicaid.

B. Procedure

This subchapter, M0280, contains the Medicaid institutional status policy, inmate of a public institution policy and procedures for determining whether an individual meets the Medicaid institutional status eligibility requirement.

Refer to M0520.001 for the policy and procedures for determining the assistance unit size for children in medical institutions or residential treatment facilities.

M0280.100 DEFINITION OF TERMS**A. Child Care Institution**

A child care institution is a

- non-profit private child-care institution, or
- a public child care institution that accommodates no more than 25 children which has been licensed by the state in which it is located or has been approved by the agency of the state responsible for licensing or approval of institutions of this type, as meeting the standards established for licensing.

The term "child care institution" does NOT include detention facilities, forestry camps, training schools or any other facility operated primarily for the detention of children who are determined to be delinquent.

B. Facility for the Mentally Retarded

A facility (institution) for the mentally retarded (ICF-MR) is not an IMD. Therefore, an individual under age 65 who is in a facility for the mentally retarded meets the institutional status eligibility requirement, unless he is incarcerated, as defined below.

C. Institution

An institution is an establishment that furnishes (in single or multiple facilities) food, shelter and some treatment or services to four or more persons unrelated to the proprietor.

D. Institution for the Treatment of Mental Diseases (IMD)

An IMD is a hospital, nursing facility or other institution with more than 16 beds that is primarily engaged in providing diagnosis, treatment or care, including medical attention, nursing care and related services, to persons with mental diseases. A facility for the mentally retarded is NOT an IMD.

E. Medical Facility

A medical facility is an institution that:

- is organized to provide medical care, including nursing and convalescent care,

- has the necessary professional personnel, equipment, and facilities to manage the medical, nursing and other health needs of patients,
- is authorized under state law to provide medical care, and
- is staffed by professional personnel who are responsible to the institution for professional medical and nursing services.

**F. Public Institution
(Facility)**

A public institution is a institution (facility) that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control, and which is NOT a medical facility.

The following are NOT public facilities for this section's purposes:

- a medical facility, including a nursing facility;
- a publicly operated community residence (serves no more than 16 residents);
- a child care institution, for children who receive foster care payments under Title IV-E or AFDC foster care under Title IV-A, that accommodates no more than 25 children;
- an institution certified as an ICF-MR for individuals with mental retardation or related conditions.

**G. Publicly Operated
Community
Residence**

A publicly operated community residence is a public residential facility (institution) with 16 beds or less, that provides some services beyond food and shelter such as social services, help with personal living activities or training in socialization and life skills. Occasional medical or remedial care may also be provided.

Publicly operated community residences do NOT include the following facilities even though these facilities have 16 or less beds:

- residential facilities located on the grounds of, or adjacent to, any large (more than 16 beds) institution;
- correctional or holding facilities for individuals who are prisoners, who have been arrested or detained pending disposition of charges, or who are held under court order as material witnesses or juveniles;
- detention facilities, forestry camps, training schools or any other facility for children determined to be delinquent;
- educational or vocational training institutions that primarily provide an approved, accredited or recognized program to individuals residing there.

M0290.000 HIPP REQUIREMENTS

M0290.001 GENERAL PRINCIPLES

- A. Introduction** To be eligible for Medicaid, certain individuals must *make application to* the Health Insurance Premium Payment (*HIPP*) Program.
- B. Procedure** The definitions of terms used in this subchapter are in section M0290.100 below.
- The HIPP requirements are in section M0290.200 below.

M0290.100 DEFINITIONS

- A. Assistance Unit** means the individual or family who applies for Medicaid and whose financial eligibility is determined. The assistance unit for Families & Children (F&C) covered groups is called the "family unit" or the "budget unit".
- The assistance unit for an ABD individual is just the individual, unless the individual is married, living with his/her spouse and the spouse is also ABD. In this situation, the assistance unit is the married ABD couple.
- B. HIPP** means the Health Insurance Premium Payment Program. HIPP is a cost-saving program administered by the Department of Medical Assistance Services (DMAS) for Medicaid *enrollees*, which *reimburses some or all of* the employee portion of the group health insurance premium for *enrollees* who have *employer sponsored group* health insurance available to them through their own or their family member's employment.

M0290.200 HEALTH INSURANCE PREMIUM PAYMENT PROGRAM (HIPP) REQUIREMENTS

- A. Policy** As a condition of Medicaid eligibility, any individual who:
- is eligible for Medicaid,
 - is a member of an assistance unit which contains an individual employed more than 30 hours per week, and
 - is eligible for coverage under an employer's group health plan
- must complete the HIPP Application Form and the Medical History Questionnaire, and submit the *Employer* Insurance Verification Form to the employer.
- If DMAS determines that enrollment of the individual in the group health plan is cost-effective; the individual must enroll in the group health plan in order to remain eligible for Medicaid.

To determine if the employer-sponsored group health plan is cost-effective, the cost of the applicant's or enrollee's insurance premium is compared to the cost of Medicaid managed-care for an individual of similar age, gender, and locality of residence. These comparison figures are known as HIPP Capitation Rates. The rates periodically change based on enrollee changes in age, aid category, or locality of residence.

Under this program, DMAS provides *reimbursement of some or all* of the employee's portion of the group health insurance premium. The HIPP Program may *reimburse some or all* of the premiums for non-Medicaid eligible family members if they must be enrolled in order for Medicaid eligible family members to obtain the health plan coverage.

B. Individuals Who Will Not Be Considered for HIPP

The following individuals will not be considered for HIPP unless extraordinary circumstances indicate the group health plan might be cost-effective:

- individuals eligible for Medicaid after meeting a spenddown;
- individuals eligible for retroactive Medicaid only;
- individuals in a nursing facility or who have a deduction from patient pay responsibility to cover the insurance premium;
- individuals eligible for or enrolled in Medicare Part B;
- individuals who are absent parents; or
- individuals with CHAMPUS/TRICARE (*military*) policies.

C. Individuals with Special Medical Conditions

An individual described in B. above may be considered for HIPP if he has a medical condition that requires ongoing treatment and the group health insurance plan might be cost-effective. Contact the HIPP Unit for guidance on situations requiring special consideration.

An individual who has a medical condition requiring ongoing treatment and who has any *employer-sponsored group health* insurance coverage available may submit a HIPP Application to the HIPP Unit at DMAS. The HIPP Unit will verify insurance coverage with the company and determine if Medicaid *reimbursement* of the premiums would be cost-effective.

D. Failure to Cooperate

If an individual, without good cause, fails to complete either the HIPP Application or Medical History Questionnaire, or fails to enroll in a cost-effective group health plan *when required to by DMAS*, the individual loses eligibility for Medicaid. An "Advance Notice of Proposed Action" must be sent prior to canceling coverage. Non-cooperation of a parent or spouse does not affect eligibility for Medicaid benefits for the individual's spouse or child.

E. Good Cause For Failure to Cooperate

Good cause for failure to cooperate shall be established when the *enrollee*, parent, spouse, or person acting on behalf of the *enrollee* demonstrates one or more of the following conditions:

- There was a serious illness or death of the parent, spouse, or a member of the parent's family.
- There was a family emergency or household disaster, such as a fire, flood, or tornado.
- The parent or spouse offers a good cause beyond the parent's or spouse's control.
- There was a failure to receive DMAS' 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.
- The required information on the group health plan could not be obtained from the employer.
- The *enrollee* 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 *enrollee* 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 a HIPP Application Package containing the HIPP Application, the Medical History Questionnaire and the *Employer Insurance Verification Form*. *The applicant* must complete the HIPP Application and Medical History Questionnaire. The applicant or *enrollee* must give the *Employer Insurance Verification Form* to the employer. The employer is to return the *Employer Insurance Verification Form* to the HIPP Unit at DMAS. *The HIPP Application Package is available on the DMAS web site at:* <http://www.dmas.virginia.gov/rcp-HIPP.htm>.

If the applicant or *enrollee* 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/*enrollee* to give the *Employer Insurance Verification Form* to the employer.

1. **Copy Insurance Card** If the applicant or *enrollee* is already enrolled in the employer's group health plan, make a copy of the insurance card.
2. **If Enrollee Is Eligible, Send To HIPP Unit** If the applicant is determined to be eligible for Medicaid or the *enrollee* is determined to remain eligible for Medicaid, complete the enrollment procedures in the *Medicaid Management Information System* (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:

HIPP Unit
 Department of Medical Assistance Services
 600 E. Broad Street, Suite 1300
 Richmond, VA 23219.

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

3. **HIPP Unit Actions** The HIPP Unit will notify the *enrollee* and DSS of the decision on cost-effectiveness of the group health plan and premium *reimbursement*.

If the *enrollee* is approved for HIPP *reimbursement of some or all* of the group health plan premium and the *enrollee* was not previously enrolled in the group health plan, *DMAS* will enter the *health insurance information in the MMIS and send the notice to the eligibility worker*.

Reimbursement will be made to the *enrollee* for *some or all* of the employee's part of the insurance premium. ***Reimbursements to the enrollee 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 *enrollee* 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.

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d. Hospice--a hospice patient is a person who is terminally ill and has elected to receive hospice care; if the individual is not aged, presume that the individual is disabled.

2. F&C Groups

- a. Low income families with children (LIFC) eligible children, parents, non-parent caretaker-relatives, and EWBs.
- b. Children under age 1 born on or after October 1, 1984, to mothers who were eligible for and receiving Medicaid as categorically needy or categorically needy non-money payment at the time of the child's birth.
- c. Non-IV-E Foster Care or Juvenile Justice Department children, or Non-IV-E Adoption Assistance children.
- d. Individuals under age 21 in an ICF or ICF-MR.
- e. F&C individuals who are institutionalized in a medical institution, who meet all Medicaid eligibility requirements and have income before exclusions that is less than 300% of the SSI individual payment limit.
- f. F&C individuals who receive or are applying for Medicaid-approved community-based care waiver services, who meet all Medicaid eligibility requirements and who have income before exclusions that is less than 300% of the SSI individual payment limit.

C. Medically Indigent (MI)

The Aged, Blind and Disabled (ABD) and the Families & Children (F&C) covered groups in the MI classification are listed below.

1. ABD Groups

- a. Qualified Medicare Beneficiaries (QMBs).
- b. Special Low-income Medicare Beneficiaries (SLMBs).
- c. Qualified Disabled and Working Individuals (QDWI).
- d. Qualified Individuals (QIs).
- e. ABD With Income \leq 80% Federal Poverty Limit (ABD 80% FPL).
- f. MEDICAID WORKS.

- 2. F&C Groups**
- a. Pregnant women and newborns under age 1 year.
 - b. Family Planning Services.
 - c. Children under age 19 years.
- 3. Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA)**
- Women screened and diagnosed with breast or cervical cancer under the Centers for Disease Control and Prevention's (CDC) Breast and Cervical Cancer Early Detection Program (BCCEDP) and eligible to receive Medicaid under the BCCPTA.
- D. Medically Needy (MN)**
- The Aged, Blind and Disabled (ABD) and the Families & Children (F&C) covered groups in the MN classification are listed below.
- 1. ABD Groups**
- a. Aged - age 65 years or older.
 - b. Blind - meets the blind definition
 - c. Disabled - meets the disability definition.
 - d. Individuals who received Medicaid in December 1973 as AB/APTD-related medically needy and who continue to meet the December 1973 eligibility requirements.
- 2. F&C Groups**
- a. Children under age 18.
 - b. Children under age 1.
 - c. Pregnant Women.
 - d. Non-IV-E Foster Care/Adoption Assistance children and Juvenile Justice Department children.
 - e. Individuals under age 21 in an ICF or ICF-MR.
- E. Refugees**
- “Refugees” are a special group of individuals who have an alien status of “refugee”, and are eligible for Medicaid under a different federal funding source. Virginia receives full federal funding with no state matching funds for the medical assistance provided to these individuals during the first 8 months they are in the U.S.
- There are two *aid categories (ACs)* for this group. *AC 078* is used for Refugee Other and Refugee Medicaid Other and *AC 079* is used for Refugee Medicaid Unaccompanied Minors. The policy and procedures used to determine whether an individual is eligible in this group are found in the Refugee Resettlement Program Manual, Volume XVIII.

M0310.109 COVERED GROUP

A. Definition

The federal Medicaid law and the State Plan for Medicaid describe the groups of individuals who may be eligible for Medicaid benefits. These groups of individuals are the Medicaid covered groups. The individuals in the covered groups must meet specified definitions, such as age or disability, and other specified requirements such as living in a medical facility.

The covered groups are classified in Virginia as categorically needy (CN), categorically needy non money payment (CNNMP), medically indigent (MI) and medically needy (MN). The covered groups are divided into the ABD and F&C covered groups for financial eligibility purposes.

B. Procedure

The covered groups are listed in section M0310.002.

The detailed requirements of the covered groups are in subchapters M0320 and M0330.

M0310.110 CHILD

A. Definition

An individual under age 21 years who has not been legally emancipated from his/her parent(s) is a child.

A married individual under age 21 is a child unless he/she has been legally emancipated from his/her parents by a court. Marriage of a child does not emancipate a child from his/her parents and does not relieve the parents of their legal responsibility to support the child.

M0310.111 DEPENDENT CHILD

A. Definition

The definition of "dependent child" is the definition in section 406(a) of the Social Security Act: the term "dependent child" means a child who is:

1. under the **age of 18**, or under the **age of 19** and is a **full-time student** in a secondary school or in the equivalent level of vocational or technical training, or in a *General Educational Development (GED) program* IF he may be reasonably expected to *complete the secondary school, training or program* before he attains age 19; and
2. **living in the home of a parent or a caretaker-relative** of the first, second, third, fourth or fifth degree of relationship in a place of residence maintained by one or more of such relatives as his or their own home. *See section M0310.107 for the definition of a caretaker-relative.*

B. Age & School Enrollment

1. Age

The child's date of birth declared on the application/redetermination form is used to determine if the child meets the age requirement. No verification is required.

A child who becomes 18 after the first day of his birth month meets the age requirement in the month of his 18th birthday; he is still considered under age 18 during his birth month. If he becomes age 18 on the first day of his birth month, he is age 18 for the whole birth month.

An 18 year old child does **not** meet the age requirement in the month following the month in which his 18th birthday occurs unless the child is enrolled full-time in a secondary school or vocational/technical school of secondary equivalency AND is reasonably expected to complete the program of secondary school or vocational/technical training before or in the month he attains age 19.

2. School Enrollment

Accept the declaration of school enrollment.

C. Living With a Parent or Caretaker-Relative

1. Relationship

The child's relationship to the parent or caretaker-relative with whom he lives as declared on the application or redetermination document is used to determine if the child is living with a relative. No verification is required.

For the purpose of determining a relationship, neither death, divorce, nor adoption terminates relationship to the biological relatives.

B. Procedures

See the following sections for definitions of F&C individuals and families:

- M0310.102 Adoption Assistance,
- M0310.107 Caretaker-relative,
- M0310.110 Child,
- M0310.111 Dependent Child,
- M0310.113 EWB,
- M0310.115 Foster Care,
- M0310.118 LIFC,
- M0310.123 Parent,
- M0310.124 Pregnant Woman
- *M0310.133 BCCPTA*

M0310.115 FOSTER CARE**A. Definition**

Foster Care provides maintenance and care for children whose custody is held by:

1. a local board of social services;
2. a licensed private, non-profit child placement agency;
3. the Department of Juvenile Justice; or
4. the child's parent(s), under a non-custodial agreement with the child's parent or guardian and the local Board of Social Services or the public agency designated by the Community Policy & Management Team (CPMT).

1. Custody

Custody may be given either by the court or through a voluntary entrustment by the parent(s).

2. Child Placing Agency

A child placing agency is an agency that is licensed by the State Department of Social Services for child placing services. Not all child placing agencies provide adoption services; some may provide foster home placement. The services offered must be identified in the description given for the license. The foster care service unit of the local department of social services should be familiar with the function of the child placing agency, and whether or not it is licensed.

3. Non-custodial Agreement

A non-custodial agreement is an agreement between the child's parent or guardian and the local Board of Social Services or the public agency designated by the Community Policy & Management Team (CPMT). The parent(s) or guardian retains legal custody of the child. The social services agency agrees to provide financial assistance and services to the child, such as placement in and payment for residential facility services.

Because the agency is assuming partial financial responsibility for the child, the child meets the foster care definition. However, the agency does not have legal custody of the child; therefore, the parent(s) or guardian must apply for Medicaid for the child.

B. Procedures**1. IV-E Foster Care**

Children in the custody of a Virginia local department of social services who are eligible for Title IV-E (AFDC-FC) foster care maintenance payments and who reside in Virginia are IV-E Foster Care for Medicaid eligibility purposes.

Children in the custody of another state's social services agency, who are eligible for Title IV-E Foster Care maintenance payments and who now reside in Virginia, are IV-E Foster Care for Medicaid eligibility purposes. Verify the child's IV-E eligibility from the other state's department of social services which makes the IV-E payment.

2. Non IV-E Foster Care

Children in the custody of a Virginia local department of social services or a private child placing agency who are eligible for Non-IV-E (state/local) Foster Care maintenance payments and who reside in Virginia are Non-IV-E Foster Care for Medicaid eligibility purposes.

A child in the custody of the Virginia Department of Juvenile Justice or who is the responsibility of a court is a "corrections child." The corrections child who meets the F&C income limit is IV-E Foster Care for Medicaid eligibility purposes. A corrections child is not eligible for IV-E Foster Care.

Children in the custody of another state's social services agency who are not IV-E eligible, do NOT meet the Virginia residency requirement for Medicaid (M0230) and are not eligible for Virginia Medicaid.

M0310.116 HOSPICE**A. Definition**

"Hospice" is a CNNMP covered group of terminally ill individuals whose life expectancy is 6 months or less and who have voluntarily elected to receive hospice care. The term "hospice" is also used to refer to the covered service for a terminally ill Medicaid recipient, regardless of his covered group. Hospice services can be provided in the individual's home or in a medical facility, *including a nursing facility*.

1. Hospice Care

"Hospice care" means items and services are provided to a terminally ill individual by, or by others under arrangements made by, a hospice program under a written plan of care for the individual that is established and periodically reviewed by the individual's attending physician and the hospice program's medical director:

2. Hospice Program

A "hospice program" is a public agency or private organization which

- is primarily engaged in providing hospice care, makes hospice care services available as needed on a 24-hour basis, and provides bereavement counseling for the terminally ill individual's immediate family;
- provides hospice care in individuals' homes or in medical facilities on a short-term inpatient basis;
- meets federal and state staffing, record-keeping and licensing requirements.

M0310.123 PARENT

A. Definition

Under federal regulations, a parent means either the mother or the father, married or unmarried, natural or adoptive following entry of the interlocutory or final adoption order, whichever comes first.

The presence in the home of a “substitute parent” or “man in the house” is not an acceptable basis for a finding of no deprivation. If a man not married to the mother is living in the home, he is the parent (the acknowledged father) when:

- the man has been found by a court to be the child’s father.
- the man has admitted paternity either before a court, or voluntarily in writing, under oath.
- the man’s name appears on the child’s birth certificate issued by the Virginia Department of Health Bureau of Vital Statistics.
- the child has been placed by a court with the man or a relative of the man on the basis that his is the child’s father.

If evidence of paternity is required to establish eligibility or ineligibility, such evidence must be entered in the eligibility case record.

B. Procedure

Section M0320.306 contains the detailed requirements for the LIFC covered group in which a parent of a dependent child can be eligible for Medicaid.

M0310.124 PREGNANT WOMAN

A. Definition

A woman of any age who is medically determined to be pregnant meets the definition of a pregnant woman.

1. Effective Date

The pregnant woman definition is met the first day of the estimated month of conception as medically verified, or the first day of the earliest month which the medical practitioner certifies as being a month in which the woman was pregnant.

The definition of “pregnant woman” is met for sixty days following the last day the woman was pregnant regardless of the reason the pregnancy ended, and continues to be met until the last day of the month in which the 60th day occurs.

Example #3: a pregnant woman applies for Medicaid in May 1997; she received medical treatment in March and April 1997. The physician gives her a written statement dated May 20, 1997 saying that he “treated her in March 1997. She was approximately 3 months pregnant at that time. She is still pregnant this date.” Therefore, her pregnancy is

medically verified for February - April 1997, since the doctor's statement verifies that she was pregnant in February, March, April, and May.

B. Procedures

1. Verification

Verification of pregnancy, including the expected delivery date, must be provided. Acceptable verification is a written or verbal statement from a physician, nurse or similar *health* practitioner. Documentation of how the pregnancy was verified must be included in the case record.

If retroactive converge is requested the statement must also include an estimated month of conception since the pregnant woman definition is not met in any month prior to the conception month. If the medical practitioner cannot or will not give an estimated month of conception, the practitioner's certification that the woman was and is pregnant in the specific months for which Medicaid coverage is requested will suffice as pregnant woman definition verification.

Proof of the birth of a child to the mother is sufficient verification of the mother's pregnancy in the three months prior to the child's birth month.

2. Covered Groups Eligibility

A pregnant woman may be eligible for Medicaid if she meets all of the Medicaid eligibility requirements including any one or more of the covered groups. Two of the Medicaid covered groups are specifically for pregnant women: MI Pregnant Women and MN Pregnant Women.

See section M0320.301 for the MI pregnant woman covered group requirements, and section M0330.301 for the MN pregnant woman covered group requirements.

M0310.125 QDWI

A. Qualified Disabled & Working Individuals (QDWI)

QDWI is the short name used to designate the Medicaid covered group of Medicare beneficiaries who are "Qualified Disabled and Working Individuals." A qualified disabled and working individual means an individual

- who is entitled to enroll for Medicare Part A,
- whose resources do not exceed twice the maximum amount of resources that an individual or couple may have and be eligible for SSI,
- whose income does not exceed 200% of the federal poverty limit,
- who is NOT otherwise eligible for Medicaid.

B. Procedure

QDWI is a mandatory covered group that the state plan must cover for the purpose of paying the beneficiary's Medicare Part A premium. See section M0320.209 for the procedures to use to determine if an individual meets the QDWI covered group.

**B. State Plan Governs
Medicaid Eligibility
Rules**

The State Plan consists of preprinted material that covers the basic Medicaid requirements and individualized material written by DMAS that reflects the particular requirements and choices made by Virginia for its Medicaid program. The State Plan is included in DMAS' state regulations promulgated according to the Virginia Administrative Process Act (APA). The State Plan is kept and updated by DMAS.

The State Plan shows the eligibility requirements for Virginia Medicaid, including the mandatory and optional groups of individuals covered by Virginia Medicaid and the medical services covered by Medicaid for those groups. The covered groups eligibility requirements in this chapter are based on the State Plan.

M0310.132 TANF

Temporary Assistance for Needy Families (TANF) is the federally-funded (with matching funds from the states) block grant program in Title IV Part A of the Social Security Act that provides temporary cash assistance to needy families. In Virginia, TANF replaced the previous Title IV-A program called Aid to Families With Dependent Children (AFDC) on February 1, 1997.

M0310.134 VIEW PARTICIPANT

A Virginia Initiative for Employment not Welfare (VIEW) participant is an individual who has signed the TANF Agreement of Personal Responsibility. VIEW participants have a higher earned income limit than non-VIEW participants. An individual under a TANF VIEW sanction is a VIEW participant for Medicaid purposes. An individual only receiving TANF transitional support services is not a VIEW participant for Medicaid purposes.

M0310.133 BCCPTA

**A. Breast and Cervical
Cancer Prevention
and Treatment Act
(BCCPTA)**

The Breast and Cervical Cancer Prevention and Treatment Act created a Medicaid covered group for women age 18 through 64 who have been identified by the Centers for Disease Control and Prevention's (CDC) Breast and Cervical Cancer Early Detection Program (BCCEDP) as being in need of treatment for breast or cervical cancer.

B. Procedures

Section M0320.312 contains the detailed requirements for the BCCPTA covered group.

- 22 for an aged individual also QMB;
- 42 for a blind individual also QMB;
- 62 for a disabled individual also QMB.

2. Not QMB

If the individual is NOT a Qualified Medicare Beneficiary (QMB) - the individual does NOT have Medicare Part A, OR has countable income over the QMB income limit - the program designation is:

- 20 for an aged individual NOT also QMB;
- 40 for a blind individual NOT also QMB;
- 60 for a disabled individual NOT also QMB.

E. Ineligible In This Covered Group

If the individual is not eligible for Medicaid in this covered group because of income, determine the individual's eligibility as medically needy spenddown. Determine the individual's eligibility as QMB, SLMB, QDWI or QI if he/she has Medicare Part A.

M0320.205 ABD HOSPICE

A. Policy

SMM 3580-3584 - The state plan includes the covered group of aged, blind or disabled individuals who are terminally ill and elect hospice benefits.

The ABD Hospice covered group is for individuals who have a signed a hospice election statement in effect for at least 30 consecutive days, and who are not eligible in any other full-benefit Medicaid covered group. Hospice care is a covered service for individuals in all full-benefit covered groups; individuals who need hospice services but who are eligible in another full-benefit covered group do not meet the Hospice covered group.

The individual must elect hospice care. Election of hospice care is verified either verbally or in writing from the hospice. If the verification is verbal, document the case record.

The 30-day requirement begins on the day the hospice care election *statement is signed*. Once the hospice election has been in effect for 30 consecutive days, the 300% of SSI income limit is used to determine Medicaid eligibility. If the individual's income *is within 300% of SSI*, eligibility in the *Hospice covered group may be determined beginning with the month in which the hospice election was signed*.

Individuals who already meet the definition of institutionalization in M1410.010 B.2 at the time of hospice election meet the 30-day requirement, provided there is no break between institutionalization and hospice election.

Individuals who meet the Hospice covered group may have their eligibility determined using the same financial requirements as institutionalized individuals. Individuals who receive hospice services in a nursing facility have a patient pay calculation, and a DMAS-122 must be completed (see subchapter M1470). Individuals who receive hospice services outside of a nursing facility do not have a patient pay.

B. Nonfinancial Eligibility

A terminally ill individual who elects hospice services is eligible in this covered group if he/she meets the following requirements:

1. Citizenship/alien status;
2. Virginia residency;
3. Social Security number provision/application requirements;
4. Assignment of rights to medical benefits requirements;
5. Application for other benefits;
6. *Institutional status requirements*;
7. Application to the Health Insurance Premium Payment Program (HIPP);
8. Meets either the Aged, Blind, or Disabled definition in M0310 or is
9. **“deemed” to be disabled because of the terminal illness. Do not refer the individual to the DDS for a disability determination.**

C. Financial Eligibility**1. Asset Transfer**

The individual in the hospice covered group must meet the asset transfer policy in subchapter M1450.

2. Resources

The hospice services recipient is an assistance unit of 1 person. All of the individual's resources must be verified, evaluated, and counted together to determine if the individual meets the Medicaid resource requirements.

If current resources are within the limit, go on to determine income eligibility.

If current resources are NOT within the limit, the individual is NOT eligible for Medicaid in this covered group. He/she may be eligible in a medically indigent covered group (which has more liberal resource methods and standards).

a. Unmarried Individual

If the individual is unmarried or is married and has no community spouse, use the resource policy in chapter S11 and subchapter M1460.

b. Married Individuals

If the individual is married and has a community spouse, use the resource policy in chapter S11 and subchapter M1480.

3. Income

To determine if an individual has income within the 300% of SSI limit, use **gross** income, not countable income. Determine what is income according to chapter S08 and subchapter M1460.

DO NOT subtract the \$20 general exclusion or any other income exclusions. The individual is an assistance unit of 1 person. DO NOT DEEM any income from the individual's spouse or parent.

Compare the total gross income to the 300% of SSI limit (see M0810.002 A. 3). If countable income is equal to or less than this limit, the individual is eligible for Medicaid in this covered group.

If the total gross income exceeds this limit, the individual is not eligible for Medicaid in this covered group. Evaluate his/her eligibility as medically needy.

D. Entitlement

Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the month in which all eligibility requirements are met. Retroactive coverage is applicable to this covered group.

Eligible individuals in this group are classified as categorically needy non-money payment (CNNMP). If the individual has Medicare Part A, re-calculate the individual's income, *applying the* appropriate exclusions. Compare the countable income to the QMB limit.

E. Enrollment

Eligible individuals must be enrolled in the appropriate aid category (AC). If the individual is aged, blind, or disabled as defined in M0310, he is enrolled under that AC. AC (054) is used for "deemed-disabled" individuals only.

For individuals who are ABD and entitled/enrolled in Medicare Part A, income must be recalculated (allowing appropriate disregards) to determine if the individual is dually eligible as a QMB.

1. ABD Individual

a. Dual-eligible As QMB

If the individual is also a Qualified Medicare Beneficiary (QMB) - the individual has Medicare Part A and has countable income within the QMB income limit – the AC is:

- 022 for an aged individual also QMB;
- 042 for a blind individual also QMB;
- 062 for a disabled individual also QMB.

b. Not QMB

If the individual is NOT a Qualified Medicare Beneficiary (QMB) the individual does NOT have Medicare Part A, OR has countable income over the QMB income limit – the AC is:

- 020 for an aged individual NOT also QMB;
- 040 for a blind individual NOT also QMB;
- 060 for a disabled individual NOT also QMB;

2. **“Deemed”
Disabled
Individual**

An individual who is “deemed” disabled based on the hospice election is enrolled using AC 054.

**E. Ineligible In This
Covered Group**

There is no corresponding medically needy hospice covered group. If the individual is aged or has been determined blind or disabled, the individual must be evaluated in a medically needy covered group for medically needy spenddown.

M0320.206 QMB (QUALIFIED MEDICARE BENEFICIARY)

A. Policy

42 CFR 435.121 - Qualified Medicare Beneficiaries are a mandatory CN covered group. Medicaid will pay the Medicare Part A premium (as well as the Part B premium) and deductibles and coinsurance for individuals eligible as QMB only.

A QMB is an individual who:

- is entitled to Medicare Part A hospital insurance benefits, but not entitled solely because he/she is eligible to enroll in Part A under section 1818A of the Act (1818A is applicable to QDWI);
- has resources (as determined for SSI purposes) that do not exceed twice the SSI resource limit; and
- has income that does not exceed 100% of the federal poverty limits.

**B. Nonfinancial
Eligibility**

The Qualified Medicare Beneficiary must meet all the nonfinancial eligibility requirements in chapter M02.

**1. Entitled to
Medicare
Part A**

The individual must be entitled to or must be enrolled in Medicare Part A. The individual does not have to be aged, blind or disabled. However, Medicare entitlement is limited to individuals who are age 65 or older, or who have received Title II social security benefits because of a disability for 24 months, or who have end stage renal (kidney) disease.

Enrollment in Part A of Medicare is verified by the individual's Medicare card, or by communication (such as SVES) with the Social Security Administration (SSA).

**2. Individual
Not
Currently
Enrolled In
Medicare
Part A**

Individuals who are not currently enrolled in Medicare Part A must apply for and enroll in Medicare Part A at the local Social Security Administration (SSA) office, and must present verification of Medicare Part A enrollment to the local department of social services (DSS) in order to be eligible for Medicaid as QMB.

C. Financial Eligibility

1. **Asset Transfer** The individual must meet the asset transfer policy in subchapter M1450.

2. **Assistance Unit** The assistance unit policy and procedures in chapter M05 apply to ABD individuals with income less than or equal to 80% FPL. If not institutionalized, deem or count any resources and income from the individual's spouse with whom he lives. If institutionalized with a community spouse, go to subchapter M1480.

3. **Resources** The resource limit is \$2,000 for an individual and \$3,000 for a couple.

The resource requirements in chapter S11 and Appendix 2 to chapter S11 apply to this covered group.

All of the individual's resources must be verified and evaluated. All nonexempt resources must be added together to determine if the individual meets the Medicaid resource requirements.

4. **Income** The income limits are \leq 80% of the FPL and are in section M0810.002. The income requirements in chapter S08 must be met.

5. **Income Exceeds 80% FPL** **Spendedown does not apply** to this covered group. If the individual's income exceeds the 80% FPL limit, he is not eligible in this covered group. Determine the individual's eligibility in all other Medicaid covered groups.

D. Entitlement

1. **Begin Date** If all eligibility factors are met in the application month, entitlement to full Medicaid coverage in this covered group begins the first day of the application month.

2. **Retroactive Entitlement** ABD individuals in this covered group are entitled to retroactive coverage if they meet all the requirements in the retroactive period.

E. Enrollment

The ABD 80% group AC is:

- 029 for an aged enrollee;
- 039 for a blind enrollee; or
- 049 for a disabled enrollee.

M0320.211 MEDICAID WORKS

A. Policy

The Appropriations Act of 2006 authorized an amendment to the Virginia State Plan for Medical Assistance that allows disabled (including blind) individuals who are:

- at least age 16 and are under age 65,**and**

- who have countable income less than or equal to 80% of the FPL, *(including SSI recipients)* **and**

- who have countable resources less than or equal to \$2,000 for an individual and 3,000 for a couple; **and**
- who are working or have a documented date for employment to begin in the future

to retain Medicaid coverage by cost-sharing through the payment of a premium as long as they remain employed and their earned income is less than or equal to 200% of the FPL. This type of cost-sharing arrangement is known as a **Medicaid** buy-in (MBI) program. **MEDICAID WORKS** is Virginia's MBI program.

B. Nonfinancial Eligibility

An individual in this covered group must meet the nonfinancial requirements in chapter M02:

- aged, blind, or disabled definition in subchapter M0310;
- citizenship/alien status;
- Virginia residency;
- Social Security number provision/application requirements;
- assignment of rights to medical benefits requirements;
- application for other benefits; and
- institutional status.

The individual must also meet the following additional nonfinancial criteria:

- The individual must not be receiving Medicaid covered long-term care services.
- The individual must be competitively employed in an integrated setting. Work must occur in a work setting in the community or in a personal business alongside people who do not have disabilities. Work performed in a sheltered workshop or similar setting is **not** considered competitive employment in an integrated setting. *Contact a Regional Medical Assistance Program Consultant if there is a question about whether the employment meets the criteria for MEDICAID WORKS.*
- The individual must receive pay at the minimum wage or at the prevailing wage or “going rate” in the community, and the individual must provide documentation that payroll taxes are withheld. Self-employment must be documented according to the policy contained in S0820.210.
- The individual must establish a Work Incentive (WIN) Account at a bank or other financial institution, such as a checking or savings accounts. The individual must provide documentation for the case record designating the account(s) as a WIN Account. *The account must either be a new account or an existing account with no other income but the wages earned while in MEDICAID WORKS. It cannot contain the individual's Social Security benefits.*

- All individuals requesting enrollment in MEDICAID WORKS must also sign a MEDICAID WORKS Agreement, available on the LDSS Intranet at: <http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi>. The agreement outlines the individual's responsibilities as an enrollee in the program.
- The individual must participate in cost sharing through the payment of a monthly premium to the Department of Medical Assistance Services. The monthly premium will be waived for the first six months of the program (January 1, 2007 through June 30, 2007).

C. Financial Eligibility

1. Assistance Unit

a. Initial eligibility determination

In order to qualify for MEDICAID WORKS, the individual must meet the assistance unit policy and procedures in chapter M05 that apply to ABD individuals with income less than or equal to 80% FPL. Resources and income from the individual's spouse with whom he lives or, if under age 21, the individual's parents with whom he lives, must be deemed available.

b. Ongoing eligibility

Once the individual is enrolled in MEDICAID WORKS, **the individual is treated as an assistance unit of one.** Spousal and parental resources and income are disregarded for ongoing enrollee eligibility.

2. Resources

a. Initial eligibility determination

For the initial eligibility determination, the resource limit is \$2,000 for an individual and \$3,000 for a couple. *Resources must be evaluated for all individuals, including SSI recipients, who wish to qualify for MEDICAID WORKS.* The resource requirements in chapter S11 and Appendix 2 to chapter S11 apply for the initial eligibility determination. The individual's countable, nonexempt resources must be verified. All countable resources, must be added together to determine if the individual's countable resources are within the limit.

b. Ongoing eligibility

Once the individual is enrolled in MEDICAID WORKS, the following resource policies apply:

- i. For **earnings** accumulated **after** enrollment in MEDICAID WORKS, up to the current 1619(b) income threshold amount will be disregarded if deposited and retained in the WIN Account. The 1619(b) threshold amount for 2006 is \$26,356.
- ii. Resources *accumulated while in MEDICAID WORKS* and held in Internal Revenue Service (IRS)-approved retirement accounts, medical savings accounts, medical reimbursement accounts, education accounts, independence accounts, and other similar State-

approved accounts are excluded. Examples of these accounts include Archer Medical Savings Accounts, 401(k) accounts, traditional Individual Retirement Accounts (IRAs), Roth IRAs, SEP-IRAs, SIMPLE IRAs, Thrift Savings Plans, and 503(b) plans. *The account must be designated as a WIN Account in order to be excluded. Resources accumulated while in MEDICAID WORKS and held in IRS-approved accounts that have been designated as WIN Accounts are also excluded in all future Medicaid determinations for former MEDICAID WORKS enrollees. The account must be exclusively used to hold resources accumulated while in MEDICAID WORKS (including interest) in order for the exclusion to continue.*

- iii. For **all** other resources, the resource requirements in chapter S11 and Appendix 2 to chapter S11 apply. All of the individual's countable, nonexempt resources must be verified and evaluated.

All nonexempt resources must be added together to determine if the individual meets the Medicaid resource requirements. The resource limit for resources not excluded in i or ii above is \$2,000 for an individual.

3. Income

a. Initial eligibility determination

For the initial eligibility determination, the income limit is $\leq 80\%$ of the FPL (see M0810.002). The income requirements in chapter S08 must be met. *Individuals who receive SSI are considered to meet the income requirements and no evaluation of income is necessary for the initial eligibility determination (see M0320.201).*

b. Ongoing eligibility

Once the individual is enrolled in MEDICAID WORKS, the following income policies apply:

- i. The income limit for earned income is 200% of the FPL for one person (see M0810.002) as long as the funds are deposited in a WIN Account. The policy for determining countable earned income is contained in subchapter S0820.

If the individual is self-employed, net earnings from self-employment (NESE) must be demonstrated through documentation of Internal Revenue Service (IRS) filings, quarterly estimated taxes, business records, and/or business plans. The individual's signed allegation of self-employment is acceptable if no other evidence of NESE can be obtained. Follow the policy in S0820.220 for determining NESE.

- ii. The income limit for unearned income remains less than or equal to 80% of the FPL. The policy for determining countable unearned income is contained in subchapter S0830.

**4. Income Exceeds
80% FPL at
Eligibility
Determination**

Spenddown does not apply to the Medicaid Works covered group. Therefore, admission into MEDICAID WORKS is not available to individuals whose income exceeds 80% of the FPL. Evaluate the individual's eligibility in all other Medicaid covered groups.

**D. Cost Sharing and
Premium Payment**

Cost sharing is required of all individuals enrolled in MEDICAID WORKS. Enrollees are responsible for copayments for services received (see M1850.100 B).

Premiums are assessed on a sliding scale based on the individual's income and are subject to change. Based on the sliding scale, some individuals may not owe a premium.

Note: *premiums are not being charged at this time.*

E. Good Cause

An individual may remain eligible for MEDICAID WORKS if one of the following good cause exceptions is met:

- If the individual is unable to maintain employment due to illness or unavoidable job loss, the individual may remain in MEDICAID WORKS for up to six months as long as any **required** premium payments continue to be made (premiums will be waived from January 1, 2007 through June 30, 2007). The six-month period begins the first day of the month following the month in which the job loss occurred. The individual must provide documentation that he is unable to work from a medical or mental health practitioner or employer.
- DMAS may establish other good cause reasons. Requests for good cause other than the temporary loss of employment due to illness or unavoidable job loss must be submitted to DMAS on the enrollee's behalf by the local department of social services.

F. Safety Net

Enrollees who are unable to sustain employment for longer than six months must be evaluated for continued coverage in all other Medicaid covered groups for which the individual meets the definition. Resources held in the WIN Account that are accumulated from the enrollee's earnings while in MEDICAID WORKS will be disregarded up to the 1619(b) threshold amount for this eligibility determination.

If found eligible and enrolled in another Medicaid covered group, the individual shall have a "safety-net" period of up to one year from MEDICAID WORKS termination and enrollment in another group to dispose of these excess resources before they are counted toward ongoing eligibility.

If the individual resumes working within the safety-net period, he may be re-enrolled in MEDICAID WORKS provided that all eligibility requirements are met, except that the resources in the WIN Account are disregarded up to the 1619(b) threshold amount. If the individual wishes to be re-enrolled in MEDICAID WORKS after the one-year safety net period, any resources retained in the WIN Account are countable.

Resources accumulated while in MEDICAID WORKS and retained in an IRS-approved account described in M0320.211 C.2.b.ii that has been designated as a WIN Account are excluded in all future Medicaid determinations for former MEDICAID WORKS enrollees.

G. Benefit Package

Individuals enrolled in MEDICAID WORKS are entitled to the standard benefits available to full-benefit Medicaid enrollees (see Chapter M18).

H. Entitlement and Enrollment

Entitlement for MEDICAID WORKS is dependent upon meeting the requirements listed above.

There is no retroactive coverage under MEDICAID WORKS. The application date in the MMIS is the date the individual signed the MEDICAID WORKS Agreement. Coverage shall begin on the first day of the month following the month in which all requirements are met. If the applicant has a future start date for employment, the effective date of eligibility shall be no earlier than the first day of employment. However, unless employment begins on the first day of the month, MEDICAID WORKS enrollment will begin on the first of the following month.

Complete the Medicaid Works fax cover sheet and fax it together with the following information to DMAS at 804-786-0973:

- *a signed Medicaid Works Agreement,*
- *the Work Incentive Account (WIN) information (a bank account statement or verification from the bank that the account was opened), and*
- *one of the following verifications of employment:*
 - *a pay stub showing current employment or*
 - *an employment letter with start date or*
 - *self-employment document(s).*

The AC for MEDICAID WORKS is 059. Use the following procedures to enroll the individual in MMIS:

New Application – Applicant Eligible as 80% FPL

1. *For the month of application and any retroactive months in which the person is eligible in the 80% FPL covered group, enroll the individual in a closed period of coverage using aid category (AC) 039 (blind) or 049 (disabled), beginning the first day of the month in which eligibility exists. The cancel date is the last day of the month in which the MEDICAID WORKS Agreement was signed. Use Cancel Code 042.*
2. *Reinstate the individual's coverage in MEDICAID WORKS using AC 059 beginning the first day of the following month (the first day of the month following the month in which the MEDICAID WORKS Agreement is signed). Use the same application date (the actual date of the initial application) that was used for the month of application.*

Current Enrollee

1. *Cancel current coverage using Cancel Code 042.*

2. *Reinstate in AC 059 beginning the first day of the following month. Use the date the MEDICAID WORKS Agreement was signed for the application date.*

Send a Notice of Action to the applicant/recipient advising him of his eligibility and acceptance into MEDICAID WORKS. Do not send the Advance Notice of Proposed Action when a recipient moves to MEDICAID WORKS, because his Medicaid coverage has not been reduced or terminated.

Eligibility for MEDICAID WORKS continues as long as the enrollee continues to:

- be employed,
- meet the definition of disability or blindness,
- meet the age limitation, and
- does not exceed the income and resource limits for MEDICAID WORKS.

The MEDICAID WORKS enrollee continues to meet the disability criteria as long as SSA has not completed a Continuing Disability Review and has not determined that the individual no longer has a disabling condition. The fact that the MEDICAID WORKS enrollee is earning over the SSA substantial gainful activity amount has no bearing on whether he meets the disability criteria. If the enrollee's disability status is unclear, contact a Regional Medical Assistance Program Consultant for assistance.

The individual's continuing eligibility must be determined at least every 12 months.

If the individual is no longer eligible for MEDICAID WORKS, the eligibility worker must determine whether the individual remains eligible in any other covered group. **The policy in M0320.211 F. above must be reviewed to determine whether the safety net rules apply.** If the individual is not eligible for Medicaid in any other covered group, coverage shall be cancelled effective the first of the month following the expiration of the 10-day advance notice

M0320.300 FAMILIES & CHILDREN CATEGORICALLY NEEDY

A. Introduction

An F&C individual must be a child under age 19 or must meet the adoption assistance, dependent child, foster care, parent or caretaker-relative of a dependent child living in the home, pregnant woman definition in M0310, or BCCPTA definition in M0310.

The F&C CN covered groups are divided into the medically indigent (MI), CN and CNNMP classifications. First determine if the F&C individual meets an MI covered group. If the individual does not meet an MI covered group, then determine if the individual meets the requirements of an F&C CN or CNNMP covered group.

B. Procedure

The policy and procedures for determining whether an individual meets an F&C MI, CN or CNNMP covered group are contained in the following sections:

- M0320.301 MI Pregnant Women & Newborn Children;
- M0320.302 Family Planning Services (FPS);
- M0320.303 MI Child Under Age 19 (FAMIS Plus);
- M0320.305 IV-E Foster Care or IV-E Adoption Assistance Recipients;
- M0320.306 Low Income Families With Children (LIFC);
- M0320.307 Individuals Under Age 21;
- M0320.308 Special Medical Needs Adoption Assistance;
- M0320.309 F&C In Medical Institution, Income \leq 300% SSI;
- M0320.310 F&C Receiving Waiver Services (CBC);
- M0320.311 F&C Hospice;
- M0320.312 Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA).

M0320.301 MI PREGNANT WOMEN & NEWBORN CHILDREN

A. Policy

The federal Medicaid law requires the Medicaid State Plan to cover pregnant women and newborn children whose family income is within 133% of the federal poverty limit. The law allows the State Plan to cover these pregnant women and newborns regardless of their resources; Virginia has chosen to waive the resource eligibility requirements for this covered group.

B. Nonfinancial Eligibility

1. Pregnant Woman

42 CFR 435.170 - The woman must meet the pregnant woman definition in M0310.124.

The MI pregnant woman must meet all the nonfinancial eligibility requirements in chapter M02.

2. Newborn Child

42 CFR 435.117 - A child born to a woman who was eligible for Medicaid at the time the child was born (*including a newborn child born to an alien eligible for Medicaid payment of emergency services only*) is eligible as a newborn child under age 1 year. The child remains eligible for Medicaid as long as the mother remains eligible for Medicaid or would be eligible if she were still pregnant, and they live together.

If current resources are within the limit, go on to determine income eligibility.

If current resources are NOT within the limit, the individual is NOT eligible in this covered group; he/she may be eligible as medically needy in a medically needy covered group.

3. Income

To determine if an individual has income within the 300% SSI income limit, **use gross income**, not countable income, and **use the ABD income policy and procedures in chapter S08 and subchapter M1460**. Determine what is income according to subchapter S0815, ABD What Is Not Income *and subchapter M1460, LTC Financial Eligibility*. **DO NOT** subtract the \$20 general exclusion or any other income exclusions.

The F&C waiver services individual is an assistance unit of 1 person. **DO NOT** deem any income from a spouse or parent.

Compare the **total gross income** to the 300% of SSI income limit (*see M0810.002 A.3*). If gross income is less than or equal to this limit, the individual is eligible for Medicaid in the CNNMP covered group of F&C individuals receiving Medicaid waiver services.

If the total gross income **exceeds** the 300% of SSI income limit, the individual is **not** eligible for Medicaid in the CNNMP covered group of F&C individuals receiving Medicaid waiver services.

D. Entitlement & Enrollment

Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Retroactive coverage is applicable to this covered group.

Eligible individuals in this group are classified as categorically needy non-money payment (CNNMP). If the individual has Medicare Part A, recalculate the individual's income - subtract the appropriate ABD income exclusions. Compare the countable income to the QMB limit.

1. Dual-eligible As QMB

If the individual is also a Qualified Medicare Beneficiary (QMB) – the individual has Medicare Part A and has countable income within the QMB income limit - the program designation is “62.”

2. Not QMB

If the individual is NOT a Qualified Medicare Beneficiary (QMB) – the individual does NOT have Medicare Part A, OR has countable income over the QMB income limit - the program designation is “60.”

E. Ineligible In This Covered Group

If the individual is not eligible for Medicaid in this covered group because of income, determine the individual's eligibility as medically needy spenddown. For unmarried individuals,

redetermine resources using the F&C medically needy policy in chapter M06. Do not recalculate resources of a married individual.

Determine the individual's eligibility as QMB, SLMB, QDWI or QI if he/she has Medicare Part A.

M0320.311 F&C HOSPICE

A. Policy

SMM 3580-3584 - The State Plan includes the covered group of children under age 21, pregnant women and parents or caretaker-relatives of dependent children who are terminally ill and who elect hospice benefits. *The hospice covered group is for individuals who are not eligible in any other full-benefit Medicaid covered group.*

In order to be eligible in the hospice covered group, the individual must file an election statement with a particular hospice which must be in effect for 30 or more consecutive days. The 30-day requirement begins on the effective date of the hospice care election. Once the hospice election has been in effect for each of 30 consecutive days, the 300% of SSI income limit is used to determine Medicaid eligibility. If the individual's income is within the limit, eligibility begins the effective date of the hospice election.

In situations where the 30-day requirement has already been met, the individual does not have to meet it again when he/she elects hospice care. When there is no break in time between eligibility in a medical facility and the effective date of hospice election, the individual does not have to wait another 30 days for eligibility in the hospice covered group.

Individuals who receive hospice services in a nursing facility have a patient pay calculation (see subchapter M1470).

B. Nonfinancial Eligibility

A terminally ill individual who elects hospice services is eligible in this covered group if he/she meets the following requirements:

1. Citizenship/alien status;
2. Virginia residency;
3. Social security number provision/application requirements;
4. Assignment of rights to medical benefits requirements;
5. Cooperation in pursuing support;
6. Application for other benefits;
7. Is not in a medical institution, may be in a residential institution that meets the institutional status requirements;
8. Application to the Health Insurance Premium Payment Program (HIPP);
9. Meets either the child, pregnant woman, or parent or caretaker-relative of a dependent child definition in subchapter M0310.

The individual must elect hospice care. Election of hospice care is verified either verbally or in writing from the hospice. If the verification is verbal, document case record.

C. Financial Eligibility

When determining **income** to compare to the 300% of SSI income limit, use the ABD income policy and procedures, regardless of the individual's definition or covered group. When determining **resources**, use F&C resource policy for unmarried F&C individuals; use ABD resource policy for married F&C individuals.

1. Asset Transfer

The individual in the hospice covered group must meet the asset transfer policy in subchapter M1450.

2. Resources

a. Resource Eligibility - Unmarried Individual

When determining resources for an unmarried F&C hospice individual, use the Medicaid F&C resource requirements in chapter **M06**. All of the individual's resources must be verified, evaluated, and counted together to determine if the individual meets the F&C CNNMP resource limit of \$1,000.

DO NOT DEEM any resources from a child's parent living in the home.

If current resources are within the limit, go on to determine income eligibility.

If current resources are NOT within the limit, the individual is NOT eligible in this covered group. He/she may be eligible as medically needy in a medically needy covered group.

c. Resource Eligibility - Married Individual

When determining resources for a married F&C hospice individual with a community spouse, use the resource policy in subchapter M1480. When determining resources for a married F&C hospice individual who has no community spouse, use the resource policy in subchapter M1460. **Evaluate countable resources using ABD resource policy in chapter S11.**

If current resources are within the limit, go on to determine income eligibility.

If current resources are NOT within the limit, the individual is NOT eligible in this covered group; he/she may be eligible as medically needy in a medically needy covered group.

3. Income

To determine if an individual has income within the 300% SSI income limit, **use gross income**, not countable income, and **use the ABD income policy and procedures in chapter S08**. Determine what is income according to subchapter S0815, ABD What Is Not Income. DO NOT subtract the \$20 general exclusion or any other

income exclusions.

The individual is an assistance unit of 1 person. DO NOT DEEM any income from the individual's spouse or parent.

Compare the total gross income to the 300% SSI income limit (see M0810.002 A. 3.). If countable income is equal to or less than this limit, the individual is eligible for Medicaid in the hospice covered group.

If the total gross income exceeds this limit, the individual is not eligible for Medicaid in the hospice covered group. Evaluate his/her eligibility as medically indigent or medically needy.

D. Entitlement & Enrollment

The hospice services recipient must elect hospice services and the election must be in effect for 30 days. The 30 day period begins on the effective date of the hospice election. Upon 30 days elapsing from the effective date of the hospice election, and the election is in effect for the entire 30 days, eligibility in the hospice covered group begins with the effective date of the hospice election if all other eligibility factors are met.

1. Entitlement

Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Retroactive coverage is applicable to this covered group.

Eligible individuals in this group are classified as categorically needy non-money payment (CNNMP). If the individual has Medicare Part A, evaluate his/her eligibility as ABD hospice in M0320.205.

2. Enrollment

If the individual is eligible in any other full-coverage Medicaid covered group, he is enrolled under that aid category (AC) and not the Hospice AC (054). Enroll with AC 054 for an individual who meets an F&C definition but who is not eligible in any other full-coverage Medicaid covered group.

E. Ineligible In This Covered Group

There is no corresponding medically needy hospice covered group. Evaluate the individual in a medically indigent or medically needy covered group.

$$\begin{array}{r}
 \$747.50 \text{ couple's countable monthly income} \\
 \times \quad 6 \text{ months} \\
 \hline
 4485 \text{ 6-month income} \\
 -1700 \text{ Group I limit for 2} \\
 \hline
 \$2785 \text{ excess}
 \end{array}$$

Because the couple's income is less than the QMB limit for 2 persons, they are eligible for QMB Medicaid. Their income exceeds the medically needy limit for two and they are placed on a spenddown.

M0530.202 DEEMING RESOURCES FROM NABD SPOUSE

A. Policy

When a married couple is living together BUT

- only one spouse applies for Medicaid, or
- only one spouse meets the Aged, Blind or Disabled definition in M0310,

the individual spouse's resource eligibility is determined as a couple--an ABD assistance unit of 2 persons, and the NABD spouse's resources are counted available to the ABD individual.

The resources of one spouse are considered available to the other whether or not they are actually made available. Resource eligibility exists if the value of the couple's combined resources does not exceed the resource limit for two persons. **The resources of an SSI recipient spouse must be counted available even if SSI recipient spouse does not apply for Medicaid.**

Verify and document the NABD spouse's resources as required for an ABD individual.

B. Excluded Resources

When determining the NABD spouse's resources, do not include the resources listed in section M0530.010 above.

C. Countable Resources

Total countable resources are the combination of the resources of the ABD individual and the NABD spouse after all applicable resource exclusions are applied.

Total countable resources are compared to the resource limit for a couple. If the amount of the resources does not exceed the limit, the applicant/recipient meets the resource eligibility requirement. If countable resources exceed the limit, the applicant/recipient is ineligible because of excess resources.

D. Example--No Resources Excluded

EXAMPLE #4: Mr. and Mrs. Daley live together. Mr. Daley, who is age 65, applies for Medicaid on February 4, 1997. His wife is under age 65 and neither blind nor disabled, nor does she meet any Medicaid

covered group. Mr. Daley has no resources of his own. However, Mrs. Daley has \$1,900 in a savings account and owns a vacant lot valued at \$500 which does not produce income.

The couple's countable resources are as follows:

\$1,900	- Mrs. Daley's savings account
<u>+ 500</u>	- Mrs. Daley's lot
\$2,400	- couple's combined resources
<u>- 0</u>	- applicable exclusions
\$2,400	- couple's countable resources
<u>- 3,000</u>	- couple's resource limit
0	excess

Mr. Daley meets the resource eligibility requirements.

E. Example--Some Resources Excluded

EXAMPLE #5: Mr. and Mrs. Sands live together. Mr. Sands, who is disabled, applies for Medicaid on October 2, 1997. Mrs. Sands does not meet a Medicaid covered group. She works for a company with a pension plan and states she has accumulated \$5,000 in her pension fund which she can withdraw at any time. Mr. and Mrs. Sands jointly own two grave sites worth \$500 each and have a joint bank account with a balance of \$ 1,000.

The couple's resources are as follows:

Excluded Resources:	
\$5,000	- pension fund
<u>+ 1,000</u>	- grave sites
\$6,000	- excluded resources

Countable Resources:	
\$1,000	- joint bank account

\$1,000	- couple's countable resources
<u>- 3,000</u>	- couple's resource limit
0	excess

Mr. Sands meets the resource eligibility requirements.

F. Example--Some Resources Excluded-- Individual is Ineligible

EXAMPLE #6: Mr. Smith, who is 69 years old, applies for Medicaid on October 15, 1997. He lives with his wife who is age 62, neither blind nor disabled, nor does she meet a Medicaid covered group. They have the following resources: a joint checking account of \$250; United States savings bonds (in both their names) worth \$400, and two automobiles-- one with a current market and equity value of \$6,000, and the other with a current market value and equity value of \$3,000. In addition, Mrs. Smith owns a plot of land which produces no income and has an equity value of \$2,000. Mr. Smith owns a life insurance policy on his own life with a face value of \$5,000 and a cash surrender value (CSV) of \$897. Mrs.

2. Unearned Income

Unearned income is all income that is not earned income. Some types of unearned income are:

- annuities, pensions, and other periodic payments;
- alimony and support payments;
- dividends, interest, and royalties; or
- rental income.

C. References

- Definition of net countable income, M0710.003
- Earned income, M0720
- Unearned income, M0730

M0710.030 WHEN INCOME IS COUNTED

A. Policy Principles

For applications and reapplications, the income generally to be counted is the income verified for the calendar month prior to the month of application or the most current equivalent (last 4 weekly pays, last 2 bi-weekly pays, or last 2 semi-monthly pays). When evaluating eligibility for a retroactive period, income eligibility is based on income actually received each month in the retroactive period.

For redeterminations, the income generally to be counted is the income verified for the month prior to the month of review or the most current equivalent.

B. Exceptions to Policy Principles

1. Payment Not Received In Normal Month of Receipt

FU/BUs receiving monthly or semi-monthly income, such as state or federal payments or semi-monthly pay checks, must have the income assigned to the normal month of receipt even if mailing cycles, weekends or holidays cause the income to be received in a different month.

EXAMPLE #1: The applicant/enrollee is employed and is paid semi-monthly on the first and sixteenth. Because June 1 falls on a Saturday, the client receives her June 1 paycheck on May 31. The Eligibility Worker will count the paycheck received May 31 as income for June.

2. Self-Employment or Sale of Livestock or Cash Crops

Profit from the sale of livestock or cash crops, such as tobacco or peanuts, or from small businesses, such as but not limited to, vending stands, home beauty shops, or small grocery stores, is prorated on an annual basis or over the number of months in which the income is earned, whichever is appropriate. Federal farm subsidies are prorated over a 12-month period.

3. Contract Income

Guaranteed salaries paid under contract are prorated over the period of the contract even though the employee elects to receive such payments in

fewer months than are covered by the contract. When the contract earnings will be received monthly over a period longer than that of the contract, the earnings must be prorated over the number of months the income is anticipated to be received.

- C. **References** Contract Income, M0720.400
Income From Self-Employment, M0720.200

M0710.610 HOW TO ESTIMATE INCOME

- A. **Monthly Estimates** Generally, estimate future income on a monthly basis.

**1. Anticipated
Income**

Anticipated income means any income the applicant/*enrollee* and local agency are reasonably certain will be received during the month. If the amount of income or when it will be received is uncertain, that portion of the FU/BU's income that is uncertain is not counted by the local agency. Reasonably certain means that the following information is known:

- who the income will come from,
- in what month it will be received, and
- how much it will be (i.e., rate, frequency and payment cycle).

**2. Fluctuating
Income**

When income fluctuates, use the previous months' actual receipts that will provide an accurate indication of the individual's future income situation. *Average the income received in no more than 3 previous months.*

See section M0720.155 C. for detailed information about how to estimate fluctuating income.

**3. Income Expected
Less Than Once
a Month**

Determine the specific month(s) of receipt and use the amount(s) estimated for the appropriate month(s).

**4. Converting to
Monthly Totals**

To estimate income for an income evaluation, convert to a monthly amount:

- multiply average weekly amounts by 4.3
- multiply average bi-weekly amounts by 2.15
- multiply semi-monthly amounts by 2

**5. Partial Month
Income**

If the FU/BU will receive less than a full month's pay, use the exact monthly figure or an average per pay period times the actual number of pays. If actual income is used in any given calculation, adjust the figure for subsequent months if the actual income varies.

**LIFC 185% OF STANDARDS OF NEED (MAXIMUM MONTHLY INCOME)
EFFECTIVE 7/01/07**

FAMILY/BUDGET UNIT SIZE	GROUP I	GROUP II	GROUP III
1	323.37	385.41	538.23
2	507.23	569.25	724.29
3	653.42	713.25	870.52
4	792.99	855.01	1012.27
5	934.77	1012.27	1200.58
6	1047.72	1127.46	1313.55
7	1185.07	1262.59	1450.88
8	1333.49	1408.81	1594.96
9	1455.31	1532.86	1725.57
10	1590.47	1670.21	1858.41
each addt'l person, add	135.09	135.09	135.09

F&C Monthly Income Limits Effective 7/01/07

Group I

Family/Budget Unit Size	100%	90%
1	174.79	156.83
2	274.17	247.82
3	353.19	317.27
4	428.64	385.53
5	505.28	454.98
6	566.33	511.26
7	640.58	577.11
8	720.80	647.75
9	786.66	707.63
10	859.70	774.67
Each person above 10, add	73.02	67.02

Group II

Family/Budget Unit Size	100%	90%
1	208.33	187.96
2	307.71	276.57
3	385.53	348.41
4	462.16	415.46
5	547.18	489.75
6	609.43	548.37
7	682.49	613.03
8	761.51	684.88
9	828.57	745.94
10	902.82	811.80
Each person above 10, add	73.02	67.02

F&C Monthly Income Limits Effective 7/01/07

Group III

Family/Budget Unit Size	100%	90%
1	290.93	263.41
2	391.51	352.01
3	470.55	423.86
4	547.18	490.91
5	648.96	584.30
6	710.02	639.37
7	784.26	706.43
8	862.13	778.28
9	932.74	839.35
10	1004.54	903.99
Each person above 10, add	73.02	67.02

MEDICALLY NEEDY INCOME LIMITS EFFECTIVE 7-01-07

GROUP I			GROUP II		GROUP III	
# of Persons In Family/ Budget Unit	Semi-Annual Income	Monthly Income	Semi-Annual Income	Monthly Income	Semi-Annual Income	Monthly Income
1	1556.59	259.43	1796.07	299.34	2334.89	389.14
2	1982.06	330.34	2211.97	368.66	2815.29	469.21
3	2334.89	389.14	2574.37	429.06	3173.07	528.84
4	2634.24	439.04	2873.72	478.95	3472.41	578.73
5	2933.59	488.93	3173.07	528.84	3771.76	628.62
6	3232.93	538.82	3472.41	578.73	4071.10	678.51
7	3532.58	588.71	3771.76	628.62	4370.45	728.40
8	3891.50	648.58	4130.97	688.49	4669.80	778.30
9	4250.72	708.45	4490.19	748.36	5088.88	848.14
10	4669.80	778.30	4909.28	818.21	5448.11	908.01
each add'l person add	402.31	67.05	402.31	67.05	402.31	67.05

MEDICALLY INDIGENT CHILD UNDER AGE 19 (FAMIS PLUS) INCOME LIMITS FEDERAL POVERTY LEVEL (FPL) EFFECTIVE 1-24-07 ALL LOCALITIES		
# of Persons in Family/Budget Unit	100% FPL Monthly Limit	133% FPL Monthly Limit
1	\$ 851	\$1,132
2	1,141	1,518
3	1,431	1,904
4	1,721	2,289
5	2,011	2,675
6	2,301	3,061
7	2,591	3,446
8	2,881	3,832
each add'l person add	290	386

MI Child under age 6 with income less than or equal to 100% FPL –AC 091

MI Child age 6 to 19 with income less than or equal to 100% FPL – AC 092

MI Child under age 6 with income greater than 100% FPL and less than or equal to 133% FPL – AC 090

Insured MI Child age 6 to 19 with income greater than 100% FPL and less than or equal to 133% FPL –AC 092

Uninsured MI Child age 6 to 19 with income greater than 100% FPL and less than or equal to 133% FPL – AC 094

MEDICALLY INDIGENT PREGNANT WOMAN INCOME LIMITS 133% FPL EFFECTIVE 1-24-07 ALL LOCALITIES	
<u># of Persons in Family/Budget Unit</u>	<u>Monthly Limit</u>
1	\$1,132
2	1,518
3	1,904
4	2,289
5	2,675
6	3,061
7	3,446
8	3,832
each add'l person add	386

Pregnant Woman with income less than or equal to 133% FPL – AC 091

**TWELVE MONTH EXTENDED MEDICAID
INCOME LIMITS
185% of FEDERAL POVERTY LIMITS
EFFECTIVE 1-24-07
ALL LOCALITIES**

<u># of Persons in Family/Budget Unit</u>	<u>Monthly Limit</u>
1	\$1,575
2	2,111
3	2,648
4	3,184
5	3,721
6	4,257
7	4,794
8	5,330
each add'l person add	537

period. Income received in prior periods is normally used to determine the amount of income to be received in future periods. Income from the prior period is averaged and converted to a monthly amount. That monthly amount is the amount anticipated to be received in each of the future months. New sources of income may be anticipated based on statements from the provider of the income.

B. Definitions

1. Anticipated Income

Income the individual and local agency are reasonably certain will be received during the ongoing evaluation period.

To be reasonably certain that income will be received determine:

- from whom the income will come (the provider);
- in what month and on what dates it will be received (frequency and payment cycle); and
- how much will be received (rate).

2. Fluctuating Income

Fluctuating income is earned income where neither the pay rate nor hours per pay period can reasonably be predicted.

3. Income Base Period

A period of time immediately prior to the month of application/redetermination that includes one or more pay periods, or the most current equivalent {last four (4) weekly pays, last two (2) bi-weekly pays, or last two (2) semi-monthly pays} that is used to provide an accurate reflection of the individual's future income.

4. Monthly Income

Monthly income is the income received in an average month. An average month contains 4.3 weeks. Income received more frequently than monthly is converted to a monthly figure.

5. Pay Period

The time period covered by each pay check. A pay period may be weekly, bi-weekly, semi-monthly, monthly or longer periods of time.

C. Income Base Period Used

Use the income received in the month prior to the month of application/redetermination unless the prior month's income cannot by itself provide an accurate indication of anticipated income.

When the prior month's income cannot by itself provide an accurate indication of anticipated income, the applicant/recipient must be given the opportunity to provide the additional information necessary to accurately project monthly income.

1. Seasonal Income

When the individual's income fluctuates seasonally, use the most recent season, past seasons, or the current calendar month prior to the month of application/redetermination, as an indicator of future income.

Use the information obtained from the income provider and worker judgment to determine the anticipated income. Document the file to support how the income was anticipated.

- 2. Migrant Or Seasonal Farm Worker** For migrant and seasonal farm workers, the income that is reasonably certain to be received is based on formal or informal commitments for work for an individual, rather than on the general availability of work in an area.
- Base income on the information obtained from the income provider and worker judgment to determine the anticipated income. Document the file to support how the income was anticipated.
- Do not base income on an assumption of optimum weather or field conditions.
- 3. New or Increased Income** Use the income provider's statement of the beginning date, the amount of income to be received, the frequency of receipt, and the day/dates of receipt to establish the amount to be received per pay period.
- 4. Terminated Income** Income from a terminated source must only be verified when it was received in a month in which eligibility is being determined.
- 5. Decreased Income** Use the income provider's statement of the beginning date of the decrease, the new amount of income to be received, the frequency of receipt, and the day/date of receipt to establish the amount to be received per income period. Document the file to support how the income was anticipated.

If an employed person anticipates a decrease in wages that is not supported by evidence in the file, the individual must be advised to report the decrease as soon as it can be verified. Adjustments are made when the decrease is verified.

D. Calculating Estimated Monthly Income

- 1. Average Income** *When the income amounts received in each pay period are different, calculate the average amount of income received per pay period. Average the income received in no more than 3 previous months. Use the income received in previous months that provide an accurate indication of the individual's future income situation.*
- 2. Full Month's Income** Total the income received in the Income Base Period. Divide that total by the number of pay periods in the Income Base Period. The result is the average amount to be received per pay period. If the income is received more frequently than monthly, convert the income to a monthly amount.

To convert to monthly income:

- Multiply weekly wage by 4.3; or
- multiply biweekly wage by 2.15; or
- multiply semi-monthly wage by 2.

3. **Partial Month's Income** If less than a full month's income is received or expected to be received, do not convert to a monthly amount. Use the actual amount received or expected to be received.

- C. **References** How to Estimate Income, M0710.610.

M0720.200 INCOME FROM SELF-EMPLOYMENT

- A. **Policy** Self-employment is defined as a business, farming or commercial enterprise in which the individual receives income earned by his own efforts, including his active engagement in management of property.

Self-employment situations include, but are not limited to, domestic workers, day care providers including babysitters, and chore and companion service providers. The profit from self-employment is earned income.

Profit from self-employment means the total income received, less the allowable business expenses directly related to producing the goods or services and without which the goods or services could not be produced.

- B. **Business Expenses** Business expenses are expenses directly related to producing goods or services and without which the goods or services could not be produced including, but not limited to, the following:

- payments on the interest of the purchase price of, and loans for, capital assets such as real property, equipment, machinery and other goods of a durable nature;
- insurance premiums;
- legal fees;
- expenses for routine maintenance and repairs;
- advertising costs;
- bookkeeping costs.

Business expenses **do not** include:

- payments on the principal of the purchase price of, and loans for, capital asset, such as real property, equipment, machinery and other goods of a durable nature;
- the principal and interest on loans for capital improvements of real property;
- net losses from previous periods;
- federal, state, and local taxes;
- money set aside for retirement purposes;
- personal expenses, entertainment expenses, and personal transportation;
- depreciation of equipment, machinery, or other capital investments necessary to the self-employment enterprise.

- C. Verification** Verification is proof of the gross amount of income received and proof of the business related expenses. Verify gross income received and business related expenses by self-employment bookkeeping or tax records.

M0720.250 INCOME FROM REAL PROPERTY

- A. Policy** Income from real property is self-employment income when the individual is actively engaged in the managerial responsibilities of the income producing property. Income from real property is determined on a monthly basis except farm subsidies which are prorated over a twelve month period.

If the individual is not actively involved in the management responsibilities, income received from the property is unearned income. See M0730.505.

When income from real property is received, the case record must clearly indicate the basis for determining whether or not the individual produces it by his own efforts or whether or not he is actively engaged in management.

- B. Profit** Deduct the amount of the allowable business expenses from the gross income to determine profit from real property.

M0720.260 INCOME FROM ROOM AND BOARD

- A. Policy** Income from room and board is earned income from self-employment if the applicant/recipient produces the income from his own efforts or carries managerial responsibilities. Income from room and board is determined on a monthly basis.

B. Procedure

- 1. Verify Gross Income** Verify gross income received by self-employment bookkeeping records.

available continues until the 8 consecutive months has ended. If the individual is not enrolled in Medicaid in the LIFC covered group in any of the following 8 consecutive months, the individual will not receive the \$30 earned income exclusion.

EXAMPLE #5: A LIFC recipient becomes employed in January and receives the \$30 plus 1/3 earned income exclusion for February, March, April and May. She is entitled to a \$30 earned income exclusion for the 8-month period of June through January. She requests her case be closed in June. The 8-month time period for the \$30 earned income exclusion continues to run. In February she reapplies and is employed. She is not eligible to receive the \$30 earned income exclusion.

c. Reapplies in 8-Month Period

If an individual becomes ineligible for Medicaid for any reason and reapplies during the 8-month \$30 earned income exclusion period, the individual will be eligible for the exclusion for the remaining months of the 8-month period.

EXAMPLE #6: A LIFC recipient becomes employed in January and receives the \$30 plus 1/3 exclusion on earned income received in February, March, April and May. She is entitled to a \$30 earned income exclusion on income received in June through January. The recipient requests her case be closed in July. The 8-month period continues to run. She reapplies in September and is found eligible. The \$30 earned income exclusion applies to her earnings in the months of September through January.

d. Received \$30 Earned Income Exclusion For Less than Eight Months Due to Loss of Earnings

If an individual receives the \$30 earned income exclusion for less than 8 months because of a loss of earnings, the individual will again be eligible for the remaining months of the 8-month period if the individual receives earned income.

EXAMPLE #7: Mrs. Tan, a Medicaid recipient, received the \$30 plus 1/3 earned income exclusion in January, February, March, and April (first 4 consecutive months). She received the \$30 earned income exclusion in May and June. She loses her job in June. In August, she becomes employed. She is eligible for the \$30 earned income exclusion for the months of September through December.

M0720.540 CHILD CARE/INCAPACITATED ADULT CARE EXCLUSION

A. Policy

Anticipated child or incapacitated adult care expenses paid or anticipated to be paid by the family/budget unit for children or incapacitated adults in the family unit, up to the appropriate maximums, must be excluded from earned income in determining Medicaid eligibility when the expenses are necessary because of employment or seeking employment.

a. Both parents are in the home

When both parents are in the household, both parents must be employed or seeking employment to *receive* the child care/incapacitated adult care exclusion. The child care/incapacitated adult care exclusion is based on a *parent's* employment status.

When only one parent is employed and the other parent is not employed or seeking employment and is not able to care for the child(ren) or incapacitated adult, the dependent/incapacitated adult care expense exclusion may be granted when:

- 1) the paid child or incapacitated adult care is necessary, **and***
- 2) a physician provides a statement that the parent is disabled and unable to care for the child(ren) or incapacitated adult in question. The doctor's statement must also indicate the anticipated length of time that the parent will be unable to care for the child(ren) or incapacitated adult.*

b. LIFC 185% screening

For LIFC, the child or incapacitated adult care exclusion is not allowed in the 185% screening.

B. Definitions

- 1. Full-time Employment**

Full-time employment means employed to work 30 hours or more per week on an on-going basis; or working, or expected to work 120 hours or more per month (for an individual working on a fluctuating basis).
- 2. Part-time Employment**

Part-time employment means employed to work less than 30 hours per week on an on-going basis; or working or expected to work less than 120 hours per month (for an individual working on a fluctuating basis).
- 3. Not Employed Throughout a Month**

Not employed throughout a month means an individual began or terminated employment within the month.

C. Operating Principle

1. Verification

a. Incapacity

Incapacity of the adult who requires care must be supported by a professional determination. The medical examination for Medicaid and GR is used for this purpose, unless incapacity is established by receipt of Social Security Disability benefits.

b. Employment Status

An individual's employment status is verified by either an employer's statement of the number of hours employed to work, or actually worked

or by pay stubs. For self-employed individuals, the agency is required to accept the client's statement concerning the number of hours worked, unless the agency has reason to question the validity of the statement.

c. Expenses

Verification of child/incapacitated adult care expenses is not required. Accept the parent/caretaker's declaration of the amount of the child/incapacitated adult care expense.

2. Amount of Exclusion

a. Full-time Employment

For full-time employment, deduct an amount equal to the anticipated cost, not to exceed \$175 per month, for care of each child, age 2 and older and/or incapacitated adult in the family unit. In the case of child care for a child under 2 years old, deduct the anticipated cost not to exceed \$200 per month.

b. Part-time Employment

For part-time employment, deduct an amount equal to the anticipated cost, not to exceed \$120 per month, for care of each child and/or incapacitated adult in the family unit.

c. Not Employed Throughout a Month

- 1) If an individual has worked, or is expected to work, 120 hours or more in that month, deduct an amount not to exceed the full-time exclusion.
- 2) If an individual has worked, or is expected to work, less than 120 hours in that month, deduct an amount not to exceed the part-time exclusion.

3. Conversion to Monthly Amount

If child care/incapacitated adult care is payable on a weekly or bi-weekly basis, the amount of the monthly expense may be calculated using the 4.3 (weekly), or 2.15 (bi-weekly), or 2 (semi-monthly) conversion factors.

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 covered group; and
- meets the nonfinancial requirements; and
- meets the covered group's resource limits; and
- meets the covered group'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 covered group 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 covered group.

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

Categorically-Needy Non-Money Payment Protected Covered Groups Which Use SSI Income Limits		
Family Unit Size	2007 Monthly Amount	2006 Monthly Amount
1	\$623	\$603
2	934	904
Individual or Couple Whose Total Food and Shelter Needs Are Contributed to Him or Them		
Family Unit Size	2007 Monthly Amount	2006 Monthly Amount
1	\$415.33	\$402
2	622.67	602.67

**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.

Categorically Needy-Non Money Payment 300% of SSI		
Family Size Unit	2007 Monthly Amount	2006 Monthly Amount
1	\$1,869	\$1,809

**4. Medically
Needy**

a. Group I		
Family Unit Size	Semi-annual	Monthly
1	\$ 1,556.59	\$ 259.43
2	1,982.06	330.34
b. Group II		
Family Unit Size	Semi-annual	Monthly
1	\$ 1,796.07	\$ 299.34
2	2,211.97	368.66
c. Group III		
Family Unit Size	Semi-annual	Monthly
1	\$ 2,334.89	\$ 389.14
2	2,815.29	469.21

**5. ABD Medically
Indigent**

**For:
ABD 80% FPL,
QMB, SLMB, &
QI without Social
Security (SS) and
QDWI, effective
1/24/07;
ABD 80% FPL,
QMB, SLMB, &
QI with SS,
effective 3/01/07;
and MEDICAID
WORKS,
effective 1/24/07**

ABD 80% FPL	Annual	Monthly
1	\$ 8,168	\$ 681
2	10,952	913
QMB 100% FPL	Annual	Monthly
1	\$10,210	\$ 851
2	13,690	1,141
SLMB 120% of FPL	Annual	Monthly
1	\$12,252	\$1,021
2	16,428	1,369
QI 135% FPL	Annual	Monthly
1	\$13,784	\$1,149
2	18,482	1,541
QDWI and MEDICAID WORKS 200% of FPL	Annual	Monthly
1	\$20,420	\$1,702
2	27,380	2,282

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RESOURCE EXCEPTIONS FOR ABD MI

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**C. Examples-
Evidence to the
Contrary**

1. **Recently Issued U.S. Savings Bond: Not a Resource**
 - a. Situation - On January 6, 1994 Ms. Minnie Marbel applied for Medicaid benefits. Among her alleged resources was a \$500 series EE U.S. Savings Bond which she had won a month earlier in a Christmas raffle at church. Since series EE bonds are never redeemable for 6 months following issue, the EW questioned whether the minimum retention period had expired.
 - b. Analysis - The bond's issue date was December 1, 1993. Therefore, Ms. Marbel by law could not redeem it before June 1, 1994. Consequently, the bond not only was not a liquid resource, it was not a resource at all. The value of the bond, including any interest accrued, does not become a liquid resource until July 1, 1994.

2. **Guardianship Account -- Guardian Dies: Non-Liquid Resource**
 - a. Situation - Ms. Harriet Dalton had a court-appointed guardian who had sole access to Ms. Dalton's savings account. On September 8, 1988 the guardian filed for Medicaid on Ms. Dalton's behalf. On November 2, while the claim was still pending, the guardian died. Because of the delay in having a new guardian appointed and establishing a new account signatory, there was no one authorized to withdraw funds from the account for at least 60 days (and possibly longer).
 - b. Analysis - For September through November the account was Ms. Dalton's liquid resource because her guardian had access to it as of the first moment of each month. Beginning in December and until the first of the month in which a new guardian had access to the account, it was a nonliquid resource.

3. **Comparison of Analyses in 1. And 2. Above**

The guardianship account continues to be a resource because, at all times, Ms. Dalton owned it and had the legal right to use it for her own support and maintenance. The delay in appointing a new guardian who could access it within 20 days does not remove Ms. Dalton's right to the funds.

In the case of the savings bond, neither Ms. Marbel nor anyone acting on her behalf had the right, authority or power to redeem the bond for cash until 6 months from the date of issue.

S1110.310 RESOURCES ASSUMED TO BE NONLIQUID

- A. Introduction** Certain non-cash resources, though they may occasionally be liquid, are nearly always non-liquid.
- B. Operating Policy**
- 1. Assumption of Nonliquidity** Absent evidence to the contrary, we assume that the following type of resources are non-liquid.
- automobile, trucks, tractors, and other vehicles;
 - machinery and livestock;
 - buildings, land and other real property rights; and
 - non-cash business property.
- 2. Evidence to The Contrary**
- a. If there is no apparent evidence to the contrary of the assumptions in 1. above, we do not seek out any evidence to the contrary. There is no need to document a lack of evidence to the contrary.
- b. In very rare situations an individual may volunteer firm evidence that one of the above types of resources is liquid (i.e., its sale has been accomplished or arranged within 20 workdays). Document the file and proceed accordingly only if the distinction is material.
- C. Operating Policy-- Life Insurance** This subchapter provides no categorical assumption regarding the liquidity or non-liquidity of life insurance policies.

VALUATION OF RESOURCES

M1110.400 WHAT VALUES APPLY TO RESOURCES

A. Policy Principles

- 1. Definitions**
- a. *The current market value (CMV) or fair market value (FMV) of a resource is:*
- *Real property – 100% of the local tax assessed value.*
 - *Countable vehicles*
 - the **average trade-in value** listed in the National Automobile Dealers Official Used Car Guide (NADA) Guide, or
 - the value assessed by the locality for tax purposes may be used, if vehicle is not listed in N.A.D.A. Guide.
- b. Equity value (EV) is the CMV of a resource minus any encumbrance on it.

b. Sale of Remainder Interest

Unless restricted by the instrument establishing the remainder interest, the remainderman is generally free to sell his/her interest in the physical property even before the life estate interest expires. In such cases, the market value of the remainder interest is likely to be reduced since such a sale is subject to the life estate interest.

3. Example

Mr. Heath, now deceased, had willed to his daughter a life estate in property which he had owned in fee simple. The will also designated Mr. Heath's two sons as remaindermen. Ms. Heath has the right to live on the property until her death at which time, under the terms of her father's will, the property will pass to her brothers as joint tenants.

C. Policy--Equitable Ownership Interest

Basically, existence of an equitable ownership interest is determined by a court of equity.

1. Unprobated Estate

For Medicaid purposes, an individual may have an equitable ownership interest in an unprobated estate if he or she:

- is an heir or relative of the deceased;
- receives income from the property; or
- has acquired rights in the property due to the death of the deceased in accordance with State intestacy laws.

M1120.215 contains instructions on how to determine whether an interest in an unprobated estate is a resource.

2. Trust

A trust is a right of property established by a trustor or grantor. One party (trustee) holds legal title to trust property which he or she manages for the benefit of another (beneficiary). The beneficiary does not have legal title but does have an equitable ownership interest.

M1120.200 contains instructions concerning resources treatment of trusts in the Medicaid program.

M1120.201 contain instructions for the resources treatment of trust established on or after August 11, 1993.

3. Equitable Home Ownership

If an individual alleges equitable ownership (e.g. an unwritten ownership interest or right of use for life) obtain any pertinent documents and a signed statement from each of the parties involved regarding any arrangement that has been agreed to. Forward the document to a medical assistance program consultant for an opinion from legal counsel.

D. References

The following references pertain to trust situations:

- Financial institution/conservatorship accounts, S1140.200 - S1140.215
- Property held under a State's Uniform Gift to Minors Act, S1120.205
- Situations involving an agent acting in a fiduciary capacity on behalf of another party, S1120.020
- Trust established on or after August 11, 1993, M1120.201

S1110.520 PROPERTY RIGHTS WITHOUT OWNERSHIP OF THE PROPERTY

A. Introduction

An individual may have certain rights with respect to property without also having the right to dispose of the property. However, the individual may have the right to sell his/her right or interest (i.e. the right to use or possess the property).

B. Definitions**1. Leasehold**

A leasehold does not designate rights of ownership. Rather, it conveys to an individual use and possession of property for a definite term and usually for an agreed rent.

2. Incorporeal Interests

There are several types of real property rights called "incorporeal interests." They do not convey ownership of the physical property itself. They convey the right to use the property but not to possess it. These rights encompass mineral and timber rights and easements (explained in more detail at S1140.110).

B. Policy Principle

A retirement fund owned by an eligible individual is a resource if he/she has the option of withdrawing a lump sum even though he/she is not eligible for periodic payments. However, if the individual is eligible for periodic payments, the fund may not be a countable resource.

A previously unavailable retirement fund is not income to its recipient when the fund becomes available. The fund is subject to resources counting rules in the month following the month in which it first becomes available.

C. Operating Policies**1. Termination of Employment**

A retirement fund is not a resource if an individual must terminate employment in order to obtain any payment.

2. Fund Not Immediately Available

A resources determination for the month following that in which a retirement fund becomes available for withdrawal must include the fund's value. A delay in payment for reasons beyond the individual's control (e.g., an organization's processing time) does not mean that the fund is not a resource since the individual is legally able to obtain the money. It is a nonliquid resource.

3. Claim of Periodic Payment Denied

If an individual receives a denial on a claim for periodic retirement payments but can withdraw the funds in a lump sum, include the fund's lump sum value in the resources determination for the month following that in which the individual receives the denial notice.

D. Development and Documentation**1. Evidence**

If an individual has a retirement fund, obtain evidence of the availability of payments from the retirement fund. Determine if the individual is eligible for lump sum or periodic payments.

2. Determination

If the individual can withdraw a lump sum, the retirement fund is a resource in the amount that is currently available.

E. Related Policies**1. Filing for Other Benefits**

If an individual is eligible for periodic retirement benefits, he/she must apply for those benefits to be eligible. If he/she has a choice between periodic benefits and a lump sum, he/she must choose the periodic benefits.

2. Nonliquid Resource

Absent evidence to the contrary, assume that resources in the form of retirement funds are nonliquid (S1110.300 B.).

3. Deeming Exclusion

If an ineligible spouse, or parent, owns a retirement fund, we exclude it from the deeming process. See S0830.500 regarding the treatment of interest income.

NOTE: If the individual is a married institutionalized individual with a community spouse, the retirement funds are evaluated as resources in the resource assessment and the eligibility determination (see M1480).

F. Example

- 1. Situation** Jeff Grant currently works 3 days a week for a company where he has been employed full-time for 20 years. Under his employer's pension plan, Mr. Grant has a \$4,000 retirement fund. The EW confirms that Mr. Grant could withdraw the funds now, but there would be a penalty for early withdrawal and he would forfeit eligibility for an annuity when he stopped working.
- 2. Analysis** Since Mr. Grant can withdraw the retirement funds without terminating employment, they are a resource in the amount available after penalty deduction. This is true despite the fact Mr. Grant forfeits eligibility for periodic annuity payments in the future. All sources of available support (unless otherwise excluded) are considered in determining eligibility.

M1120.215 INHERITANCES AND UNPROBATED ESTATES

A. Introduction

Property in the form of an interest in an undivided estate is to be regarded as an asset when the value of the interest plus all other resources exceed the applicable resource limit, unless it is considered unsalable for reasons other than being an undivided estate. An heir can initiate a court action to partition. If a partition suit is necessary (because at least one other owner of or heir to the property will not agree to sell the property) in order for the individual to liquidate the interest, estimated partition costs may be deducted from the property's value. However, if such an action would not result in the applicant/recipient securing title to property having value substantially in excess of the cost of the court action, the property would not be regarded as an asset. An ownership interest in an unprobated estate may be a resource if an individual:

- is an heir or relative of the deceased; or
- receives any income from the property; or
- under State intestacy laws, has acquired rights in the property due to the death of the deceased.

The procedure for determining the countable value of an unprobated or undivided estate is found in Appendix 1 to subchapter S1130.

B. For QDWI, QMB, SLMB, QI and ABD 80%FPL

The policy for treatment of an unprobated or undivided estate for the QDWI covered group is in Appendix 1 to chapter S11. The policy for treatment of an unprobated or undivided estate for the QMB, SLMB, QI and ABD 80% FPL covered groups is in Appendix 2 to chapter S11.

C. Operating Policies

- 1. When to Develop** We develop for this type of resource only if:
 - the property in question is not excludable under any of the provisions in S1110.210 B.; and
 - counting the property's value would result in excess resources.

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funeral director;

- 2) then, the funeral home director in turn places the money, life insurance policy or annuity into a trust, established by a person other than the individual.

2. Treatment of Assets in Trust

In the case of a trust, the corpus of which includes assets of an individual and assets of any other person or persons, the provisions of this section shall apply to the portion of the trust attributable to the assets of the individual.

This section shall apply without regard to:

- the purpose for which a trust is established,
- **whether the trustee has or exercises any discretion under the trust,**
- any restrictions on when or whether distributions may be made from the trust, or
- any restriction on the use of distributions from the trust.

3. Revocable Trust

In the case of a revocable trust:

- a. the corpus of the trust shall be considered resources available to the individual.
- b. Payments from the trust to or for the benefit of the individual shall be considered income of the individual.
- c. Any other payments from the trust shall be considered assets disposed of by the individual.

4. Irrevocable Trust

a. Payment Can Be Made To Individual

When there are any circumstances under which payment from the trust corpus or income could be made to or for the benefit of the individual, the following rules apply:

- payments from the trust corpus or income which are made to or for the benefit of the individual shall be considered **income** to the individual;
- income from the trust corpus that could be paid to the individual is considered a **resource** to the individual;
- the portion of the trust corpus that could be paid to the individual is considered a **resource** to the individual;
- a payment from the trust that is NOT made to or for the benefit of the individual shall be considered a transfer of assets by the individual.

NOTE: An irrevocable trust for burial is a trust from which payment will be made for the benefit of the individual.

b. Payment CANNOT Be Made To Individual

- 1) When all or any portion of the corpus of the trust cannot be paid under any circumstances to the individual, all (or any such portion) of the trust corpus shall be considered a transfer of assets. The effective date of the transfer of assets is the date the trust was established.
 - 2) Any income earned by the corpus of the trust, from which no payment could be made (under any circumstances) to the individual, shall be considered a transfer of income.
- c.** Under the provisions of Section 55-19.5 of the Code of Virginia, clauses in a trust which foreclose or prohibit payments to an individual if he requires nursing home or medical care, or if he applies for Medicaid, are void. However, if a trust has been written in another state in which such clauses are legally enforceable, the date payment is foreclosed by such a clause is a transfer of assets that occurs on the date the payment is foreclosed.
- d.** In determining the value of the trust assets transferred, include all payments made from the trust after the date the trust was established or, if later, the date payment to the individual was foreclosed.

If the individual adds funds to the trust after these dates, the addition of those funds is considered to be a new transfer and effective on the date the funds are added.

M1140.500 WORKERS' COMPENSATION MEDICARE SET-ASIDE ARRANGEMENT ACCOUNTS

A. Introduction

A Workers' Compensation Medicare Set-aside Arrangement (WCMSA) is an arrangement which allocates a portion of a Workers' Compensation settlement for future medical expenses. The initial amounts of any set asides are determined on a case-by-case basis and are reviewed by the Centers for Medicare and Medicaid Services (CMS). Most WCMSAs will be placed in interest bearing accounts and are self-administered by applicants/enrollees, or by a competent administrator.

Funds authorized by a WCMSA are unearned income in the month of receipt, and any amount retained following the month of receipt is a countable resource. Section S0830.235 contains information on Workers' Compensation payments.

B. Operating Policy

1. Ownership

Assume that the person designated as owner in the account title owns all the funds in the account.

2. Right to Withdraw Funds

Absent evidence to the contrary, assume that the person shown as owner in the account title has the legal right to withdraw funds from the account.

3. Fiduciaries

A fiduciary's right to withdraw funds is the same as the owner's right to withdraw them.

4. Right to Use for Support and Maintenance

Although funds are intended for specific medical expenses, there are no legal restrictions as to how an individual uses the funds. Assume that an individual who owns and has the legal right to withdraw funds from a WCMSA also has the legal right to use them for his own support and maintenance.

C. Development and Documentation

The development and documentation instructions for checking and savings accounts contained in section S1140.200 apply to WCMSA accounts.

S1140.990 RESOURCES GUIDE -- OPTIONAL DESK AID

A. Introduction

This section provides:

- general information about various investment vehicles encountered; and
- serves as a guide to appropriate instructions which follow this table.

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Term	See	Cross Reference
Balanced Fund Bond	E.4. C.	See Mutual Fund below. Interest, Capital Gains, Security Trades
CATS (Certificate of Accrual on Treasury Securities) CD (Certificate of Deposit)	D.3. B.4.	See U. S. Government Security below. Disqualified Interest, Forfeit Interest, Interest
Checking Account Common Stock	B. F.1.	Interest Dividends, Co-op Dividends, In-kind Dividends, Capital Gains
Convertible Bond Corporate Bond	C.1.c. C.1.	See Corporate Bond below. Interest, Capital gains, Security Trades
Federal Agency Security	D.4.	See U.S. Government Security below.
FREDDIE MAC	D.4.	See U.S. Government Security below.
GINNIE MAE	D.4.	See U.S. Government Security below.
Growth Fund Income Fund IRA (Individual Retirement Account) Junk Bond Keogh Account	E.2. E.3. H. C.1.d. H.	See Mutual Fund below. See Mutual Fund below. Varies with type of investment See Corporate Bond above. See Indiv. Retirement Account below.
MMDA (Money Market Deposit Account) Money Market Fund Municipal Bond	B.3. E.6. C.2.	Interest See Mutual Fund below. Interest, Capital Gains, Security Trades

4. Individual Owns The Land

For purposes of excluding "the land on which the shelter is located" (A.2. above), it is not necessary that the individual own the shelter itself.

EXAMPLE: If an individual lives on his or her own land in someone else's trailer, the land meets the definition of home and is excluded.

5. Extent of Property To Which The Exclusion Applies

a. Land

The home exclusion applies not only to the plot of land on which the home is located, but to any land that adjoins it.

Land adjoins the home plot if not completely separated from it by land in which neither the individual nor his or her spouse has an ownership interest.

Easements and public rights of way (utility lines, roads, etc.) do not separate other land from the home plot.

b. Buildings

The home exclusion applies to all buildings on land excluded per a. above.

6. Property That No Longer Serves As The Principal Place of Residence

a. General Rule

Property ceases to be the principal place of residence - and, therefore, to be excludable as the home - as of the date that the individual, having left it, does not intend to return to it.

Such property, if not excluded under another provision, will be included in determining countable resources as of the first moment of the first day of the following month.

b. Exceptions to General Rule

Even if the individual leaves the home without the intent to return, the property remains an excluded resource for as long as:

- *a spouse or dependent relative of the individual continues to live there while the individual is institutionalized; or*
- *its sale would cause undue hardship, due to loss of housing, to a co-owner of the property.*

7. Dependent Relative Defined

a. Dependency *may be of any kind (financial, medical, etc.).*

b. Relative *means:*

- *child, stepchild, or grandchild;*
- *parent, stepparent, or grandparent;*
- *aunt, uncle, niece, or nephew;*
- *brother or sister, stepbrother or stepsister, half brother or half sister;*
- *cousin; or*
- *in-law.*

B. Development and Documentation - Initial Claims

1. Ownership

a. Use of Allegation

Accept an individual's allegation of home ownership unless the file raises a question about it (e.g., a life estate is involved, the individual is under age 18, does not live with a parent, and does not live with someone else). If there is a question, have the individual submit one of the items of evidence listed in b. - d., below.

b. Evidence of Real Property Ownership

- tax assessment notice;
- recent tax bill;
- current mortgage statement;
- deed;
- report of title search;
- evidence of heirship in an unprobated estate (e.g., receipt of income from the property, a will, or evidence of relationship recognizable under State intestate laws in cases where the home is unprobated property).

c. Evidence of Personal Property Ownership (e.g., a Mobile Home)

- **title;**
- **current registration.**

d. Evidence of Life Estate or Similar Property Rights

- deed;
- will;
- other legal document.

e. Equitable Ownership

If an individual alleges equitable ownership (e.g., an unwritten ownership interest or right of use for life) obtain any pertinent documents and a signed statement from each of the parties involved regarding any arrangement that has been agreed to. Forward the document to a medical assistance program consultant for an opinion from legal counsel.

- other legal document.

e. **Equitable Ownership**

If an individual alleges equitable ownership (e.g., an unwritten ownership interest or right of use for life) obtain any pertinent documents and a signed statement from each of the parties involved regarding any arrangement that has been agreed to. Forward the document to a medical assistance program consultant for an opinion from legal counsel.

2. **Principal Place of Residence -- Operating Assumption**

Absent ownership in more than one residence or evidence that raises a question about the matter, **assume** that the alleged home is the individual's principal place of residence.

3. **Indication of More than One Residence**

If an individual alleges or other evidence indicates ownership of more than one residence, **obtain** his or her signed statement concerning such points as:

- how much time is spent at each residence;
- where he or she is registered to vote;
- which address he or she uses as a mailing address or for tax purposes.

Determine the principal place of residence accordingly and document the determination in file.

4. **Evidence Indicates Nonadjoining Property**

a. **Individuals Agrees With Evidence**

If evidence indicates that land the individual owns does not adjoin the home plot, and the individual agrees that it does not;

- **obtain** his or her statement to that effect and
- **develop** the nonadjoining portion per S1140.100 (Nonhome Real Property) or S1130.500 (Property Essential to Self-Support), as applicable.

b. **Individual Disagrees With Evidence**

If the individual maintains that all the land adjoins the home plot, document the file with:

- a sketch of the land showing the boundaries of the various plots and the location of the shelter used as the home; and
- evidence of how the land is treated for tax assessment purposes.

The sketch may be by the individual, from public records, or by the Eligibility Worker (from direct observation).

The tax assessment information may be in the form of a tax assessment notice or obtained from the appropriate tax jurisdiction and recorded in the case record.

c. Combined or Single Holding for Tax Assessment

Assume that the land is a single piece of property in which all the land adjoins the home plot if:

- it is recorded and treated as a single holding for tax assessment purposes; or
- the original holding has been subdivided, but still is treated as a single holding for tax assessment purposes.

d. More Than Single Holding for Tax Assessment

If the land is recorded and treated as two or more holdings for tax assessment purposes, use the sketch to determine whether other holdings adjoin the home plot.

**5. Absences From
The Home**

a. Summary of Development

If the individual is in an institution, determine whether a spouse or dependent relative is living in the home (see b. below).

If no spouse or dependent relative is living in the home, determine:

- whether the individual intends to return to the home (see c. below); and
- if not, whether the sale of the home would cause undue hardship, due to loss of housing, to a co-owner (see D.1. below).

NOTE: If a previously undeveloped absence from the home has ended, assume that the individual always intend to return. The absence, regardless of duration, will not affect the home exclusion.

b. Spouse or Dependent Relative Development

Obtain a signed statement from the individual as to:

- whether anyone is living in the home while the individual is in the institution;
- if so, how that person is related to the individual, if at all; and
- if related (except for the individual's spouse), how that person is dependent on the individual, if at all.

Absent evidence to the contrary, accept the allegations.

M1410.010 GENERAL--LONG-TERM CARE

A. Introduction

Chapter M1410 contains the rules that apply to individuals needing long-term care (LTC) services. The rules are contained in the following subchapters:

- M1410 General Rules
- M1420 Pre-admission Screening
- M1430 Facility Care
- M1440 Community-based Care Waiver Services
- M1450 Transfer of Assets
- M1460 Financial Eligibility
- M1470 Patient Pay - Post-eligibility Treatment of Income
- M1480 Married Institutionalized Individuals' Financial Eligibility

The rules found within this Chapter apply to those individuals applying for or receiving Medicaid who meet the definition of institutionalization.

B. Definitions

The definitions found in this section are for terms used when policy is addressing types of long-term care (LTC), institutionalization, and individuals who are receiving that care.

1. Authorized Representative

An **authorized representative** is a person who is authorized to conduct business for an individual. A competent individual must designate the authorized representative in a written statement, which is signed by the individual applicant. The authorized representative of an incompetent or incapacitated individual is the individual's

- spouse
- parent, if the individual is a child under age 18 years
- attorney-in fact (person who has the individual's power-of-attorney)
- legally appointed guardian
- legally appointed conservator (*formerly known as the committee*)
- trustee.

EXCEPTION: Patients in the Department of Mental Health, Mental Retardation, & Substance Abuse Services (DMHMRSAS) facilities may have applications submitted by DMHMRSAS staff.

2. Institutionalization

Institutionalization means receipt of 30 consecutive days of

- care in a medical institution (such as a nursing facility), or
- *Medicaid Community-Based Care (CBC)* services; or
- a combination of the two.

The 30 consecutive days requirement is expected to be met if the pre-admission screening committee provides verbal or written confirmation of its approval for the individual's receipt of long-term care (LTC).

The worker must verify that LTC services started within 30 days of the date on the Notice of Action on Medicaid. *A Medicaid-eligible*

individual who was screened and approved for Medicaid community-based care (CBC) services must begin receiving Medicaid-covered CBC services within 30 days of the date on the Notice of Action. If services do not start within 30 days of the Notice of Action on Medicaid, the individual can no longer be considered an institutionalized individual and continued eligibility must be re-evaluated as a non-institutionalized individual.

NOTE: For purposes of this definition, continuity is broken by 30 or more consecutive days

- absence from a medical institution, or
- of non-receipt of waiver services.

3. **Institution** An establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor is an **institution**.
4. **In An Institution** "**In an institution**" refers to an individual who is admitted to live in an institution and receives treatment or services provided there that are appropriate to his requirements.
5. **Long-term Care** **Long-term care** is medical treatment and services directed by a licensed practitioner of the healing arts toward maintenance, improvement, or protection of health or lessening of illness, disability or pain which have been received, or are expected to be received, for longer than 30 consecutive days.
6. **Medical Institution (Facility)** A **medical institution** is an institution (facility) that:
 - is organized to provide medical care, including nursing and convalescent care,
 - has the necessary professional personnel, equipment, and facilities to manage the medical, nursing and other health needs of patients,
 - is authorized under state law to provide medical care, and
 - is staffed by professional personnel who are responsible to the institution for professional medical and nursing services.

An acute care hospital is a medical institution.
7. **Patient** An individual who is receiving needed professional services that are directed by a licensed practitioner of the healing arts toward maintenance, improvement, or protection of health or lessening of illness, disability, or pain, is a **patient**.
8. **Inpatient** An **inpatient** is a patient who has been admitted to a medical institution on the recommendation of a physician or dentist **and** who:
 - receives room, board, and professional services in the institution for a 24-hour period or longer, **or**

If the verification is provided within the 10 days, continue to pend the application until the guardian is appointed or custody awarded. If the application pends for 45 days, send a notice to the applicant to extend the pending application and extend it in the MedPend system using the "E" code and the MA case type "LT."

Once the guardian has been appointed or custody awarded, request verification of the appointment or custody award and that the application be signed by the guardian or adult who was awarded custody. Retain a copy of the application and mail the original application to the guardian or custodian. Allow 10 days for the signed application and the guardian or custody papers to be returned. If the guardian or custody papers and the signed application are not returned by the specified date, deny the application as invalid.

4) Action NOT Initiated - Refer to Services

If guardian or custody procedures have not begun or have not been verified as being on the court docket, refer the child to the appropriate child welfare service worker. Continue to pend the application until the service investigation and any court proceedings are completed. If the application pends for 45 days, send a notice to the applicant to extend the pending application and extend it in the MedPend system using the "E" code and the MA case type "LT." Once the guardian has been appointed or custody awarded, request a copy of the appointment or custody award and that the application be signed by the guardian or adult who was awarded custody. Retain a copy of the application and mail the original application to the guardian or custodian. Allow 10 days for the signed application and the guardian or custody papers to be returned. If the child was emancipated by the court, request the child's signature on the application. If the application is mailed to the child, allow 10 days for the signed application to be returned.

If the application is not signed by the applicant, the guardian or custodial adult and is not returned by the specified date, deny the application as invalid.

b. Minor Parent Applying For His/her Child

A minor child under age 18 may apply for his or her own child because he/she is the child's parent.

c. Foster Care Child

The Medicaid application for a child under age 18 who is in foster care must be signed by an authorized employee of the public or private agency which has custody of the child. *If there is a non-custodial agreement, the parent or legal guardian must sign the Medicaid application.*

6. Invalid Application Procedure

An application that is not signed by the applicant or his authorized representative, as required above in this section, is invalid. If the application was mailed to or dropped off at the agency, the agency must send a letter to the applicant requesting the required signature(s). If the application was made with the help of an EW at the agency, the EW must give a letter to the person who made the application requesting the required signature(s). A sample letter is in subchapter M0120, Appendix 1. If an invalid application is received, *do not* enter it into the computer tracking system.

If one of the following circumstances applies, the EW must provide follow-up so that the application can be processed as soon as a person who is legally able to sign the application is located or appointed:

- the adult applicant is unable to sign or make a mark AND a court guardianship hearing is scheduled or the applicant requires Adult Protective Services to locate an authorized representative;
- the child applicant requires Child Welfare services intervention or has a guardianship or custody hearing scheduled.

7. Redetermination Application Procedures

When preparing to redetermine the Medicaid eligibility of an individual age 18 or older, review the case record to determine if the recipient completes and signs the review application form, or if the recipient has an authorized representative. Ask the following questions:

Has the recipient been judged legally incapacitated by a court of law, as evidenced by a copy of the conservator or guardian certificate in the record?

Yes: authorized representative is the appointed guardian or conservator. STOP.

No: recipient is competent. Does recipient have an attorney-in-fact who has the power-of-attorney to apply for Medicaid for the recipient as evidenced by a copy of the power-of-attorney document in the record?

Yes: authorized representative is the attorney-in-fact. STOP.

No: Has recipient signed a written statement authorizing a person (or staff person of an organization) to apply for Medicaid on his behalf?

Yes: authorized representative is the person or organization authorized by the individual to represent him. STOP.

No: Is the recipient able to sign or make a mark on a Medicaid application form?

Yes: Ask the recipient for signature or mark on review form, or a written statement authorizing someone to apply for Medicaid on his behalf. Give the recipient 10 working days to return the completed and signed form(s). If the completed and correctly signed form(s) are not returned by the specified date, CANCEL Medicaid because of inability to determine continuing eligibility.

No: Does the recipient have at least one of the following:

- spouse,
- adult child,
- parent,
- adult sibling,
- adult grandchild,
- adult niece or nephew,
- aunt or uncle
- representative payee (only for those recipients who were in a medical facility and eligible for Medicaid on October 1, 1996)

Yes: the authorized representative is the individual identified above who is willing and able to act on the recipient's behalf.

No: Refer to Adult Protective Services (APS). **Do not cancel Medicaid.** At the conclusion of the APS investigation, if APS concludes that guardianship proceedings will not be initiated, the applicant must sign or make a mark or designate his authorized representative in writing. If the signed review form is not received by the specified date, CANCEL Medicaid.

D. Procedures

1. Application Completion

Signed application is received. See Chapter M01 for application requirements.

A face-to-face interview with the applicant or the person authorized to conduct his business is not required, but is strongly recommended, in order to correctly determine eligibility.

2. Pre-admission Screening

Notice from pre-admission screener is received by the local Department of Social Services (DSS).

NOTE: Verbal communications by both the screener and the local DSS Eligibility Worker (EW) may occur prior to the completion of screening. Also, not all LTC cases require pre-admission screening; see M1420.

3. Processing

EW completes the application processing. Processing includes receipt of required verifications, completion of the non-financial and financial eligibility determinations, and necessary case record documentation. See chapter M15 for the processing procedures.

An individual's eligibility is determined as an institutionalized individual if he is in a medical facility or has been screened and approved for Medicaid. For any month in the retroactive period, an individual's eligibility can only be determined as an institutionalized individual if he met the definition of institutionalization in that month (i.e. he had been a patient in a medical institution—including nursing facility or an ICF-MR-- for at least 30 consecutive days).

If it is known at the time the application is processed that the individual did not or will not receive LTC services (i.e. the applicant has died since making the application) do not determine eligibility as an institutionalized individual.

If the individual's eligibility was determined as an institutionalized individual prior to the receipt of waiver services, the EW must verify that LTC services started within 30 days of the date of the Notice of Action on Medicaid. If LTC services did not start within 30 days of the date of the Notice of Action on Medicaid, the individual's continued eligibility must be re-evaluated as a non-institutionalized individual.

If the individual later begins receiving LTC services within the one-year screening certification period, the individual's eligibility as an institutionalized individual is determined without a new screening certification. However, the begin date of service must be verified prior to Medicaid enrollment.

4. Notices

See section M1410.300 for the required notices.

M1410.200 INITIATING LONG-TERM CARE FOR CURRENT RECIPIENTS

A. Introduction

Individuals who currently receive Medicaid and enter LTC must have their eligibility redetermined using the special rules that apply to LTC.

For example, an *enrollee* may be ineligible for Medicaid payment of LTC services because he/she transferred assets without receiving adequate compensation. The asset transfer policy found in M1450 applies to

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 *enrollees* 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 the recipient has been in a nursing facility for at least 30 consecutive days, a pre-admission screening is not required (See M1420.400). If an individual is receiving private-pay community-based care (e.g. personal care services) in the home, a pre-admission screening is required (see M1410.200 B. above).*

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.

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M14 LONG-TERM CARE

M1450.000 TRANSFER OF ASSETS

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M1450.000 TRANSFER OF ASSETS

M1450.001 OVERVIEW

A. Introduction

Individuals who are eligible for Medicaid may NOT be eligible for Medicaid payment of long-term *care (LTC)* services (facility or CBC) for a specific period of time (penalty period) if they or their spouses have transferred assets for less than fair market value without receiving adequate compensation. The asset transfer policy applies to all individuals in all types of long-term care.

B. Policy

The EW must evaluate an asset transfer according to the instructions found in the sections below. The applicable policy rules depend on

- when the transfer occurred;
- who transferred the asset;
- to whom the asset was transferred;
- what was transferred.

Information must be obtained from all Medicaid applicants *and recipients who require LTC services* about transfers of both income and resources that occurred during the **five years** before the Medicaid application date.

Whether the transfer will affect LTC services eligibility depends on:

- the date the transfer occurred,
- to whom the asset was transferred,
- the type of asset that was transferred,
- the reason for the transfer,
- the value of the transferred asset
- the amount of compensation received.

M1420.002 LEGAL BASE

A. Public Law 96-611

This federal law established a transfer of property eligibility rule for the SSI program and also permitted states to adopt a transfer eligibility rule for their Medicaid programs which could be, in certain respects, more restrictive than in SSI or the money payment programs. The rule adopted by Virginia was more restrictive than the SSI rule.

B. Public Law 100-360

Public law 100-360 (The Medicare Catastrophic Coverage Act), enacted on July 1, 1988, changed the federal Medicaid law relating to property transfers. Further revisions were made by the Family Support Act of 1988 (Welfare Reform) Public Law 100-485, enacted on October 13, 1988.

C. Public Law 103-66 (OBRA)

Section 13611 of this federal law, enacted on August 10, 1993, revised transfer provisions for the Medicaid Program. It amended section 1917 of the Social Security Act by incorporating in section 1917 new requirements for asset transfers and for trusts.

D. Public Law 109-171 (DRA)

The Deficit Reduction Act (DRA) of 2005, enacted on February 8, 2006, further revised asset transfer provisions for the Medicaid program.

E. The Code of Virginia Virginia state law governing the Department of Medical Assistance Services (DMAS) and the Medicaid program in Virginia is contained in sections 32.1-323 through 32.1-330. It includes a definition of assets, and it states that an asset transfer includes a disclaimer of interest(s) in assets.

Section 20-88.01 empowers DMAS to request a court order requiring the transferees of property to reimburse Medicaid for expenses Medicaid paid on behalf of recipients who transferred property.

M1450.003 DEFINITION OF TERMS

A. Adequate Compensation *For purposes of asset transfer, an individual is considered to have received “adequate compensation” for an asset when the fair market value of the asset or greater has been received.*

B. Assets For the purposes of asset transfer, assets are all income and resources of the individual and the individual’s spouse, including *any* income and resources to which *the* individual *or the spouse* is entitled but does not receive because of an action by:

- the individual or the spouse,
- any person, including a court or administrative body, with legal authority to act in the place of or on behalf of the individual or spouse, or
- a person, including a court or administrative body, acting at the direction or request of the individual or spouse.

The term “asset” may also include:

- life estate (life rights) in another individual’s home, and
- the funds used to purchase a promissory note, loan, or mortgage.

C. Asset Transfer An **asset transfer** is any action by an individual or other person that reduces or eliminates the individual’s ownership or control of an asset(s). Transfers include:

- giving away or selling property
- disclaiming an inheritance or not asserting inheritance rights in court
- clauses in trusts that stop payments to the individual
- putting money in a trust
- payments from a trust for a purpose other than benefit of the individual
- irrevocably waiving pension income
- not accepting or accessing injury settlements
- giving away income during the month it is received
- refusing to take legal action to obtain a court-ordered payment that is not being paid, such as alimony or child support
- placement of lien or judgment against individual's property when not an "arm's length" transaction (see below)
- other similar actions.

When the placement of a lien or a judgment against an individual's asset is not an "arm's length" transaction, it is an uncompensated transfer of assets. An arm's length transaction, as defined by Black's Law Dictionary, is a transaction negotiated by **unrelated** parties, each acting in his or her own self interest. When an individual's relative has a lien or judgment against the individual's property, the lien or judgment is an asset transfer that must be evaluated.

D. Baseline Date

The **baseline date** is the first date as of which the individual was both

- an institutionalized individual (as defined below) AND
- a Virginia Medicaid applicant.

When an individual is already a Medicaid recipient and becomes institutionalized, the baseline date is the first day of institutionalization.

E. Fair Market Value

Fair market value (FMV) is an estimate of an asset's value if it were sold at the prevailing price at the time it was actually transferred. Value is based on criteria used in determining the value of assets for the purpose of determining Medicaid eligibility.

NOTE: For an asset to be considered transferred for fair market value, or to be considered to be transferred for valuable consideration, the compensation received for the asset must be in tangible form with intrinsic value. A transfer for love and *affection* is not considered a transfer for fair market value.

Also, while relatives and family members legitimately can be paid for care they provide to the individual, it is presumed that services provided for free at the time were intended to be provided without compensation. Thus, a transfer to a relative for care provided for free in the past is a transfer of assets for less than fair market value. However, an individual can rebut this presumption with tangible evidence that is acceptable. For example, the individual proves that a payback arrangement had been agreed to in writing at the time services were provided.

F. Income

Any *monies* received by an individual or the individual's spouse to meet the individual's basic needs for food or shelter, is **income**. See subchapter M1460 for items that are not income.

G. Institutionalized Individual

For the purposes of asset transfer, an **institutionalized individual** is:

- a person who is an inpatient in a nursing facility;
- a person who is an inpatient in a medical institution and for whom payment for care is based on a level of care provided in a nursing facility. Included are persons in long-stay hospitals (including rehabilitation hospitals and rehabilitation units of general hospitals) and patients in Virginia Department of Mental Health, Mental Retardation & Substance Abuse Services (DMHMRSAS) facilities who

are housed in an area certified as a nursing facility or intermediate care facility for the mentally retarded; *or*

- a *Medicaid applicant/recipient* who has been screened and approved for or is receiving Medicaid community-based care (CBC) waiver services.

H. Legally Binding Contract

Virginia law requires written contracts for the sale of goods (not services) valued over \$500, and for transactions involving real estate. Contracts for services may be oral.

To prove a contract is **legally binding**, the individual must show:

1. Parties Legally Competent

The parties to the contract were legally competent to enter into the contract. (Generally, this excludes (1) *individuals declared to have mental incapacity or a diminished mental capacity* and (2) *children less than 18 years of age, who may not enter into a contract under Virginia law*. The purpose here is to ensure that both parties knew what they were doing when they entered into the contract).

2. Valuable Consideration

“Valuable consideration” is received by each party *when the “adequate compensation” requirement for the asset transfer rule is met*.

3. Definite Contract Terms

Contract terms are sufficiently definite so that the contract is not void because of vagueness. Payments under contracts with immediate family members must be at reasonable rates. Those rates must be discernable from the terms of the contract. For example, it is not sufficient for a mother to agree to give her son all the stocks she owns upon her death in exchange for his agreeing to take care of her for an undefined period of time (such a contract might have to be written, depending on the value). The contract must set forth the per diem rate, specify a time period, or in some other manner establish definable and certain terms.

4. Mutual Assent

Contract terms were agreed to by mutual assent. Confirm that both parties understood and agreed upon the same specific terms of the contract when they entered into the contract.

I. Look-Back Date

The **look-back date** is the earliest date on which a penalty for transferring assets for less than fair market value can be imposed. Penalties can be imposed for transfers that take place on or after the look-back date. Penalties cannot be imposed for transfers that take place before the look-back date.

1. Transfers Made Before February 8, 2006

- a. In the case of a **revocable trust**, any payment from the trust which is NOT to the individual or for the benefit of the individual is considered an asset transferred for less than fair market value as of the date the payment was made. The look back date is 60 months before the baseline date.
- b. In the case of an **irrevocable trust from which payment can be made to the individual**, any payment from the trust which is NOT to the individual or for the benefit of the individual is considered an asset transferred for

less than fair market value as of the date the payment was made. The look back date is 36 months before the baseline date.

- c. In the case of an **irrevocable trust from which payment CANNOT be made to the individual**, the transfer of assets into the trust is considered an asset transferred for less than fair market value as of the date the trust was established. The look back date is 60 months before the baseline date.

2. Transfers Made On or After February 8, 2006

The **look-back date** is the date that is 60 months before the first date the individual is both (a) an institutionalized individual and (b) has applied for Medicaid. **This policy applies to actions taken on applications, renewals or changes on or after July 1, 2006, for transfers made on or after February 8, 2006.**

J. Look-back Period

The **look-back period** is the period of time that begins with the look-back date and ends with the baseline date.

1. Transfers Made Before February 8, 2006

The look-back period is 36 months (or 60 months in the case of a trust that is treated as an asset transferred for less than market value) prior to the baseline date.

2. Transfers Made On or After February 8, 2006

The look-back period is 60 months. **This policy applies to actions taken on applications, renewals or changes on or after July 1, 2006, for transfers made on or after February 8, 2006.**

K. Other Person

Other person means:

- the individual's spouse or co-owner of an asset;
- a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse; and
- a person, including a court or administrative body, acting at the direction, or upon the request, of the individual or the individual's spouse.

L. Payment Foreclosed

Payment to any individual from an irrevocable trust *that is not for the benefit of the individual for whom the trust was created is an uncompensated transfer of assets. See M1140.404 B. 4. c. for information regarding when a trust is foreclosed.*

M. Penalty Period

The **penalty period** is the period of time during which Medicaid payment for LTC services is denied because of a transfer of assets for less than market value. The length of the penalty period is based on the value of the uncompensated transfer of assets and the average cost of nursing facility care in Virginia.

N. Property/Resources

“Property” and “resources” both refer to real and personal property legally available to the individual or the individual's spouse.

O. Uncompensated Value

The uncompensated value is the amount of an asset's fair market value that was not or will not be received as a result of the asset transfer.

*The uncompensated value for **real property** at the time of transfer is:*

- *the difference between the asset's FMV and the Gross Amount Due to Seller, when the lien/other encumbrance against the asset is satisfied from the seller's proceeds, or*
- *the difference between the asset's equity value (FMV minus the lien) and the Gross Amount Due to Seller, when the lien is assumed by the buyer. Refer to examples in M1450.610 H.*

P. Undue Hardship

An undue hardship exists when the imposition of a penalty period would deprive the individual of medical care such that his health or his life would be endangered or be deprived of food, clothing, shelter, or other necessities of life.

M1450.004 POLICY PRINCIPLES

A. Policy

An institutionalized individual who transfers (or has transferred), or whose spouse transfers or has transferred, an asset in ways not allowed by policy is not eligible for Medicaid payment of long-term care services.

B. Organization of Policy in This Subchapter

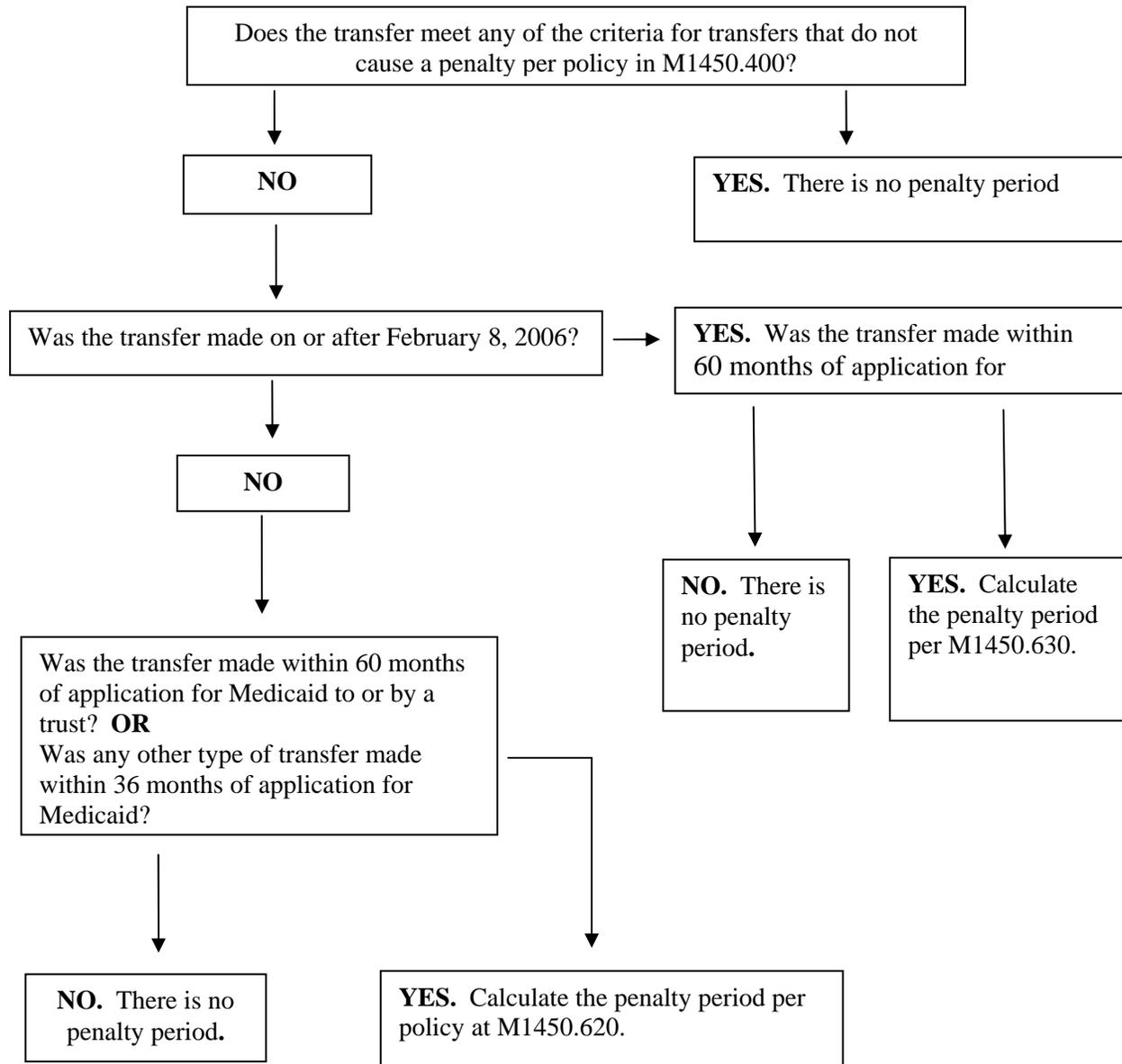
The treatment of the asset transfer depends on the date of the transfer. Certain areas of policy in this subchapter are divided into separate sections or subsections that address (1) asset transfers on or after August 11, 1993, but prior to February 8, 2006 and (2) asset transfers on or after February 8, 2006. Where no date is specified in the policy, the policy applies to all asset transfers on or after August 11, 1993.

Contact a Medical Assistance Program Consultant for guidance when *the case record indicates the individual is still in a penalty period that occurred prior to August 11, 1993.*

C. Transfer of Assets Flow Chart

See the Transfer of Assets Flow Chart on the next page.

Transfer of Assets Flow Chart



M1450.100 TRANSFERS ON OR AFTER AUGUST 11, 1993 BUT BEFORE FEBRUARY 8, 2006

A. Policy

An institutionalized individual who disposes of, or whose spouse disposes of, assets for less than fair market value on or after the look-back date specified in subsection B below is ineligible for Medicaid payment of LTC services (nursing facility services, a level of care in any institution equivalent to that of nursing facility services, and home or community-based services furnished under a CBC waiver). This rule applies to asset transfers occurring on or after August 11, 1993.

Once an individual has established eligibility for Medicaid payment of LTC services, transfer of assets owned by the community spouse do not affect the institutionalized spouse's Medicaid eligibility.

B. Procedures

When an enrolled Medicaid recipient is institutionalized, review his/her eligibility to determine if an asset transfer occurred within the 60 months prior to institutionalization. When a Medicaid applicant reports an asset transfer, or the worker discovers a transfer, determine if the transfer occurred within 60 months prior to the month in which the individual is both institutionalized and a Medicaid applicant. Take the following actions to determine if an asset transfer affects eligibility for Medicaid payment of long-term care services:

1. Transfers Not Involving Trusts

Determine if any assets of the individual or the individual's spouse were transferred during the 36 months (the "look-back period") prior to the first date on which the individual was both an institutionalized individual and a Medicaid applicant/recipient.

2. Transfers Involving Trusts

Determine if any of the individual's or the individual's spouse's assets were transferred into or from a trust fund during the 60 months (the "look-back period") prior to the first date on which the individual was both an institutionalized individual and a Medicaid applicant/recipient.

3. Determine Effect

If an asset was transferred during any of the look-back periods specified above, determine if the transfer affects eligibility for LTC services' payment, using sections M1450.300 through M1450.550 below.

If the transfer affects eligibility and was for less than market value, determine the uncompensated value (M1450.610) and establish a penalty period (period of ineligibility for Medicaid payment of LTC services, M1450.620).

M1450.200 TRANSFERS ON OR AFTER FEBRUARY 8, 2006

A. Policy

The DRA established new policy for evaluating transfers made on or after February 8, 2006. The look-back period for all transfers is 60 months; there is no distinction between transfers involving trusts and other transfers. **The policy in this section applies to applications processed on or after July 1, 2006 for transfers made on or after February 8, 2006. For applications processed prior to July 1, 2006, use the policy in M1450.100.**

B. Procedures

When a Medicaid recipient is institutionalized, review the individual's eligibility to determine if an asset transfer occurred within the 60 months prior to institutionalization. When a Medicaid applicant reports an asset transfer, or the worker discovers a transfer, determine if the transfer occurred within 60 months prior to the month in which the individual is both institutionalized and a Medicaid applicant/*recipient*.

1. All Transfers

Determine if any assets of the individual or the individual's spouse were transferred during the 60 months (the "look-back period") prior to the first date on which the individual was both an institutionalized individual and a Medicaid applicant/*recipient*.

2. Determine Effect

If an asset was transferred during the look-back periods specified above, determine if the transfer affects eligibility for LTC services' payment, using sections M1450.520 through M1450.550 below.

If the transfer affects eligibility and was for less than market value, determine the uncompensated value (M1450.610) and establish a penalty period (period of ineligibility for Medicaid payment of LTC services, M1450.630).

M1450.300 ASSETS THAT ARE NOT RESOURCES FOR TRANSFER RULE

A. Policy

The assets listed in this section are NOT resources for asset transfer purposes. Therefore, the transfer of any of the assets listed in this section does NOT affect eligibility for Medicaid payment of LTC services.

B. Personal Effects and Household Items

A transfer of personal effects or household items does not affect eligibility.

C. Certain Vehicles

The transfer of a vehicle that meets the following requirements does not affect Medicaid payment for LTC services:

- a vehicle used by the applicant/*recipient* to obtain medical treatment.
- a vehicle used by the applicant/*recipient* for employment.
- a vehicle especially equipped for a disabled applicant or *recipient*.
- a vehicle necessary because of climate, terrain, distance, or similar factors to provide necessary transportation to perform essential daily activities.

If the vehicle was not used as provided above at the time of transfer, \$4,500 of the trade-in value of the vehicle used for basic transportation is excluded. Any value in excess of \$4,500 must be evaluated as an asset transfer.

- D. Property Essential to Self Support** The transfer of property essential to the institutionalized individual's self-support (tools, equipment, etc. used by the individual to produce income), including up to \$6,000 equity in income-producing real property(ies) owned by the applicant/recipient, does not affect eligibility for LTC services' payment.
- To be income-producing, the property(ies) must usually have a net annual return that is:
- 6% of the equity, if the equity is \$6,000 or less or
 - \$360 if the equity is more than \$6,000.
- If an unusual circumstance caused a temporary reduction in the net annual return and the net annual return is expected to meet the requirements the following year, the property is still considered income-producing.
- E. Resources Under PASS** Transfer of resources specifically designated for a disabled or blind SSI recipient's plan of self-support (PASS), as determined by SSI, does not affect eligibility for LTC services' payment.
- F. Certain Life Insurance** Transfer of term or group insurance that has no cash value, or transfer of life insurance with a total face value of \$1,500 or less (total of all policies) on an individual, does not affect eligibility for LTC services' payment. Life insurance includes policies that presently do not have a cash value but will have a cash value in the future.
- G. Certain Cash and In-kind Items** Transfer of cash or in-kind items received to replace/repair lost, damaged, or stolen exempted resources (see M1130.630) does not affect eligibility for LTC services' payment.
- H. Burial Spaces or Plots** Transfer of burial spaces or plots held for the use of the individual, the individual's spouse, or the individual's immediate family does not affect eligibility for LTC services' payment.
- I. Excluded Burial Funds** Transfer of up to \$1,500 in resources excluded under the burial fund exclusion policy does not affect eligibility for LTC services' payment.
- J. Cash to Purchase Medical/Social Services** Transfer of cash received from a governmental or nongovernmental program to purchase medical care or social services does not affect eligibility for LTC services' payment IF the cash was transferred in the receipt month or the month following the receipt month.
- K. Alaskan Natives' Stock** Transfer of certain shares of stock held by Alaskan natives does not affect eligibility for LTC services' payment.
- L. Other Assets That Are Not Resources** The transfer of the following resources, **if they have been kept separate from other resources**, do not affect eligibility for LTC services' payment:
- Payments from the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970.

- Payments from sections 25-239, 25-240, and 25-241 of the Code of Virginia for relocation assistance.
- Payments from sections 404(g) and 418 of the Domestic Volunteer Service Act of 1973.
- Retroactive Supplemental Security Income and/or retroactive Social Security payments for *nine (9)* months after the month of receipt of the payment(s).
- Retained disaster assistance.

M1450.400 TRANSFERS THAT DO NOT AFFECT ELIGIBILITY

A. Policy

An asset transfer does NOT affect eligibility for Medicaid payment of LTC services if the transfer meets the following criteria:

- *the transfer(s) of assets was made for reasons exclusive of becoming or remaining eligible for Medicaid payment of LTC services (M1450.400 B),*
- *the individual received adequate compensation for the asset(s), or*
- *the asset transfer meets the criteria in either section B, C or D below.*

If the transfer **does not** meet the criteria in this section, see section 1450.500 below to evaluate the asset transfer.

B. Reason Exclusive of Becoming or Remaining Medicaid Eligible

Asset transfers do not affect eligibility if they were made for reasons exclusive of becoming or remaining eligible for Medicaid payment of LTC services.

1. Evidence Required

The individual must provide convincing and objective evidence showing that the individual or spouse had no reason to believe that Medicaid payment of LTC services might be needed. The sudden loss of income or assets, the sudden onset of a disabling condition or personal injury may provide convincing evidence.

A subjective statement of intent or ignorance of the asset transfer provision is not sufficient. The individual must provide evidence that other assets were available at the time of transfer to meet current and expected needs of that individual, including the cost of nursing home or other medical institutional care.

2. Making an Asset Unavailable

A Medicaid applicant/recipient shall not directly or indirectly make an asset unavailable by any means or persons, which is unlawful and contrary to Medicaid statutes, regulations and policy. Any such transactions will be considered to have been made with the intent of becoming or remaining eligible for Medicaid payment of LTC services and will be regarded as uncompensated transfer of assets.

C. Home Property Transferred to Certain Individuals

Transfer of the individual's home, whether it was excluded or not excluded at the time of transfer, does NOT affect eligibility for LTC services' payment when the home property is transferred to one or more of the individuals listed below.

1. Spouse, Minor Child, Disabled/Blind Child

The transfer of the home property does not affect eligibility when transferred to the individual's

- spouse,
- child(ren) under age 21 years, or
- child(ren) of any age who is blind or disabled as defined by SSI or Medicaid.

2. Sibling

The transfer of the home property does not affect eligibility when transferred to the individual's sibling or half-sibling (not step-sibling) who:

- has an equity interest in the home, and
- who resided in the individual's home for at least one year immediately before the date the individual became an institutionalized individual.

3. Adult Child

The transfer of the home property does not affect eligibility when transferred to the individual's son or daughter (not including step-child) who resided in the home for at least two years immediately before the date the individual became an institutionalized individual, and all of the criteria listed in items a. through d. below are met.

a. Provided Care for 2 Years

The individual's son or daughter must have been providing care to the individual during the entire two-year period which permitted the individual to reside at home rather than in a medical institution or nursing facility.

b. Physician's Statement

The individual or his/her representative must provide a statement from his/her treating physician which states

- the individual's physical and/or mental condition during this two-year period,
- why the individual needed personal and/or home health care during this period, and
- the specific personal/home health care service needs of the individual.

c. Statement of Services Provided

The son or daughter must provide a statement showing:

- 1) the specific services and care he/she provided to the individual during the entire two years;
- 2) how many hours per day he/she provided the service or care;

- 3) whether he/she worked outside the home or worked from the home during this period; how the individual's needs were taken care of while he/she worked; and
- 4) if the son or daughter paid someone to actually give the care to the individual, who was paid, the rate of pay, the specific services, and the length of time the services were provided.

d. Third Party Statement

The individual or his/her representative must provide an objective statement from a third party(ies) who had knowledge of the individual's condition and his/her living and care arrangements during this period which corroborates the son or daughter's statement. The statement must specify the care/services the son or daughter provided and who cared for the individual when the son or daughter was not at home.

D. Transfer to Certain Individuals or Trusts

Transfer of any asset

- to the individual's spouse or to another person for the sole benefit of the individual's spouse;
- to another individual by the spouse for the sole benefit of the spouse;
- to the individual's child under 21 or child of any age who is blind or disabled as defined by SSI or Medicaid;
- to a trust that is established solely for the benefit of the individual's
 - 1) child under age 21, or
 - 2) child of any age who is blind or disabled as defined by SSI or Medicaid when the trust meets the conditions in M1120.202;
- to a trust established solely for the benefit of an individual under 65 who is disabled as defined by SSI or Medicaid, when the trust meets the conditions in M1120.202;

does not affect eligibility for Medicaid payment of LTC services.

1. For the Sole Benefit of Spouse, Blind/disabled Child, or Disabled Individual

A transfer is for the sole benefit of a spouse, blind or disabled child or a disabled individual if the transfer is arranged in such a way that no individual or entity except the spouse, blind or disabled child or a disabled individual can benefit from the assets transferred in any way, whether at the time of transfer or at any time in the future. Similarly, a trust is established for the sole benefit of a spouse, blind or disabled child or a disabled individual if no one but the spouse, blind or disabled child or disabled individual can benefit from the assets in the trust, whether at the time of transfer or at any time in the future.

In order to be for the sole benefit of one of these individuals, the instrument or document must provide for the spending of the trust funds for the benefit of the individual that is actuarially sound based on the life expectancy of the individual involved. When the instrument or document does not so provide, any potential exemption from penalty or consideration for eligibility purposes is void. Exception: trusts established for disabled individuals, as described in M1120.202.

However, the trust may provide for reasonable compensation for a trustee(s) to manage the trust, as well as for reasonable costs associated with investing or otherwise managing the funds or property in the trust. In defining what is reasonable compensation, consider the amount of time and effort involved in managing a trust of the size involved, as well as the prevailing rate of compensation, if any, for managing a trust of similar size and complexity.

2. Not for the Sole Benefit of Spouse, Blind/disabled Child, or Disabled Individual

A transfer, transfer instrument, or trust that provides for funds or property to pass to a beneficiary who is NOT the spouse, a blind or disabled child or a disabled individual, is NOT considered established for the sole benefit of one of these individuals. Thus, the establishment of such a trust is a transfer of assets that affects eligibility for Medicaid payment of LTC services.

3. Trusts for Disabled Individuals Under Which the State Is Beneficiary

Trusts established for disabled individuals, as described in M1120.202, do not have to provide for an actuarially sound spending of the trust funds for the benefit of the individual involved. However, under these trusts, the trust instrument must provide that any funds remaining in the trust upon the death of the individual must go to the state, up to the amount of Medicaid benefits paid on the individual's behalf.

The trust does not have to provide for an actuarially sound spending of the trust funds for the benefit of the individual involved when:

- the trust instrument designates the state as the recipient of funds from the trust, and
- the trust requirements in M1120.202 require that the trust be for the sole benefit of an individual.

The trust may also provide for disbursement of funds to other beneficiaries provided that the trust does not permit such disbursements until the state's claim is satisfied. "Pooled" trusts may provide that the trust can retain a certain percentage of the funds in the trust account upon the death of the beneficiary.

4. Cross-reference

If the trust is not for the sole benefit of the individual's spouse, blind or disabled child or a disabled individual, and it does not meet the criteria in item 3 above, go to M1450.540 below to determine if the transfer of assets into the trust affects Medicaid payment for LTC services.

NOTE: Evaluate the trust to determine if it is a resource. See M1120.200, M1120.201 and M1120.202.

E. Other Asset Transfers

For asset transfers other than those described in sections M1450.400 B and C, the transfer does not affect eligibility for Medicaid payment of LTC services if the individual shows that he intended to receive or received adequate compensation for the asset. To show intent to receive adequate compensation, the individual must provide objective evidence according to items 1 through 3 below, and provide evidence that the transfer was made for reasons exclusive of becoming or remaining eligible for Medicaid payment of LTC services.

1. **Evidence of Reasonable Effort to Sell**

The individual must provide objective evidence for real property that he/she made an initial and continuing reasonable effort to sell the property. See M1130.140.
 2. **Evidence of Legally Binding Contract**

The individual must provide objective evidence that he/she made a legally binding contract (as defined in M1450.003 above) that provided for his/her receipt of adequate compensation in a specified form (goods, services, money, etc.) in exchange for the transferred asset.

If the goods received include term life insurance, see M1450.510 below.
 3. **Irrevocable Burial Trust**

The individual must provide objective evidence that the asset was transferred into an irrevocable burial trust. The trust is NOT compensation for the transferred money unless the individual provides objective evidence that all the funds in the trust will be used to pay for identifiable funeral services.

Objective evidence is the contract with the funeral home which lists funeral items and services and the price of each, when the total price of all items and services equals the amount of funds in the irrevocable burial trust.

NOTE: Evaluate the trust to determine if it is a resource. See M1120.200, M1120.201 and M1120.202.
- F. Post-Eligibility Transfers by the Community Spouse**
- Post-eligibility transfers of resources owned by the community spouse (institutionalized spouse has no ownership interest) do not affect the institutionalized spouse's continued eligibility for Medicaid payment of LTC services.
- Exception: The purchase of annuity by the community spouse on or after February 8, 2006 may be treated as an uncompensated transfer. See G. below.
- G. Purchase of an Annuity by Community Spouse**
- For applications made on or after July 1, 2006, an annuity purchased by the community spouse on or after February 8, 2006, will be treated as an uncompensated transfer unless:
- the state is named as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the annuitant; or
 - the state is named the remainder beneficiary in the second position after the community spouse or minor or disabled child. *If the spouse or the representative of a minor or disabled child disposes of any remainder for less than fair market value, the state must be named in the first position.*
- H. Transfers Made on or After February 8, 2006 with Cumulative Value Less Than or Equal to \$4,000**
- The policy in this subsection applies to actions taken on applications, renewals or changes on or after July 1, 2006 for transfers made on or after February 8, 2006.**
- Asset transfers made on or after February 8, 2006 that have a total cumulative value of less than or equal to \$1,000 per calendar year will not be considered

a transfer for less than fair market value and no penalty period will be calculated.

Assets transferred on or after February 8, 2006, that have a total cumulative value of more than \$1,000 but less than or equal to \$4,000 per calendar year may not be considered a transfer for less than fair market value if documentation is provided that such transfers follow a pattern that existed for at least three years prior to applying for Medicaid payment of LTC services. Christmas gifts, birthday gifts, graduation gifts, wedding gifts, etc. meet the criteria for following a pattern that existed prior to applying for Medicaid payment of LTC services.

I. Return of Asset

The transfer of an asset for less than fair market value does not affect eligibility for Medicaid LTC services' payment if the asset has been returned to the individual.

J. Undue Hardship Policy

Policy for claiming undue hardship was moved to *M1450.700*.

M1450.500 TRANSFERS THAT AFFECT ELIGIBILITY

A. Policy

If an asset transfer does not meet the criteria in sections M1450.300 or M1450.400, the transfer will be considered to have been completed for reasons of becoming or remaining eligible for Medicaid payment of LTC services, unless evidence has been provided to the contrary.

Asset transfers that affect eligibility for Medicaid LTC services payment include, but are not limited to, transfers of the following assets:

- cash, bank accounts, savings certificates,
- stocks or bonds,
- personal effects or household items of unusual value,
- resources **over \$1,500** that are excluded under the burial fund exclusion policy,
- cash value of life insurance when the total face values of all policies owned on an individual exceed \$1,500,
- interests in real property, including mineral rights,
- rights to inherited real or personal property or income.

B. Procedures

Use the following sections to evaluate an asset transfer:

- M1450.510 for a purchase of term life insurance.
- M1450.520 for a purchase of an annuity before February 8, 2006.
- M1450.530 for a purchase of an annuity on or after February 8, 2006.
- M1450.540 for promissory notes, loans, or mortgages.
- M1450.550 for a transfer of assets into or from a trust.
- M1450.560 for a transfer of income.

M1450.510 PURCHASE OF TERM LIFE INSURANCE**A. Policy**

The purchase of any term life insurance after April 7, 1993, except term life insurance that funds a pre-need funeral under section 54.1-2820 of the Code of Virginia, is an uncompensated transfer for less than fair market value if the term insurance's benefit payable at death does not **equal or exceed twice the sum of all premiums paid for the policy.**

B. Procedures

**1. Policy Funds
Pre-need
Funeral**

Determine the purpose of the term insurance policy by reviewing the policy. If the policy language specifies that the death benefits shall be used to purchase burial space items or funeral services, then the purchase of the policy is a compensated transfer of funds and does not affect eligibility.

However, any benefits **paid** under such policy in excess of the actual funeral expenses are subject to recovery by the Department of Medical Assistance Services for Medicaid payments made on behalf of the deceased insured Medicaid recipient.

**2. Policy Funds
Irrevocable
Trust**

Since **an irrevocable trust for burial is not a pre-need funeral**, the purchase of a term life insurance policy(ies) used to fund an irrevocable trust is an uncompensated transfer of assets for less than fair market value.

**3. Determine If
Transfer Is
Uncompensated**

When the term life insurance policy does not fund a pre-need funeral, determine if the purchase of the term insurance policy is an uncompensated transfer:

- a. Determine the benefit payable at death. The face value of the policy is the "benefit payable at death."
- b. From the insurance company, obtain the sum of all premium(s) paid on the policy; multiply this sum by 2. The result is "twice the premium."
- c. Compare the result to the term insurance policy's face value.
 - 1) If the term insurance's face value equals or exceeds the result (twice the premium), the purchase of the policy is a transfer for fair market value and does not affect eligibility.
 - 2) If the term insurance's face value is less than the result (twice the premium), the purchase of the policy is an uncompensated transfer for less than fair market value. Determine a penalty period per M1450.620 or M1450.630 below.

EXAMPLE #1: Mr. C. uses \$5,000 from his checking account to purchase a \$5,000 face value term life insurance policy on August 13, 1995. Since the policy was purchased after April 7, 1993, and \$5,000 (benefit payable on death) is not twice the \$5,000 premium, the purchase is an uncompensated transfer. The uncompensated value and the penalty period for Medicaid payment of long-term care services must be determined.

M1450.520 PURCHASE OF ANNUITY BEFORE FEBRUARY 8, 2006**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.

Although usually purchased to provide a source of income for retirement, annuities are sometimes used to shelter assets so that the individuals purchasing them can become eligible for Medicaid. To avoid penalizing individuals who validly purchased annuities as part of a retirement plan, determine the ultimate purpose of the annuity, i.e., whether the annuity purchase is a transfer of assets for less than fair market value.

B. Policy

The following policy applies to annuities purchased before February 8, 2006. Determine if the annuity is a countable resource using the policy in M1140.260. If the expected return on the annuity is commensurate with a reasonable estimate of the beneficiary's life expectancy, the annuity is actuarially sound and its purchase is a transfer of assets for fair market value.

C. Procedures**1. Determine If Actuarially Sound**

Determine if the annuity is actuarially sound. Use the Life Expectancy tables in M1450, Appendix 2:

- a. Find the individual's age at the time the annuity was purchased in the "Age" column for the individual's gender ("Male" or "Female").
- b. The corresponding number in the "Life Expectancy" column is the average number of years of expected life remaining for the individual.
- c. Compare the life expectancy number to the life of the annuity (the period of time over which the annuity benefits will be paid).
- d. When the average number of years of expected life remaining for the individual (the "life expectancy" number in the table) equals or exceeds the life of the annuity, the annuity is actuarially sound. When the annuity is actuarially sound, the purchase of the annuity is a compensated transfer for fair market value and does not affect eligibility.
- e. When the average number of years of expected life remaining for the individual (the "life expectancy" number in the table) is less than the life of the annuity, the annuity is NOT actuarially sound. The annuity purchase is a transfer for less than fair market value. The transfer occurred at the time the annuity was purchased.
- f. When the annuity is not actuarially sound, determine the uncompensated value and the penalty period (sections M1450.610 and M1450.620 below).

2. *Example #2*

EXAMPLE #2: A man at age 65 purchases a \$10,000 annuity to be paid over the course of 10 years. His life expectancy according to the table is 14.96 years. Thus, the annuity is actuarially sound; the purchase of the annuity is a compensated transfer for fair market value and does not affect eligibility for LTC services payment.

3. *Example #3*

EXAMPLE #3: A man at age 80 purchases the same \$10,000 annuity to be paid over the course of 10 years. His life expectancy according to the table is only 6.98 years. The annuity is not actuarially sound. The purchase of the annuity is a transfer for less than fair market value.

M1450.530 PURCHASE OF ANNUITY ON OR AFTER FEBRUARY 8, 2006

A. Introduction

The DRA established new policy for evaluating the purchase of an annuity as an asset transfer. The policy applies to annuities purchased on or after February 8, 2006. A significant change made under the DRA is that annuities purchased by either the institutionalized individual or the community spouse must be evaluated even after initial eligibility as an LTC recipient has been established. **The policy in this section applies to actions taken on applications, renewals and changes on or after July 1, 2006 for transfers made on or after February 8, 2006.**

B. Policy

All annuities purchased by an applicant/recipient or his spouse on or after February 8, 2006, must be declared on the Medicaid application or renewal form. In addition to determining if the annuity is a countable resource, the eligibility worker must evaluate the purchase of the annuity to determine if it is a compensated transfer.

The following rules apply to the purchase of an annuity:

1. *Purchased by Institutionalized Individual or Community Spouse On/After Feb. 8, 2006*

An annuity purchased by the institutionalized individual or the community spouse on or after February 8, 2006, will be treated as an uncompensated transfer unless:

- the state is named as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the *institutionalized individual*; or
- the state is named the remainder beneficiary in the second position after the community spouse or minor or disabled child. *If the spouse or the representative of a minor or disabled child disposes of any remainder for less than fair market value, the state must be named in the first position.*

2. *Purchased by Institutionalized Individual On/After Feb. 8, 2006*

An annuity purchased by the institutionalized individual on or after February 8, 2006, will be considered an uncompensated transfer unless:

- a. the annuity is described in one of the following subsections of section 408 of the Internal Revenue Service (IRS) Code:
 - individual retirement account,
 - accounts established by employers and certain associations of employees,

- simple retirement accounts; or
- b. the annuity is a simplified employee pension (within the meaning of section 408(k) of the IRS Code; or a Roth Individual Retirement Account (IRA); or
- c. *the annuity is:*
 - irrevocable and non-assignable;
 - actuarially sound (see M1450.520 C.); and
 - provides for equal payments with no deferral and no balloon payments.

3. Send Copy to DMAS

A copy of the annuity agreement must be sent to:

DMAS, Division of Policy and Research
Eligibility Section
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

4. Maintain Copy of Annuity

The copy must be maintained by DMAS until the terms of the annuity have expired. A copy of the annuity must also be maintained in agency's case record.

M1450.540 PURCHASE OF A PROMISSORY NOTE, LOAN, OR MORTGAGE ON OR AFTER FEBRUARY 8, 2006

A. Introduction

This policy applies to the purchase of a promissory note, loan, or mortgage on or after February 8, 2006. Subchapter S1140.300 contains explanations of promissory notes, loans, and mortgages.

B. Policy

Funds used to purchase a promissory note, loan, or mortgage on or after February 8, 2006, must be evaluated as an uncompensated transfer unless the note, loan, or mortgage:

- has a repayment term that is actuarially sound (see M1450.520),
- provides for payments to be made in equal amounts during the term of the loan with no deferral and no balloon payments, and
- prohibits the cancellation of the balance upon the death of the lender.

C. Uncompensated Amount

If the promissory note, loan, or mortgage does not meet the above criteria, the uncompensated amount is the outstanding balance as of the date of the individual's application for Medicaid.

Note: The countable value as a resource is the outstanding principal balance for the month in which a determination is being made.

M1450.545 TRANSFERS INVOLVING LIFE ESTATES

- A. Introduction** This policy applies to the purchase of a life estate on or after February 8, 2006.
- B. Policy** Funds used to purchase a life estate in another individual's home on or after February 8, 2006, must be evaluated as an uncompensated transfer unless the purchaser resides in the home for at least 12 consecutive months. If the purchaser resides in the home for less than 12 consecutive months, the entire purchase amount will be considered a transfer for less than fair market value.

M1450.550 TRANSFERS INVOLVING TRUSTS

- A. Introduction** A transfer of assets into or from a trust may be a transfer of assets for less than market value. See M1120.200 for trust resource policy, definitions pertaining to trusts, and for instructions for determining if the trust is a resource.
- B. Revocable Trust**
- 1. Transfer Into Revocable Trust** A transfer of assets **into** a revocable trust does not affect eligibility because the entire principal of a revocable trust is an available resource to the individual.
 - 2. Payments From a Revocable Trust** Any payments from the revocable trust which are made to or for the benefit of the individual are counted as income to the individual and are not transfers for less than market value.

Any payments from the revocable trust's principal or income which are NOT made to or for the benefit of the individual are assets transferred for less than fair market value.
 - 3. Look-back Date** The look-back date is 60 months for assets transferred (payments made) **from** a revocable trust.

EXAMPLE #4: Mr. B established a revocable trust with a principal of \$100,000 on March 1, 1994. He enters a nursing facility on November 15, 1997, and applies for Medicaid on February 15, 1998. The trustee has complete discretion in disbursing funds from the trust. Each month, the trustee disburses \$100 to Mr. B and \$500 to a property management firm for the upkeep of Mr. B's home. On June 14, 1994, the trustee gave \$50,000 of the trust principal to Mr. B's brother.

The \$100 and \$500 payments are counted as income to Mr. B. Because the trust is revocable, the entire principal is a resource to Mr. B. Because the trustee gave \$50,000 away, the countable value of the trust is the remaining \$50,000. The transfer of the \$50,000 to Mr. B's brother is a transfer for less than fair market value. The look-back date is February 15, 1993, which is 60 months prior to February 15, 1998, the date Mr. B was both in an institution and applied for Medicaid. The transfer occurred on June 14, 1994 which is after the look-back date. The uncompensated value is \$50,000. The penalty

date is June 1, 1994, the first day of the month in which the transfer occurred. The penalty period is 19 months beginning June 1, 1994.

C. Irrevocable Trust

A transfer of funds **into** an irrevocable trust and a transfer of funds **from** an irrevocable trust **MAY** be asset transfers for less than fair market value, depending on whether the terms of the trust

- allow for payments to or for the benefit of the individual, OR
- do not allow for payments to or for the benefit of the individual.

1. When Payment to Individual Is Allowed

When the trust allows for circumstances under which payment can be made to or for the benefit of the individual from all or a portion of the trust,

- 1) the portion of the trust principal that could be paid to or for the benefit of the individual is a resource available to the individual;
- 2) income (produced by the trust principal), which could be paid to or for the benefit of the individual, is a resource available to the individual;
- 3) payments from the trust income or principal, which are made to or for the benefit of the individual, are counted as income to the individual;
- 4) payments from income or from the trust principal which are **NOT** made to or for the benefit of the individual are assets transferred for less than fair market value.

a. Transfer Into Trust

A transfer of assets **into** an irrevocable trust that allows for payment to or for the benefit of the individual does **NOT** affect eligibility because the irrevocable trust is a resource to the individual.

b. Payments From Trust

Payments from income or from the trust principal which are made to or for the benefit of the individual are counted as income.

Payments from income or from the trust principal which are **NOT** made to or for the benefit of the individual are assets transferred for less than fair market value.

The date the transfer occurs is the date that the payment to the individual was foreclosed (the date the payment was paid to another person not for the benefit of the individual).

c. Look-back Date When Payment to Individual Is Allowed

The look-back date is **36 months** for assets transferred from an irrevocable trust under which some payment can be made to or for the benefit of the individual.

EXAMPLE #5: Mr. C established an irrevocable trust with a principal of \$100,000 on March 1, 1994. He enters a nursing facility on November 15, 1997, and applies for Medicaid on February 15, 1998. The trustee has discretion to disburse the entire principal of the trust and all income from the trust to anyone, including Mr. C, the grantor. Each month, the trustee

disburses \$100 to Mr. C and \$500 to a property management firm for the upkeep of Mr. C's home. On June 14, 1994, the trustee gave \$50,000 of the trust principal to Mr. C's brother.

The \$100 and \$500 payments are counted as income to Mr. C. Because the trustee gave \$50,000 away, the value of the trust is the remaining \$50,000. The \$50,000 principal is a resource to Mr. C since the trust allows circumstances under which payment of all the trust principal could be made to Mr. C. The transfer of the \$50,000 to Mr. C's brother is a transfer for less than fair market value. The look-back date is February 15, 1995, which is 36 months prior to the baseline date February 15, 1998, the date Mr. C was both in an institution and applied for Medicaid. The transfer occurred on June 14, 1994 which is before the look-back date. No penalty due to this transfer can be imposed; the transfer does not affect eligibility for LTC services payment. Mr. C is not eligible for Medicaid because the \$50,000 available trust resource exceeds the Medicaid resource limit.

2. When Payment to Individual Is NOT Allowed

When the trust **DOES NOT allow payment to or for the benefit of the individual** from all or a portion of the trust principal (or income on the trust principal), treat the trust as a transfer of assets for less than fair market value.

a. Transfer Into Trust

A transfer of assets **into** an irrevocable trust that does NOT allow payment to or for the benefit of the individual is a transfer of assets for less than fair market value that affects eligibility.

The date the transfer occurred is

- the date the trust was established.
- the date payment to the individual was foreclosed (the date the exculpatory clause came into effect that made the trust funds no longer payable to the individual), if later.

A transfer of additional funds into an irrevocable trust is a new asset transfer and must be evaluated separately from the asset transfer that established the trust. The date the new transfer occurred is the date the additional funds were placed in the irrevocable trust.

b. Payments From Trust

Payments from the trust cannot be made to or for the benefit of the individual, so any payments from the trust do not affect the individual's eligibility.

c. Look-back Date When Payment to Individual Not Allowed

When the trust states that payment cannot be made to the individual, the look-back date is 60 months before the baseline date.

EXAMPLE #6: Mr. D established an irrevocable trust with a principal of \$100,000 on March 1, 1994. He enters a nursing facility on November 15, 1997, and applies for Medicaid on February 15, 1998. The trust does not allow the trustee to disburse any of the principal of the trust to or for the benefit of Mr. D. The trustee disburses \$100 to Mr. D and \$500 to a property management firm for the upkeep of Mr. D's home each month from the trust income. On June 14, 1994, the trustee gave \$50,000 of the trust principal to Mr. D's brother. On July 2, 1996, Mr. D placed another \$10,000 of his savings into the trust.

The \$100 and \$500 payments are counted as income to Mr. D. Because none of the principal can be disbursed to Mr. D, the entire value of the trust at the time the trust was established (\$100,000 in 3-1-94) is a transfer of assets for less than fair market value. The look-back date is February 15, 1993, which is 60 months prior to the baseline date of February 15, 1998, the date Mr. D was both in an institution and applied for Medicaid. The transfer occurred on 3-1-94 which is after the look-back date. The uncompensated value is \$100,000.

The 7-2-96 transfer of \$10,000 into the trust is another asset transfer for less than fair market value that occurred on 7-2-96. The transfer occurred on 7-2-96 which is after the look-back date. The uncompensated value is \$10,000.

M1450.560 INCOME TRANSFERS

A. Policy Income is an asset. When an individual's income is given or assigned in some manner to another person, such gift or assignment may be a transfer of an asset for less than market value.

B. Procedures Determine whether the individual has transferred lump sum payments actually received in a month. Such payments are counted as income in the month received for eligibility purposes, and are counted as resources in the following month if retained. Disposal of a lump sum payment before it can be counted as a resource could be an uncompensated asset transfer.

Attempt to determine whether amounts of regularly scheduled income or lump sum payments, which the individual would otherwise have received, have been transferred. Normally, such a transfer takes the form of transferring the right to receive income. For example, a private pension may be diverted to a trust and no longer be paid to the individual. Question the individual concerning sources of income, income levels in the past versus the present, direct questions about giving away income or assigning the right to receive income, to someone else, etc.

In determining whether income has been transferred, do not attempt to ascertain in detail the individual's spending habits during the look-back period. Absent a reason to believe otherwise, assume that the individual's income was legitimately spent on the normal costs of daily living.

When income or the right to income has been transferred, and none of the criteria in M1450.300 or M1450.400 are met, determine the uncompensated value of the transferred income (M1450.610) and determine a penalty period (M1450.620 or 630).

M1450.570 SERVICES CONTRACTS

A. Policy *Services contracts (i.e. personal care contract, care contracts, etc.) are typically entered into for the completion of tasks such as, but not limited to, grocery shopping, house keeping, financial management and cooking, that individuals no longer can perform for themselves. For purposes of Medicaid payment of LTC services, payments made under these types of contracts may be considered an uncompensated transfer of assets.*

- B. Procedures** *When a services contract, sometimes referred to as a personal care contract, is presented as the basis for a transfer of assets, the eligibility worker must do the following:*
1. **Determine Institutionalization** *Determine when the individual met the requirement for institutionalization.*
 2. **Verify Contract Terms and Value of Services** *Obtain a copy of the written contract, or written statements verifying the terms of the agreement by all parties. Determine when the agreement was entered into/signed, who entered into/signed the contract and if the contract is legally binding as defined by policy at M1450.003 H. The terms of the contract must include the types of services, rate of payment and the number of hours for each service. The terms must be specific and verifiable. Verification of payments made and services provided must be obtained. Any payment for a service which does not have a fair market value is an uncompensated transfer.*
 3. **Contract Services Must Be Received Before Admission to LTC** *The contract must have been for services received prior to the individual's entrance into LTC. Once an individual begins receipt of Medicaid LTC services, the individual's personal and medical needs are considered to be met by the LTC provider. Payments to other individuals for services received after the individual enters LTC are considered an uncompensated transfer for Medicaid purposes.*
 4. **Physician Statement Required** *A statement must be provided by the individual's physician that indicates the types of services that were to be provided under the contract, and that these services were necessary to prevent the individual's entrance into LTC.*
 5. **Contract Made By Individual or Authorized Representative** *The contract must have been made by the applicant/recipient or his authorized representative.*
 6. **Payments Prior To Contract Date** *Any payment(s) made prior to the date the contract was signed (if contract is written) or date the contract was agreed upon (if contract is a legally binding oral contract) by all parties is considered an uncompensated transfer.*
 7. **Advance Lump Sum Payments Made To Contractor** *Certain contracts for services provide an advance lump sum payment to the person who is to perform the duties outlined in the contract. Any payment of funds for services that have not been performed is considered an uncompensated transfer of assets. The Medicaid applicant/recipient has not received adequate compensation, as he has yet to receive valuable consideration.*
 8. **Determine Penalty Period** *If it is determined that an uncompensated transfer of assets occurred, follow policy in this subchapter to determine the penalty period.*

M1450.600 PENALTY PERIOD DETERMINATION

A. Introduction

When a transfer of assets was for less than fair market value, the individual is not eligible for Medicaid payment of LTC services for a specific period of time (penalty period) based on the uncompensated value of the transferred asset and the date the transfer occurred. *However, if the individual meets all other Medicaid eligibility requirements, the individual is enrolled in Medicaid and is eligible for Medicaid payment of all other Medicaid-covered services.*

The asset transfer precludes Medicaid payment for LTC services during the penalty period unless and until the individual receives adequate compensation in return for the transferred asset.

Penalty periods that are imposed cannot overlap or run concurrently. The total cumulative uncompensated value of the assets transferred is used to determine the length of the penalty period.

*Once a penalty period begins it does not change or stop. The penalty period continues regardless of whether Medicaid eligibility continues, the institutionalized individual is discharged from LTC, or the individual changes from nursing facility care to community-based care. If the individual is re-admitted to LTC and the penalty period has not expired or ended, Medicaid payment for LTC services will continue to be denied for the remainder of the penalty period. **EXCEPTION:** The penalty period may be shortened if subsequent compensation is received (see M1450.640) or eliminated if an undue hardship is granted (see M1450.700).*

B. Determination Procedures

Determine the uncompensated value using policy and procedures in M1450.610 below. Go to M1450.620 or 630 to determine the penalty period.

If the individual subsequently receives compensation in return for the transferred asset, re-evaluate the penalty period using policy and procedures in M1450.640 below.

M1450.610 UNCOMPENSATED VALUE

A. Policy

The uncompensated value is the amount of an asset's fair market value (FMV) that was not or will not be received as a result of the asset transfer. FMV is based on criteria used in determining the value of assets in determining Medicaid eligibility.

*The uncompensated value for **real property** at the time of transfer:*

- *is the difference between the asset's FMV and the Gross Amount Due to Seller, when the lien/other encumbrance against the asset is satisfied from the seller's proceeds, or*
- *the difference between the asset's equity value (FMV minus the lien) and the Gross Amount Due to Seller, when the lien is assumed by the buyer.*

See M1450.610 H for the procedures for determining the uncompensated value of transferred real property.

Determine the uncompensated value of the transferred asset in this section and go to M1450.620 or 630 to determine the penalty period.

B. Term Life Insurance Purchase On or Before April 7, 1993

For term life insurance policies purchased on or before April 7, 1993, the purchase is a compensated transfer of assets and the purchase does not affect eligibility.

C. Term Life Insurance Purchase After April 7, 1993

For term life insurance policies purchased after April 7, 1993, the purchase is a transfer of assets for less than fair market value if the term insurance's face value is less than twice the sum of all premium(s) paid on the policy. The uncompensated value is the total premium(s) paid on the policy.

If more than one premium was paid on the policy, and the premiums were paid in different months, each premium paid on the policy is a separate transfer of assets for less than fair market value. A transfer occurred in the month each premium was paid.

EXAMPLE #7: Mr. C applied for Medicaid on November 2, 1996. On August 13, 1995, Mr. C. used \$3,000 from his checking account to pay a \$3,000 premium on a \$5,000 face value term life insurance policy. On October 5, 1995, he used \$2,000 from his checking account to pay up premiums on the same \$5,000 face value term life insurance policy. Since the policy was purchased after April 7, 1993, and \$5,000 (benefit payable on death) is not twice the \$5,000 total premiums, the premium payments are transfers of assets for less than fair market value.

The uncompensated value of the first transfer on 8-13-95 is \$3,000. The uncompensated value of the second transfer on 10-5-95 is \$2,000. The penalty period for the first transfer is based on the \$3,000 uncompensated value and the transfer date of August 1995. The penalty period for the second transfer is based on the \$2,000 uncompensated value and the transfer date of October 1995.

D. Annuity Purchase

When the average number of years of expected life remaining for the individual (the "life expectancy" number in the table) *is less than* the life of the annuity, the annuity is NOT actuarially sound. The annuity purchase is a transfer for less than fair market value.

The transfer occurred at the time the annuity was purchased.

To determine the transferred asset's uncompensated value:

1. divide the face value of the annuity by the number of years in the life of the annuity.
2. the result is the yearly payout amount.

3. from the number of years in the life of the annuity, subtract the individual's life expectancy from table.
4. the result is the uncompensated payout years (number of the annuity's "payout" years that are uncompensated).
5. multiply the uncompensated payout years by the yearly payout amount.
6. the result is the uncompensated value of the assets transferred to purchase the annuity.

EXAMPLE #8: An 80-year old man uses \$9,000 from his savings account on May 6, 1996, to purchase a \$10,000 annuity to be paid over the course of 10 years. His life expectancy according to the table is only 6.98 years. The annuity is not actuarially sound. The purchase of the annuity is a transfer for less than fair market value.

The uncompensated value is determined:

$$\begin{array}{r}
 \$10,000 \text{ annuity value} \\
 \div \quad 10 \text{ years life of annuity} \\
 \hline
 \$1,000 \text{ yearly payout} \\
 \quad 10 \text{ years life of annuity} \\
 - \quad 6.98 \text{ life expectancy} \\
 \hline
 \quad 3.02 \text{ uncompensated payout years} \\
 \times \$1,000 \text{ yearly payout} \\
 \hline
 \quad \$3,020 \text{ uncompensated value}
 \end{array}$$

The penalty period is based on the \$3,020 uncompensated value and the transfer date of May 1996.

E. Funds From Revocable Trust

Any payments **from** a revocable trust's principal or income which are NOT made to or for the benefit of the individual are assets transferred for less than fair market value. The uncompensated value is the amount of the payment.

EXAMPLE #9: Mr. B established a revocable trust with a principal of \$100,000 on March 1, 1994. Each month, the trustee disburses \$100 to Mr. B and \$500 to a property management firm for the upkeep of Mr. B's home. On June 14, 1994, the trustee gave \$50,000 of the trust principal to Mr. B's brother.

The \$100 and \$500 payments are counted as income to Mr. B. The transfer of the \$50,000 to Mr. B's brother is a transfer for less than fair market value. The uncompensated value is \$50,000; the penalty period starts on June 1, 1994, the date the transfer occurred.

F. Irrevocable Trust

1. When Payment Is Allowed to Individual

When the irrevocable trust allows payments to the individual from all or a portion of the trust, any payments **from** the trust income or **from** the trust principal which are NOT made to or for the benefit of the individual are

assets transferred for less than fair market value. The uncompensated value is the amount of the payment.

EXAMPLE #10: Mr. C established an irrevocable trust with a principal of \$100,000 on March 1, 1994. The trustee has discretion to disburse the entire principal of the trust and all income from the trust to anyone, including Mr. C, the grantor. All of the trust principal (\$100,000) could be disbursed to Mr. C under the terms of the trust. Each month, the trustee disburses \$100 to Mr. C and \$500 to a property management firm for the upkeep of Mr. C's home. On June 14, 1994, the trustee gave \$50,000 of the trust principal to Mr. C's brother.

The \$100 and \$500 payments are counted as income to Mr. C. The transfer of the \$50,000 to Mr. C's brother is a transfer for less than fair market value. The transfer occurred in June 1994. The uncompensated value is \$50,000.

2. When Payment Is Not Allowed to Individual

When the irrevocable trust does NOT allow payment to the individual from the trust, the transfer of funds into the trust is a transfer of assets for less than fair market value.

a. Trust Value

In determining the value of the trust which cannot be paid to the individual, do not subtract from the trust value any payments made for whatever purpose after the date the trust was established or, if later, the date payment to the individual was foreclosed. The value of the transferred amount is no less than its value on the date the trust is established or the date payment to the individual was foreclosed.

b. Uncompensated value

The uncompensated value is the amount of assets transferred into a trust which cannot be paid to the individual. If payment from the trust was foreclosed after the trust was established, the uncompensated value is the value of the trust as of the date payment was foreclosed.

c. Transfer Date

The date the transfer occurred is the date the trust was established, or, if later, the date payment to the individual was foreclosed.

d. Example #11

EXAMPLE #11: Mr. D established an irrevocable trust with a principal of \$100,000 on March 1, 1994. The trust allowed the trustee to disburse any of the principal of the trust to or for the benefit of Mr. D until Mr. D is admitted to a nursing facility. Mr. D was admitted to a nursing facility on May 30, 1996. Each month from the trust income, the trustee disburses \$100 to Mr. D and \$500 to a property management firm for the upkeep of Mr. D's home. On June 14, 1996, the trustee gave \$50,000 of the trust principal to Mr. D's brother. Mr. D applied for Medicaid on February 15, 1998.

The \$100 and \$500 payments are counted as income to Mr. D. Because none of the principal can be disbursed to Mr. D on or after the date he was admitted to the nursing facility, the value of the trust at the time payment was foreclosed (\$100,000 on 5-30-96) is a transfer of assets for less than fair market value. The date the transfer occurred is May 30, 1996, the date payment to Mr. D was foreclosed. The look-back period is 60 months. The look-back date is February 15, 1993, which is 60 months prior to the baseline date of February 15, 1998, the date Mr. D was both in an institution and applied for Medicaid.

The uncompensated value is \$100,000. The fact that \$50,000 was paid out of the trust to Mr. D's brother after payment to Mr. D was foreclosed does not alter the uncompensated amount upon which the penalty is based because the value of the transferred asset can be no less than its value on the date payment from the trust was foreclosed.

Mr. D placed an additional \$25,000 in the same trust on June 20, 1996. Under the terms of the trust, none of this \$25,000 can be disbursed to him. This is a new transfer of assets for less than fair market value. The uncompensated value is \$25,000; the transfer date is 6-20-96.

G. Income Transfers

1. *Lump Sum Transfer*

When a single lump sum, or single amounts of regularly paid income, is transferred for less than fair market value, the uncompensated value is the amount of the lump sum, less any compensation received. For example, an individual gives a \$2,000 stock dividend check that is paid once a year to the individual, to another person in the month in which the individual received the check. No compensation was received. The uncompensated value is \$2,000.

2. *Stream of Income Transfer*

When a stream of income (income received regularly) or the right to a stream of income is transferred, determine the total amount of income expected to be transferred during the individual's life, based on an actuarial projection of the individual's life expectancy. The uncompensated value is the amount of the projected income, less any compensation received. Use the life expectancy tables in M1450, Appendix 2.

3. *Income Transfer Example*

EXAMPLE #12: A man aged 65 years, assigns his right to a \$500 monthly annuity payment to his brother. He receives no compensation in return. Based on the life expectancy tables for males, the uncompensated value of the transferred income is \$89,760.

\$ 500
<u> </u> x12 months
\$6,000 yearly income
<u> </u> x14.96 life expectancy from table
\$89,760 value
<u> </u> - 0 compensation
\$89,760 uncompensated value

H. *Real Property Transfers*

The uncompensated value of transferred real property is determined by evaluating the settlement document which outlines the monetary transactions between the individual who sells the property and the individual who buys the property. A copy of the Settlement Document is in M1450, Appendix 4.

The eligibility worker must obtain:

- *documentation of the tax assessed value of the property at the time of the transfer; and*
- *a copy of the closing or settlement documents from the client or the financial institution.*

1. Summary of Seller's Transactions

Review the summary of the seller's transactions:

- Determine the Gross Amount Due to Seller.
- Is the Gross Amount Due to Seller less than the **tax assessed value**?
 - If **no**, the seller received adequate compensation for the property and there is **no** uncompensated transfer.
 - If **yes**, determine the uncompensated value of the asset transfer.

2. Real Property Uncompensated Value Calculations

- a. When the lien is satisfied from the proceeds received by the seller, deduct the Gross Amount Due to Seller from the tax assessed value to determine the uncompensated amount of the asset transfer.
- b. When the lien is assumed by the buyer, deduct the lien amount from the tax assessed value of the property, to determine the equity value. From the equity value deduct the Gross Amount Due to Seller for the property to determine the uncompensated amount of the asset transfer.
- c. Determine the penalty period. The beginning of the penalty period depends upon whether the transfer took place prior to or on/after 2/08/2006.

Note: Any funds deducted from the Gross Amount Due to Seller that are paid to another individual, such as funds for repair of the property, are not considered usual and customary fees and must be evaluated as a separate asset transfer. If the transfer was uncompensated then the amount of this transfer may be added to any uncompensated value from the sale of property, as the transfer occurred at the same point in time.

Example #13a: Mrs. K. is receiving CBC services. The worker discovers that Mrs. K. has moved in with her daughter and has sold her home to her son. The tax assessed value of her home at the time of transfer was \$200,000. The closing documents indicate that she sold her home for \$125,000 (the gross amount due to seller). The closing costs were paid by Mrs. K. There was no lien against the property.

The uncompensated value of the transferred real property is calculated as follows:

\$200,000	tax assessed value
<u>-125,000</u>	Gross Amount Due to Seller
\$ 75,000	uncompensated value

The penalty period is based on the uncompensated value of \$75,000. The begin date of the penalty period depends on whether the transfer took place prior to or after February 8, 2006.

Example #13b: On October 20, Mr. B. was admitted to a nursing facility. He transferred his home in July of the same year, which was within the look-back period. His home was assessed at \$100,000 in July. The mortgage against his home had a balance due of \$16,000 in July.

In reviewing the settlement statement for the sale of the property, it is noted that the sale price of the home was \$70,000 (gross amount due to seller), which was less than the tax assessed value of the home. The lien of \$16,000 was satisfied at closing from the \$70,000 sale price. The other fees deducted were usual and customary and were determined to have been paid by the buyer. Mr. B. received a \$54,000 net settlement for the sale of his home.

The uncompensated value of the transferred real property is calculated as follows:

$$\begin{array}{r} \$100,000 \text{ tax assessed value} \\ - 70,000 \text{ Gross Amount Due to Seller (includes the lien amount)} \\ \hline \$ 30,000 \text{ uncompensated value} \end{array}$$

The penalty period is based on the uncompensated transfer value of \$30,000. When the penalty period begins depends on whether the transfer took place prior to or after February 8, 2006.

Example #13c: The scenario is the same as in example 13b. However, the lien will be assumed by the purchaser rather than satisfied from the seller's gross settlement amount (Gross Amount Due to Seller). The equity value of the home is used to determine the uncompensated value in this case, because the seller was not responsible for satisfaction of the lien.

$$\begin{array}{r} \$100,000 \text{ tax assessed value} \\ -16,000 \text{ lien amount} \\ \hline \$ 84,000 \text{ equity value (EV)} \end{array}$$

$$\begin{array}{r} \$ 84,000 \text{ EV} \\ - 70,000 \text{ Gross Amount Due to Seller} \\ \hline \$ 14,000 \text{ uncompensated value} \end{array}$$

M1450.620 PENALTY PERIOD FOR TRANSFERS BEFORE FEBRUARY 8, 2006

A. Policy

When a transfer of an asset before February 8, 2006 affects eligibility, the penalty period during which Medicaid will not pay for long-term care services, begins with the penalty date, which is:

- for applicants, the first day of the month in which the asset was transferred;
- for recipients, the first day of the month **following** the month in which the asset was transferred.

B. Penalty Date

For applicants who are applying for Medicaid, the penalty date is **the first day of the month in which the asset transfer occurred** provided that date does not occur during an existing penalty period.

For recipients of Medicaid who transfer an asset while receiving Medicaid, the penalty date is **the first day of the month FOLLOWING the month** in which the asset transfer occurred, provided that date does not occur during an existing penalty period.

C. Penalty Period Calculation

The penalty period is the number of months calculated by taking the uncompensated value of the assets transferred on or after the look-back date, divided by the average monthly cost of nursing facility services to a private patient **at the time of application for Medicaid**. Beginning 10-1-97, the average cost differs for individuals in Northern Region localities (see M1450, Appendix 3 for the list of localities in the Northern Region). The average cost is determined based on the locality in which the **individual is physically located at the time of application for Medicaid**.

See the chart below for the average private nursing facility cost for Northern Region localities and all other Virginia localities.

D. Average Monthly Private Nursing Facility Cost

Average Monthly Private Nursing Facility Cost*		
<u>Application Date</u>	<u>Northern Region</u>	<u>All Other Localities</u>
10-1-96 to 10-1-97	\$2,564	\$2,564
10-1-97 to 12-31-99	\$3,315	\$2,585
01-01-00 to 12-31-00	\$3,275	\$2,596
01-01-01 to 12-31-01	\$4,502	\$3,376
01-01-02 to 12-31-03	\$4,684	\$3,517
01-01-04 and after	\$5,403	\$4,060

*Figures provided by Virginia Health Information.

Contact a Medicaid Consultant for amounts prior to October 1, 1996.

E. One Transfer

1. Determine the penalty period:
 - divide the uncompensated value by the average monthly private pay nursing facility cost at the time the individual applied for Medicaid;
 - round the result down;
 - the result is the number of months in the penalty period.
2. Determine the penalty date.
3. Beginning with the penalty date, count the number of months in the penalty period to the end of the period.
4. The last day of the last month in the penalty period is the end date of the penalty period.

EXAMPLE #14: Mr. D. a 67 year old widower who lives in his own home applies for Medicaid on October 1, 1996. He is found eligible for retroactive and ongoing Medicaid.

On September 20, 1998, Mr. D. is admitted to a nursing facility. Upon reviewing his eligibility, the agency finds that he transferred his home to his nephew on August 16, 1996, after he had been in the hospital for a few days and possible nursing facility placement had been discussed. His home was assessed at \$85,000 in August 1996. He received no compensation. The agency determines the transfer occurred within the 36 months prior to 9-20-98, the date Mr. D. was both institutionalized and a Medicaid recipient. The look-back date is September 20, 1995; the look-back period is September 20, 1995 through September 20, 1997. The transfer occurred after the look-back date. The agency evaluates the transfer and determines that the transfer affects eligibility because it does not meet any of the criteria in section M1450.300 and 400.

The agency must impose a penalty period. The uncompensated property value is \$85,000.

$$\begin{array}{r} \$85,000 \text{ assessed value} \\ \div 2,564 \text{ avg. cost NF care at time of his 10-1-96 application} \\ \hline 33.15 \text{ rounded down to 33} \end{array}$$

The penalty period based on the uncompensated value is 33 months. Because Mr. D is a recipient, the penalty date is September 1, 1996. The penalty period begins September 1, 1996 and ends May 30, 1999.

**F. Multiple Transfers
In Same Month**

When a number of assets are transferred within the **same month**, calculate the penalty period using the total value of all assets transferred in the month, divided by the average monthly private nursing facility cost.

**G. Multiple Transfers
Different Months**

When assets are transferred in **different months**, use the following procedures:

**1. Calculate Each
Penalty Period**

Calculate the individual transfer penalty period for each month's transfer.

**2. Penalty
Periods
Overlap**

When assets have been transferred in amounts and/or frequency that make the calculated penalty periods overlap, add together the value of all assets transferred and divide by the average monthly private nursing facility cost. This process produces a single penalty period which begins on the penalty date.

If the penalty periods overlap:

- add together the value of all assets transferred;
- divide by the average monthly private nursing facility cost;
- the result is a single penalty period which begins on the penalty date.

EXAMPLE #15: An individual transfers \$10,000 in January, \$10,000 in February and \$10,000 in March 1996, all of which are uncompensated. Medicaid application dated April 1996. Each penalty period is calculated individually:

$$\begin{array}{r}
 \$10,000 \text{ uncompensated value} \\
 \div \underline{2,554} \text{ average private NF cost at April 1996 application} \\
 3.91 \text{ rounded down to 3 months penalty period for each transfer}
 \end{array}$$

The penalty period for each transfer is 3 months. The first penalty period runs from 1-1-96 through 3-31-96. The second penalty period runs from 2-1-96 through 4-30-96. The third penalty period runs from 3-1-96 through 5-31-96. These periods overlap. The single penalty period is calculated:

$$\begin{array}{r}
 \$10,000 \\
 +10,000 \\
 +\underline{10,000} \\
 \$30,000 \text{ total amount transferred} \\
 \div \underline{2,554} \text{ average private NF cost at April 1996 application} \\
 11.74 \text{ rounded down to 11 months penalty period}
 \end{array}$$

The single 11-month penalty period runs from the penalty date. Because this is an applicant, the penalty date is the first day of the month in which the first transfer occurred. The penalty period is 1-1-96 through 11-30-96.

3. Penalty Periods Do Not Overlap

When multiple asset transfers' penalty periods **do not overlap**, treat each transfer as a separate event with its own penalty period.

EXAMPLE #16: Mrs. E. entered a nursing facility on June 15, 1996, and applied for Medicaid on November 16, 1996. The agency is determining eligibility on December 16, 1996. She transferred \$10,000 to her son on June 12, 1996, \$10,000 to her daughter on September 13, 1996, and \$5,000 to a granddaughter on December 25, 1996, for a total of \$25,000.

The agency determines the transfers occurred after the look-back date of November 16, 1993, 36 months prior to the date Mrs. E. was both institutionalized and a Medicaid applicant, 11-16-96. The agency evaluates the transfers and determines that they affect eligibility because they occurred after the look-back date and they do not meet any of the criteria in section M1450.300 and 400.

Since the transfers all occurred before a penalty period had been imposed, the agency calculates each penalty period as follows:

$$\begin{array}{r}
 \$10,000 \text{ asset transferred} \\
 \div \underline{2,564} \text{ average private NF cost at 11-16-96 application} \\
 3.90 \text{ rounded down to 3 months penalty period for each} \\
 \$10,000 \text{ transfer}
 \end{array}$$

$$\begin{array}{r}
 \$5,000 \text{ asset transferred} \\
 \div \underline{2,564} \\
 1.95 \text{ rounded down to 1 month}
 \end{array}$$

The penalty periods are:

- June 1, 1996 through August 31, 1996 for the asset transferred 6-12-96.

- September 1, 1996 through November 30, 1996 for the asset transferred 9-13-96.
- December 1, 1996 through December 31, 1996 for the asset transferred 12-25-96.

Mrs. E. no longer has excess resources, and she is eligible for Medicaid beginning November 1, 1996. She is not eligible for Medicaid payment of LTC services in November and December 1996. Since the last penalty period ended on 12-31-96, she becomes eligible for Medicaid payment of long-term care services beginning January 1, 1997.

H. Transfers While In An Existing Penalty Period

When additional transfers for less than market value occur during an existing penalty period, recalculate the penalty period using the procedures in item G. above.

I. Transfers After A Penalty Period Ended

When a transfer for less than market value occurs after a penalty period has ended, calculate a new penalty period by dividing the uncompensated value by the average monthly private pay nursing facility cost at the time the individual applied for Medicaid, and round down.

For applicants, the penalty date is the first day of the month in which the asset was transferred; for recipients, the penalty date is the first of the month following the month in which the asset was transferred.

EXAMPLE #17: Mr. F. entered a nursing facility on June 13, 1996, and applied for Medicaid on October 14, 1996. When the agency evaluated his application, the worker learned that Mr. F. had transferred real estate assessed at \$10,000 on October 12, 1996. Since the transfer did not meet any of the criteria in M1450.300 and 400, a penalty period for Medicaid payment of long-term care services was determined. The 3-month period ran from October 1, 1996, through December 31, 1996.

On March 10, 1997, while Mr. F. was receiving Medicaid, he disclaimed an inheritance of \$30,000. Since the disclaimer is a transfer that did not occur in another penalty period, the agency calculated a new penalty period. The penalty date is April 1, 1997, the first day of the month following March 1997, the month in which the transfer occurred. The new period is 11 months from April 1, 1997 through February 28, 1998. Therefore, Mr. F. was ineligible for Medicaid payment of long-term care services from October 1, 1996 through December 31, 1996, and is ineligible for Medicaid payment of long-term care services from April 1, 1997 through February 28, 1998.

J. Penalty Period for a Couple When Both Are Eligible and Institutionalized

When an institutionalized individual is ineligible for Medicaid payment of long-term care services because of a transfer made by his/her spouse, and the spouse is or becomes institutionalized and eligible for Medicaid, the penalty period must be apportioned between the spouses. One of two actions may be taken by the couple:

- have the penalty period, or the remaining time in the penalty period, divided between the spouses, or
- assign the penalty period or remaining penalty period to one of the two spouses.

When one spouse is no longer subject to the penalty, such as one spouse is no longer institutionalized or one spouse dies, the remaining penalty period applicable to **both** spouses must be applied to the remaining spouse.

EXAMPLE #18: Mr. A. enters a nursing facility and applies for Medicaid. Mrs. A. transfers an asset that results in a 36 month penalty period for Mr. A. 12 months into the penalty period, Mrs. A. enters a nursing facility and is eligible for Medicaid. The penalty period against Mr. A. still has 24 months to run. Because Mrs. A. is now in a nursing facility and a portion of the penalty period remains, the penalty period is reviewed. Mr. and Mrs. A. decide to have the penalty period divided between them. Therefore, both Mr. A. and Mrs. A. are ineligible for Medicaid payment of LTC services for 12 months beginning the first day of Mrs. A's Medicaid eligibility.

After 6 months, Mr. A. leaves the facility and is no longer institutionalized. Mrs. A. remains institutionalized. Because Mr. A. is no longer subject to the penalty, the remaining total penalty period for the couple, 12 months (6 months for Mr. A. and 6 months for Mrs. A.), must be imposed on Mrs. A. If Mr. A. becomes institutionalized again before the end of the 12 months, the remaining penalty period is again reviewed and divided or applied to one spouse, depending on the couple's choice.

M1450.630 PENALTY PERIOD FOR TRANSFERS ON OR AFTER FEBRUARY 8, 2006

A. Policy

The policy in this section applies to actions taken on applications, renewals or changes processed on or after July 1, 2006 for transfers made on or after February 8, 2006. The DRA enacted significant changes to the implementation date of the penalty period. When the transfer is made prior to the request for Medicaid LTC, the penalty period does not begin until the individual is eligible for Medicaid LTC. Penalty periods are assessed for fractional portions of a month. The number of months is not rounded down; therefore, the penalty period may end on a day during the month.

B. Penalty Date

When a transfer of an asset made on or after February 8, 2006, affects eligibility, the period of ineligibility for Medicaid payment for long-term care services, begins the **later** of:

- the first day of the month during or after which assets have been transferred for less than fair market value; or
- the date on which the individual is eligible for Medicaid and would otherwise be receiving institutional level of care but for the application of the penalty period; and

- which does not occur in any other period of ineligibility imposed for any reason.

However, if the individual meets all Medicaid eligibility requirements, he is eligible for Medicaid payment of all other covered services.

C. Penalty Period Calculation

The penalty period is the number of months, including any fractional portion of a month that an individual will be ineligible for the Medicaid payment of LTC services.

The period is calculated by taking the uncompensated value of the assets transferred on or after the look-back date, divided by the average monthly cost of nursing facility services to a private-pay patient in his locality at the time of the application for Medicaid. The remainder is divided by the daily rate (the monthly rate divided by 31).

When the uncompensated value of an asset transfer is less than the monthly nursing facility rate, go to step #4 in E below to calculate the partial month penalty period.

D. Average Monthly Nursing Facility Cost

See M1450.620.D for the average monthly nursing facility cost for the locality in which the individual is physically located at the time of application for Medicaid.

E. Partial Month Transfer

The following example shows how to compute a penalty period for an uncompensated transfer that occurred on or after February 8, 2006 and involving a partial month.

Example #19: An individual makes an uncompensated *asset* transfer of \$30,534 in April 2006, the same month he applies for Medicaid. The uncompensated *value* of \$30,534 is divided by the average monthly rate of \$4,060 and equals 7.52 months. The full 7-month penalty period runs from April 2006, the month of the transfer, through October 2006, with a partial *penalty calculated for November 2006. The partial month penalty is calculated by dividing the partial month penalty amount (\$2,114) by the daily rate. The calculations are as follows:*

$$\begin{array}{r}
 \text{Step \#1} \quad \$30,534.00 \quad \text{uncompensated value of transferred asset} \\
 \div 4,060.00 \quad \text{avg. monthly nursing facility rate at time of} \\
 \quad \quad \quad \text{application} \\
 = \quad 7.52 \quad \text{penalty period (7 full months, plus a partial month)}
 \end{array}$$

$$\begin{array}{r}
 \text{Step \#2} \quad \$4,060.00 \quad \text{avg. monthly nursing facility rate at time of} \\
 \quad \quad \quad \text{application} \\
 \times \quad \quad \quad 7 \quad \text{seven-month penalty period} \\
 \hline
 \$28,420.00 \quad \text{penalty amount for seven full months}
 \end{array}$$

$$\begin{array}{r}
 \text{Step \#3} \quad \$30,534.00 \quad \text{uncompensated value} \\
 \quad \quad \quad \underline{-28,420.00} \quad \text{penalty amount for seven full months} \\
 \quad \quad \quad \$2,114.00 \quad \text{partial month penalty amount}
 \end{array}$$

$$\begin{array}{rcl}
 \text{Step \#4} & \$2,114.00 & \text{partial penalty amount} \\
 & \div 130.97 & \text{daily rate } (\$4,060 \div 31) \\
 & = 16.14 & \text{number of days for partial month penalty}
 \end{array}$$

For November 2006, the partial month penalty of 16 days would be added to the seven (7) month penalty period. This means that Medicaid would authorize payment for LTC services beginning November 17, 2006.

F. Penalty Period for a Couple When Both Are Eligible and Institutionalized

When an institutionalized individual is ineligible for Medicaid payment of long-term care services because of a transfer made by the spouse, and the spouse is or becomes institutionalized and eligible for Medicaid, the penalty period must be apportioned between the spouses. M1450.620 J. contains instructions for apportioning the penalty period.

M1450.640 SUBSEQUENT RECEIPT OF COMPENSATION

A. Policy

When all assets transferred are returned to the individual, no penalty for transferring assets can be assessed. When a penalty has been assessed and payment for services has been denied, a return of the assets requires a retroactive evaluation, including erasure of the penalty, back to the beginning of the penalty period.

However, such an evaluation does not necessarily mean that Medicaid payment for LTC services must be paid on behalf of the individual. Return of the assets in question to the individual leaves the individual with assets which must be evaluated in determining eligibility during the retroactive period. Counting those assets as available may result in the individual being ineligible (because of excess income or resources) at the time of evaluation as well as for a period of time after the assets are returned.

NOTE: To void imposition of a penalty, all of the assets in question or their fair market equivalent must be returned. For example, if the asset was sold by the individual who received it, the full market value of the asset must be returned to the transferor.

When only part of an asset or its equivalent value is returned, a penalty period can be modified but not eliminated. For example, if only half of the value of the asset is returned, the penalty period can be reduced to one-half.

B. Example #20 Full Compensation Received

Example #20 Mr. G., who is in a nursing facility, applied for Medicaid on November 24, 2004. On October 10, 2004, he transferred his non-home real property worth \$30,000 to his son. The transfer did not meet any of the criteria in M1450.501, so a penalty period was imposed from October 1, 2004, through April 30, 2005.

On December 12, 2004, Mr. G.'s son paid medical bills for his father totaling \$30,000. The agency re-evaluated the transfer and determined a penalty period was no longer appropriate since full compensation was received. Mr. G.'s eligibility for Medicaid payment of long-term care services was re-evaluated, beginning with October 1, 2004.

**C. Example #21
Partial
Compensation
Received**

Example #21: Ms. H. applied for Medicaid on November 2, 2004, after entering a nursing facility on March 15, 2004. On October 10, 2004, she transferred her non-home real property worth \$40,000 to her son and received no compensation in return for the property. Ms. H.'s Medicaid application was approved, but she was ineligible for Medicaid payment of long-term care services for 9 months beginning October 1, 2004 and continuing through June 30, 2005.

On December 12, 2004, the agency verified that Ms. H.'s son paid her \$20,000 for the property on December 8, 2004. The agency re-evaluated the transfer and determined a remaining uncompensated value of \$20,000 and a penalty period of 4 months, beginning October 1, 2004 and continuing through January 31, 2005.

The \$20,000 payment must be evaluated as a resource in determining Ms. H.'s Medicaid eligibility for January 2005.

M1450.700 CLAIM OF UNDUE HARDSHIP

A. Policy

The opportunity to claim an undue hardship must be given when the imposition of a penalty period affects Medicaid payment for LTC services. The individual has the burden of proof and must provide written evidence to clearly substantiate the circumstances surrounding the transfer, attempts to recover the uncompensated value and the impact of the denial of Medicaid payment of LTC services.

B. Procedures

**1. Eligibility
Worker**

The worker must complete documentation of the uncompensated asset transfer as outlined below and inform the applicant/recipient of the evidence which he must provide, as indicated in section C.2, below.

a. *The worker must send a letter to the individual that includes the following:*

- *The uncompensated value of each asset transfer,*
- *the penalty period, **and***
- *the right to claim undue hardship.*

A copy of the Asset Transfer Hardship Claim Form must be included with the letter (see M1450 Appendix 1). The individual must be given 10 calendar days to return the completed form to the local agency.

b. *If undue hardship is claimed, the eligibility worker must provide to DMAS, the client's name, Medicaid case number, if appropriate, and the date on which LTC services began.*

c. Retain a copy of all documentation for the case the record and send the undue hardship claim and supporting documents to DMAS at the following address:

DMAS, Division of Policy and Research
 Eligibility Section
 600 East Broad Street, Suite 1300
 Richmond, Virginia 23219

- d. DMAS will notify the worker of the decision on the hardship claim. If undue hardship is not claimed or if a penalty period must be imposed per DMAS, follow the procedures in *M1450.800 through M1450.830* for notifying the individual and DMAS of the action. The individual must be informed that a denial of a claim for undue hardship may be appealed in accordance with the provisions of 12 VAC 30-110. If the individual meets all other eligibility requirements, he is eligible for Medicaid payment of all covered services other than LTC.

2. Applicant or Recipient

The evidence as required below must show that the assets transferred can not be recovered and that the immediate adverse impact of the denial of Medicaid coverage for payment of LTC services due to the uncompensated transfer would result in the individual being removed from the institution or becoming unable to receive life-sustaining medical care, food, clothing, shelter or other necessities of life.

The applicant/recipient or his authorized representative must provide a written statement including all of the following information and attachments for a claim of undue hardship:

- *What was transferred, to whom it was transferred and the relationship between the parties;*
- *The reason(s) for the transfer;*
- *A list of all assets owned at the time of the transfer and verification of their value at the time of transfer;*
- *A statement from an independent third party substantiating the reason(s) for the transfer;*
- *Documentation of what efforts have been made to recover the asset, or if no effort for recovery has been made, the reason(s) why no effort was made;*
- *If the asset was alleged to have been stolen or transferred without permission, attach documentation of the legal action taken to recover the asset and the results of that action;*

Note: *If the applicant/recipient was a victim of an individual who is not the individual's attorney in fact, guardian, conservator or trustee and undue hardship is claimed, the **eligibility worker** must provide a statement documenting the facts and what actions were taken by the agency with regard to their findings. If the transfer was by a court-appointed guardian or conservator, documentation*

of any bond insurance that would cover the loss if the property cannot be directly recovered or if compensation by the guardian/conservator or transferee was not received must be provided.

- *Documentation of the impact of a denial of payment of long-term care services. If there is an allegation that the individual's medical condition is life-threatening or requires immediate attention, a doctor's statement must be included.*
- *Include documents such as deeds, wills and bank statements.*

This information must be provided to the Eligibility Worker along with the Asset Transfer Hardship Claim form for submission to DMAS.

M1450.800 AGENCY ACTION

A. Policy

If an institutionalized individual's asset transfer is not allowable by policy, the individual is eligible for Medicaid but is not eligible for Medicaid payment of long-term care services. The individual, the service provider, and the Department of Medical Assistance Services (DMAS) must be notified of his/her ineligibility for Medicaid payment of long-term care services.

B. Procedures

The procedures used for notifying the recipient, the provider and DMAS are in sections M1450.810, 820, and 830 below.

M1450.810 APPLICANT/RECIPIENT NOTICE

A. Policy

Whenever an institutionalized individual is not eligible for Medicaid payment of long-term care services because of an asset transfer, the form which notifies him/her of Medicaid eligibility must include the penalty period during which Medicaid will not cover LTC services for the individual.

B. Notice Contents

The Notification of Action on Medicaid sent to the individual must specify:

- the individual is eligible for Medicaid beginning (the appropriate date) and
- Medicaid will not pay for nursing facility or CBC waiver services for the months (state the begin and end dates of the penalty period) because of the uncompensated asset transfer(s) that occurred (date/dates).
- the penalty period may be shortened if compensation is received.

C. Advance Notice

When an institutionalized Medicaid recipient is found no longer eligible for Medicaid payment of long-term care services because of an asset transfer, the Advance Notice of Proposed Action must be sent to the individual at least 10 days before cancelling coverage of LTC services, and must specify:

- the individual is eligible for Medicaid.
- Medicaid will not pay for long-term care services for the months (state the penalty period begin and end dates) because of the asset transfer(s) that occurred (date/dates).
- The penalty period may be shortened if compensation is received.

M1450.820 PROVIDER NOTICE

A. Introduction

Use the DMAS-122 to notify the provider of the individual's Medicaid eligibility and ineligibility for Medicaid payment of long-term care services.

B. DMAS-122

The DMAS-122 form includes:

- the individual's full name, Medicaid and Social Security numbers;
- the individual's birth date;
- the patient's Medicaid coverage begin date;
- the patient's income;
- no deductions or patient pay amounts; and
- that the patient is not eligible for Medicaid payment of nursing facility/CBC waiver services for the months (state the penalty period begin and end dates) because of an asset transfer(s).

M1450.830 DMAS NOTICE

A. Introduction

The worker must notify DMAS that the recipient is not eligible for LTC services payment because of an asset transfer. DMAS must input the code in the MMIS that will deny payment of LTC services claims.

The worker notifies DMAS via a copy of the DMAS-122 sent to the provider.

B. Copy of DMAS-122

The copy of the DMAS-122 that is sent to DMAS must contain the following information, in addition to the information on the provider's copy of the DMAS-122:

- date(s) the asset transfer(s) occurred;
- the uncompensated value(s); and
- penalty period(s) (begin and end dates) and computation of that period(s).

C. Send DMAS Notice The agency worker must send a copy of the DMAS-122 to:

Program Delivery Systems
Long-Term Care Unit
Department of Medical Assistance Services
600 E. Broad St., Suite 1300
Richmond, VA 23219.

The copy of the DMAS-122 must be signed and dated by the worker, and must show the worker number and the local agency's FIPS code.

Any information the agency receives about the individual's subsequent receipt of compensation which shortens the penalty period must be sent to the Long-Term Care Unit at the above address.

ASSET TRANSFER HARDSHIP CLAIM FORM

TO:
DMAS, Division of Policy and Research
Eligibility Section
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Agency Name:
Case Name:
Case #:
Worker Name:
Worker Telephone #:

If you wish to claim that an Undue Hardship would result if you were ineligible for Medicaid payment of nursing facility services or community-based care (CBC) waiver services, check the first box below, attach copies of any necessary documentation and sign and date where indicated.

If you do not wish to claim an Undue Hardship, check the second box, sign your name and the date where indicated below the second box.

I want to claim Undue Hardship.

Please provide all of the following information:

- What was transferred, to whom it was transferred and the relationship between the parties;
The reason(s) for the transfer(s);
A list of all assets owned at the time of the transfer and verification of their value at the time of transfer;
A statement from an independent third party substantiating the reason(s) for the transfer(s) must be attached;
Documentation of what efforts have been made to recover the asset, if no effort for recovery has been made the reason(s) why must be indicated;
If the asset was alleged to have been stolen or transferred without permission, documentation of any legal action taken must be attached;
The impact of a denial of payment of long-term care services must be documented. If there is an allegation that the individual's medical condition is life-threatening or requires immediate attention, a doctor's statement must be attached.
Also, include documents such as deeds, wills and bank statements.

Your explanation will be evaluated by the Department of Medical Assistance Services. You will be notified in writing of the decision that is made.

I affirm that the information provided about my claim for an Undue Hardship is true and correct to the best of my knowledge and belief.

Signature of Claimant or Authorized Representative

Date

I do not want to claim hardship. My right to claim hardship has been explained to me, and I choose not to claim a hardship.

Signature of Claimant or Authorized Representative

Date

Settlement Statement-

Form HUD-1 follows on pages 2 and 3 of this appendix. This form is frequently used as the settlement statement when closing a real estate transaction or transfer. Note that there is a specific section for the borrower and the seller. The Borrower is the individual(s) who is purchasing the property. The Seller is the owner of the property.

The Gross Amount Due to Seller for the property noted on line 420 of the first page of the statement represents the amount of funds being paid for purchase the property. This amount includes the funds which satisfy any outstanding liens against the property at the time of transfer, which are noted on lines 504 and 505 of the first page.

Usual and customary fees associated with real estate transactions are already indicated on the form, such as the lien amounts, any additional deductions must be added to the form. These types of deductions should be carefully examined by the eligibility worker, as they may represent a separate uncompensated transfer from the seller's portion of the proceeds from the sale of the property.

Any questions regarding this form and any deductions listed should be referred to the appropriate Medical Assistance Program Consultant.

A. Settlement Statement

U.S. Department of Housing and Urban Development

OMB Approval No. 2502-02 (expires 11/30/200)

B. Type of Loan

1. FHA 2. FmHA 3. Conv. Unins. 4. VA 5. Conv. Ins.

6. File Number:

7. Loan Number:

8. Mortgage Insurance Case Number:

C. Note: This form is furnished to give you a statement of actual settlement costs. Amounts paid to and by the settlement agent are shown. Items marked "(p.o.c.," were paid outside the closing; they are shown here for informational purposes and are not included in the totals.

D. Name & Address of Borrower:

E. Name & Address of Seller:

F. Name & Address of Lender:



G. Property Location:

H. Settlement Agent:

Place of Settlement:

I. Settlement Date:

J. Summary of Borrower's Transaction

100. Gross Amount Due From Borrower

101. Contract sales price
102. Personal property
103. Settlement charges to borrower (line 1400)
104.
105.

Adjustments for items paid by seller in advance

106. City/town taxes to
107. County taxes to
108. Assessments to
109.
110.
111.
112.

120. Gross Amount Due From Borrower

200. Amounts Paid By Or In Behalf Of Borrower

201. Deposit or earnest money
202. Principal amount of new loan(s)
203. Existing loan(s) taken subject to
204.
205.
206.
207.
208.
209.

Adjustments for items unpaid by seller

210. City/town taxes to
211. County taxes to
212. Assessments to
213.
214.

220. Total Paid By For Borrower

300. Cash At Settlement From/To Borrower

301. Gross amount due from borrower (line 120)

302. Less amounts paid by/for borrower (line 220) ()

303. Cash From To Borrower

K. Summary of Seller's Transaction

400. Gross Amount Due To Seller

401. Contract sales price
402. Personal property
403.
404.
405.

Adjustments for items paid by seller in advance

406. City/town taxes to
407. County taxes to
408. Assessments to
409.
410.
411.
412.

420. Gross Amount Due To Seller

500. Reductions In Amount Due To Seller

501. Excess deposit (see instructions)
502. Settlement charges to seller (line 1400)
503. Existing loan(s) taken subject to
504. Payoff of first mortgage loan
505. Payoff of second mortgage loan
506.
507.
508.
509.

Adjustments for items unpaid by seller

510. City/town taxes to
511. County taxes to
512. Assessments to
513.
514.
515.
516.
517.
518.
519.

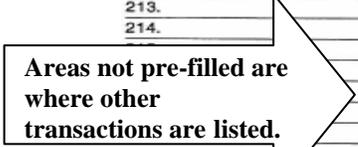
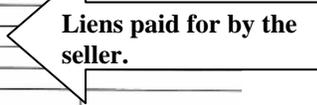
520. Total Reduction Amount Due Seller

600. Cash At Settlement To/From Seller

601. Gross amount due to seller (line 420)

602. Less reductions in amt. due seller (line 520) ()

603. Cash To From Seller



Section 5 of the Real Estate Settlement Procedures Act (RESPA) requires the following: • HUD must develop a Special Information Booklet to help persons borrowing money to finance the purchase of residential real estate to better understand the nature and costs of real estate settlement services; • Each lender must provide the booklet to all applicants from whom it receives or for whom it prepares a written application to borrow money to finance the purchase of residential real estate; • Lenders must prepare and distribute with the Booklet a Good Faith Estimate of the settlement costs that the borrower is likely to incur in connection with the settlement. These disclosures are mandatory.

Section 4(a) of RESPA mandates that HUD develop and prescribe this standard form to be used at the time of loan settlement to provide full disclosure of all charges imposed upon the borrower and seller. These are third party disclosures that are designed to provide the borrower with pertinent information during the settlement process in order to be a better shopper.

The Public Reporting Burden for this collection of information is estimated to average one hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information.

This agency may not collect this information, and you are not required to complete this form, unless it displays a currently valid OMB control number. The information requested does not lend itself to confidentiality.

L. Settlement Charges						
700. Total Sales/Broker's Commission based on price \$					@	% =
Division of Commission (line 700) as follows:						
701. \$		to			Paid From Borrowers Funds at Settlement	Paid From Seller's Funds at Settlement
702. \$		to				
703. Commission paid at Settlement						
704.						
800. Items Payable In Connection With Loan						
801. Loan Origination Fee			%			
802. Loan Discount			%			
803. Appraisal Fee			to			
804. Credit Report			to			
805. Lender's Inspection Fee						
806. Mortgage Insurance Application Fee to						
807. Assumption Fee						
808.						
809.						
810.						
811.						
900. Items Required By Lender To Be Paid In Advance						
901. Interest from		to	@ \$	/day		
902. Mortgage Insurance Premium for				months to		
903. Hazard Insurance Premium for				years to		
904.				years to		
905.						
1000. Reserves Deposited With Lender						
1001. Hazard insurance		months @ \$		per month		
1002. Mortgage insurance		months @ \$		per month		
1003. City property taxes		months @ \$		per month		
1004. County property taxes		months @ \$		per month		
1005. Annual assessments		months @ \$		per month		
1006.		months @ \$		per month		
1007.		months @ \$		per month		
1008.		months @ \$		per month		
1100. Title Charges						
1101. Settlement or closing fee		to				
1102. Abstract or title search		to				
1103. Title examination		to				
1104. Title insurance binder		to				
1105. Document preparation		to				
1106. Notary fees		to				
1107. Attorney's fees		to				
(includes above items numbers:)						
1108. Title insurance		to				
(includes above items numbers:)						
1109. Lender's coverage		\$				
1110. Owner's coverage		\$				
1111.						
1112.						
1113.						
1200. Government Recording and Transfer Charges						
1201. Recording fees: Deed \$; Mortgage \$; Releases \$						
1202. City/county tax/stamps: Deed \$; Mortgage \$						
1203. State tax/stamps: Deed \$; Mortgage \$						
1204.						
1205.						
1300. Additional Settlement Charges						
1301. Survey to						
1302. Pest inspection to						
1303.						
1304.						
1305.						
1400. Total Settlement Charges (enter on lines 103, Section J and 502, Section K)						

- f. Assiniboine Tribe of Fort Peck Montana [ref. P.L. 98-124]
- g. Assiniboine Tribe of Port Belknap [ref. P.L. 98-124]
- h. Shoshone and Arapaho Tribes of Wind River Reservation of Wyoming [ref. P.L. 98-64].

21. Indian Trust or Restricted Land Payments

Income from individual interests in Indian Trust or Restricted Lands up to \$2,000 per year in payments is excluded [ref. P.L. 103-66].

22. Walker v. Bayer Settlement Payments

The following payments from the settlement of the Walker v. Bayer Corp., et.al., lawsuit (sometimes called the “Hemophilia Litigation Settlement”) are excluded as income: [ref. P.L.105-33].

- a. payments made from any fund established pursuant to a class settlement in the case of Susan Walker v. Bayer Corp., et.al., or
- b. payments made pursuant to a release of all claims in a case that is 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.

The **interest** received on these excluded funds is NOT excluded and must be counted as income in the month received.

23. Home Produce

Home produce consumed by the individual or his household is excluded as income. Proceeds from the sale of home produce ARE counted as earned or unearned income [ref. 1612(b)(8)].

C. What Is NOT Income For All Covered Groups EXCEPT F&C MN

The items below are NOT income when determining eligibility for all covered groups EXCEPT for the F&C MN covered groups. Count these income sources in the F&C medically needy income determination, **but NOT in the patient pay calculation.**

1. Specific VA Payments

The following VA payments are NOT income for all covered groups EXCEPT the F&C MN covered groups:

- a. Payments for Aid and Attendance or housebound allowances. Refer to section M1470.100 for counting Aid and Attendance payments as income in the patient pay calculation.

NOTE: This applies to all LTC recipients, including those patients who reside in *state* veterans’ care centers.

- b. Payments for unusual medical expenses.
- c. Payments made as part of a VA program of vocational rehabilitation.
- d. VA clothing allowance.
- e. Any pension paid to a nursing facility patient who is
 - a veteran with no dependents, or
 - a veteran's surviving spouse who has no child.

NOTE: Refer to section M1470.100 for counting VA pension payments as income for post-eligibility determinations. This applies to all LTC recipients who reside in *state* veterans' care centers.

- f. Any portion of a VA educational benefit which is a withdrawal of the veteran's own contribution is a conversion of a resource and is not income.

2. VA Augmented Benefits

An absent dependent's portion of an augmented VA benefit received by the individual on or after 11-17-94 is NOT income to the individual when determining his eligibility in any covered group EXCEPT an F&C MN covered group.

VA Augmented benefits are COUNTED as income when determining eligibility in the F&C MN covered groups.

3. Return of Money

(S0815.250) A rebate, refund, or other return of money that an individual has already paid is NOT income to the individual when determining his eligibility in any covered group EXCEPT an F&C MN covered group. The key idea is a return of the individual's own money. Some "rebates" do not fit this category, such as a cooperative operating as a jointly owned business pays a "rebate" as a return on a member's investment; this "rebate" is unearned income similar to a dividend.

4. Death Benefits

Death benefits **equal** to cost of last illness and burial are NOT income in all covered groups EXCEPT the F&C MN covered groups.

Any amount of the death benefit that **exceeds** the costs of last illness and burial **is counted as income** for eligibility and patient pay **in all covered groups**.

5. Austrian Social Insurance

Austrian Social Insurance payments that meet the requirements in S0830.715 are NOT income in all covered groups EXCEPT the F&C MN covered groups.

6. Native American Funds

- a. Seneca Nation Settlement Act [ref. P.L. 101-503]
- b. Yakima Indian Nation [ref. P.L. 99-433]
- c. Papago Tribe of Arizona [ref. P.L. 97-408]
- d. Shawnee Indians [ref. P.L. 97-372]

M1460.650 RETROACTIVE INCOME DETERMINATION

- A. Policy**
- The retroactive period is the three months immediately prior to the Application month. The three-month retroactive period cannot include a portion of a prior Medicaid medically needy spenddown budget period in which eligibility was established.
- 1. Institutionalized Individual** For the retroactive months in which the individual was institutionalized *in a medical facility*, determine income eligibility on a monthly basis using the policy and procedures in this subchapter (M1460). *An individual who lived outside of a medical institution during the retroactive period must have retroactive Medicaid eligibility determined as a non-institutionalized individual.*
A spenddown must be established for any month(s) during which excess income existed. Go to M1460.700 for spenddown policies and procedures for medically needy institutionalized individuals.
 - 2. Individual Not Institutionalized** For the retroactive months in which the individual was NOT institutionalized, determine income eligibility for the ABD groups using the ABD policy and procedures in chapter S08. Determine income eligibility for the F&C groups using policy and procedures in chapter M07. A spenddown must be established for any month(s) during which excess income existed. See Chapter M13 for spenddown policies and procedures.
 - 3. Retroactive Entitlement** If an applicant meets all eligibility requirements, he is entitled to Medicaid coverage for the month(s) in which all eligibility factors were met.
- B. Countable Income**
- Countable income is that income which was actually received in the retroactive month(s). Count the income received in the months in which the individual meets all other Medicaid eligibility requirements.
- If the individual was CNNMP in the retroactive month, the countable income is compared to the appropriate income limit for the retroactive month. **Medicaid income eligibility is determined on a monthly basis for the MN institutionalized individual.**
- C. Entitlement**
- Retroactive coverage cannot begin earlier than the first day of the third month prior to the application month. When an applicant reports that he received a medical service within the retroactive period, entitlement for Medicaid will begin with the first day of the third month prior to the application month, provided all eligibility factors were met in all three months. If the institutionalized applicant had excess income in the retroactive period, entitlement may begin the first day of the month in which the retroactive spenddown was met.
- For additional information, refer to section M1510.101.
- D. Retroactive Income Determination Example**
- EXAMPLE #3:** A disabled institutionalized individual applies for Medicaid on June 5 and requests retroactive coverage for unpaid medical bills that he incurred in March, April, and May. His disability onset date was April 10. He was institutionalized on April 10. The retroactive period is March, April and

May. He is not eligible for March because he did not meet a covered group in March. The income he received in April and May is counted monthly because he was institutionalized in each month. He is resource eligible for all three months.

His April income is calculated and compared to the monthly 300% SSI income limit. It exceeds that limit. His May income is calculated and compared to the monthly 300% SSI income limit; it is within the limit. Therefore, he is placed on a one-month retroactive spenddown for April, and is enrolled in the 300% SSI covered group for May.

M1460.660 NOTICES & ENROLLMENT PROCEDURES FOR CATEGORICALLY NEEDY AND MEDICALLY INDIGENT

A. Eligible--CN, CNNMP & F&C MI

Enroll the recipient with the appropriate CN, CNNMP or F&C MI program designation (PD) as follows:

1. CN

- a. Supplemental Security Income (SSI) recipients EXCEPT AG recipients, regardless of living arrangements.

11 Aged
31 Blind
51 Disabled

- b. All Auxiliary Grant (AG) recipients, including those who receive SSI.

12 Aged
32 Blind
52 Disabled

- c. IV-E foster care (AFDC-FC) or IV-E adoption assistance (AFDC-AA) child who is IV-E eligible.

74

2. CNNMP

- a. Individuals not receiving SSI or TANF because of an eligibility condition specifically prohibited by Medicaid (e.g., stepparent's income deemed available); protected individuals such as former SSI, AG, or AFDC recipients; 12-month Extended and Transitional Medicaid recipients.

21 Aged
41 Blind
61 Disabled
81 Low Income Families With Children (LIFC)
83 LIFC--Unemployed/underemployed parent deprivation

- b. Child under age 21 in intermediate care facility or ICF-MR.

82

- c. Non-IV-E (state/local) Adoption Assistance child & Special Medical Needs Adoption Assistance child under age 21.

72

- d. Child under age 21, responsibility of Juvenile Justice Department.

75

4. **CBC Additional Care** Additional care purchased outside of a CBC recipient's plan of care is not counted as income available for patient pay if it is purchased by someone other than the recipient. This additional care may be purchased from any source including the agency providing the CBC.
5. **Advance Payments That Will Be Refunded** Advance payments made by a person other than the patient which are expected to be reimbursed once Medicaid is approved and payments made by outside sources to hold the facility bed while the patient is hospitalized, are **not counted as income** in determining eligibility or patient pay.

There are instances when the family of a prospective Medicaid patient, or other interested party(ies), makes an advance payment on the cost of facility care prior to or during the Medicaid application process to assure the patient's admission and continued care. The individual may have been promised that the advance payment will be refunded if Medicaid eligibility is established.

Any monies contributed toward the cost of patient care pending a Medicaid eligibility determination must be reimbursed to the contributing party by the facility once Medicaid eligibility is established.

M1470.200 FACILITY PATIENTS - ALLOWABLE DEDUCTIONS FROM INCOME

- A. Introduction** This section describes the only deductions which are subtracted from a facility patient's gross monthly income when calculating patient pay in the month of entry and subsequent months when the patient does not have a community spouse.

Deductions are allowed only for items that are described in sections M1470.210 through 240 below.

NOTE: If the individual is married and his spouse is in a nursing facility, then there is no community spouse and each spouse is treated as an unmarried individual for patient pay purposes. When the patient is an institutionalized spouse with a community spouse, as defined in subchapter M1480, go to subchapter M1480 to determine the institutionalized spouse's patient pay.

- B. Order of Patient Pay Deductions** Subtract the deduction(s) from gross monthly income in the order presented below. *If the patient has no income remaining after a deduction, no further deductions can be made.*
1. **Personal Needs** See section M1470.210 "Facility Personal Needs Allowance."
 2. **Dependent Child Allowance** See section M1470.220 "Dependent Child Allowance."

3. **Noncovered Medical Expenses** See section M1470.230 "Facility - Noncovered Medical Expenses."

4. **Home Maintenance Deduction** See section M1470.240 "Facility - Home Maintenance Deduction."

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 or Medicaid Technician who made the decision prepares the appeal summary and attends the hearing.

M1470.210 FACILITY PERSONAL NEEDS ALLOWANCE

A. Policy

The personal needs allowance is calculated according to the instructions in this section for the month of entry and subsequent months. The amount of the personal needs allowance depends on whether or not:

- the patient has a guardian or conservator who charges a fee; or
- the patient has earnings from employment that is part of the treatment plan.

1. **Basic Personal Allowance** Deduct \$40 per individual, *effective July 1, 2007. The personal needs allowance for prior months is \$30.*

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 representative payee or "power of attorney" fees or expenses.

3. **Special Earnings Allowance** Working patients are allowed a higher personal needs allowance if they meet the following criteria. These patients will be identified by the facility. The patient must regularly participate in vocational activity which is a planned habilitation program and is carried out as a therapeutic work program, such as:

- sheltered workshops
- vocational training
- pre-vocational training.

Deduct a special earnings allowance if the patient participates in a work program as part of treatment. The special earnings allowance is deducted from earned income only. Subtract:

- the first \$75 of gross monthly earnings, PLUS
- ½ the remaining gross earnings,
- up to a maximum of \$190 per month.

The special earnings allowance cannot exceed \$190 per month.

EXAMPLE #1: A patient in the nursing facility is employed as a telephone salesperson as part of his plan of care in the facility. He has a legally appointed guardian who charges a 2% fee. His only income is gross earnings of \$875 per month.

His special earnings allowance is calculated first:

$$\begin{array}{r}
 \$875 \quad \text{gross earned income} \\
 - \quad 75 \quad \text{first \$75 per month} \\
 \hline
 800 \quad \text{remainder} \\
 \div \quad 2 \\
 \hline
 400 \quad \text{½ remainder} \\
 + \quad 75 \quad \text{first \$75 per month} \\
 \hline
 \$475 \quad \text{which is } > \$190
 \end{array}$$

His personal needs allowance is computed as follows:

$$\begin{array}{r}
 \$ 40.00 \quad \text{basic allowance} \\
 +190.00 \quad \text{special earnings allowance} \\
 + \quad 17.50 \quad \text{guardian fee (2\% of \$875)} \\
 \hline
 \$247.50 \quad \text{personal needs allowance}
 \end{array}$$

EXAMPLE #2: A patient who works in a sheltered workshop has gross earnings of \$275 this month. He also receives \$25 from SSA. He does not have a guardian or conservator. His special earnings allowance is calculated:

$$\begin{array}{r}
 \$ 275 \quad \text{gross earned income} \\
 - \quad 75 \quad \text{first \$75 per month} \\
 \hline
 \$ 200 \quad \text{remainder} \\
 \div \quad 2 \\
 \hline
 \$ 100 \quad \text{½ remainder} \\
 + \quad 75 \quad \text{first \$75 per month} \\
 \hline
 \$ 175 \quad \text{which is } < \$190
 \end{array}$$

His personal needs allowance is computed as follows:

$$\begin{array}{r}
 \$ 40 \quad \text{basic needs allowance} \\
 +175 \quad \text{special earnings allowance} \\
 \hline
 \$215 \quad \text{personal needs allowance}
 \end{array}$$

M1470.220 DEPENDENT CHILD ALLOWANCE

A. Unmarried Individual or Married Individual With No Community Spouse

An unmarried individual, or married individual without a community spouse, who has a minor dependent child(ren) under age 21 in the community, can have a dependent child allowance. When the individual verifies that he/she has a dependent child(ren) in the community:

- Calculate the difference between the appropriate monthly medically needy income limit (MNIL) for the child's locality for the number of minor dependent children in the home, and the child(ren)'s gross monthly income. If the child lives outside of Virginia, use the Group III MNIL.
- The result is the dependent child allowance. If the result is greater than \$0, deduct it from the patient's monthly income as the dependent child allowance. If the result is \$0 or less, there is NO dependent child allowance.

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

Do not deduct an allowance if money is not made available or they do not accept the monthly income allowance.

Do NOT deduct any allowance for other family member(s).

1. Example--Two Dependent Children

EXAMPLE #3: Mr. H is a single individual with gross monthly income of \$920, living in a nursing facility. He is divorced and has two children under age 21 who live with his ex-wife in Group I. His two children each receive \$75 monthly SSA.

The allowance for the dependent children is calculated as follows:

\$ 283.33	MN limit for 2 (Group I)
<u>- 150.00</u>	children's total monthly SSA income
\$ 133.33	dependent children's allowance

2. Example--One Dependent Child

EXAMPLE #4: Mrs. K is a married individual who is now residing in a nursing facility. Her spouse is in another medical facility. Their dependent child lives with her sister in a Group II locality. The child receives \$95.00 per month SSA.

The allowance for the dependent child is calculated as follows:

\$ 250	MN limit for 1 (Group II)
<u>- 95</u>	child's SSA income
\$ 155	dependent child's allowance

b. DMAS Approval Not Required

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 allowance(s), and health insurance premiums are deducted.

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 month following the month the change is reported. If the deduction exceeds the available income, the remaining balance can be carried over to the following month(s).

c. 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. In the comments section, note that a deduction for the noncovered service has been made.
- 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. Allowed
Deduction for
Prescription
Drugs Purchased
Before Medicare
Part D
Enrollment**

Individuals who:

- *qualify for Medicare Part D,*
- *are NOT enrolled in a Medicare Part D prescription drug plan (PDP), and*
- *are NOT Medicaid eligible at the time of admission to a nursing facility*

will be fully responsible for their drug costs until Medicaid eligibility is determined and the Medicare Part D PDP enrollment process is completed. The individual remains responsible for any drugs purchased prior to the effective date of the PDP enrollment; Medicaid cannot pay for these drugs. The cost of drugs purchased before the PDP begin date can be deducted from patient pay.

7. Medicare Part D Deductions Not Allowed

Medicaid-enrolled nursing facility patients who are enrolled in a Medicare Part D PDP are **not** responsible for the payment of deductibles or co-pays, nor will they be subject to a coverage gap in their Part D benefits. Do NOT deduct from patient pay any Medicare PDP deductibles, co-pays or coverage gap costs.

If a full-benefit Medicaid/Medicare recipient was subject to PDP co-pays prior to his admission to a nursing facility, he may continue to be assessed co-pays until the PDP is notified of his admission to the nursing facility. Once DMAS has identified him as a nursing facility patient, the PDP will reimburse him for co-pays incurred during the month(s) in which he was in a nursing facility.

If an individual is enrolled in Part D and is in a nursing facility but was not eligible for Medicaid at the time of admission to the nursing facility, he may continue to be charged co-pays or deductibles until the PDP is notified of his eligibility as a full-benefit Medicaid enrollee. The PDP will reimburse him for co-pays or deductibles incurred during the months in which he was determined to be a full-benefit Medicaid enrollee.

M1470.240 FACILITY - HOME MAINTENANCE DEDUCTION

A. Policy

A single institutionalized individual can be allowed a deduction for the cost of maintaining a home for not more than six months, if a physician has certified he or she is likely to return home within that period.

Home maintenance means that the individual has the responsibility to pay shelter costs on his former place of residence in Virginia, such as rent, mortgage, utilities, taxes, room and board, or Adult Care Residence payments, and that the home, apartment, room or bed is being held for the individual's return to his former residence in Virginia. For Adult Care Residence residents in the month of entry to a nursing facility, deduct a home maintenance (MNIL) allowance even if the Adult Care Residence room or bed is not being held.

Only one spouse of an institutionalized married couple (both spouses are in a medical facility) is allowed the deduction to maintain a home for up to six months, if a physician certifies that he is likely to return home within that period.

NOTE: If the individual is receiving the full SSI benefit for the first three months of institutionalization, do not allow a home maintenance deduction in those months.

B. Temporary Care

Temporary care is defined as not exceeding 6 months of institutionalization, beginning the **month** of admission to the medical facility. A physician's written statement, *including a DMAS-96*, that the individual is expected to return to his home within 6 months of admission is required to certify temporary care. When the temporary care period ends, the home maintenance deduction must be discontinued and if necessary resource eligibility reevaluated.

C. Amount Deducted

The home maintenance deduction is the MN income limit for one person in the individual's locality of residence. See Appendix 5 to subchapter M0710 or section M0810.002 A. 4 for the MN income limits.

- Medicaid CBC Recipient Entering A Facility (M1470.320)
- Facility Admission From Another Facility (M1470.340)

M1470.310 FACILITY ADMISSION FROM A COMMUNITY LIVING ARRANGEMENT

A. Policy

The policy in this section describes the procedures for calculating patient pay for the month of admission and ongoing months for all persons admitted to an LTC facility except:

- persons who received Medicaid CBC in the community during the admission month;
- persons who were admitted from another facility;
- persons admitted to a facility from a state institution.

B. Procedures

To determine patient pay for the admission month, use the procedures in this subsection.

1. All Covered Groups Except MN Spenddown

For an individual admitted to a facility (except an individual who meets a spenddown), take the following steps in the order presented:

- a. Count all income received in the admission month (per M1470.100).
- b. Deduct a personal needs allowance:
 - \$40.00 (*\$30 for months prior to July 2007*) basic personal needs;
 - additional amount for guardianship fees, if appropriate;
 - additional amount for special earnings allowance, if working.
- c. Deduct a dependent child allowance, if appropriate (M1470.220).
- d. Deduct the Medicare premium withheld if the applicant is a Medicare recipient and was not receiving Medicaid prior to admission (see M1470.230).
- e. Deduct other health insurance premiums, deductibles or co-insurance charges, if appropriate (M1470.230).
- f. Deduct other allowable noncovered medical expenses, if appropriate (M1470.230).
- g. Deduct the home maintenance (MNIL) deduction **if appropriate**, if doctor has certified that the individual is likely to return home within a six-month period (see M1470.240). For recipients who are admitted for a stay that has been for less than 30 days, a physician certification of length of stay is NOT required.

- h. Any remainder is the patient pay for the month(s).
2. **MN Spenddown Individual in Facility for Less than 30 Days** For a medically needy individual on a spenddown who is in a facility for less than 30 days, see section M1470.350 B. for procedures.
3. **MN Spenddown Individual In Facility For More Than 30 Days** For an institutionalized medically needy individual, see Section M1470.600 for procedures.

M1470.320 MEDICAID CBC RECIPIENT ENTERING A FACILITY

A. Policy

For persons who received Medicaid-covered CBC in the community in the month of admission to a facility, the cost of the Medicaid CBC services is deducted in the admission month only.

B. Procedures

To determine patient pay for the admission month, take the following steps in the following order:

1. Determine the cost of Medicaid CBC services actually received in the month of admission to the facility. To determine this amount:
 - contact the Medicaid CBC provider and ascertain how many hours of Medicaid covered CBC were received and multiply the number of hours by the Medicaid per hour rate.
 - If the Medicaid CBC service is not billed by the hour, deduct the cost of services for the month as verified by the CBC provider.
2. Compare the Medicaid CBC monthly patient pay amount that was shown on the DMAS-122 for the month of nursing facility admission to the cost of the Medicaid CBC services actually received. If the actual Medicaid CBC costs for the month of admission to the facility are less than the Medicaid CBC patient pay for the month, revise the Medicaid CBC provider's DMAS-122 to show the actual Medicaid CBC costs as the patient pay for the month.

Subtract the actual Medicaid CBC costs from the original Medicaid CBC patient pay. The difference is the patient pay to the facility for the admission month.

3. If the actual Medicaid CBC costs for the month of admission to the facility are equal to or greater than the Medicaid CBC patient pay for the

month, do not revise the DMAS-122 to the Medicaid CBC provider. The individual has no patient pay to the facility for the admission month.

Prepare and send a DMAS-122 to the facility showing the individual's patient pay responsibility to the facility.

M1470.330 RESERVED

M1470.340 FACILITY ADMISSION FROM ANOTHER FACILITY

A. Policy

When a patient is admitted to a medical facility from another medical facility, deduct the cost of care at the former facility from the patient's income in determining patient pay for the admission month to the current facility. This policy applies to patients who were eligible for Medicaid in the former facility and to patients who were not eligible for Medicaid while in the former facility.

B. Procedures

To determine patient pay for the month of entry into the current facility:

1. Not Medicaid Eligible Prior to Transfer

- a. Count all of the patient's income per M1470.100.
- b. Deduct a personal needs allowance:
 - \$40.00 (\$30 for months prior to July 2007) basic allowance;
 - additional amount for guardianship fee, if any;
 - additional amount for special earnings allowance, if appropriate.
- c. Deduct a dependent child allowance, if appropriate. (See M1470.220).
- d. Deduct the amount owed to the former facility for care received in the admission month prior to admission to the current facility. To determine the amount owed to the former facility:
 - multiply the number of days the patient was in the former facility in the admission month by the facility's **private** daily rate.
- e. Deduct any other allowable non-covered medical expenses (see M1470.230).
- f. Any remainder is the patient pay for the current facility admission month only. If the remainder is zero or less, the DMAS-122 will show zero patient pay for the admission month.

2. Medicaid Eligible Prior to Transfer

This subsection applies to Virginia Medicaid patients admitted to a medical facility from a Virginia Department of Mental Health/Mental Retardation & Substance Abuse Services (DMHMRSAS) institution, or from another LTC medical facility either in Virginia or outside of Virginia, who received Virginia Medicaid while in the other institution. For specific instructions on transferring cases, refer to subchapter M1520.

a. Patient Pay Procedures

Transferring to another Medicaid-certified facility within a month requires a DMAS-122 for the current facility and may require that a revised DMAS-122 be sent to the former facility.

Compare the patient pay amount for the transfer month to the former facility's cost, which is the former facility's Medicaid per diem rate multiplied by the number of days the patient was in the former facility that month. NOTE: Do not count the date of discharge when determining how many days the patient was in the former facility.

b. Patient Pay Exceeds Former Facility Cost

When the patient pay exceeds the former facility cost:

- the former facility cost (Medicaid per diem multiplied by number of days in the former facility) is the patient pay in the former facility for that month. Complete and send a revised DMAS-122 to the former facility.
- the remaining balance, if any, is the patient pay for the admission month to the current facility and is shown on the current facility's DMAS-122 for the admission month only. Complete and send a DMAS-122 to the facility for the admission month and subsequent month(s).

c. Patient Pay Less Than Former Facility Cost

When the patient pay amount is less than the former facility cost, the former facility patient pay for that month does not change. Do not send a revised DMAS-122 to the former facility.

The patient pay for the current facility admission month is \$0. Complete and send a DMAS-122 to the current facility showing no patient pay for the admission month and showing the regular patient pay amount to be effective the following month.

M1470.350 PATIENT PAY FOR FACILITY STAY OF LESS THAN 30 DAYS**A. All Covered Groups Except MN Spenddown**

To determine patient pay for a non-institutionalized individual admitted to a facility for less than 30 days (except an individual who meets a spenddown), use the procedures in subsection M1470.310 B.1. for the admission month and for the subsequent month when the facility stay continues into the month after admission.

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B. Procedures**1. Assisting the Applicant**

The EW must advise the applicant of the information needed to complete the resource assessment and assist the applicant in contacting the separated spouse to obtain resource and income information.

If the applicant cannot locate the separated spouse, document the file. *Refer to Section B below.*

If the applicant locates the separated spouse, the EW must contact the separated spouse to explain the resource assessment requirements for the determination of spousal eligibility for long-term care services and the possibility of a request for an expected contribution.

If the separated spouse refuses to cooperate in providing information necessary to complete the resource assessment and determine an expected contribution, document the file. *Refer to Section B below.*

EXCEPTION: If the separated spouse is institutionalized and is a Medicaid applicant/recipient, the definition of “community spouse” is not met, and *a resource assessment is not needed.*

2. Undue Hardship

If the applicant is unable to provide the necessary information to complete the resource assessment, he/she must be advised of the hardship policy and the right to claim undue hardship.

a. Undue hardship not claimed:

If the applicant does not wish to claim undue hardship, the EW must document the record and deny the application due to failure to verify resources held at the beginning of institutionalization.

b. Undue hardship claimed:

If the applicant claims undue hardship, he must provide documentation of efforts made to obtain the needed information.

1) Applicant or Authorized Representative

The applicant or his authorized representative must provide to the EW a letter indicating the following:

- *the name of the applicant’s attorney-in-fact (i.e. who has the power of attorney) or authorized representative;*
- *the length of time the couple has been separated;*

- *the name of the estranged spouse and his*
 - *date of birth,*
 - *Social Security number,*
 - *last known address,*
 - *last known employer,*
 - *the types (i.e. telephone, in-person visit) and number of attempts made to contact the separated spouse:*
 - *who made the attempt, the dates the attempts were made,*
 - *the name of the individual contacted and relationship to estranged spouse; and*

- *any legal proceeding initiated, protective orders in effect, etc.*

The applicant/recipient or his representative must make an effort to locate and contact the estranged spouse or provide documentation as to why this is not possible. Contact or action by the EW alone to locate or contact the estranged spouse is not sufficient to complete an undue hardship evaluation.

2) Eligibility Worker

A cover sheet is to be prepared that includes the following information:

- *the applicant's name, case number, and*
- *documentation of any actions the EW took to locate or contact the estranged spouse.*

The cover sheet and all information supporting the undue hardship claim must be sent to:

Division of Policy and Research, Eligibility Section
DMAS
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

If DMAS determines that undue hardship does not exist, *and* the resource assessment cannot be completed, the EW must deny the application due to failure to verify resources held at the beginning of institutionalization.

If DMAS determines that undue hardship does exist, the EW will be sent instructions for continued processing of the case as well as the DMAS Affidavit and Assignment forms, which the applicant/recipient or his representative must sign, have notarized and return to the agency.

M1480.200 RESOURCE ASSESSMENT RULES

A. Introduction

A resource assessment must be completed when an institutionalized spouse with a community spouse applies for Medicaid coverage of long term care services and may be requested without a Medicaid application.

A resource assessment is strictly a:

- compilation of a couple's reported resources that exist(ed) at the first moment of the first day of the month in which the first continuous period of institutionalization began on or after September 30, 1989.
- calculation of the couple's total countable resources at that point, and
- calculation of the spousal share of those total countable resources.

A resource assessment does not determine resource eligibility but is the first step in a multi-step process. A resource assessment determines the spousal share of the couple's combined countable resources.

B. Policy Principles

1. Applicability

The resource assessment and resource eligibility rules apply to individuals who began a continuous period of institutionalization on or after September 30, 1989 and who are likely to remain in the medical institution for a continuous period of at least 30 consecutive days, or have been screened and approved for Medicaid CBC waiver services, or have elected hospice services.

The resource assessment and resource eligibility rules do **NOT** apply to individuals who were institutionalized before September 30, 1989, **unless** they leave the institution (or Medicaid CBC waiver services) for at least 30 consecutive days and are then re-institutionalized for a new continuous period that began on or after September 30, 1989.

2. Who Can Request

A resource assessment without a Medicaid application can be requested by the institutionalized individual in a medical institution, his community spouse, or an authorized representative. See section M1410.100.

3. When to Do A Resource Assessment

a. Without A Medicaid Application

A resource assessment without a Medicaid application may be requested when a spouse is admitted to a **medical institution**. Do not do a resource assessment **without** a Medicaid application unless the individual is in a medical institution.

b. With A Medicaid Application

A resource assessment must be completed when a married institutionalized individual with a community spouse

- is in a nursing facility,

3. Verification

The EW must advise the requesting party of the verification necessary to complete the assessment. Ownership interest and value of resources held **on the first moment of the first day of** the first month of the first continuous period of institutionalization must be verified.

Verify all *non-excluded* resources. Acceptable verification, for example, is a copy of the couple's bank statement(s) for the period. Do not send bank clearances; the requesting party is responsible to obtain verification of resources.

The EW is not required to assist the requesting party in obtaining any required verification for the resource assessment.

4. Failure To Provide Verification

If the applicant refuses to or fails to provide requested verification of resources held at the beginning of the first continuous period of institutionalization and does not notify the EW of difficulty in securing the requested data, the worker is unable to complete the resource assessment and is unable to determine the spousal share of resources. Go to item 8 below, "Notification Requirements."

5. Processing Time Standard

A resource assessment must be processed within 45 days of the date on which the agency receives the written and signed Medicaid Resource Assessment Request form.

If the requestor fails to provide requested verification within 45 days of receipt of notification, notify the applicant that the assessment cannot be completed, and of the reason(s) why. Use the Notice of Medicaid Resource Assessment (#032-03-817).

6. Completing the Medicaid Resource Assessment Form or Electronic Workbook

When verification is provided, completion of the resource assessment establishes the spousal share which is equal to ½ of a couple's total countable resources as of **the first moment of the first day of** the first month of the first continuous period of institutionalization that began on or after September 30, 1989.

a. Compile the Couple's Resources

The value of *non-excluded* resources must be verified and recorded. Either the Medicaid Resource Assessment form (#032-03-816) or the electronic Resource Assessment and Eligibility Workbook may be used. The workbook is located on the Virginia Institute for Social Services Training Activities (VISSTA) web site at:

http://www.vcu.edu/vissta/bps/bps_resources/lc_medicaid.htm.

Excluded resources must be listed separately on the form or electronic workbook, but their value does not need to be noted or verified.

On the assessment form, list all resources in which the couple has an ownership interest, *including* resources in their joint names, those in the institutionalized spouse's name and those in the community spouse's name, including those resources owned jointly with others. List each resource separately.

b. Calculate the Spousal Share

Calculate the total value of the couple’s countable resources. Divide this total by 2 to obtain the spousal share. The spousal share is ½ of the couple’s combined countable resources as of **the first moment of the first day of the first month** of the first continuous period of institutionalization that began on or after September 30, 1989.

Calculate the spousal share only once; it remains a constant amount for any Medicaid application filed after the resource assessment.

EXAMPLE #2: A Medicaid Resource Assessment Request is received on October 20, 1996 for Mrs. H who was admitted to the nursing facility on October 18, 1996. Her first continuous period of institutionalization began on December 21, 1995, and ended with her discharge on May 30, 1996. Mr. H provides verification which proves that the couple’s total countable resources as of December 1, 1995 (the first day of the first month of the first continuous period of institutionalization) were \$131,000. The spousal share is ½ of \$131,000, or \$65,500.

On the Medicaid Resource Assessment form *or electronic workbook*, the worker lists the couple's resources as of December 1, 1995 as follows:

<u>Resource</u>	<u>Owner</u>	<u>Countable</u>	<u>Countable Value</u>
Home	Mr & Mrs	No	0
Savings	Mr & Mrs	Yes	\$100,000
CD	Mr	Yes	\$ 31,000
<u>\$131,000</u>	Total Value of Couple's Countable Resources		
<u>\$ 65,500</u>	Spousal Share		

If in the future, Mrs. H applies for Medicaid and she is still married to Mr. H, the worker must use the spousal share of \$65,500 determined by the October 1996 resource assessment.

7. Send Loans and/or Judgments to DMAS

When the resource assessment identifies a loan or a judgment against resources, send the documents pertaining to the loan and/or judgment to DMAS for review before taking action on the resource assessment. Send the documents, along with case identifying information (institutionalized spouse's and community spouse's names, address, SSN, case number) to:

Division of Policy and Research, Eligibility Section
 DMAS
 600 E. Broad Street, Suite 1300
 Richmond, Virginia 23219

8. Notification Requirements

a. When the Assessment Is Not Completed

Both spouses and the guardian, conservator or authorized representative must be notified in writing that the assessment was not completed; note the specific reason on the form. Use the form Notice of Medicaid Resource Assessment (#032-03-817).

To determine an income type or source and to determine how to count the income, use the policy and procedures in chapter S08 for all individuals (ABD and F&C) in the 300% SSI group.

Income is projected for the month for which eligibility for LTC is being determined. This calculation is based upon the income received in the past month unless there is documentation that a change has occurred or can reasonably be expected to occur which will change the amount expected to be received.

1. Income Less Than or Equal to 300% SSI Limit

If the individual's gross income is less than or equal to the 300% SSI income limit, enroll the individual in the appropriate CNNMP PD and determine patient pay according to the policy and procedures found in section M1480.400.

a. Individual Has Medicare Part A

If the individual has Medicare Part A, determine if his income is within the QMB income limit. Calculate the individual's countable income for QMB according to chapter S08, and compare to the QMB limit. If the individual's gross income is less than or equal to the QMB limit, enroll the recipient with the appropriate CNNMP dual-eligible QMB *aid category (AC)*:

- Aged = 022
- Blind = 042
- Disabled = 062

If the income is over the QMB limit, enroll the recipient with the appropriate CNNMP non-QMB AC:

- Aged = 020
- Blind = 040
- Disabled = 060

b. Individual Does Not Have Medicare Part A

If the individual does NOT have Medicare Part A, enroll the ABD recipient with the appropriate CNNMP AC:

- Aged = 020
- Blind = 040
- Disabled = 060

Enroll the F&C recipient with the appropriate CNNMP AC:

- Institutionalized child under age 21 = 082
- Institutionalized F&C individual age 21 or older = 060.

3. Income Exceeds 300% SSI Limit

If income exceeds the 300% SSI limit, evaluate the institutionalized spouse as MN. Go to section M1480.330 below.

C. ABD 80% FPL

The income limit for the ABD 80% FPL covered group is 80% of the federal poverty level (see M0810.002.A.5). See section M0320.210 for details about this covered group.

The ABD income policy in chapter S08 is used to determine countable income for the ABD 80% FPL covered group. Income is projected for the month for which eligibility for LTC is being determined. This calculation is based upon the income received in the past month unless there is documentation that a change has occurred or can reasonably be expected to occur which will change the amount expected to be received.

If the individual's *countable* income is less than or equal to the 80% FPL income limit, enroll the individual in the MMIS with the appropriate ABD 80% FPL PD and determine patient pay according to the policy and procedures found in section M1480.400. The ABD 80% FPL ACs are:

- Aged = 029
- Blind = 039
- Disabled = 049

February spenddown eligibility evaluated.

M1480.350 SPENDDOWN ENTITLEMENT

- A. Entitlement After Spenddown Met** When an institutionalized spouse meets a spenddown within a month, the begin date of eligibility will be the first day of the month in which the spenddown was met. Eligibility will end on the last day of the month in which the spenddown was met.
- B. Procedures**
- 1. Coverage Dates** Coverage begin date is the first day of the month; the coverage end date is the last day of the month.
- 2. Aid Category**
- a. If the institutionalized spouse does NOT have Medicare Part A:**
- Aged = 018
 - Blind = 038
 - Disabled = 058
 - Child Under 21 in ICF/ICF-MR = 098
 - Child Under Age 18 = 088
 - Juvenile Justice Child = 085
 - Foster Care/Adoption Assistance Child = 086
 - Pregnant Woman = 097
- b. If the institutionalized spouse has Medicare Part A:**
- Compare the individual's monthly MN countable income to the QMB monthly income limit for 1 person (see M0810.002 for the current QMB limit):
- 1) When income is less than or equal to the QMB limit, enroll using the following ACs:
- Aged = 028
 - Blind = 048
 - Disabled = 068
- 2) When income is greater than the QMB limit, enroll using the following ACs:
- Aged = 018
 - Blind = 038
 - Disabled = 058
- 3. Patient Pay** Determine patient pay according to section M1480.400 below.
- 4. Notices & Re-applications** The institutionalized spouse on a spenddown must have his eligibility re-evaluated monthly, unless he is in a facility and the spenddown liability is less than or equal to the Medicaid rate. The institutionalized spouse must complete an annual redetermination.

After eligibility is established, the usual reporting and notification processes apply. Send the “Notice of Action on Medicaid” and the “Notice of Obligation for LTC Costs” for the month(s) during which the individual establishes Medicaid eligibility.

M1480.400 PATIENT PAY

- A. Introduction** This section contains the policy and procedures for determining an institutionalized spouse’s (as defined in section M1480.010 above) patient pay in all covered groups.
- B. Married With Institutionalized Spouse in a Facility** For a married LTC patient with an institutionalized spouse in a facility, **NO** amount of the patient’s income is deducted for the spouse’s needs in the patient pay calculation.

M1480.410 MAINTENANCE STANDARDS & ALLOWANCES

- A. Introduction** This subsection contains the standards and their effective dates that are used to determine the community spouse’s and other family members’ income allowances. The income allowances are deducted from the institutionalized spouse’s gross monthly income when determining the monthly patient pay amount. Definitions of these terms are in section M1480.010 above.
- B. Monthly Maintenance Needs Standard**

\$1,711.25	7-1-07	
\$1,650.00	7-1-06	
- C. Maximum Monthly Maintenance Needs Allowance**

\$2,541.00	1-1-07	
\$2,488.50	1-1-06	
- D. Excess Shelter Standard**

\$513.38	7-1-07	
\$495.00	7-1-06	
- E. Utility Standard Deduction (Food Stamps)**

\$281	1 - 3 household members	10-1-06
\$352	4 or more household members	10-1-06
\$253	1 - 3 household members	2-1-06
\$317	4 or more household members	2-1-06

M1480.420 PATIENT PAY FOR ABD 80% FPL AND 300% SSI INSTITUTIONALIZED SPOUSE

- A. Policy** After a 300% SSI or ABD 80% FPL institutionalized spouse has been found eligible for Medicaid, determine his patient pay (post-eligibility treatment of income).

- B. What Is Patient Pay** The institutionalized spouse's gross monthly income, less all appropriate deductions according to this section, constitutes the patient pay - the amount of income the institutionalized spouse will be responsible to pay to the LTC facility or waiver services provider. The community spouse's and family member's monthly income allowances rules for patient pay apply to all institutionalized spouses with community spouses, regardless of when institutionalization began.
- C. Dependent Allowances** A major difference in the institutionalized spouse patient pay policy is the allowance for a dependent child and for a dependent family member. If the institutionalized spouse has a dependent child, but the dependent child does NOT live with the community spouse, then **NO** allowance is deducted for the child. Additionally, an allowance may be deducted for other dependent family members living with the community spouse.
- D. Home Maintenance Deduction** A major difference in the institutionalized spouse patient pay policy is the home maintenance deduction policy. A married institutionalized individual with a community spouse living in the home is **NOT allowed** the home maintenance deduction because the community spouse allowance provides for the home maintenance, **UNLESS**:
- the community spouse is not living in the home (e.g., the community spouse is in an ACR), and
 - the institutionalized spouse still needs to maintain their former home.
- E. Patient Pay Workbook and Worksheet** An electronic patient pay workbook and worksheet, including the DMAS-122, are available on the VISSTA web site at:
http://www.vcu.edu/vissta/bps/bps_resources/ltc_medicaid.htm.

M1480.430 ABD 80% FPL and 300% SSI PATIENT PAY CALCULATION

- A. Patient Pay Gross Monthly Income** Determine the institutionalized spouse's patient pay gross monthly income for patient pay. Use the gross income policy in section M1480.310 *B.1* for both covered groups.
- B. Subtract Allowable Deductions** **If the patient has no patient pay income, he has no patient pay deductions.**
- When the patient has patient pay income, **deduct the following amounts in the following order** from the institutionalized spouse's gross monthly patient pay income. Subtract each subsequent deduction as long as the individual has income remaining for patient pay. If the individual has no remaining income, do not subtract further deductions.
- personal needs or maintenance allowance,
 - community spouse monthly income allowance,
 - family member's income allowance,

- noncovered medical expenses.
- home maintenance deduction, if applicable.

C. Personal Needs or Maintenance Allowance

The personal needs allowance for an institutionalized spouse in a facility is different from the personal maintenance allowance of an institutionalized spouse in a Medicaid CBC waiver. The amount of the personal needs or maintenance allowance also depends on whether or not the patient has a guardian or conservator who charges a fee, and whether or not the patient has earnings from employment that is part of the treatment plan.

1. Facility Care

a. Basic Allowance

Deduct the \$40 basic allowance, *effective July 1, 2007. For prior months, the personal needs allowance is \$30.*

b. Guardian Fee

Deduct the actual fee a guardian or conservator charges, up to a maximum of 5% of the patient's actual gross income (including amounts not counted as income and excluded income) for guardianship fees, IF:

- the patient has a legally appointed guardian and/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.

c. Special Earnings Allowance

Deduct a special earnings allowance if the patient participates in a work program as part of treatment. The special earnings allowance is deducted from earned income only. Deduct:

- the first \$75 of gross monthly earnings, PLUS
- ½ the remaining gross earnings,
- up to a maximum of \$190 per month.

The special earnings allowance cannot exceed \$190 per month.

d. Example - Facility Care Personal Needs Allowance

EXAMPLE #18: A patient in the nursing facility is employed as a telephone salesperson as part of his plan of care in the facility. He has a legally appointed conservator who charges a 2% fee. His only income is gross earnings of \$875 per month. His special earnings allowance is calculated first:

\$875 gross earned income
 - 75 first \$75 per month
 800 remainder
 ÷ 2
 400 ½ remainder
 + 75 first \$75 per month
 \$475 which is > \$190

His personal needs allowance is calculated as follows:

\$ 40.00 basic personal needs allowance
 +190.00 special earnings allowance
 + 17.50 guardianship fee (2% of \$875)
 \$247.50 personal needs allowance

2. Medicaid CBC Waiver Services

a. Maintenance Allowance

Deduct the appropriate maintenance allowance for one person, based on the specific Medicaid CBC waiver under which the individual receives LTC services:

- 1) For the Elderly or Disabled with Consumer Direction Waiver (EDCD Waiver), Mental Retardation (MR) Waiver, Technology-Assisted Individuals Waiver, Individual and Family Developmental Disabilities Support (DD) Waiver, and Day Support (DS) Waiver:
 - Prior to September 1, 2006, the personal maintenance allowance is equal to the monthly SSI payment limit for one person (see M0810.002 A. 2).
 - Effective September 1, 2006, the personal maintenance allowance is 165% of the monthly SSI payment for one person, which is:
 - September 1, 2006 through December 31, 2006: \$995
 - January 1, 2007 through December 31, 2007: \$1028
- 2) For the AIDS Waiver: the personal maintenance allowance is equal to 300% of the SSI limit for one person (see M0810.002 A. 3.).

b. Guardian Fee

Deduct the actual fee a guardian or conservator charges, up to a maximum of 5% of the patient's actual gross income (including amounts not counted as income and excluded amounts) 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.

c. Special Earnings Allowance For DD, DS and MR Waivers

EXAMPLE #19: (deleted)

For DD, DS and 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:

- a) for individuals employed 20 hours or more per week, all earned income up to 300% of SSI per month.
- b) for individuals employed at least 8 but less than 20 hours per week, all earned income up to 200% of SSI per month.

EXAMPLE #20: (Using January 2000 figures)

A working patient *in* the MR Waiver is employed 18 hours per week. *He* has gross earnings of \$928.80 per month and SS of \$300 monthly. His special earnings allowance is calculated first:

\$ 928.80	gross earned income
- <u>1,024.00</u>	200% SSI maximum
\$ 0	remainder

\$928.80 = special earnings allowance

His personal maintenance allowance is calculated as follows:

\$ 512.00	maintenance allowance
+ <u>928.80</u>	special earnings allowance
\$1,440.80	personal maintenance allowance

B. Procedures**1. Documentation**

If the applicant does not have a Social Security number, the agency must document in the record when he/she has applied for an SSN.

When entering the individual in ADAPT or MedPend, use the date the individual applied for an SSN, or the individual's date of birth, preceded by "APP." For example, an individual applied for an SSN on October 13, 2006. Enter "APP101306" as the individual's SSN.

2. Follow-up

The agency must follow-up this action within 90 days of the Social Security number application date or 120 days if application was made through hospital enumeration:

- document the recipient's assigned Social Security number in the case record,
- enter the recipient's Social Security number on the MMIS computer recipient eligibility file, *and in ADAPT if the enrollee is in ADAPT.*

2. Renewal Action

- a. *At renewal, check the MMIS and ADAPT records for the enrollee's SSN. If the SSN has "888" or "APP" as the first 3 digits, contact the enrollee to obtain the enrollee's SSN verbally, by mail or email, or on the renewal form if a renewal form is required.*
- b. *Verify the SSN by a computer system inquiry of the SSA records.*
- c. *Enter the enrollee's SSN in MMIS, and in ADAPT if the enrollee is in ADAPT. If the enrollee is in an active Medicaid case in ADAPT, and his pseudo SSN is not changed to a valid SSN at renewal, ADAPT will determine him ineligible for Medicaid.*

M1510.303 PATIENT PAY NOTIFICATION**A. Policy**

After an individual in long-term care is found eligible for Medicaid, the recipient's patient pay must be determined. When the patient pay amount is initially established or when it is changed, a written notice must be sent to the recipient or the recipient's authorized representative.

B. Procedure

When patient pay is determined, the "Notice of Obligation for Long-Term Care Costs" form must be sent. For any subsequent decrease in patient pay, the form will serve as adequate notice.

When patient pay increases, the "Notice of Obligation for Long-Term Care Costs" form must be sent in advance of the date the new amount is effective. Following the advance notice period, the new DMAS-122 is released to the provider, if an appeal was not filed.

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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 enrollee's circumstances that might affect the enrollee's continued Medicaid eligibility.

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

When a Medicaid enrollee 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.

When a change is reported that impacts eligibility or a renewal is completed and the enrollee is no longer eligible, the Advanced Notice of Proposed Action must be sent to the enrollee before the enrollee's benefits can be reduced or his eligibility can be terminated (see M1520.401).

When a change is reported and eligibility continues, no notice is necessary. When a renewal is completed and eligibility continues, the Notice of Action is used to inform the enrollee of continued eligibility and the next scheduled renewal.

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 enrollee's Medicaid coverage or reducing the enrollee'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. Enrollee's Responsibility

The enrollee 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 an SSN, receipt of SSA benefits and the delivery date for a pregnant woman.

1. Changes That Require Partial Review of Eligibility

When changes in an enrollee's situation are reported by the enrollee or when the agency receives information indicating a change in an enrollee's circumstances (i.e. SSI purge list, reported transfer of assets), the worker must take action to partially review the enrollee's continued eligibility.

A reported increase in income and/or resources can be acted on without requiring verification, unless 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 when it causes the individual to move from a limited-benefit covered group to a full-benefit covered group.

2. Changes That Do Not Require Partial Review

When changes in an enrollee's situation are reported or discovered, such as the enrollee's SSN and card have been received, the worker must document the change in the case record and take action appropriate to the reported change in the appropriate computer system(s).

Example: The Medicaid enrollee who did not have an SSN, but applied for one when he applied for Medicaid, reports by calling the worker that he received his SSN. The worker records the telephone call and the enrollee's newly assigned SSN in the case record, verifies the SSN via SPIDeR and enters the enrollee's verified SSN in MMIS and ADAPT.

3. HIPP Requirements

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 an enrollee's situation that may affect the premium payment.

4. Program Integrity

The Medicaid eligibility of enrollees is subject to periodic review through the program integrity process (such as Medicaid Quality Control). It may be necessary for program integrity staff to request information, such as income verification, from the enrollee. The enrollee will be notified in writing and given a reasonable amount of time, as determined by the program integrity staff, to provide the information.

Should the enrollee not provide the requested information to the program integrity staff within the specified time, program integrity staff will notify the eligibility worker, and the worker must take action (including sending advance notice) to cancel coverage due to the inability to determine continued eligibility. An individual's failure to provide information to program integrity staff does not affect any future Medicaid applications.

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.

An eligibility determination for a child born to a Medicaid eligible pregnant woman (including an emergency services alien certified for Medicaid payment for labor and delivery) is not required until the month in which the child turns one year old, unless there is an indication that the child is no longer living with the mother. If the child continues to live with the mother, an application and an eligibility determination must be completed prior to MMIS cut-off in the month the child turns one year old.

If the child is no longer living with the mother, the child's caretaker must be given the opportunity to file an application and receive an eligibility determination prior to the agency taking action to cancel the child's coverage.

2. Child Turns Age 6

When a child who is enrolled as an MI child turns age 6, the child's Aid Category (AC) in MMIS will automatically be changed to 092 or 094. No action is required when the child is enrolled as AC 092. If the child is enrolled as AC 094, a partial review must be completed to determine if the child has creditable health insurance coverage. If the child does not have creditable health insurance, no additional action is required. If the child has creditable health insurance, the eligibility worker must cancel the child's enrollment in AC 094 effective the end of the month and reinstate coverage in AC 092 effective the first day of the following month. **Do not use change transactions to move a child to or from AC 094.**

3. SSI Medicaid Enrollee Becomes a Qualified Severely Impaired Individual (QSII) – 1619(b)

When an SSI Medicaid enrollee loses eligibility for an SSI money payment due to receipt of earned income, continued Medicaid eligibility under the Qualified Severely Impaired Individual (QSII) -1619(b) covered group may exist. A partial review to determine the individual's 1619(b) status via the State Online Query Internet (SOLQ-I) or the State Verification Exchange System (SVES) must be completed. To identify a 1619(b) individual, check the "Medicaid Test Indicator" field on the SOLQ-I or SVES screen. If there is a code of A, B, or F, the individual has 1619(b) status. The eligibility worker must change the AC to the appropriate AC.

M1520.200 RENEWAL REQUIREMENTS

A. Policy

The agency must evaluate the eligibility of all Medicaid enrollees, with respect to circumstances that may change, at least every 12 months. An individual's continued eligibility for Medicaid requires verification of income for all covered groups and resources for covered groups with resource requirements. Blindness and disability are considered continuing unless it is reported that the individual is no longer blind or disabled.

1. 12-Month Renewal Period

The first 12-month period begins with the month of application for Medicaid. Subsequent renewals must be completed by the MMIS cut-off date no later than 12 months following the month of the last renewal. Monthly annual renewal lists are generated by the MMIS. These lists notify eligibility workers of enrollees due for renewal.

2. Scope of Renewals

The scope of renewals is limited to information that is necessary to determine ongoing eligibility and that relates to circumstances that are subject to change, such as income and resources. *Verification of information that is not subject to change, such as date of birth and Social Security number (SSN), is not required at renewal.*

Individuals who claim citizenship but cannot obtain documentation of citizenship and identity must be given reasonable opportunity to provide verification. See M0220.100.

3. Ex Parte Renewal

An ex parte renewal is an internal review of eligibility based on available information. By relying on information available, the agency can avoid unnecessary and repetitive requests for information from individuals and families that can add to administrative burdens, make it difficult for individuals and families to retain coverage, and cause eligible individuals and families to lose coverage.

Local departments of social services are required to conduct renewals of ongoing eligibility through an ex parte renewal process when the local agency has access to on-line systems information for verifications necessary to determine ongoing eligibility, there is no resource test, and the enrollee is not receiving long-term care (LTC) services. Individuals in the SSI Medicaid covered group may have an ex parte renewal unless they reported ownership of non-exempt real property.

4. Medicaid Renewal Forms

If ongoing eligibility cannot be established through an ex parte renewal because the individual's covered group has a resource test or he receives LTC services, or the ex parte renewal suggests that the individual may no longer be eligible for Medicaid, the agency must provide the individual the opportunity to present additional or new information using the Medicaid Renewal form #032-03-669 (available at: <http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi>) and verifications necessary to determine ongoing eligibility before the coverage is cancelled.

The Eligibility Review Part A (#032-03-729A) and Eligibility Review Part B (#032-03-729B) forms are acceptable when the individual is required to complete them for another program under which he is receiving benefits. These forms are available on the intranet at: <http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi>.

**B. Renewal
Requirements and
Time Standard**

The agency must make all reasonable efforts to obtain relevant information from Medicaid files and other sources (subject to confidentiality requirements) in order to conduct eligibility renewals.

An evaluation of the information used to determine continued eligibility must be completed and included in the case record. The enrollee must be informed of the findings of the renewal and the action taken using the Notice of Action when continued eligibility exists. The Advanced Notice of Proposed Action must be used when there is a reduction of benefits or termination of eligibility. Renewals must be completed prior to cut-off in the 12th month of eligibility.

**1. Ex Parte
Renewal Process**

The agency must utilize on-line systems information verifications that are available to the agency without requiring verifications from the individual or family and make efforts to align renewal dates for all

before the effective date of the action, excluding the date of mailing and the effective date.

3. Matches That Require Advance Notice

The following list indicates some of the computer match sources which require a ten (10) day advance notice.

<u>Match Source</u>	<u>Notification Period</u>
Internal Revenue Service (IRS) unearned income files	10 days
Beneficiary and Earnings Data Exchange (Bendex)	10 days
State Data Exchange (SDX)	10 days
Enumeration Verification System (SSN)	10 days
Systematic Alien Verification For Entitlements (SAVE)	10 days
Department of Motor Vehicles (DMV)	10 days
Virginia Employment Commission (VEC)	10 days
Benefit Exchange Earnings Record (BEERS)	10 days

C. Procedures

1. Action Appealed

Adverse action must not be taken if the recipient requests an appeal hearing before the effective date of the action. The DMAS Chief Hearing Officer will notify the local agency whether to continue coverage during the appeal.

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 is not continued when a request for appeal is filed on or after the effective date of the action.

When notification is received from DMAS that the agency's proposed adverse action was sustained, the recipient's eligibility must be terminated effective the date of the receipt of that letter. No further advance notice to the recipient is necessary since he/she is also informed of DMAS' decision.

2. Death of Recipient

The eligibility worker must take the following action when it is determined that an enrollee is deceased:

- *If the enrollee has an SSN, the worker must verify the date of death. If the individual receives Social Security (Title II) payments or Supplemental Security Income, SOLQ-I can be used to verify the date of death. If the recipient does not receive these benefits but has an SSN, the worker must run a SVES request to verify the date of death. SVES will display an “X” and the date of death in the “SSN VERIFICATION CODE” field on Screen 1.*
- *If the recipient does not have an SSN, or if SOLQ-I or SVES does not return information showing that the recipient is deceased, contact the parent/caretaker relative or authorized representative to obtain the date of death. Information from a medical professional/facility is also acceptable.*
- *The worker must document the case file. Send adequate notice of cancellation to the estate of the enrollee at the enrollee’s last known address and to any authorized representative(s) using the “Notice of Action on Medicaid.”*
- *Cancel coverage in MMIS using cancel code “001.” The effective date of cancellation is the date of death. Enter the date of death on the enrollee’s demographics screen under data field “DOD.”*

3. End of Spenddown Period

When eligibility automatically terminates at the end of a six-month spenddown period, advance notice is not required. The individual is notified of the limited period of spenddown eligibility on the Notice of Action sent at the time the application is approved. Explanation of this limitation and information relative to reapplication is provided at the time of the eligibility determination and enrollment.

M1520.402 CANCELLATION ACTION OR SERVICES REDUCTION

A. Introduction

1. MMIS Computer Transaction

A case must be canceled in *MMIS* prior to the date of the proposed action. The change to the *MMIS enrollee* file must be made after *system* cut-off in the month the proposed action is to become effective. For example, if the Notice of Action specifies the intent to cancel *coverage* on October 31, a change to the Medicaid computer is made prior to cut-off in October.

In the event the proposed action is not taken or an appeal is filed prior to the proposed date of action, the case must be immediately reopened.

**2. Reason "012"
Cancellations**

When information is received from DMAS that a case is canceled for cancel reason "012", the local social services department must determine if the cancellation is valid. When cancellation is not valid, the case must be re-enrolled immediately.

When the cancellation is valid, the local department must mail the individual an adequate notice of cancellation using the NOA. Adequate notice consists of specifying the date the cancel action took place, which is the date the notice is mailed, in the section marked "Other" on the notification form.

Cancel actions done by DMAS staff or the MMIS are reported in the Client Information Document (CID) report available on the intranet at:

<https://securelocal.dss.virginia.gov/reports/benefits/vammis/index.cgi>.

M1520.403 ENROLLEE REQUESTS CANCELLATION**A. Introduction**

An *enrollee* may request cancellation of his Medicaid coverage. The request must be written and documented in the record.

B. Procedure

When the *enrollee* requests cancellation of Medicaid, the local department must send a **Notice of Action** to the *enrollee* no later than the effective date of cancellation. *Advance notice is not required when the enrollee requests cancellation.*

On the notice:

- check the "other" block and list the reason as "*Medicaid coverage cancelled at the enrollee's request,*"
- *include the effective date of cancellation and instruct the enrollee to discontinue using the card after that date, and*
- instruct the *enrollee* to retain the Medicaid card for future use in case coverage is reinstated within the next 12 months (the system will generate a new card after 12 months).

Cancel Medicaid coverage in the MMIS using the cancel reason "004."

**E. Extra Help
Policy Principles**

Extra Help provides assistance with the out-of-pocket costs associated with Medicare Part D. An individual is eligible for Extra Help if all of the following are met:

- he is a resident of the United States,
- he is entitled to Medicare Part A and/or enrolled in Medicare Part B,
- he and his spouse, if married and living together, have countable income *less* than 150% of the federal poverty level (FPL) for his assistance unit size,
- he has countable resources of no more than \$10,210 (or if he is married and living with a spouse, they have countable resources of no more than \$20,410), and
- he must reside in the service area of a Part D prescription drug plan (service area does not include facilities in which individuals are incarcerated but otherwise covers the 50 States, District of Columbia, and U.S. Territories).

M2020.100 NONFINANCIAL ELIGIBILITY REQUIREMENTS**A. Introduction**

The nonfinancial eligibility requirements for Extra Help are different than the nonfinancial requirements for the Medicare Savings Programs (see chapter M02). An individual who does not meet the nonfinancial requirements for the Medicare Savings Programs may meet the nonfinancial requirements for Extra Help.

**B. Extra Help
Nonfinancial
Requirements**

Only the following nonfinancial eligibility requirements apply when Extra Help eligibility is determined by the LDSS:

- residency in Virginia, and
- entitlement to Medicare. The individual does not need to be enrolled in Medicare at the time of application, but Extra Help will not begin until he has enrolled in Medicare Part D.

M2030.100 DETERMINING EXTRA HELP SUBSIDY ELIGIBILITY**A. Introduction**

In the event that an applicant requests an Extra Help determination by the LDSS, the LDSS must comply with the request. Unless the applicant is later found to be deemed eligible for Extra Help or has been found eligible by SSA, the LDSS will also be responsible for ongoing case activity, including notices, appeals, and redeterminations.

B. Applicant's Representative

The applicant may be represented by any of the following individuals:

- an individual who is authorized to act on behalf of the applicant;
- if the applicant is incapacitated or incompetent, someone acting responsibly on his or her behalf; or
- an individual of the applicant's choice who is requested by the applicant to act as his or her representative in the application process;

Anyone may help the individual apply for the subsidy. The person assisting the applicant is required to attest to the accuracy of the information on the application.

C. Interview

A face-to-face interview is not required for Extra Help.

D. Screening for Deemed Status

LDSS must conduct its usual screening process to determine if the applicant is enrolled in Medicaid (full benefit or the limited benefit QMB, SLMB, or QI) or receives SSI. If the applicant is found to be in one of these programs, the applicant is deemed eligible for the subsidy and no application is required. M20, Appendix 1, Screening Script for Help with Medicare Costs (Form #032-03-701) and M20, Appendix 2, Screening Worksheet for Help with Medicare Costs (Form #032-03-702) are suggested screening tools.

E. Clearances

Eligibility workers should conduct their usual SDX/SVES/SOLQ clearances to verify the applicant's entitlement/enrollment in Medicare Parts A and B. If no Medicare entitlement/enrollment can be confirmed, deny the Extra Help application. If the available data confirm Medicare Buy-In in another U.S. jurisdiction, the applicant has already been deemed eligible for the subsidy. The LDSS must inform the applicant's former state of the change of address, and offer a Medicaid application to the applicant explaining that if he qualifies for Medicaid in Virginia, he automatically qualifies for Extra Help.

F. Spenddown

If the applicant is on a Medicaid spenddown in the month of application for the subsidy, continue with the Extra Help determination, using monthly countable income. If the applicant meets Medicaid eligibility during the month of subsidy application, he is deemed eligible for Extra Help. Once deemed eligible, the individual will receive the subsidy for the remainder of the calendar year.

G. Family Size

For the purpose of establishing the applicable income limit only, the following persons are counted in the family size:

- the applicant;
- the applicant's spouse, if living together; and
- any persons who are related by blood, marriage, or adoption, who are living with the applicant and spouse and who are dependent on the applicant or spouse for at least one half of their financial support. Accept the applicant's statement that he has a dependent.

M2040.100 FINANCIAL REQUIREMENTS

A. Introduction

Modified Supplemental Security Income (SSI) regulations are used to evaluate income and resources for Extra Help. For certain sections, the worker is referred to the on-line Program Operations Manual System (POMS) at <http://policy.ssa.gov/poms.nsf/aboutpoms> for more information. All types of countable income and resources must be verified.

The intent of the MMA was that the state and SSA determinations would be identical given the same information about the applicant/spouse. The guidance in this chapter and POMS must be used to determine eligibility for Extra Help.

M2040.200 RESOURCE REQUIREMENTS

A. Evaluating Resources

Resources of the applicant and his spouse if living together, but not resources of dependent family members are used to determine resource eligibility.

Count liquid resources which are cash or can be converted to cash within 20 days, including but not limited to:

- stocks;
- bonds;
- mutual fund shares;
- promissory notes (including mortgages held by the applicant);
- whole life insurance policies;

- financial institution accounts, including:
 - savings and checking accounts; and
 - time deposits, also known as certificates of deposit;
 - individual Retirement Accounts (IRAs) and
 - 401(K) accounts; and
- the equity value of real property not contiguous with home property (see M2040.200.E).

B. Resource Standards

The maximum subsidy resource standards are \$10,210 for one person and \$20,410 for a married couple. Resources at or below \$6,120 for an individual and \$9,190 for a married couple and income at or below 135% FPL will entitle the applicant(s) to the full subsidy.

The SSA subsidy application (SSA-1020) lists \$11,710 for an individual and \$23,410 for a married couple to reflect the burial fund exclusion of \$1500 for one person and \$3000 for a couple. These amounts apply **only** if the applicant/spouse indicates intent to use resources for burial or funeral arrangements. If the applicant/spouse has no intent to use resources for burial or funeral arrangements, the resource standards are \$10,210 for one person and \$20,410 for a married couple.

C. Resource Exclusions

The following resources are not to be considered for purposes of determining Extra Help eligibility:

- the applicant's home. For the purposes of this exclusion, a home is any property in which the applicant and his spouse have an ownership interest and which serves as his principal place of residence. There is no restriction on acreage of home property. This property includes the shelter in which an individual resides, the land on which the shelter is located, and any outbuildings;
- non-liquid resources, other than real property. These include, but are not limited to
 - household goods and personal effects;
 - automobiles, trucks, tractors and other vehicles;
 - machinery and livestock;
 - noncash business property;
- property of a trade or business which is essential to the applicant/spouse's means of self-support;
- nonbusiness property which is essential to the applicant/spouse's means of self-support;

- application date;
- description of how the subsidy was calculated; what income, family size, and resources were used;
- premium percentage;
- effective date of eligibility;
- who made the decision and how to contact them;
- appeal rights and procedures; and
- a reminder to apply for a prescription drug plan.

M20, Appendix 5 contains the Notice of Approval on Your Application for Extra Help with Medicare Part D Costs (Form #032-03-703).

C. Denial Notice

When the LDSS denies an application for Extra Help, a denial notice must be sent and must include the following information:

- application date;
- reason for denial and policy citation;
 - not Medicare-eligible;
 - failure to complete the application process;
 - income *is equal to or exceeds* 150% FPL;
 - resources exceed \$11,710/\$23,410;
 - not a resident of the State;
 - not a resident of U.S./incarcerated;
- description of how the denial was calculated; what income, family size, and resources were used;
- who made the decision and how to contact them;
- appeal rights and procedures; and
- depending on the denial reason, a reminder to apply for a prescription drug plan.

M20, Appendix 6 contains the Notice of Denial on Your Application for Extra Help with Medicare Part D Costs (Form #032-03-704).

D. Termination Notice

When the LDSS determines an individual is no longer eligible for Extra Help, a termination notice must be sent and must include the following information:

- reason for termination and policy citation;
 - not Medicare-eligible;
 - failure to complete the redetermination process;
 - income *is equal to or exceeds* 150% FPL;
 - resources exceed \$11,710/\$23,410;
 - not a resident of the State;
 - not a resident of U.S./incarcerated.

- description of how the termination was calculated; what income, family size, and resources were used;
- effective date of termination;
- who made the decision and how to contact them;
- appeal rights and procedures; and
- depending on the termination reason, a reminder that he can still use his prescription drug plan.

M20, Appendix 7 contains the Notice of Termination of Your Extra Help with Medicare Part D Costs (Form #032-03-705).

E. Change Notice

When the LDSS determines that an individual's eligibility for Extra Help has changed, it is required to send a change notice containing the following information:

- reason for change in subsidy level and policy citation;
- new premium percentage;
- description of how the change was calculated; what income, family size, and resources were used;
- effective date of change;
- who made the decision and how to contact them;
- appeal rights and procedures; and
- reminder that he can still use his prescription drug plan but that his costs within the plan have changed.

M20, Appendix 8 contains the Notice of Change in the Amount of Extra Help with Medicare Part D Costs (Form #032-03-706).

All notices must meet the adequate and timely notice requirements of the Medicaid State Plan.

M2070.100 APPEALS AND FAIR HEARINGS

A. Decision made by LDSS

The applicant may appeal his Extra Help determination according to the appeal procedures found in chapter M16. The individual has 30 days from the receipt of the notice to file an appeal.

B. Decision made by SSA

SSA will be responsible for appeals of decisions made by SSA, including decisions made on SSA applications forwarded to SSA by the State.

Screening Script for Help with Medicare Costs

“This is a preliminary, voluntary screening to see if you might be eligible for programs that help pay Medicare expenses. It is not an application for these programs. The information you provide will assist us in determining if you may be eligible for these programs.

Do you have Medicare Part A or Part B Yes _____ No _____

Are you: (1) single or married but not living with your spouse? _____ Go to A. below

or

(2) married and living with your spouse? _____ Go to B. below

A. Single or Not Living with Spouse

“Income includes Social Security benefits such as retirement, disability, or SSI; any pensions; earned wages; interest; dividends; monthly cash gifts; and contributions.”

Is your monthly income before any deductions less than \$1276.25 per month? Yes _____ No _____

“Resources are things such as cash on hand, bank accounts such checking, savings, certificates of deposit, IRAs, Christmas Clubs, and trusts; as well as stocks, bonds, the cash value of life insurance policies; and property that does not adjoin your home. Your home and adjoining property, vehicles, burial plots, household furnishings, and personal items such as jewelry are not counted as resources.”

Do you have less than \$11,710 in resources? Yes _____ No _____

B. Married and Living with Spouse

“Income includes Social Security benefits such as retirement, disability, or SSI; any pensions; earned wages; interest; dividends; monthly cash gifts; and contributions.”

Is your combined monthly income before any deductions less than \$1711.25 per month? Yes _____ No _____

“Resources are things such as cash on hand, bank accounts such checking, savings, certificates of deposit, IRAs, Christmas Clubs, and trusts; as well as stocks, bonds, the cash value of life insurance policies; and property that does not adjoin your home. Your home and adjoining property, vehicles, burial plots, household furnishings, and personal items such as jewelry are not counted as resources.”

Do you and your spouse have less than \$23,410 in resources? Yes _____ No _____

“Based on this screening, it appears that you (choose one) may / may not be eligible for Extra Help with your Medicare Part D costs. You may apply for Extra Help directly at the Social Security Administration office or by calling 1-800-772-1214. You may apply even if it appears that you may not be eligible. Your income and resources can be verified by the Social Security Administration.”

“If your income is less than \$1,149 for one person or \$1,541 for a couple and your resources are less than \$4,000 for one person or \$6,000 for a couple, you may want to apply for Medicaid. If you are found eligible, Medicaid will cover some or all of your Medicare expenses, and you will automatically be eligible for Extra Help with your Medicare Part D costs .”

Screening Worksheet for Help with Medicare Costs

- I. Do you have Medicare Part A or Part B Yes _____ No _____

- II. Marital status:
 Is person single? Yes _____ No _____
 Or married and living with spouse? Yes _____ No _____
 (Count income and resources of a couple who are married and living together).

- III. Income:
 a. Total monthly earned income: _____
 b. Minus \$65 and ½ : _____ = countable earned
 c. Total monthly unearned income _____
 d. Minus \$20 _____ = countable unearned

 Total countable income (add lines b. and d.): _____

- IV. Total countable resources: _____

- V. Dependents: Does the individual/couple live with any relatives for whom he/she provides at least 1/2 of their financial support? Yes _____ How Many? _____ No _____

- VI. Screen:

Countable Limits	MSP Eligible		Extra Help Eligible			
	1	2	1	2	3	4
Income	\$1,149	\$1,541	< \$1,276.25	< \$1,711.25	< \$2,146.25	< \$2,581.25
Resources	\$4,000	\$6,000	\$10,210	\$20,410 (C)	\$10,210 (S) \$20,410 (C)	\$10,210 (S) \$20,410 (C)

S = Single C = Married Couple

If income is less than or equal to 135% and resources do not exceed MSP limits, the individual may be eligible for Medicaid. A Medicaid application must be completed and all information must be verified.

If income is greater than 135% and/or resources do not exceed the Extra Help limits, offer to assist the individual with applying for Extra Help from the Social Security Administration.

EXTRA HELP INCOME LIMITS ALL LOCALITIES EFFECTIVE 1/24/07 MONTHLY GUIDELINES					
FAMILY SIZE	PERCENT OF FEDERAL POVERTY LEVEL (FPL)				
	100%	135%	140%	145%	150%
1	<i>\$850.83</i>	<i>\$1,148.63</i>	<i>\$1,191.17</i>	<i>\$1,233.71</i>	<i>\$1,276.25</i>
2	<i>1,140.83</i>	<i>1,540.13</i>	<i>1,597.17</i>	<i>1,654.21</i>	<i>1,711.25</i>
3	<i>1,430.83</i>	<i>1,931.63</i>	<i>2,003.17</i>	<i>2,074.71</i>	<i>2,146.25</i>
4	<i>1,720.83</i>	<i>2,323.13</i>	<i>2,409.17</i>	<i>2,495.21</i>	<i>2,581.25</i>
5	<i>2,010.83</i>	<i>2,714.63</i>	<i>2,815.17</i>	<i>2,915.71</i>	<i>3,016.25</i>
6	<i>2,300.83</i>	<i>3,106.13</i>	<i>3,221.17</i>	<i>3,336.21</i>	<i>3,451.25</i>
7	<i>2,590.83</i>	<i>3,497.63</i>	<i>3,627.17</i>	<i>3,756.71</i>	<i>3,886.25</i>
8	<i>2,880.83</i>	<i>3,889.13</i>	<i>4,033.17</i>	<i>4,177.21</i>	<i>4,321.25</i>

For family units of more than 8 members, contact a Medical Assistance Program *Consultant*.

MAXIMUM VALUE OF CONTRIBUTED FOOD AND SHELTER

SINGLE/COUPLE	MONTHLY AMOUNT
SINGLE	<i>\$207.67</i>
COUPLE	<i>311.33</i>

CALCULATION TABLES

Subsidy Calculation for One Person

Countable Resources in \$	<135% FPL	> 135% to <140% FPL	> 140% to < 145% FPL	> 145% to < 150% FPL	≥ 150%
< \$6,120	A	C	D	E	F
> \$6,120 to < \$10,210	B	C	D	E	F
> \$10,210	F	F	F	F	F

Subsidy Calculation for a Couple

Countable Resources in \$	< 135% FPL	> 135% to < 140% FPL	> 140% to < 145% FPL	> 145% to < 150%	≥ 150%
< \$9,190	A	C	D	E	F
> \$9,190 to < \$20,410	B	C	D	E	F
> \$20,410	F	F	F	F	F

Subsidy Benefits

Subsidy	Subsidized Monthly Premium	Yearly Deductible	Pre- Catastrophic Co-pay per Prescription	Coverage Gap? Y/N	Catastrophic Co-pay per Prescription
A	100%	\$0	\$2.15/\$5.35	N	\$0
B	100%	\$53	15%	N	\$2.15/\$5.35
C	75%	\$53	15%	N	\$2.15/\$5.35
D	50%	\$53	15%	N	\$2.15/\$5.35
E	25%	\$53	15%	N	\$2.15/\$5.35
F (No subsidy)	0%	\$265	25%	Y	@5%

Commonwealth Of Virginia
Department Of Social Services

County/City:	Case Number:
Case Name:	

**NOTICE OF DENIAL ON YOUR APPLICATION FOR
EXTRA HELP WITH MEDICARE PART D COSTS**

[Last Name, First Name, Middle Initial]
[Address]
[City, State, Zip Code]

Your application for Extra Help with your Medicare prescription drug plan (Medicare Part D) costs dated _____ has been denied. The information below explains the reason(s) for the denial and how we determined you are not eligible for Extra Help.

Why Your Application Was Denied

Your application for Extra Help was denied for the following reason(s): Policy Citation: _____

You are not Medicare-eligible.

You did not complete the application process.

Your income *equals or exceeds* 150% (percent) of the Federal Poverty Guideline for your household size. This is the income limit for Extra Help established by law.

Your resources exceed the limit of \$ _____ established by law for your income level and household size.

You are not a resident of Virginia.

You are incarcerated.

Information Used To Determine Your Eligibility

We used the following information you reported on your application for Extra Help to determine your eligibility:

Countable income of \$ _____ per month;

Countable resources of \$ _____;

Household size of _____ person/people. To determine your household size, we count you, your spouse who lives with you, and any relative who lives with you and receives one-half of his or her support from you or your spouse.

To determine your eligibility, we compared your countable income and resources to the limits adopted by law for your household size. We also used your information about where you live and whether you have Medicare to verify whether you meet the Virginia residency requirement and Medicare eligibility requirement for Extra Help.

About Medicare Prescription Drug Coverage

If you are not already enrolled in a Medicare-approved prescription drug plan, you may still enroll in one if you have Medicare Part B or are eligible for Medicare Part A. You will receive more information from Medicare about how to choose a prescription drug plan. You may also visit www.medicare.gov or call toll-free 1-800-MEDICARE (1-800-633-4227) for more information. If you are hearing impaired, you may call the Medicare TTY number toll-free at 1-877-486-2048.

Your application was processed by:

Date Mailed	Worker's Name	Title	Worker's Phone Number

If You Disagree With This Decision

It is YOUR RIGHT TO APPEAL decisions of the local social services agency. **You have 30 days to ask for an appeal.** The 30 days start the day after you receive this letter. You must have a good reason for waiting more than 30 days. If you want more information or help with an appeal, you may contact the local social services agency. It will not cost you anything to request a fair hearing, and you will not be penalized for asking for a fair hearing. If you desire free legal advice, you may contact your local legal aid office.

A fair hearing provides you the opportunity to review the way a local social services agency has handled your situation concerning your stated need for Extra Help. The fair hearing is a private, informal meeting at the local social services agency with you and anyone you wish to bring as a witness or to help you tell your story, such as a lawyer. The person who conducts the hearing is someone from the Department of Medical Assistance Services, not someone from your local social services agency. The hearing officer makes a decision on your appeal.

To request an appeal, please send written notification of the action you disagree with within 30 days of receipt of the agency's notice about the action. You or your authorized representative may write a letter or complete an Appeal Request Form. Forms are available on the internet at www.dmas.virginia.gov, at your department of social services, or by calling (804) 371-8488. It would be helpful to include a copy of the notice or letter about the action you are appealing. Please be sure to sign the request and mail it to:

Appeals Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Appeal requests may also be faxed to: (804) 371-8491.

You will be notified of the date and time for your hearing at the local social services agency or at a location agreeable to you and the agency. If you cannot be there on that day, call the hearing officer immediately. You may bring a representative and/or witnesses to the hearing to help you tell your story. Your eligibility worker, a local agency supervisor, and possibly other agency staff who know about your case may also be at the hearing to tell how the agency's decision was reached.

At the hearing, you and/or your representative will be given the opportunity to:

- (1) examine all documents and records, which are used at the hearing;
- (2) present your case or have it presented by a lawyer or by another authorized representative;
- (3) bring witnesses;
- (4) establish pertinent facts and advance arguments; and
- (5) question or refute any testimony or evidence, including the opportunity to confront and cross-examine adverse witnesses.

The decision or recommendation of the hearing officer shall be based exclusively on testimony and evidence provided before and during the hearing, except when medical information is requested or other essential information is needed. In such an event, you and the local social services agency would be given the opportunity to question or refute this additional information.

You will be notified in writing of the hearing officer's decision on your appeal within 90 days of the date your appeal request is received by the Department of Medical Assistance Services.

Virginia DSS, Volume XIII

M20, Appendix 7

Commonwealth Of Virginia
Department Of Social Services

Form with fields: County/City, Case Number, Case Name

NOTICE OF TERMINATION OF YOUR EXTRA HELP WITH MEDICARE PART D COSTS

[Last Name, First Name, Middle Initial]
[Address]
[City, Virginia, Zip Code]

Your Extra Help with your Medicare prescription drug plan (Medicare Part D) costs will be terminated effective ... The information below explains the reason(s) for the termination and how we determined that you are no longer eligible for Extra Help.

Why Your Extra Help Was Terminated

Your application for Extra Help was terminated for the following reason(s): Policy Citation:

- You are not Medicare-eligible.
You did not complete the redetermination process.
Your income equals or exceeds 150% (percent) of the Federal Poverty Guideline for your household size.
Your resources exceed the limit of \$...
You are no longer a resident of Virginia.
You are incarcerated.

Information Used To Determine You Are No Longer Eligible

We used the following information you reported to your local department of social services to determine that you are no longer eligible for Extra Help:

Countable income of \$... per month;
Countable resources of \$...;
Household size of ... person/people. To determine your household size, we count you, your spouse who lives with you, and any relative who lives with you and receives one-half of his or her support from you or your spouse.

To determine your continued eligibility, we compared your countable income and resources to the limits adopted by law for your household size. We also used your information about where you live and whether you have Medicare to verify whether you meet the Virginia residency requirement and Medicare eligibility requirement for Extra Help.

About Your Medicare Prescription Drug Coverage

Even though your Extra Help has been terminated, you will still have prescription drug coverage under your prescription drug plan if you have Medicare Part B or are eligible for Medicare Part A. If you have moved out of Virginia, you may need to choose a new prescription drug plan in your area. To find out how the termination of your Extra Help will affect you, please contact your prescription drug plan provider. You may also visit www.medicare.gov or call toll-free 1-800-MEDICARE (1-800-633-4227) for more information. If you are hearing impaired, you may call the Medicare TTY number toll-free at 1-877-486-2048.

The decision on the termination of your Extra Help was made by:

Date Mailed Worker's Name Title Worker's Phone Number

If You Disagree With This Decision

It is YOUR RIGHT TO APPEAL decisions of the local social services agency. **You have 30 days to ask for an appeal.** The 30 days start the day after you receive this letter. You must have a good reason for waiting more than 30 days. If you want more information or help with an appeal, you may contact the local social services agency. It will not cost you anything to request a fair hearing, and you will not be penalized for asking for a fair hearing. If you desire free legal advice, you may contact your local legal aid office.

A fair hearing provides you the opportunity to review the way a local social services agency has handled your situation concerning your stated need for Extra Help. The fair hearing is a private, informal meeting at the local social services agency with you and anyone you wish to bring as a witness or to help you tell your story, such as a lawyer. The person who conducts the hearing is someone from the Department of Medical Assistance Services, not someone from your local social services agency. The hearing officer makes a decision on your appeal.

To request an appeal, please send written notification of the action you disagree with within 30 days of receipt of the agency's notice about the action. You or your authorized representative may write a letter or complete an Appeal Request Form. Forms are available on the internet at www.dmas.virginia.gov, at your department of social services, or by calling (804) 371-8488. It would be helpful to include a copy of the notice or letter about the action you are appealing. Please be sure to sign the request and mail it to:

Appeals Division
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You will be notified of the date and time for your hearing at the local social services agency or at a location agreeable to you and the agency. If you cannot be there on that day, call the hearing officer immediately. You may bring a representative and/or witnesses to the hearing to help you tell your story. Your eligibility worker, a local agency supervisor, and possibly other agency staff who know about your case may also be at the hearing to tell how the agency's decision was reached.

At the hearing, you and/or your representative will be given the opportunity to:

- (1) examine all documents and records, which are used at the hearing;
- (2) present your case or have it presented by a lawyer or by another authorized representative;
- (3) bring witnesses;
- (4) establish pertinent facts and advance arguments; and
- (5) question or refute any testimony or evidence, including the opportunity to confront and cross-examine adverse witnesses.

The decision or recommendation of the hearing officer shall be based exclusively on testimony and evidence provided before and during the hearing, except when medical information is requested or other essential information is needed. In such an event, you and the local social services agency would be given the opportunity to question or refute this additional information.

You will be notified in writing of the hearing officer's decision on your appeal within 90 days of the date your appeal request is received by the Department of Medical Assistance Services.

<p align="center">FAMILY ACCESS TO MEDICAL INSURANCE SECURITY PLAN (FAMIS) INCOME LIMITS ALL LOCALITIES EFFECTIVE 1/24/07</p>				
<p align="center"># of Persons in FAMIS Assistance Unit</p>	<p align="center">FAMIS 150% FPL</p>		<p align="center">FAMIS 200% FPL</p>	
	<p align="center">Annual Limit</p>	<p align="center">Monthly Limit</p>	<p align="center">Annual Limit</p>	<p align="center">Monthly Limit</p>
1	\$15,315	\$1,277	\$20,420	\$1,702
2	20,535	1,712	27,380	2,282
3	25,755	2,147	34,340	2,862
4	30,975	2,582	41,300	3,442
5	36,195	3,017	48,260	4,022
6	41,415	3,452	55,220	4,602
7	46,635	3,887	62,180	5,182
8	51,855	4,322	69,140	5,762
each add'l person add	5,220	435	6,960	580

M2200.000 FAMIS MOMS

M2210.100 FAMIS MOMS GENERAL INFORMATION

A. Introduction

The 2005 Appropriations Act directed the Department of Medical Assistance Services (DMAS) to amend the Family Access to Medical Insurance Security Plan (FAMIS) and expand medical coverage to uninsured pregnant women who are ineligible for Medicaid and have income in excess of the Medicaid limits, but whose family income is less than or equal to 185% of the federal poverty level (FPL). An eligible woman will receive coverage through her pregnancy and 60 days following the end of the pregnancy.

FAMIS MOMS is not an entitlement program, which means that if funds for this program are exhausted, no additional individuals will receive benefits under the program. The DMAS will notify the Department of Social Services (DSS) Central Office if funds for this program run out.

Initial eligibility for FAMIS MOMS is determined by local departments of social services (LDSS), including LDSS outstationed sites, or by the FAMIS Central Processing Unit (CPU). Pregnant women found eligible for FAMIS MOMS receive the same benefits as Medicaid pregnant women.

Eligible women are enrolled for benefits effective the first day of the application month if all eligibility requirements are met in that month. There is no retroactive coverage in FAMIS MOMS. Case management and ongoing case maintenance, and selections for managed care, are handled by the FAMIS CPU.

B. Policy Principles

FAMIS MOMS covers uninsured low-income pregnant women who are not eligible for Medicaid due to excess income, and whose countable income is less than or equal to 185% of the FPL.

A pregnant woman is eligible for FAMIS MOMS if all of the following are met:

- she is not eligible for Medicaid and has income in excess of the Medicaid limits;
- she is a resident of Virginia;
- she is uninsured;
- she is **not** a member of a family eligible for health benefits coverage under the State Employee Health Insurance Plan on the basis of a family member's employment with a State agency (see Appendix 3 to Chapter M21 for a list of state agencies);
- she is not an inmate of a public institution;

- she is **not** an inpatient in an institution for mental diseases; and
- she has countable family income less than or equal to 185% FPL.

M2220.100 NONFINANCIAL ELIGIBILITY REQUIREMENTS

- A. Policy** The pregnant woman must meet, with certain exceptions, the Medicaid nonfinancial eligibility requirements in Chapter M02 and the nonfinancial eligibility requirements imposed by FAMIS.
- B. M02 Applicable Requirements** The Medicaid nonfinancial eligibility requirements in Chapter M02 that must be met are:
- Virginia residency requirements;
 - assignment of rights;
 - application for other benefits;
 - institutional status requirements regarding inmates of a public institution.
- C. FAMIS Nonfinancial Requirements** The FAMIS nonfinancial eligibility requirements are:
- 1. Citizenship & Alienage Requirements** FAMIS MOMS alienage requirements are the same as the FAMIS alienage requirements.
- a. Citizens and qualified aliens who entered the U.S. before August 22, 1996 meet the citizenship/alienage requirements.
 - b. The following qualified aliens who entered the U.S. on or after August 22, 1996 meet the alienage requirements **without any time limitations**:
 - refugees (see M0220.310 A. 2),
 - asylees (see M0220.310 A. 4),
 - veteran or active military (see M0220.311),
 - deportation withheld (see M0220.310 A. 6), and
 - victims of a severe form of trafficking (see M0220.313 A.52)
 - c. The following qualified aliens who entered the U.S. on or after August 22, 1996 meet the alienage requirements **after 5 years of residence in the United States**:
 - lawful permanent residents (LPRs),

- long-term care insurance;
- 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. A woman is considered to be insured if she is covered by a creditable health insurance plan, even if the policy or plan does not cover pregnancy-related services.

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 pregnant woman resides.

C. Policy

1. Must be Uninsured A nonfinancial requirement of FAMIS MOMS is that the pregnant woman be uninsured. A pregnant woman **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 chapter M21].

2. Prior Insurance Prior insurance coverage is not a factor as long as the pregnant woman is uninsured during the month for which FAMIS MOMS eligibility is being determined.

M2220.300 NO CHILD SUPPORT COOPERATION REQUIREMENTS

A. Policy There are no requirements for FAMIS MOMS applicants or recipients to cooperate in pursuing support from an absent parent.

M2230.100 FINANCIAL ELIGIBILITY

A. Financial Eligibility

1. **FAMIS MOMS Assistance Unit** The FAMIS MOMS assistance unit policy is the same as the Medicaid pregnant woman assistance unit policy. Use subchapter M0520, F&C Family/Budget Unit, to determine the pregnant woman's family unit for her financial eligibility determination. If ineligible in the family unit, determine her eligibility in the budget unit (if appropriate).
2. **Asset Transfer** Asset transfer rules do not apply to FAMIS MOMS.
3. **Resources** Resources are not evaluated for FAMIS MOMS.
4. **Income** The FAMIS MOMS income limit is 185% of the FPL (see Appendix 1 to this chapter) for the number of individuals in the FAMIS MOMS family unit, or budget unit (if applicable).

The source and amount of all income other than Workforce Investment Act and student income, must be verified and counted. FAMIS MOMS uses the same income types and methods for estimating income as in Medicaid Families & Children (F&C) policy (see chapter M07).

Medicaid F&C income disregards, other than the \$30 plus 1/3 earnings disregard in LIFC, apply when determining countable income for FAMIS MOMS (see chapter M07).

5. **No Spenddown** Spenddown does not apply to FAMIS MOMS. If countable income exceeds the FAMIS MOMS income limit, the pregnant woman is not eligible for the FAMIS MOMS program and she must be given the opportunity to have a medically needy (MN) Medicaid evaluation.

M2240.100 APPLICATION and CASE PROCEDURES

A. Application Requirements

The following forms are acceptable application forms for FAMIS MOMS:

- Health Insurance for Children and Pregnant Women application,
- Medicaid Application for Medically Indigent Pregnant Women
- Application for Benefits, and
- ADAPT Statement of Facts.

Applications can be mailed to the LDSS or the FAMIS Central Processing Unit (CPU). A face-to-face interview is not required.

The date of the application is the date the signed application is received at the LDSS, including DSS outstationed sites, or at the FAMIS CPU.

FAMIS MOMS INCOME LIMITS ALL LOCALITIES EFFECTIVE 7/01/2007		
# of Persons in FAMIS MOMS Assistance Unit	FAMIS MOMS 185% FPL	
	Annual Limit	Monthly Limit
1	\$18,889	\$1,575
2	25,327	2,111
3	31,765	2,648
4	38,203	3,184
5	44,641	3,721
6	51,079	4,257
7	57,517	4,794
8	63,955	5,330
Each additional, add	6,438	537